

**WCAT Decision Number:** WCAT-2006-01167-RB  
**WCAT Decision Date:** March 10, 2006  
**Panel:** Marguerite Mousseau, Vice Chair

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## Introduction

The worker appeals decisions regarding her entitlement to compensation for symptoms that developed following occupational exposures to film processing chemicals. These decisions were communicated in four letters of the Workers' Compensation Board (Board) over the course of several years.

In the decision letter of March 27, 1996 the worker's claim for compensation was accepted for temporary aggravation of a pre-existing allergy up to and including May 16, 1995. She was told that subsequent symptoms were not due to occupational exposures given that the causative agent had been removed.

In the decision letter of September 11, 1998 the Board officer accepted that the worker's ongoing symptoms since 1995 were due to exposure to chemicals at work resulting in occupational asthma, skin dermatitis, laryngitis and sinusitis. Her claim was reopened for health care benefits. She was informed that her symptoms appeared to be temporary, occurring when the worker was exposed to unbagged x-ray films and perfume in the workplace. The worker's file was referred to the Disability Awards Department for consideration of whether she had a permanent functional impairment (PFI).

In the decision letter of January 14, 2000 the worker was informed that she was not entitled to a permanent disability award as she had no PFI that would affect her earning capacity.

In the decision letter of February 29, 2000 the worker was informed that she is not entitled to vocational rehabilitation assistance on a preventative basis since the x-ray processing methods have changed and she is no longer exposed to chemicals.

The worker's appeal of these decisions was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, *the Workers Compensation Act* (Act) was amended to replace the Appeal Division and Review Board with the Workers' Compensation Appeal Tribunal (WCAT). As this appeal had not been considered by a Review Board panel before that date, it has been decided as a WCAT appeal. (See the *Workers Compensation Amendment Act (No. 2), 2002*, section 38.)

Oral hearings were held over a three-day period from November 14 to 16, 2005 with respect to the worker's appeal and the appeals of five co-workers with similar claims

histories related to the same occupational exposures. All of the workers are represented by legal counsel retained by their union. They all attended during their representative's opening statements and during the final submissions. Each worker gave evidence at a separate hearing, unattended by any co-workers. The employer is participating and is represented by a management consultant. Prior to the hearings, the employer's representative advised WCAT that he would not attend the hearings nor make any submission with respect to the workers' appeals.

Documents pertaining to a particular claim have not all been maintained on the file of the individual technologist. One file was maintained as a "master" file at least for some period of time by one of the Board officers and copies of most documents were placed on that file. However, documents were also found on the files of the two supervisors, who have also made claims, which were relevant to the claims of the technologists they supervised, but these documents were not always also found on the appropriate claim file. Each of the technologists was asked by WCAT to sign a waiver of confidentiality so that they could have access to each other's files and that documents on all files could be used in the adjudication of each file.

### **Issue(s)**

The issues on this appeal are:

- Whether an occupational exposure in late 1994/95 caused the worker's allergies or caused permanent aggravations of pre-existing allergies;
- Whether the symptoms of the accepted occupational asthma, skin dermatitis, laryngitis and sinusitis are temporary and occur only with exposure to unbagged films and perfume in the workplace;
- Whether the worker has a PFI as a result of her occupational exposures; and
- Whether the worker meets the criteria for preventative vocational rehabilitation assistance.

### **Background**

The worker was employed as a magnetic resonance imaging (MRI) technologist and had been employed in this capacity since 1987. Prior to that, she had been employed as an x-ray technician for more than ten years. On April 13, 1995 she submitted an application for compensation for symptoms described as a rash, hives, itchy eyes, itchy skin to her waist area, sore throat, and difficulty breathing at some times. She stated that she had been working in the MRI control area on February 15, 1995 when she had developed hives, itchy eyes and tightening of her throat and chest. She had taken Benedryl and then gone to the Emergency Department within the hour. She was still working at the time that she submitted her application but she had taken some time off to see an allergist and she was taking medication to reduce her reactions. She noted in an accompanying letter, that she had first noticed symptoms in January 1995.

The employee health nurse who completed the employer's report of injury stated that there was "some concern" as two other employees had reported similar symptoms. Ultimately, the six technologists working in the MRI unit submitted claims for compensation for symptoms of a similar nature. The worker, like the other five technologists, had a lengthy history of employment in radiology and had been in contact with x-ray processing chemicals at various times over the course of her employment. She had no history of prior symptoms as a result of working with and around these chemicals.

Initially, the technologists only had symptoms while in the MRI area but by February 23, 1995 the employer's occupational health and safety officer (OHSO) noted that the symptoms were continuing for longer periods of time. The MRI department was in a newly renovated building which had been occupied since June 1994. The department housed a new scanner and film processor. A number of investigations and actions were taken by the employer and the Board in an attempt to identify the cause of the symptoms.

