As of May 12, 2015, this decision is no longer considered by WCAT to be noteworthy.

WCAT Decision Number: WCAT-2005-03022
WCAT Decision Date: June 10, 2005
Panel: Anthony F. Stevens, Vice Chair

Introduction

The worker appeals two decisions that were issued by the Review Division of the Workers' Compensation Board (Board) on July 23, 2004 (*Review Reference #14102*) and August 31, 2004 (*Review Reference #17108*). Those decisions were in relation to the worker's 2001 claim, which the Board established for asbestos-related pericardial disease and asbestos-related bilateral pleural disease. However, those decisions were specific to entitlement associated with the worker's bilateral pleural disease.

The review officer who issued the July 23, 2004 decision confirmed the Board's previous February 17, 2004 decision. The claims adjudicator who undertook the February 17, 2004 decision accepted the worker's diagnosed bilateral pleural disease, but concluded that the worker's respiratory impairment associated with that condition commenced August 1, 2003. In confirming that decision, the review officer concluded that there was no evidence of permanent respiratory impairment associated with the worker's bilateral pleural disease until August 1, 2003.

The review officer who issued the August 31, 2004 decision confirmed the Board's April 27, 2004 decision to grant the worker a 20% of total permanent disability award, effective August 1, 2003 and based on the previous long-term rate of compensation established on this claim ($842.44 net per week). In so doing, the review officer concluded that the current provisions applied, as the first evidence of permanent disability occurred on or after the June 30, 2002 transition date (see section 35.1 of the *Workers Compensation Amendment Act*, 2002), with the exception of the average earnings used and there being no deduction of the worker's Canada Pension Plan disability pension benefits, given this was the first pension on his claim. The review officer also concluded that the worker was not entitled to a loss of earnings assessment under section 23(3) of the *Workers Compensation Act* (Act). In particular, the review officer concluded that the medical evidence supported a conclusion that the worker was not precluded from resuming his pre-injury employment, and further, a previous WCAT panel (see *WCAT Decision #2004-04302*) had indicated that the worker had not returned to gainful employment due to his non-compensable health problems.

These appeals were considered by way of an oral hearing convened on May 10, 2005, at which time the worker provided direct evidence and was represented by a lawyer. The employer participated in the worker's appeals by telephone conference.

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Issue(s)

The worker's representative raised the following issues in the worker's appeals:

1. Whether the worker is entitled to temporary disability benefits for his bilateral pleural disease.

2. Whether the worker's permanent disability associated with his bilateral pleural disease commenced before June 30, 2002 such that the former provisions apply, or subsequent to that date such that the current provisions apply.

3. Whether the worker's 20% of total functional disability award appropriately reflected the degree of functional permanent disability entitlement associated with his bilateral pleural disease.

4. If the former provisions apply, whether the worker is entitled to a loss of earnings award under section 23(3) of the Act. And, if the current provisions apply, whether the combined effect of the worker's occupation and the disability resulting from his compensable condition is so exceptional that the functional pension amount does not appropriately compensate him (see section 23(3) and (3.1) of the Act), such that a loss of earnings assessment under section 23 of the Act is indicated.

Jurisdiction

These appeals were filed with WCAT under section 239(1) of the Act, which allows for appeals from Review Division decisions to WCAT, subject to exceptions set out in section 239(2) of the Act. Section 239(2) of the Act provides that a review officer's decision may not be appealed to WCAT where the decision relates to the application under section 23(1) of rating schedules compiled under section 23(2), where the specified percentage of impairment has no range or has a range that does not exceed 5%. In the worker's claim, his functional award was not referenced to the Board's Permanent Disability Evaluation Schedule, and thus I conclude that I have jurisdiction to consider the matter of the sufficiency of his functional pension award.

Under section 250 of the Act, WCAT may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent. It must make its decision based on the merits and justice of the case, but in so doing it must apply policies of the board of directors of the Board that apply to the case, except in circumstances as outlined in section 251 of the Act. Section 254 of the Act provides that WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal.

Background and Evidence

The worker completed his application for compensation on April 12, 2002 to contend that he had complaints due to previous occupational exposure to asbestos that arose in his employment with a railway. The employer wrote the Board on April 22, 2002 to note that the worker had been on early retirement bridging since March 12, 2001.

The Board requested the worker's previous treatment records. Those records included reports from lung x-rays taken in October 2000 that revealed the presence of bilateral pleural effusions.

Also, a March 20, 2001 consultation report from Dr. Kryski included information that the worker had recently been put on long-term disability benefits, due to his optic neuritis and associated blindness in his right eye. Dr. Kryski assessed the worker in relation to a chronic cough that he indicated he had experienced since an episode of pneumonia in May 2000. According to that report, the worker indicated that he had noticed some shortness of breath with activity. Following assessment, Dr. Kryski concluded that the worker had clinical evidence of constrictive pericardial disease.

A chest CT scan of July 13, 2001 revealed constrictive pericarditis, but the lung parenchyma was clear and there was no evidence of pleural fluid. That report noted that the combination of thickened pericardium and the presence of a large amount of ascites in the worker's upper abdomen was very suggestive of constrictive pathology.

X-rays of December 10, 2001 indicated that there was no evidence of congestive failure, or evidence of significant pulmonary edema.

The worker had surgery on December 10, 2001, in the form of a pericardiectomy for his diagnosed restrictive pericarditis. Histopathology of four pieces of the worker's pericardium demonstrated fibrous plaque that was considered to be histologically identical to the fibrous pleural plaques that are associated with asbestos exposure. Medical documents on file also suggested there was a possible relationship between the development of restrictive pericarditis and previous asbestos exposure.

The surgeon, Dr. Bayes, completed a report on December 14, 2001 to indicate that the worker was much better symptomatically after the pericardial stripping procedure that had been performed. On February 12, 2002 Dr. Bayes reported that the worker had symptomatically markedly improved.

Dr. Kryski outlined in a consultation report of February 12, 2002 that the worker had obtained "dramatic improvement" and had done "remarkably well, and no longer had chest pains or shortness of breath." Dr. Kryski concluded, following assessment on that date, that the worker could return to normal activities with no restrictions being placed on him.

A respirologist, Dr. Robertson, indicated in his April 9, 2002 consultation report that the pleural effusions that were seen on previous x-rays were likely asbestos-related. He also noted that pulmonary function testing that he performed revealed no evidence of airflow obstruction, and the worker's diffusion was preserved. Given the worker's known previous asbestos exposure, Dr. Robertson recommended that pulmonary function testing and x-rays be performed once each year.