In March 1995 a maintenance mechanic conducted an inspection and noted problems with temperature control in the scanner and control rooms. The heating and cooling systems were described as running against each other due to some cross-wiring. In addition, the air-conditioning unit in one area was cycling too often and overheating in two rooms. A number of recommendations were made, including the installation of an exhaust over the processor.

On April 27, 1995 a Board engineer conducted an inspection of the department and noted that the flow in an exhaust duct off the processor was much less than would be required to prevent the escape of odours. There were deposits on the outside of one tank indicating that the tank had leaked and some of the liquid had evaporated.

Various changes were made prior to and following the various investigations, including heating the area to high temperatures in order to hasten the off-gassing process in the newly renovated area, removing the carpet, draining the chemicals from the processor, placing a cover over an open drain, and improving the ventilation systems. It was noted that radiologists using other film processors had not developed symptoms but they were housed in a much larger space and more efficiently ventilated owing to the room size.

By May 25, 1995 most of the technologists in the MRI unit were reporting asthma-like symptoms and Dr. P, an employee health consulting physician, thought that the technologists had likely developed a sulphide/metabisulphite sensitivity which had caused asthma-like effects. In a memorandum recording a meeting on that date, Dr. P stated that an overriding concern was that the affected workers were now sensitized. He recommended that the workers undergo methacholine and metabisulphite testing and pulmonary function testing. The sensitizing material remained unclear.

Use of the film processor in the MRI unit was discontinued in May 1995 and processors in the main radiology unit were used for film processing. On May 23, 1995 the worker's physician reported that the worker's allergy symptoms were much better since the processor had been turned off at work. The symptoms did not altogether resolve, however.

In June 1995 it was recommended that the MRI technologists stop processing MRI films altogether. However, the technologists continued to experience primarily respiratory symptoms as well as skin reactions.

In November 1997 the film manufacturer advised the Board's occupational health physician that the Material Safety Data Sheets (MSDS) for photo chemicals that contain sulphite and bisulphite salts were being revised to add that sulphites, in contact with strong acids or if heated, could liberate sulphur dioxide gas which is irritating to the respiratory tract. Some asthmatics or sulphite-sensitive individuals could experience wheezing and chest tightness.

Under "ingestion" the MSDS was being revised to add that the product might be harmful if swallowed. Some asthmatics or sulphite-sensitive individuals "may experience wheezing, chest tightness, stomach upset, hives, faintness, weakness and diarrhea." The manufacturer noted that this information appeared consistent with the statements made by the worker(s) and that, although the incidence of such reactions was "extremely low," it was felt that current science supported the addition of this information to the MSDS.

On May 22, 1998 the film manufacturer responded by letter to previously held discussions between a Board occupational health medical advisor and the manufacturer. Two x-ray film samples had been sent to the manufacturer for investigation and quantities of sulphite had been extracted from both samples. One sample had been processed in late 1997 and the other sample was an older film taken from the hospital library. The amounts found were described in ug/cm<sup>2</sup>, which is micrograms per square centimetre; there was more sulphite found on the older films. The manufacturer described these amounts as "minute traces" and said that normally it would be expected that even these minute traces would be removed in the washing process of the processor. It was thought that there may have been an insufficient wash to remove the sulphite at the time the films were developed. A person with hypersensitivity to sulphite could possibly have a reaction to these amounts of sulphite.

The Board accepted that the x-ray processing machine had not been installed according to the manufacturer's recommendations. As a result, there was reason to believe that a number of chemicals may have been released in the immediate vicinity of the machine in quantities in excess of what would normally occur.

The chemicals used in film processing include glutaraldehyde and hydroquinone. The MSDS information for these products state that hydroquinone is at a low hazard for inhalation but, when inhaled, it causes skin irritation and allergic skin reactions. Glutaraldehyde is described as being harmful if it is inhaled. It may cause respiratory tract irritation and severe burns and allergic skin reactions.

*Occupational Health and Safety Regulation – BC Regulation 296/97* (Regulation) establishes exposure limits for each of these substances. It identifies both hydroquinone and glutaraldehyde as “sensitizers” and “ALARA substances.” Sensitizers are defined as “substances [which] have been shown to produce an allergic type of response in some workers after an initial exposure, resulting in the development of symptoms upon subsequent exposure at much lower concentrations.”

ALARA substances are defined as “substances to which exposure of workers must be kept as low as reasonably achievable.”

Section 5.57 of the Regulation states that, where a substance which has been designated as a sensitizer is present in the workplace, the employer must, whenever practicable, replace it with a material which reduces the risk to workers. It also states that where a substance is used in the workplace which is both a sensitizer and an ALARA substance “the employer must implement an exposure control plan to maintain workers’ exposure as low as reasonably achievable below the exposure limit listed in the Table” if it is not practicable to substitute the substance with a lower risk alternative.