In a follow-up report of April 23, 2002 Dr. Robertson noted that recent x-rays and a CT scan did not reveal any obvious pleural involvement, fluid, or scarring.

A Board internal medicine consultant reviewed the worker's file and concluded that the CT scan and x-rays of the worker's chest did not provide evidence of asbestos-related pleural disease or pulmonary parenchymal disease. The internal medicine consultant also indicated that there was accordingly no evidence of respiratory impairment that could be attributable to the worker's previous asbestos exposure, and further, he had responded to surgical intervention for his constrictive pericarditis such that no cardiac impairment existed either.

Dr. Kryski reassessed the worker on November 26, 2002 and documented the worker's information that he felt great, apart from a transient pain under his left arm pit. On examination, the worker's lungs were clear to auscultation and percussion.

On November 27, 2002 Dr. Robertson reported that the worker was not clubbed or cyanotic, he felt quite well from a pulmonary standpoint, and he had no shortness of breath. Dr. Robertson also outlined that repeat pulmonary function testing revealed a borderline mild restrictive pattern, no airflow obstruction, and diffusion that was within normal limits.

X-rays of November 28, 2002 established that there had been moderate pleural change in the left lung base and moderate lung scarring that had occurred since October 18, 2000. The radiologist outlined that it was uncertain whether the pleural change represented a pleural effusion or pleural thickening.

The Board's internal medicine consultant completed a claim log entry on February 19, 2003 to provide the opinion that the worker's pericardial disease was due to his asbestos exposure. The internal medicine consultant also concluded that the worker had been disabled from his surgery from December 10, 2001 to February 12, 2002, and he was clinically well thereafter with no medical restrictions or evidence of permanent disablement associated with that particular condition.

Dr. Kryski's March 4, 2003 report noted that following the worker's November 2002 annual post-pericardial stripping assessment he stopped using Prednisone, and had subsequently developed a small left pleural effusion. Respiratory examination did not

reveal any major abnormalities, and there was good air entry on both sides. Dr. Kryski indicated that a CT scan had confirmed the presence of a small to moderate-sized left pleural effusion, and mild left pleural thickening.

A claims adjudicator issued a March 6, 2003 decision to accept the worker's claim for asbestos-related pericardial disease and necessary surgery. The claims adjudicator provided the worker with wage loss benefits from December 10, 2001 to February 12, 2002, and concluded there was no evidence of permanent disablement arising from the worker's pericarditis or its treatment.

The employer took exception to the Board's decision to provide the worker with wage loss benefits. The employer sent an April 8, 2003 letter to the Board to argue that the worker had received early retirement bridging since March 12, 2001, such that there had been no loss of wages to which temporary wage loss benefits could be directed. The claims adjudicator responded on June 13, 2003 to indicate that the worker's medical illness began in or about October 2000, if not earlier, and that part of the reason the worker stopped working in early 2001 was his overall declining health, including that associated with his pericardial disease.

Dr. Kryski wrote the Board on April 8, 2003 to note that the worker had evidence of pericardial disease that dated back to October 2000. He also noted that the worker had shortness of breath dating back to October 2000, and that he showed signs of disability since at least that date. Dr. Kryski further indicated that the worker now had left pleural effusion that was causing some symptoms of shortness of breath.

The employer requested that the Board's Review Division review the March 6, 2003 decision to accept the worker's claim for asbestos-related pericardial disease; however, that decision was confirmed by a review officer on August 18, 2003. The worker also sought a review of the March 6, 2003 decision, and argued that he was entitled to wage loss prior to December 10, 2001, wage loss subsequent to February 12, 2002, and consideration of a permanent disability award. The outcome of that request for review will be discussed later.

Lung function studies of August 12, 2003 revealed a restrictive pattern with decreased diffusion that was worse than previous studies.

Dr. Robertson completed a consultation report on August 12, 2003 that included information to suggest that the worker had been feeling worse in the preceding few months, with a productive cough, intermittent left-sided chest pains, and shortness of breath with walking. Dr. Robertson concluded that the worker had a progression of his symptoms and pulmonary function findings.

The worker's attending physician, Dr. Starke, wrote a letter on November 4, 2003 to state that a review of his charts indicated that the worker's chest problems began on May 4, 2000, his lung problems continued to deteriorate, and on May 18, 2000 x-rays revealed the first evidence of pleural effusion. Dr. Starke believed that the worker was disabled from work from May 18, 2000 onwards, and partially disabled after February 12, 2002 following recovery from his surgery. Dr. Starke also noted that the worker's lung condition had subsequently deteriorated.

Also on file is a November 5, 2003 consultation report from Dr. McFadden. He noted the worker's information that for the previous few months he had experienced increasing shortness of breath, with associated left-sided chest pain and cough. The worker had also indicated that his shortness of breath limited him from going up more than one flight of stairs at any significant pace.

Dr. McFadden reported on December 17, 2003 that a left thorascopic pleural biopsy had revealed asbestos-related pleural changes, which were causing an effusion. He also predicted that those changes would likely develop into mesothelioma in time.

In a January 15, 2004 report Dr. McFadden suggested that the worker's pleural problem dated back to shortly after his heart surgery. He noted that there was a small pleural effusion identified, which had progressed in 2003 to be a complex, fairly large pleural effusion. Dr. McFadden also indicated that with the worker's shortness of breath, and the production of significant amounts of fluid, he was limited from working, and that "over the last little bit he would not have been able to work because of this problem." In a follow-up letter of March 10, 2004 Dr. McFadden advised the Board:

> …I should have been more exact in my terminology. Since the onset of [the worker's] original problem with respect to his pericardial disease, subsequent surgery, recovery time frame, coupled by his then progressive shortness of breath related to his lung problem, all of this would have prevented [the worker] from working during this time frame.

The worker was provided with notification on May 3, 2004 that his earlier application for Canada Pension Plan disability benefits had been accepted. The associated documentation indicates that the worker's application for those benefits was in relation to lung complaints, as well as for his pericarditis and optic neuritis. His attending physician provided certification on February 3, 2004 to indicate that the worker's pericarditis was stable, but the worker had permanent disability associated with the other two conditions.