Section 5.51 of the Regulation states “If there is exposure to a mixture of 2 or more substances with established exposure limits, the effects of such exposure must be considered additive...” This section goes on to provide a formula for establishing the exposure limit in this situation.

## **Evidence**

The worker saw Dr. Stark, allergist, on March 29, 1995. She reacted to grass pollen and had a mild reaction to a number of moulds. She did not react to latex. His impression was of allergic rhinoconjunctivitis and acute urticarial reactions (hives) with exacerbation of asthma symptoms. These were suggestive of anaphylactic reactions related to something in the work environment. He also thought the symptoms were suggestive of possible latex sensitivity. She saw Dr. Stark again on April 18, 1995. Dr. Stark reported that she was still having problems with hives at work. On May 1, 1995 the worker saw Dr. Stark again. Patch testing failed to show any significant positive chemical sensitivities. Dr. Stark’s impression was that the worker had asthma and urticaria precipitated by suspected chemical sensitivities in the work environment. He thought there might be mould in the air-conditioning system or chemicals from the processing units might be triggering her symptoms. He thought that sulphite-based chemicals were the most likely triggers.

The worker saw Dr. Stark again on May 24, 1995 and he noted that there had been some improvement in the worker's symptoms at work. He said that the worker had not had any hives or breathing problems, although her eyes were still somewhat red and itchy on occasion. The worker had also had one further episode of chest tightness since the processor had been turned off, and it was suggested that this could be due to exposure to an ammoniated window cleaning compound. He also noted that the worker had spent the previous weekend in a community with a pulp and paper mill and she had noticed increased congestion of her nose and her chest with some chest tightness. Dr. Stark said he now suspected sulphite sensitivity triggered by developing chemicals in the workplace and non-specific sensitivity with exposure to air pollution and sulphur dioxide and other chemical smells. He was hopeful that with changes in the work environment it would be less likely that she would have ongoing problems. He recommended that the worker continue with her current medications, and that she use a Ventolin inhaler intermittently.

On July 7, 1995, the worker had a metabisulphite challenge test with a positive result. Dr. Stark saw her on July 12, 1995. In his report of that date, he noted that the worker had developed increased bronchial reactivity in response to the challenge, indicating a positive result. She had also developed some itching after her one-second dose of metabisulphite, confirming that this was likely the cause of her hive-like reactions at work. She had developed more clear-cut hives later in the day. The worker had also had one other episode in which she had had an asthmatic attack on an air flight. He said the worker had been working full-time again in the MRI scanning area, and she had no difficulties with the processor turned off. Dr. Stark's impression was of significant sulphite sensitivity with asthma and rhinoconjunctivitis symptoms as well as urticaria, related to exposure to sulphites from the film processing unit in her work area. He recommended that the worker continue to avoid sulphite preservatives.

Dr. Stark saw the worker again on September 25, 1995, and at this time, she reported developing problems with diarrhea on several occasions within half an hour of eating out at various restaurants. The worker had previously had minimal problems with diarrhea. On September 8, 1995 she had tried putting films up at work in a viewer and her eyes became quite irritated red and burning, her symptoms did not seem to be as troublesome now when she was back at work, but she still had troubles with increased sensitivity to paint smells and perfumes causing chest tightness. Dr. Stark's impression was again specific metabisulphite sensitivity associated with asthma, rhinoconjunctivitis and urticaria and a possible development of diarrhea related to ingestion of sulphites. He thought the worker had become sensitive to sulphite through inhalation of sulphur dioxide and other irritant gas in the film processing unit in the MRI area at work.

On October 19, 1995 Dr. Stark reported that the worker had spent more time at the work site during a recent accreditation visit and noticed that her chest felt sore, and she had increased wheezing at night, her eyes continued to bother her at work despite using the eye drops. Dr. Stark thought the worker's symptoms had recently worsened because of increased exposure to sulphites at work. Again, on December 18, 1995 the

worker reported problems with diarrhea. The worker had a negative skin test to monosodium glutamate (MSG), but he did not feel that this ruled out that substance as causing the chemical reactivity.

On January 4, 1996 the worker's physician reported recurrent asthmatic attacks when the worker was handling x-ray films or when exposed to x-ray processors.

The worker saw Dr. Stark again on February 28, 1996, June 11, 1996, July 17, 1996, August 28, 1996, and December 16, 1996. The worker's gastrointestinal (GI) complaints improved as result of not eating in restaurants. In July she had resumed using her Pulmicort Turbuhaler due to increased symptoms related to the use of a new, dry x-ray processing machine. Her GI symptoms flared up in August, while she was on vacation. In December the worker had itchy and irritated eyes after an on-site radiology visit in another city, her throat also felt tight and her voice was hoarse, which she attributed to exposure to increased cigarette smoke on the weekend. She was still having difficulty with perfume sensitivity.