In terms of the worker's earlier request for review, a review officer confirmed the March 6, 2003 decision in a further decision issued on September 11, 2003. The worker appealed the review officer's September 11, 2003 decision to WCAT, and a panel issued a decision on August 17, 2004 (*WCAT Decision #2004-04302*) to confirm

the decision that the worker was entitled to wage loss benefits from December 10, 2001 to February 12, 2002. That panel noted that in actuality the worker remained at work until March 12, 2001, and that he went off work at that time for his non-compensable neuritis. In terms of potential benefits beyond February 12, 2002 that panel said:

> …the evidence is that following his pericardial surgery the worker had a good recovery and, for a period of approximately six months, was virtually symptom free. Subsequent to that time the second problem caused by the pleural effusion developed and, while the worker maintained this condition has been present from the first, it did not develop into anything approaching disability until well after the December 10, 2001 surgery. The available evidence supports a good recovery from the surgery by February 12, 2002. Given the worker's good recovery following his pericardial surgery, the likelihood is that he did not return to gainful employment because of his non compensable health conditions. In these circumstances I find no entitlement to wage loss benefits beyond February 12, 2002….

The worker had by that time been provided with the July 23, 2004 Review Division decision that is a subject of the present appeals before me.

Subsequent to that decision Dr. Robertson provided the Board with a September 27, 2004 opinion to indicate:

> It is certainly true that his chest x-rays and CT scan in October 2000 showed pleural effusions. What is not commented on, however, is the fact that his lung function at that point in time did show a mild restrictive pattern, and that the patient was complaining of cough and shortness of breath on exertion. These symptoms dated from May 2000, as indicated in my October 16, 2000 consultation letter.
>
> While his symptoms did improve during 2002, as documented in my consultation letters, he persisted with a mild restrictive pattern on pulmonary function testing, as well as a pleural effusion on the left in both November and December 2002. I feel that the November 5, 2002 report that "there is no radiographical evidence of pleural or pulmonary parenchymal disease and therefore no respiratory impairment could be attributable to his asbestos exposure" made by your Board Internal Medicine Consultant, is thus not valid since he did have restrictive lung disease on pulmonary function testing, as well as a pleural effusion on chest x-ray, at that point in time.

> Certainly his symptoms did worsen in August 2003, as did his chest x-ray and pulmonary function findings. However, [the worker] has never felt his breathing was completely normal since May 2000. In my opinion, this was the start of his symptoms, and certainly radiographic evidence of pleural disease compatible with asbestos exposure was present in October 2000.

The Board had also by that time initiated consideration of the worker's permanent disability entitlement. The Board's internal medicine consultant completed a claim log entry on January 27, 2004 to indicate that taking into consideration all of the pulmonary function tests that had been performed since August 2003 the worker would be in Class 2, and warrant a 20% impairment rating, using the criteria of the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition. He also indicated that the first evidence of pulmonary impairment appeared in the August 2003 testing.

According to a March 30, 2004 memorandum on file, in relation to a team meeting at the Board, a Board vocational rehabilitation consultant noted that the worker's employment with his employer was as an assistant operations coordinator. That job was described as involving supervision of locomotive staff performing maintenance, inspection and repair of freight cars and locomotives. The worker dispatched the personnel, tracked schedules and maintenance, and also was responsible for quality control and safety on the job site. The worker also performed a training function. During that meeting, and with that description of the worker's employment in mind, the Board's internal medicine consultant concluded that there were no medical restrictions that would preclude the worker from performing such work.

The Board's internal medicine consultant also provided an opinion on April 6, 2004 to indicate that a person suffering from a 20% respiratory impairment would be capable of sedentary activities, but not any occupation that required physical activity. In particular, he concluded that climbing around freight cars and locomotives to perform inspections would not be an occupation that a person with that degree of impairment could perform.

In turn, the vocation rehabilitation consultant noted that the worker's duties also required him to determine whether repairs were necessary. The vocational rehabilitation consultant also noted that both the worker and his employer considered that he was no longer able to resume work with his previous employer. The vocation rehabilitation consultant said:

> I have considered alternate occupations that his transferable skills would allow him to do. He has supervisory skills, but is not able to work full-time. Most supervisors must be available full-time. I also considered occupations where he could do bench repairs or assembly. His vision

> may be a problem with most of these occupations, and in bench work relating to machinery and mechanical parts, he could easily be exposed to solvents, etc that could aggravate his condition.

The claims adjudicator adopted the 20% impairment rating figure, and also concluded that the worker was capable of returning to his pre-injury employment. In the result, the Board issued the April 27, 2004 pension decision. The Review Division subsequently confirmed that decision, by way of the August 31, 2004 decision that is also before me in these appeals.

At his oral appeal hearing the worker indicated that he started working for the employer when he was 16 years of age, and that was the only employment setting he has worked in. He said that he had been healthy until May 1999 when he suffered from neuritis in his right eye. The worker said that it was while trying to resume work after being off for that condition that he experienced his first lung difficulties, which he said his doctor related to pneumonia. Since that time, according to the worker, he has been involved in all sorts of medical assessments, particularly during the time when he went from 160 to 126 pounds in weight, leading up to his heart surgery.

The worker acknowledged that he took early retirement in March 2001. He confirmed that he had lost the sight in his right eye, but he also suggested that his doctor advised him that he would be able to work with one good eye. He also said that his lung function was worsening, as was the quality of his life as a result. The worker said that his employer was looking to reduce two positions and that due to his medical conditions he enquired about the opportunity to take early retirement, which was provided to him by his employer.

The worker's evidence was that even though he had difficulties associated with his right eye, he nevertheless also experienced shortness of breath and fluid in his lungs since May 2000. He said that following his heart surgery, and recovery from that procedure, his lung dysfunction remained and would in and of itself have precluded a return to his pre-injury employment. The worker indicated that his overall condition improved somewhat as a result of his heart surgery, but he remained unable to go for long walks.

In terms of his previous employment, the worker confirmed the information on file that he worked as a supervisor and did not actively undertake repairs on the train units. He said that he supervised 30 employees in a train shop, and that his duties included making sure the proper repairs were performed and that there were no safety violations in existence. The worker noted that he worked 12-hour shifts, and that to perform his work he had to walk around the train shop, in which there were 4 tracks. He said that each track held 3 or 4 cars, and that when the work was performed, such as changing wheels or couplers, he would observe the performance of such work. The worker also indicated that his work involved determining what repairs were necessary, and that

involved climbing around freight cars and locomotives. Moreover, he estimated that he would have walked between 10 to 15 miles each shift while on the shop floor performing his supervisory work.