The worker saw Dr. Yeung, respirologist, on February 10, 1997. Dr. Yeung described the worker as previously having symptoms of hay fever, but never a history of asthma. Dr. Young's opinion was that the worker had obviously developed occupational asthma as a result of exposure to some chemicals in her workplace. She said that the chemicals used for processing x-rays include glutaraldehyde and ethylene diamine and other chemicals. The first two she said were known to give rise to occupational asthma. She said that it was quite possible that sulphite was also present in these chemicals and the worker had metabisulphite sensitivity. Dr. Yeung noted that patients with occupational asthma tend to improve in time, if they are removed from exposure but she noted that the worker seemed extremely sensitive to the chemicals. She said that films which have been developed a long time ago, continued to give the worker some symptoms.

In May 1997 a Board officer contacted the worker and her co-workers, indicating that the Board was contemplating reconsideration of its previous decisions regarding the extent of the symptoms which had been recognized as likely due to occupational exposures. It was suggested that skin patch testing be undertaken using the chemicals to which the workers would be exposed in the course of their work.

The worker underwent skin patch testing with Dr. Morton, dermatologist, on August 25, 1997. In his report of August 28, 1997 he reported the worker's belief that exposure to something on the films was precipitating symptoms. On the day of testing, the worker had developed a mild skin rash which she attributed to viewing films although they were enclosed in plastic. The worker also reported that exposures to perfume and to the films decreased her peak flow, which she was monitoring herself. In the testing conducted that day, the worker had a reaction to fragrance mix within one hour but no reaction to any of the chemicals used in film processing. At 48 hours there was no reaction to any of the substances tested.

In the meantime, the worker continued to see Dr. Stark on April 7, 1997, July 30, 1997 and December 22, 1997. In the report of December 22, 1997 Dr. Stark said the worker's main concern at the time was chronic headache symptoms, which had been made worse by exposure to paint fumes at work. The worker had developed an acute asthmatic attack about a week after the painting started. Dr. Stark's impression was acute sinusitis with exacerbation of asthma, also aggravated by exposure to paint fumes.

The clinical records of the worker's physician from January 1997 to April 1998 indicate that the worker saw her physician approximately every month for asthma, typically related to exposures at work throughout that period.

In a memo dated October 24, 2002 a Board officer noted that in the worker had contacted the Board regarding symptoms apparently caused by exposure to a fragrance in her home. At that time, the Board opened a new claim and obtained her medical records from 1998 onwards.

The worker's counsel had also asked whether the worker would be entitled to future vocational rehabilitation assistance if she wished to change occupations to another facility where x-ray films were not handled the same way and found that she was unable to do so due to risk of permanent impairment. The manager advised that preventative vocational rehabilitation was only available where a worker was able to return to their pre-injury employment but was medically deemed at undue risk if he or she did so. The policy on preventative rehabilitation was not applicable to situations in which a worker had successfully returned to their pre-injury employment and subsequently decided to go to another job.

The chart notes on the worker's file do not go beyond May 11, 2001. These records, however, describe chronic problems with asthmatic and other reactions to exposures, primarily in the workplace. As examples: in January 1999 there is an entry regarding asthma due to x-ray film exposure; in February 1999 the worker broke out in hives when exposed to films; in April 1999 she was exposed to paint at work and she developed hives and shortness of breath; in June 1999 there is a report of swelling on the left side of her face after dental work; in June 1999 there is a record of an allergic reaction to perfume; in 2000 (month is illegible) there is a record of an allergic reaction to a procedure using a tube that was sterilized in glutaraldehyde; in March 2001 an allergic conjunctivitis in reaction to perfume was noted. This entry, which is dated March 6, 2001, indicates that the worker's allergies are generally well controlled but the worker has to be very careful about exposure to x-ray developers, sulphites, etc. Finally, an entry in May 2001 records an asthmatic reaction to exposure to perfume at work.

During this period the worker continued to see Dr. Stark intermittently, with respect to allergic reactions. In June 2001 Dr. Stark reported that the worker had been doing reasonably well in recent months until she had been exposed to perfume at work, which

had caused an exacerbation of her respiratory symptoms. Dr. Stark's impression was of allergic rhinosinusitis, with recent worsening because of grass pollen. He thought that non-specific irritants such as the developing chemicals and perfumes could be aggravating symptoms; her allergic asthma seemed to be under control at the present. On September 14, 2001 Dr. Stark saw the worker again after the worker had experienced an anaphylactic reaction to a radiocontrast medium, which she had taken prior to a CT scan. Dr. Stark thought the Vioxx that the worker was taking may have been a predisposing factor for her reaction.

The first opinion provided by a Board medical advisor (BMA) regarding the causes of the worker's symptoms is contained in memo #4, dated March 22, 1996. In that memo, the BMA described numerous factors, which argued against a relationship between the worker's symptoms and exposures to chemicals at work. A significant factor was that the symptoms of a number of the workers had persisted and some had worsened despite the numerous interventions undertaken at the work site, which included shutting down the processor. The BMA felt that if the workers' symptoms were in response to exposures caused by the functioning of the processor, these symptoms would have lessened progressively in response to these interventions.

In addition, the BMA considered that if the workers had developed a sulphite sensitivity it was not likely due to any occupational exposure, given the ubiquitous nature of sulphites. It was plausible that the workers had been rendered symptomatic on a short time acute basis due to exposure to this chemical at work, but there was nothing in the scientific literature to suggest that one could become more sensitive to sulphites as a result of such an exposure or that the threshold for becoming symptomatic in response to exposure to sulphites could, in this manner, be permanently reduced.

However, he also noted that a number of chemicals used in x-ray processing could give rise to symptoms similar to those experienced by the workers. He noted glutaraldehyde in particular, which he stated was a known dermatological (not respiratory) sensitizer. He also noted that the products contained acetic acid, formaldehyde, sulphur dioxides, ammonium glycols and possibly hydrogen sulphides, all of which were potentially problematic for some individuals.

He also noted that there had been deficiencies in the installation and operation of the processing equipment and there had been internal leaks of chemicals, as evidenced by chemical residues in the internal pipes and on the floor under the installations. In addition, there had been design faults in the local exhaust ventilation system and at some point the processor was at positive pressure relative to the room in which it was installed.

The BMA stated that it was virtually impossible to determine which specific chemicals had been responsible for the symptoms experienced by the workers. He considered there was insufficient evidence to state on the balance of probabilities that any of the workers were suffering from occupational asthma or any other allergic or sensitivity reaction, which could specifically be attributed to their workplace exposure. The

evidence only supported the conclusion that the worker had suffered short-term symptoms as a result of chemical exposures. It could not be concluded that she had developed a permanent sensitivity or other form of permanent disease or injury as a result of the exposures.

Subsequently, another BMA provided an opinion on July 3, 1997 that the worker's exposure to glutaraldehyde must be considered a likely cause of her asthma. After investigations and correspondence with the film manufacturer and the receipt of further medical evidence, the BMA provided a further opinion regarding the worker's medical condition and its causes.

In an opinion dated August 21, 1998, the BMA stated that the medical information was "consistent with rather than supportive of" the worker having developed a sensitivity to chemicals at work. He noted that there seemed to be a temporal relationship between the onset of the worker's symptoms and exposure to x-ray processing chemicals, and there appeared to be a temporal relationship between the recurrence of her symptoms and exposure to unbagged films.

In addition, her symptoms appeared to improve when she was away from work. These non-medical factors supported a work cause or aggravation, and the periodic recurrence of the same or similar symptoms suggested a relationship to the initial episode.

Since there was no medical evidence on file since early September 1997, the BMA said he was unable to comment on symptoms that the worker was now experiencing. However, if they were similar to those previously recorded he would suggest that they arose directly or indirectly from the processing of x-ray film. He confirmed the diagnoses of asthma and dermatitis which were most likely to be work caused. He considered it likely that recurring sinusitis and laryngitis were part of the same disease process. He noted that there were non-occupational factors contributing to the worker's symptoms such as exposure to an ammonia cleaning agent and exposure to pollution in another community. He did not know whether these exposures contributed to the underlying disease.

Finally, in a memo dated April 1, 1999 the BMA confirmed that all of the MRI technicians had probably developed a sensitivity to at least one of the chemicals used in the processing of x-ray film. He advised that sensitivities are usually permanent but they do not cause disability, unless there is re-exposure to the causative agent. He went on to say that, as a general rule, sensitivity which constitutes a permanent impairment of the immune system is likely to increase with further exposures to the causative agent. In turn, this would likely result in a more severe and more prolonged reaction, which in these cases (that of the worker and her co-workers) showed as a dermatitis or asthma. Ultimately, he said this could result in chronic asthma or dermatitis. It was his opinion that if the worker continued to be exposed to the chemical or chemicals which caused their sensitivity they were at a significantly increased risk for a permanent disability of

either their respiratory system or skin. He said that he could almost guarantee that further exposure would precipitate an asthma attack or an acute dermatitis, either of which could cause a temporary disability.

### **Prior Decisions**

In the Board decision letter dated March 27, 1996 a Board officer explained at some length what had transpired respecting the worker's claim to date. He noted that it was generally agreed that the x-ray processing machine had not been installed according to the manufacturer's recommendations. As a result, there was reason to believe that a number of chemicals may have been released in the immediate vicinity of the machine in quantities in excess of what would normally occur.

Based on an extensive opinion by a BMA, the worker's claim was accepted for a temporary aggravation of a pre-existing allergy up to and including May 16, 1995, when the processor was taken out of service. Any subsequent symptoms could not be related to an occupational exposure.