The worker indicated that, contrary to the conclusion of the Board, he would not have been able to return to his pre-injury employment in 2003. Moreover, he suggested that he would not have been able to have resumed his employment subsequent to his heart surgery, with that inability being due to the lung dysfunction that he said he had in that earlier timeframe. On questioning as to the "dramatic improvement" noted in Dr. Kryski's February 12, 2002 consultation report, the worker suggested that Dr. Kryski misconstrued his statement that he felt better. The worker also suggested that contrary to the other information documented in that report he did experience continued shortness of breath at that time. He also suggested that Dr. Kryski was aware that he was having ongoing difficulties associated with his lungs, and that he was advised to be only as active as his condition would allow.

The worker also said that his condition has continually worsened with the passage of time. That said, he also suggested that his condition in 2003 was no different than it was in 2002 or 2001.

The worker indicated that he only has a grade 8 education, and he is currently 56 years of age. He said that he may be able to perform work for about 10 minutes or so, but he would have to rest as a result. In the worker's view, he is not suited for any form of employment.

The worker's representative submitted that the worker's asbestos-related bilateral pleural disease has been constant throughout his claim, and consistently caused the worker shortness of breath and fluid in his lungs. He noted that the worker was known to have pleural effusions in 2000, and although the removal of that fluid would provide temporary relief, the underlying disease would remain. The worker's representative submitted that the appropriate evaluation of the worker's lung condition would be to look at the overall picture rather than a snapshot in time; he said that there was only a short period in which the worker experienced improvement following his heart surgery. The worker's representative further submitted that although the worker felt improved compared to the acute difficulties he was experiencing before his heart surgery, that reported improvement would not establish that he had normal function, or an ability to resume his work. He noted that although the August 2003 lung function testing established lung dysfunction, that did not establish that there was no lung dysfunction pre-dating that testing. The worker's representative submitted that the worker had evidence of disability prior to the August 1, 2003 date used by the Board. In turn, he argued that the worker had disability that pre-dated the June 30, 2002 transition date, such that the worker's pension ought to be considered with regard to the former provisions. The worker's representative also argued that the worker is not able to return to any form of employment, such that he is entitled to a loss of earnings pension.

He submitted that the worker is not able to do physical activities, he has no particular transferable skills, and even though he managed people in his pre-injury employment that would not be transferable to other fields of employment.

There was no argument in relation to the average earnings used to determine the worker's pension award. The worker's representative did attempt to argue the 20% functional pension award through the worker's evidence pertaining to his complaints, although I noted that the pension assessment was based on expert opinion as to the level of residual disability. The worker's representative also submitted that the previous WCAT appeal was particular to the worker's pericardial disease, and that there was no specific binding conclusion within that decision associated with the worker's bilateral pleural disease.

The employer's representative held a differing view, and submitted that the previous WCAT panel concluded that the worker had not returned to his pre-injury employment due to a non-compensable condition. In the employer's submission the worker did not sustain any requisite time loss from work due to his pleural disease on which to extend wage loss benefits; she submitted that he had retired from his employment as a result of his loss of vision in his right eye, such that there was no impairment of earnings resulting from his pleural disease. The employer's representative also supported the review officer's conclusion that the work injury did not make it impossible for the worker to resume his pre-injury employment. She submitted that the worker is entitled to a functional pension award, but not a loss of earnings award.

Findings and Reasons

The employer's argument that there was no impairment of earnings associated with the worker's bilateral pleural disease requires consideration. In particular, section 6(1) of the Act requires there to be disablement from earning full wages at the work at which the worker was employed, otherwise only health care benefits are payable.

In considering that specific matter it is evident that the worker has been diagnosed as having two medical conditions, being asbestos-related pericarditis and asbestos-related bilateral pleural disease. The consideration required by section 6(1) of the Act as noted above is in relation to the occupational disease accepted under a claim. As such, it could be argued that each of the worker's diagnosed asbestos-related conditions is a distinct occupational disease requiring separate consideration under section 6(1) of the Act. However, that has not been the manner in which the Board has adjudicated the worker's claim, having at all times completed adjudication in relation to both diagnosed conditions under one claim, on the basis that the worker's overall medical condition was the result of asbestos-related disease. I see no particular error in that approach, and note that both conditions have arisen consequential to the worker's occupational

exposure to asbestos. I also note that the worker has at all relevant times had findings associated with both conditions, although the timing and degree to which each caused disability varied.

I further note that the Board previously considered the employer's argument that there was no impairment of earnings in existence, given the worker took retirement bridging in March 2001. The Board did not accept that argument, and instead concluded that the worker's cessation of employment was also on the basis of his compensable disease that arose due to his occupational exposure to asbestos. It was on that basis that the Board previously provided the worker with wage loss benefits under this claim between December 10, 2001 and February 12, 2002, subsequent to the commencement of his retirement bridging.

Assistance concerning what is meant by "disabled from earning full wages at the work" is found at item #26.30 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) which provides, in part, as follows:

> No compensation other than health care benefits are payable to a worker who suffers from an occupational disease (with the exception of silicosis, asbestosis, or pneumoconiosis and claims for hearing loss to which section 7 of the *Act* apply) unless the worker "is thereby disabled from earning full wages at the work at which the worker was employed"…

In the case before me, the worker has asbestos-related bilateral pleural disease, but has not been diagnosed as having either asbestosis or pneumoconiosis. As such, the question of whether the threshold economic test of there being disablement from earning full wages at the work at which he was employed remains an essential question that must be addressed. The economic test found in section 6(1) of the Act is discussed in depth in *Appeal Division Decision #96-0727* (12 W.C.R. 291). I accept the panel's analysis, at page 208, that once a worker has demonstrated entitlement to compensation for an occupational disease under section 6(1) of the Act, there is no requirement in the Act, or anywhere else, for the worker to go back through section 6(1) of the Act in order to obtain a pension under that claim, for example.

As such, although I have concluded that the disability arising from the worker's asbestos-related bilateral pleural disease arose August 1, 2003, I nevertheless accept that he continued to satisfy the requirements of section 6(1) of the Act at that time because the Board had previously accepted responsibility for a period of disability from earning full wages under the claim.

Another argument before me is that the worker suffered from disability as a consequence of his asbestos-related bilateral pleural disease since May or October 2000. I am unable to agree with that argument both from an evidentiary perspective, as well as from a technical standpoint.