On September 11, 1998 a Board officer issued a decision letter to the worker stating that her claim for ongoing respiratory symptoms and rash had been reconsidered. The results of a methacholine challenge administered on June 6, 1995 indicated that the worker had asthma and Dr. Yeung considered that the worker had developed occupational asthma as a result of exposure to chemicals in the workplace. The Board officer stated that, following a conversation with the worker on June 24, 1998, she was satisfied that there was a temporal relationship between the onset of the worker's symptoms including asthmatic reaction, face rash, laryngitis, and sinusitis "with the exposure to x-ray processing chemicals of unbagged films."

The Board officer also noted that the only medical documentation on file since September 1997 was a visit to the worker's family doctor on April 16, 1998 for an allergic reaction to possibly perfume. On examination it had been noted that the worker had hives on her cheeks and a frontal sinus congestion. Her chest was clear. As a result, the officer concluded that any symptoms experienced by the worker since 1997 had been minor and had not required medical attention.

The officer stated that she accepted ongoing symptoms since 1995 resulted from the worker's exposure to chemicals at work which had resulted in "occupational asthma, skin dermatitis, laryngitis and sinusitis." As a result, the worker's claim had been reopened for health care benefits. The officer stated that the symptoms appeared to be temporary and only surfaced when the worker was exposed to unbagged film and perfume in the workplace. The worker was being referred to the Disability Awards Department for consideration of a PFI award regarding her asthma.

In the next decision letter, dated January 14, 2000, the worker was informed that she did not have a permanent impairment as a result of her asthmatic condition. The rationale for this decision is set out in memo #29 which was appended to the decision letter sent to the worker. In that memo the disability awards officer noted that the medical evidence revealed objective evidence of permanent impairment. However, since the worker had been disabled from working for approximately four days only and she was no longer disabled from working, there was no entitlement to a permanent disability award.

The final decision appealed by the worker is dated February 29, 2000. In that letter a vocational rehabilitation manager informed the worker's then counsel that her clients were not currently eligible for vocational rehabilitation assistance. The manager stated that their claims had been accepted for temporary symptoms which surfaced when the workers were exposed to unbagged films in the workplace. Since the x-ray process had been changed to eliminate any exposure to the offending chemicals, the workers were not eligible for preventative vocational rehabilitation assistance since they were not at undue risk of developing permanent disability or at risk of increased disability.

### **Submissions and New Medical Evidence.**

Dr. Stark has provided a medical-legal opinion with respect to each of the workers in the MRI unit. In his opinion dated January 6, 2005, Dr. Stark states that he is a specialist in Allergy and Clinical Immunology and has also received specialist certification in Internal Medicine. In his accompanying *curriculum vitae*, Dr. Stark provides an extensive list of publications and further information with respect to his field of expertise.

Dr. Stark has summarized his findings and impressions of the worker's medical status during the 27 times that he saw her between March 29, 1995 and December 15, 2004. In summary, he states that the worker has developed a number of symptoms since her exposure to chemical fumes from a poorly ventilated film processing unit in 1994/1995. He lists the symptoms as: cough and asthma, chronic rhinosinusitis, chronic eye irritation, chronic bowel complaints, sensitivities to sulphite preservatives and MSG in foods. He notes that the worker has had positive methacholine challenge and metabisulphite challenge tests. She suffers from increased fatigue and has developed anaphylactic reactions to radiocontrast media and sensitivity to tuberculin PPD skin testing. All of these symptoms, he states, have resulted since her exposure to the processing chemicals, with the possible exception of pre-existing grass pollen hay fever symptoms.

Dr. Stark states that it is his opinion that the worker's "prolonged exposure to x-ray developing fumes from June of 1994 until February of 1995 was of causative significance in the development and worsening of her respiratory, ocular, fatigue, and food and drug reactions." He notes that she had no significant previous problems with symptoms, other than seasonal hay fever symptoms, prior to her exposure to the faulty

x-ray processing unit's chemicals. He agreed with the BMA that sulphite was likely not the only factor in exacerbating the worker's symptoms although he thought that it had played a role in combination with other chemicals.

He thought that glutaraldehyde sensitivity was the more significant factor based on subsequent studies that have become available regarding x-ray technologists. He thought that exposures to this and other processing chemicals could have caused immunological sensitivity and irritant effects. He compared the relationship between the exposure to film processing chemicals and the worker's allergic reaction to the relationship between exposure to western red cedar dust and the development of western red cedar asthma as a result of a plicatic acid allergy. He said that patients who develop this type of asthma, appear to remain sensitive to the plicatic acid most of the rest of their lives and they may also have non-specific hyperreactivity of their lungs for years to come "even if they are totally removed from exposure to western red cedar saw dust." Such patients, like the MRI technologists, become more sensitive to non-significant irritants such as dust, cigarette smoke and perfume.