Turning first to the technical aspect, I conclude that the previous WCAT panel undertook a specific decision in relation to whether the worker's bilateral pleural effusions caused disability. That panel considered that matter, and concluded that although the worker had maintained that such disability existed, that condition did not develop into anything approaching disability until well after the December 10, 2001 surgery. Pursuant to section 255 of the Act a WCAT decision is final, subject only to reconsideration under section 256 of the Act, being a function that I am not empowered to undertake. As such, I am obliged to recognize the previous WCAT decision. As a result, I cannot undertake a contrary finding to establish disability related to the worker's bilateral pleural disease for that initial period, ending in a rather undefined period some time well after the December 10, 2001 surgery.

Also, it is appropriate to note that the medical evidence most assuredly establishes that the worker had bilateral plural effusions present in an October 2000 x-ray. There was, however, no opinion at the time to establish that the worker had disability associated with that particular finding, or that he had ongoing lung dysfunction thereafter of any significance until much later. In fact, it was through further investigation through a CT scan on July 13, 2001 that no pleural fluid was observed, and the existence of a thickened pericardium became known. There certainly was documented shortness of breath, but the investigations indicated that the worker suffered from the restrictive heart disease of pericarditis, which was treated surgically on December 10, 2001, and as a result his shortness of breath could reasonably be explained on the basis of that disease. I also observe that the February 12, 2002 medical report following recovery from that surgery documents that the worker no longer suffered from shortness of breath, and that he could return to normal activities without restrictions. It is also relevant to note that according to respirologist Dr. Robertson in his April 9, 2002 consultation report, lung function testing revealed no evidence at that time of airflow obstruction, and established that the worker's diffusion was normal. With that type of medical information being documented following the worker's recovery from his heart surgery, I have great difficulty accepting his current assertion that he suffered from significant lung dysfunction in that earlier timeframe.

On my review of the medical evidence it is apparent that the worker suffered from a gradual deterioration in lung function following the heart surgery. Dr. Robertson noted in his April 23, 2002 report that x-rays did not reveal any obvious pleural involvement, fluid or scarring. Dr. Kryski reported on November 26, 2002 that the worker's lungs were clear and that his only complaint was of transient pain under his left arm pit. On November 27, 2002 Dr. Robertson reported that according to the worker he had no shortness of breath at that time. However, he also noted that repeat pulmonary function testing revealed a borderline restrictive pattern, which I conclude would be a deterioration from the results noted in April 2002. That too is reflected in the November 28, 2002 x-rays, which at that time once again revealed findings consistent with pleural effusion. Moreover, the worker's information to a number of the doctors who examined him subsequently, as recorded in the reports completed

contemporaneous to those assessments, was that he began to experience shortness of breath in the months prior to the August 2003 lung function studies. Those studies revealed a restrictive pattern with decreased diffusion, and it was with reference to those results that the Board concluded that was the first evidence to confirm the presence of disability associated with the worker's asbestos-related bilateral pleural disease.

The issue respecting the date the worker's bilateral pleural disease became a disability is not resolved by when that particular condition was first detected; the issue is when that condition first became sufficiently significant as to be classified as a disability. I conclude that the medical documents on file, both in terms of the medical findings documented and the patient information provided by the worker, serve to confirm the Board's decision that the first evidence of disability associated with the worker's lung dysfunction was August 1, 2003.

In terms of the issues before me, I conclude that the worker is not entitled to temporary disability benefits for his bilateral pleural disease. The evidence in this case supports a conclusion that the worker's condition developed into a permanent disability, without the existence of a preceding temporary disability.

Also, and because I have concluded that the worker's disability associated with his bilateral pleural disease commenced August 1, 2003, or subsequent to the June 30, 2002 transition date, it follows that the current provisions apply. I accept that the worker likely had bilateral pleural disease from the outset, but also accept that the first evidence establishing permanent disability was the lung function studies in August 2003. However, as established by the transition provisions of the Act, at section 35.1(4) and (5), the current provisions apply except in relation to section 23(3)(d)(i), and average earnings being 75% of gross rather than 90% of net.

I accept the expert opinion of the Board's internal medicine consultant, and conclude that the worker's permanent disability, effective August 1, 2003, was 20% of total. Considering my conclusion respecting the date the worker's permanent disability commenced, it follows that I confirm that aspect of the Board's decision relating to the effective date of the pension award. I also find no reason to disturb the Board's pension decision related to the average earnings used to calculate the worker's pension award.

Turning next to the loss of earnings issue, it is appropriate to detail the current provisions of the Act, together with the Board's policy on that aspect of potential pension entitlement.

Sections 23(3), (3.1) and (3.2) of the Act provide that a worker is only entitled to a loss of earnings pension if the Board determines (see (3.1)) that the combined effect of the worker's occupation at the time of the injury, and the worker's disability resulting from

the injury is so exceptional that an amount determined under section 23(1) does not appropriately compensate the worker for the injury. In undertaking that consideration, the Board must also consider (see (3.2)) the ability of the worker to continue in the pre-injury employment, or to adapt to another suitable occupation.

In contrast, section 23(1) of the Act provides for a functional pension award that is estimated based on the nature and degree of the injury. As noted in item #38.00 of the RSCM II, the section 23(1) assessment is mandatory, whereas the section 23(3) assessment is discretionary and only undertaken in exceptional cases.

The Board's policy with respect to section 23(3) assessments discusses the "so exceptional" test in detail. Item #40.00 of the RSCM II states that:

> This test requires that the Board determine whether the combined effect of a worker's occupation at the time of injury and a worker's disability resulting from the injury is so exceptional that an amount determined under section 23(1) does not appropriately compensate the worker for the injury. Occupation is broadly defined as a collection of jobs or employments that are characterized by a similarity of skills.

Item #40.00 of the RSCM II also sets out several threshold criteria which must be satisfied in order for a worker to be assessed under section 23(3) of the Act. It states:

> The following is a list of criteria that must be considered under section 23(3) and (3.1). Each of these criteria must be satisfied in order for a worker to be assessed under section 23(3).
>
> - The occupation at the time of injury requires specific skills which are essential to that occupation or to an occupation of a similar type or nature;
>
> - As a result of the compensable disability, the worker is no longer able to perform the essential skills needed to continue in the occupation at the time of injury or in an occupation of a similar type or nature;
>
> - The effect of the compensable disability is that the worker is unable to work in his or her occupation or in an occupation of a similar type or nature, or to adapt to another suitable occupation, without incurring a significant loss of earnings.
>
> Skills are defined in this context as the learned application of knowledge and abilities.