In Dr. Stark's view, the worker's exposure to sensitizing chemicals from the poorly ventilated x-ray developing unit was a causative factor in her developing symptoms of chronic rhinosinusitis, asthma, abdominal bloating, gas, reflux symptoms, fatigue, and sensitivity to sulphites, MSG, and glutaraldehyde chemicals. He states that the worker has also become sensitive to various medications and she will likely remain sensitive to these chemicals for many years to come. In addition, she has also experienced non-specific irritant reactions to other chemicals and substances such as perfumes, cigarette smoke and dust. These would also likely be life long sensitivities.

The representative also provided a report prepared by Dr. Yassi, a specialist in Community Medicine and Occupational Medicine, and Dr. Ouelette, a Community Health Medicine resident. The report, which is dated May 2004 was prepared at the request of the representative and is titled *X-Ray Processing Chemical Exposure in Imaging Technologists at [name of hospital]: A brief assessment of health impact and recommendations*. The report includes a brief summary of the clinical presentation of five of the six technologists who worked in the MRI unit and a summary of the case history similarities. It also contains a literature review, a section on the relationship between the clinical presentation of the technicians and the literature, and a recommendation section. Generally, the conclusions respecting the causes of the symptoms developed by the technicians are consistent with those of Dr. Stark although the authors have also addressed multiple chemical sensitivities in their report. In this regard, they state that "Four technologists' reported symptoms, medical histories and exposure histories who meet the criteria for diagnosis of MCS [multiple chemical sensitivity] and their demographic characteristics match the typical patient profile [for this syndrome]." [Reproduced as written.]

In the recommendations section of their report, the authors state that compensation of the affected individuals needs to be case specific. They state that this is a "tricky

subject, as MCS, although real, is undiagnosable with any degree of certainty, and as the pathophysiology is unknown there is often reluctance to accept this syndrome as a compensable occupational disease. Personal exposures and previous medical histories often confound the assessment of work-relatedness as well.”

The representative states that the remedy sought by the worker is a finding that the worker continues to suffer the accepted compensable conditions of occupational asthma, sinusitis, laryngitis and dermatitis, as well as the symptomatology she has listed, as follows:

- Asthma
- Brain fog
- Disoriented
- Hives on face
- Red rash on face
- Headaches
- Sinusitis
- Sore throat
- Laryngitis
- Loss of voice/voice hoarseness
- Shortness of breath
- Fatigue
- Achy body/muscle aches/ exhausted feeling
- Metal (chemical) taste in month especially on tongue
- Sneezing
- Coughing
- Red, itchy eyes
- Upset stomach and diarrhea
- Reactive lymph nodes
- Messy handwriting when experiencing brain fog

In the alternative the worker seeks that her compensable conditions be found to be permanent and that she be referred to Disability Awards for a PFI assessment and that the matter of the other symptoms be referred back to the Board for adjudication.

The worker also seeks reimbursement of the costs of her medication. Her representative states that the Board has not covered any of the costs of medication for her symptoms despite the fact that the worker has a number of accepted conditions. WCAT is requested to direct the Board to reimburse the worker for all of the medication expenses incurred since 1995 for these compensable conditions and to ensure that they are promptly paid in the future.

The worker seeks the cost of attending the hearing and the costs of the medical-legal opinion of Dr. Stark dated January 6, 2005 and Dr. Yassi dated May 2004.

## Law and Policy

In this case, the worker's exposure and the symptoms that form the basis of the decisions under appeal occurred before June 30, 2002. As a result, the worker's entitlement to compensation is adjudicated under the provisions of the Act that preceded changes contained in the *Workers Compensation Amendment Act, 2002* (Bill 49). WCAT panels are bound by published policies of the Workers' Compensation Board (the Board) pursuant to the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63).

Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I), which relates to the former (pre-Bill 49) provisions of the Act.

There are several policies which address entitlement to compensation in cases of skin and respiratory reactions to occupational exposures. The relevant portions of these policies are set out below:

Item #29.10 of the RSCM I addresses compensation for respiratory diseases. It provides:

Schedule B lists "Acute upper respiratory inflammation, acute pharyngitis, acute laryngitis, acute tracheitis, acute bronchitis, acute pneumonitis, or acute pulmonary edema (excluding any allergic reaction, reaction to environmental tobacco smoke, or effect of an infection)" as an occupational disease. The process or industry listed opposite to it is "Where there is exposure to a high concentration of fumes, vapours, gases, mists, or dust of substances that have irritating or inflammatory properties, and the respiratory symptoms occur within 48 hours of the exposure, or within 72 hours where there is exposure to nitrogen dioxide or phosgene".

There are many agents used in industry and commerce in the province which have irritating or inflammatory properties, and which in sufficient concentrations can produce respiratory symptoms if inhaled. Symptoms associated with the inhalation of such substances can vary from mild transient symptoms (such as a mild burning sensation affecting the eyes, nose and throat) to significant symptoms throughout the respiratory tract (such as dyspnea and respiratory distress). Significant exposure to some substances may result in persistent respiratory symptoms.