Item #40.00 of the RSCM II further provides:

> In all cases, the Board must determine if, following recovery from a work injury, a worker is either able to return to the occupation at the time of injury or to adapt to another suitable occupation. This determination includes consideration of both the worker's transferable skills and the worker's post-injury functional abilities. In the vast majority of cases a worker's entitlement to a permanent partial disability award is determined under the section 23(1) method and this estimate of impairment of earning capacity is considered to be appropriate compensation.
>
> However, in exceptional cases, the amount determined under section 23(1) may not appropriately compensate a worker. In these cases, medical evidence confirms that the work injury makes it impossible for a worker to continue in the occupation at the time of injury or in an occupation of a similar type or nature. In addition, the worker is considered unable to adapt to another suitable occupation without incurring a significant loss of earnings due to the work injury.
>
> For the purposes of this policy, a significant loss of earnings means the Board may conclude in these exceptional cases, that the loss of earnings a worker will experience as a result of the combined effect could not have been anticipated under the section 23(1) method of estimating a worker's long term loss of earning capacity.
>
> An example of when the combined effect may be considered so exceptional is one where a work injury results in a significant disability of two digits on the dominant hand of a worker whose occupation requires fine motor skills. As a result of the disability, the worker is no longer able to perform fine motor skills, and consequently, is unable to continue in the pre-injury occupation, or another occupation of a similar type or nature. In addition, due to the disability, the worker is unable to adapt to another suitable occupation without incurring a significant loss of earnings.
>
> As a result, the section 23(1) award may not be considered to appropriately compensate the worker for the impact of the combined effect, and may therefore result in a consideration under section 23(3).

As noted in item #40.01 of the RSCM II, section 23(3) of the Act assessments are undertaken if a permanent partial disability results from a worker's injury, and the Board makes a determination under subsection (3.1) with respect to the worker. It further provides:

> The Disability Awards Committee is ultimately responsible for the conclusion on permanent partial disability awards assessed under section 23(3) of the Act. The Board officer in Disability Awards is required to conduct the necessary investigations and make a specific recommendation to the committee regarding a worker's eligibility for a section 23(3) assessment and, in cases where an assessment is undertaken, the worker's entitlement to an award.
>
> It is the function of the Committee, following any further investigation it considers necessary, to agree or disagree with the Board officer's recommendation. If the Committee agrees, the Board officer will implement the initial recommendation. If the Committee disagrees with the Board officer's recommendation, it will either implement its findings or return the file for further investigation. The Disability Awards Committee consists of one senior representative from the Disability Awards, Medical, and Vocational Rehabilitation Services Departments.

From the above it is apparent that the Board's policy involves a two-tiered process, which involves an initial consideration of whether a worker meets the threshold criteria to warrant an assessment under section 23(3) of the Act, followed by the actual assessment which in turn may or may not warrant further investigation.

It is also appropriate to note that the Board has in place a number of practice directives, which, although not Board policy, nevertheless do provide instruction to Board officers in relation to the adjudication of specific matters. Practice Directive #46 deals with the approach to be taken in undertaking a section 23(3) of the Act assessment under the current provisions. It provides, in part:

> The policy requires that three criteria must be satisfied in order for a worker to be assessed under section 23(3):
>
> 1. *The occupation at the time of injury requires specific skills which are essential to that occupation or to an occupation of a similar type or nature;*
>
> Policy defines skills as the learned application of knowledge and abilities. Occupation is broadly defined as a collection of jobs or employments that are characterized by a similarity of skills.
>
> The worker's occupation at the time of injury will be identified in terms of the NOC classification system, at the four-digit (unit group) code level.
>
> 2. *As a result of the compensable disability, the worker is no longer able to perform the essential skills needed to continue in the occupation at the time of injury or in an occupation of a similar type or nature;*

A similar occupation is defined as an occupation where the first three digits of the NOC code (minor group) are the same as the worker's pre-injury occupational code. Where a worker is considered to be able to perform any one or more of the jobs listed in the preinjury four digit NOC occupation code, or any one or more of the jobs under a similar four digit occupation, the worker does not meet the "so exceptional" test. The medical evidence must confirm that the disability makes it impossible for the worker to perform the essential skills of the occupation. The duties for an occupation must be considered in terms of the essential skills necessary to perform those duties.

Skills are not to be confused with physical demands such as standing, sitting, etc. The impact of limitations on physical demands may be mitigated through workplace modifications and therefore, the worker would still be able to perform the essential skills of the occupation.

For example, an ironworker with a knee injury may not be able to return to his pre-injury job because it requires that he climb ladders several times a day, which he is no longer able to do. Climbing ladders would not necessarily be determined to be an essential skill for the occupation of ironworkers. The worker still has the skills to be an ironworker. The NOC four-digit code for ironworkers (7264) lists various jobs within that occupation, which a worker may still be able to perform, even with the knee injury.

For example, an electronics technician is required to have fine motor skills to perform the core duties of his occupation. If the technician sustains a back injury, he still retains the fine motor skills necessary to be an electronics technician. The worker may experience difficulty with physical activity of prolonged sitting or standing. However, these are physical demands, not skills of the occupation required to perform the duties of an electronics technician.

3. *The effect of the compensable disability is that the worker is unable to work in his or her occupation or in an occupation of a similar type or nature, or to adapt to another suitable occupation without incurring a significant loss of earnings.*

Where a worker is unable to return to the pre-injury occupation or a similar occupation, consideration will then be given to whether the worker can adapt to another suitable occupation. For this purpose a worker is considered to retain all the essential skills of the pre-injury occupation, with the exception of the limitations caused by the permanent disability. Pre-injury transferable skills (considering as well the possibility of

enhancements or re-certifications, through vocational rehabilitation assistance) will also be included to determine the worker's residual (post-injury) skill set. Where the worker is considered able to return to a suitable occupation, it must further be determined whether the worker will incur a significant loss of earnings.

For the purposes of the policy, a significant loss of earnings means the Board may conclude in these so exceptional cases, that the loss of earnings a worker will experience as a result of the combined effect could not have been anticipated under the section 23(1) method of estimating a worker's long-term loss of earning capacity. A loss of earnings is not sufficient to meet the requirements of the "so exceptional" test. Consideration must also be given to the nature of the section 23(1) award in relation to the Permanent Disability Evaluation Schedule and/or other schedules, judgements and considerations used to determine the functional impairment and whether these could not have anticipated this worker's disability and resulting loss of earnings capacity. In considering such loss, consideration may also be given to comparing the extent of loss through aggregate statistical references on average occupational earnings.

For example, a logging helicopter pilot suffers a moderate head injury and has residual audiovestibular disturbance assessed at 10% disability. The disability is such that it renders it impossible for him to meet the physical requirements for holding a helicopter pilot's license and he is also unable to return to a different job in the same occupation or a similar occupation. The 10% award may be appropriate compensation for the average worker. However, it may not represent appropriate compensation in the case of the helicopter pilot.

Section 23(3) Assessment

Where a worker is considered to meet the "so exceptional" test, the worker will be entitled to a section 23(3) assessment, which includes an employability assessment. This will identify the suitable occupations that will maximize the worker's long-term earnings. This may include additional occupations in light of all reasonable vocational rehabilitation assistance that may be offered to the worker.

In the worker's case before me, the claims adjudicator in Disability Awards and the review officer both concluded that the worker was not precluded from resuming his previous employment by virtue of his bilateral pleural disease, such that a section 23(3) of the Act assessment was not indicated. From my review of the worker's claim file, that decision was obviously based on the earlier opinion generated by the Board's

internal medicine consultant at the March 30, 2004 team meeting. However, I observe that the Board's internal medicine consultant provided a subsequent opinion to indicate that the worker's level of respiratory impairment would preclude the performance of any occupation that required physical activity, such as climbing around freight cars and locomotives. The Board's internal respiratory consultant indicated that the worker was only fit for sedentary work. I note that the worker's previous employment involved climbing around freight cars and locomotives, such that I am unable to agree with the conclusion that he was physically able to perform his previous employment. I also accept the worker's evidence regarding the significant amount of walking involved in his previous employment, and observe that that required activity would also be beyond his physical capacity, given the medical evidence on file.

As such, a preliminary criterion has been satisfied in the worker's case, being that he is unable to return to his previous employment by virtue of the limitations imposed by his residual disability attributable to his bilateral pleural disease.

However, a necessary consideration, according to Board policy in item #40.00 of the RSCM II, is whether the worker is no longer able to perform the essential skills needed to continue in his previous employment. According to associated Practice Directive #46, skills are not to be confused with physical demands, considering the impact of physical limitations on physical demands may be mitigated by workplace modifications. An example provided is that of an ironworker who would still be considered to have the skills of an ironworker even though that person may no longer be able to climb ladders. Item #40.00 of the RSCM II also provides that skills are defined as the learned application of knowledge and abilities. In applying that definition to the worker in the case before me, I observe that the skills that he learned included repair of railcar and locomotive units, followed by the supervision of those repairs. Moreover, the skills he learned and applied in his previous employment as a supervisor required him to assess what repairs were necessary, to observe the repairs that were being completed by others to ensure their correctness, and to evaluate the repairs once completed to ensure that the necessary remedial work had been satisfactorily done. Thus, in applying the definition noted above, I conclude that by virtue of the worker's compensable reduction in respiratory capacity he is no longer able to perform the essential skills needed to continue in his previous employment.

I find the notion of separating physical demands from general skill attributes to be an exceedingly difficult concept to grasp. However, it is appropriate to note that Practice Directive #46 does not suggest that physical demands are not to be considered, and instead seemingly only suggests that they are not to be a primary consideration, considering that workplace modifications may be available. The question then is what should occur when workplace modifications are not available; neither the policy nor Practice Directive #46 really discusses such an event, which is unfortunate, because

job site modification is not always an available or viable option. That seems to the case in the worker's claim, considering that the employer agrees that the worker is unable to return to his previous duties.

I also rely on the analysis contained in *WCAT Decision #2004-06402* (available at www.wcat.bc.ca/research/appeal-search.htm), which discussed this very concept. The vice chair in that appeal commented:

> The CADA noted that the question was whether the worker still had the ability to apply those skills, and referred specifically to understanding directions, identifying the materials, equipment and tools used on the jobsite, and using the tools in his tool belt.
>
> I agree that the worker does retain those specific skills. However, if the listed duties are considered, it becomes apparent that one of the essential "skills" necessary for occupations in NOC #7611 is the ability to handle potentially heavy materials. It is difficult to envision any job falling within NOC #7611 that could be performed by a worker who is limited to light/medium work, with no repetitive bending or flexing of the trunk, no fixed static standing and no sustained forward bending. Although those activities are not necessarily "skills" and could be classified as "physical demands," they are not the type of physical demands that could be mitigated through workplace modifications. If the worker were a skilled trades person, he may have "helpers" available to do the heavy lifting and bending, but the worker's skills, and his employment history, all required the ability to perform relatively heavy physical labour. I consider that his L1 compression fracture, which is acknowledged to constitute a serious injury, to have limited his ability to perform an essential "skill" of his occupational category, which is heavy physical labour.
>
> I acknowledge that in most cases heavy physical labour is not a "skill," in the sense that it is a learned application of knowledge and abilities. However, in the limited circumstances of this case, where the vast majority of jobs in the NOC classification require heavy physical labour, it must be considered a "skill." There is very little else that could be classified as a "learned application of skills and knowledge" in the jobs listed, and while the worker retains the ability to follow directions, and identify his tools, he is limited in his ability to use those tools because of his compensable disability, which includes chronic pain and the inability to do heavy lifting, sustained standing or bending.
>
> In support of that conclusion, and as an example, if the worker had become paraplegic because of his spinal injury, he would still retain the ability to follow instructions, to identify his tools and to "use" the tools in

> his tool belt, but he most certainly would not have been able to return to work as a trades helper or labourer. As such, physical ability to perform heavy labour must be considered a "skill" required of a trades helper or labourer.

In terms of the appeal before me, I conclude that an essential skill required in the worker's previous employment as a supervisor in a train shop included his ability to have sufficient respiratory capacity that he was able to evaluate the necessary repairs, to monitor the repairs in progress, and to assess the completed repairs. I also find that an essential skill for him was his ability to climb freight cars and locomotives. As such, I conclude that as a consequence of his residual disability the worker no longer has the essential skills needed to continue in his previous employment.

However, it is also a requirement of the Board's policy that an analysis be undertaken to determine whether the worker had essential skills from which he could access an occupation of a similar type or nature, or to adapt to another suitable occupation.

Turning next to whether the worker's essential skills would allow him to access work in a similar occupation, the vocational rehabilitation consultant concluded that the worker had transferable supervisory skills. While that may be the case, I conclude that general categorization falls short of what is necessary in the section 23(3) assessment described above. In short, I conclude that the determination of a worker's essential skills that exist in the previous employment involves a finding of fact, rather than a presumption that certain skills exist based solely on the job title that a particular worker held. Although I agree that the worker performed a supervisory function in his previous employment, it is obvious that he did so in a finite employment environment in which he had worked his entire working life. That supervision was confined to a particular employment setting, and involved limited work functions. It is also clear that the worker has a limited educational background. As a result, I conclude that the worker held limited supervisory skills, and that it is doubtful that his supervisory experience was sufficient that it would enable him to access general supervisory work in other fields of endeavor.

Of more relevance, at least insofar as a proper application of Board policy, and recognition of Practice Directive #46, the National Occupational Classification (NOC) code for the worker's pre-injury employment is 7221 (Supervisors, Railway Transport Operations). The NOC describes that supervisors in this group supervise and co-ordinate the activities of railway and yard locomotive engineers, railway yard workers and railway labourers. They are employed by railway transport companies. A similar occupation, using the first three digits of the NOC code as suggested by the Practice Directive, is limited to "Supervisors, Motor Transport and Other Ground Transit Operators." According to the NOC, supervisors in this unit group supervise and co-ordinate activities of truck drivers, bus drivers, delivery drivers, subway and other transit operators, chauffeurs and taxi and limousine drivers. This unit group also

includes bus dispatchers who co-ordinate the activities of transit system bus drivers and subway traffic controllers who operate and monitor signal and track switch control panels. They are employed by motor transportation and ground transit companies and by urban transit systems. Moreover, completion of secondary school is usually required, as is several years of experience as a driver or operator of motor transport or ground transit equipment. From the above, I conclude that the worker did not hold the essential skills needed to access and perform the duties required in an occupation of a similar type to that in which he had been employed.

I also observe that the vocational rehabilitation consultant also concluded that the worker's functional limitations would preclude him from working on a full-time basis, whereas most supervisory positions required such availability. That too is relevant to the issue before me.
In terms of whether the worker could adapt to another form of employment, the vocational rehabilitation consultant considered bench repair/assembly; however, the vocational rehabilitation consultant indicated that the worker's vision would be a problem in such work, as would exposure to solvents and the like. Therefore, that form of employment would not be suitable. I also note the worker would likely not be fit for full-time work in this occupation in any event, given that the vocational rehabilitation consultant held the view that he could not undertake supervisory work on a full-time basis.

The Act, and the Board's policy respecting potential loss of earnings entitlement, describe that in most cases the functional pension award under section 23(1) of the Act is intended to compensate for impairment of earnings occasioned by the compensable disability. However, both the Act, and the Board's policy in relation to it, indicate that if the combined effect of the worker's pre-injury occupation and compensable disability is so exceptional that the section 23(1) of the Act award does not appropriately compensate the worker for the injury, then consideration is to be given to a loss of earnings award under section 23(3) of the Act. In the worker's case specifically, I conclude that he was precluded from resuming his pre-injury employment. I also conclude from the information on file that access to alternative employment is doubtful, in relation to possible part-time supervisory positions or bench repair/assembly. In my view, the residual consequences of the worker's occupational disease make it impossible for him to return to his previous employment or to access an occupation that is similar in class and nature.

For clarity, given the length of my findings above, it is appropriate to summarize my conclusions respecting a section 23(3) of the Act loss of earnings consideration in the following manner:

- I conclude that the worker was physically precluded from returning to his previous employment.

- I conclude that due to his residual disability the worker is no longer able to perform the essential skills needed to continue in his previous occupation.

- I conclude that the worker's previous skills as a supervisor were extremely limited both in terms of his supervisory role, and the environment in which his supervision was performed. I conclude that the worker does not hold the requisite skills to access employment in an occupation of a similar type or nature to that of his previous employment.

- I conclude that the worker is unable to adapt to another suitable occupation without incurring a significant loss of earnings.

The worker has a significant functional pension in place, given that his award is 20% of total. However, considering that there is doubt on whether the worker can access even sedentary alternate employment on more than a part-time basis, I conclude that the threshold criteria have been met in this particular case. In short, I conclude that the combined effect of his previous occupation and his compensable disability is so exceptional that the section 23(1) of the Act award does not appropriately compensate him for the disability resulting from his bilateral pleural disease. In undertaking that conclusion, I observe that the worker's potential future earning capacity is likely far less than the amount of compensation that he is receiving through his functional pension award. Although the current provisions have changed in comparison to the former provisions, as has relevant Board policy, the fact remains that the underlying consideration remains whether there is likely a loss of earnings in excess of the functional pension, such that the section 23(1) pension does not appropriately compensate the worker. That is the consideration described within Board policy, and I see no ambiguity in either the current provisions of the Act or the RSCM II in that regard.

In accordance with Board policy, I refer the worker's claim to the Board's Disability Awards Committee to complete the decision-making process respecting potential loss of earnings entitlement under this claim.

In summary, I conclude:

1. The worker is not entitled to temporary disability benefits for his bilateral pleural disease.

2. The worker's permanent disability associated with his bilateral pleural disease commenced subsequent to June 30, 2002 such that the current provisions apply.

3. The worker's permanent disability in relation to his bilateral pleural disease commenced August 1, 2003.

4. The worker's 20% of total functional pension award appropriately reflected his level of functional impairment associated with his bilateral pleural disease.

5. The combined effect of the worker's occupation and the disability resulting from his compensable condition is so exceptional that the functional amount does not appropriately compensate him, such that a loss of earnings assessment under section 23(3) is warranted.

Pursuant to section 7 of the *Workers Compensation Act Appeal Regulation*, I allow appeal expenses associated with the worker's travel by motor vehicle to attend his oral hearing, and return. Those expenses are to be paid in accord with the Board's policy respecting such travel.

Conclusion

I confirm the July 23, 2004 decision of the Review Division. I vary the August 31, 2004 decision of the Review Division.

Anthony F. Stevens
Vice Chair

AFS/gl