Onset of symptoms can occur within a few minutes or several hours of the exposure, depending on the substance. For the presumption in Section 6(3) of the Act to apply, the symptoms must appear within 48 hours of the

exposure, unless the exposure is to nitrogen dioxide or phosgene, in which case the onset of symptoms must occur within 72 hours.

A claim for compensation made by a worker who has developed persistent or chronic respiratory symptoms considered to be due to exposure to a substance with irritating or inflammatory properties, must be considered on its own individual merits without the benefit of a presumption in favour of work causation (unless the claim meets the requirements of one of the other items of Schedule B). In particular, claims for chronic bronchitis, emphysema, chronic obstructive pulmonary disease, obliterative bronchiolitis, reactive airways dysfunctional syndrome (RADS), chronic rhinitis, and conditions considered to be due to exposure to tobacco smoke, are determined on the merits and justice of the claim without the benefit of any presumption. The same is true of a claim made by a worker with acute respiratory symptoms where the requirements of Section 6(3) of the Act are not met (see #26.22). Where a worker who develops an acute reaction to a substance with irritating or inflammatory properties subsequently develops a persistent or chronic respiratory condition, a decision will be made based on the merits and justice of that claim on whether the chronic condition is a compensable consequence of the acute reaction.

Item #29.20 of the RSCM I addresses compensation for asthma. It provides in part:

Compensation is not payable because a worker develops an allergy or sensitivity to a substance or substances as a result of their employment. Compensation may be paid where a workplace exposure to the allergen or substance results in an asthmatic reaction.

In the case of a compensable asthma or a reaction of the respiratory tract to a substance with irritating or inflammatory properties, temporary disability benefits are payable until the temporary disability ends or until the worker's symptoms become stabilized. Where the worker's symptoms do not entirely resolve and he or she is left with a permanent impairment of the respiratory system, a disability award may be granted. However, no such award can be made when the worker's symptoms have resolved and they are simply left with the underlying allergy or sensitivity. Not only is the worker not now suffering from the occupational disease set out in Schedule B, but they are not disabled from working. The Board cannot grant a permanent disability award to a person who has the same physical capabilities as they had previous to the occurrence of the occupational disease, but who is precluded from a limited number of occupations because of a remaining allergy or sensitivity. No permanent disability

award can be made to a worker with a pre-existing condition when they have returned to their pre-exposure state.

Item #30.50 of the RSCM I addresses compensation for contact dermatitis. It provides:

Schedule B lists "Contact dermatitis" as an occupational disease. The process or industry described opposite to it is "Where there is excessive exposure to irritants, allergens or sensitizers ordinarily causative of dermatitis".

The payment of temporary disability benefits and permanent disability pensions are subject to the same general principles as are set out in #29.20 in respect of asthma or a reaction of the respiratory tract to a substance with irritating or inflammatory properties. Therefore, there is no disability for the purpose of the *Workers Compensation Act* unless the worker has an actual loss of body function or physical impairment resulting from the dermatitis which causes the worker to be disabled from earning full wages at the work at which he or she was employed.

Temporary disability benefits are payable while the disability is a temporary one, but cease when it disappears or stabilizes or becomes permanent. If the worker's symptoms do not entirely resolve and they are left with a permanent impairment, a disability award may be granted. However, neither temporary disability benefits nor a permanent disability pension is payable simply because the worker has developed a susceptibility to react to a certain substance as a result of his or her work which causes periods of temporary impairment if he or she is exposed to the particular substance, but otherwise causes no complaints. Rehabilitation assistance may be provided to assist the worker in obtaining alternative employment which does not expose him or her to the substance in question (see #86.30).

### **Preliminary Matter**

Each of the technologists has provided a list of symptoms and a list of precipitating factors. They submit, through their representative, that all of the symptoms described should be accepted as permanent compensable sequelae of their occupational exposures. The implication is that the technologists have developed a condition which manifests itself variously as respiratory, sinus and skin irritations, eye irritations, fatigue, headaches, gastrointestinal symptoms and other symptoms. This condition causes these symptoms to occur with exposure to numerous occupational and non-occupational situations and substances. The representative has not requested that WCAT make a finding that the technologists have developed multiple chemical sensitivity nor has the representative specifically submitted that these appeals involve adjudication of a disorder that may be described as "multiple chemical sensitivities" or,

alternatively, in some of the literature, as “darkroom disease.” Yet, this submission is implicit in the evidence of symptomatology, the medical evidence, and the appellate level decisions relied upon in the submission.

The representative submits that there is a recognized entity known as multiple chemical sensitivity, as described in the May 2004 report and scientific literature. She also submits that there is precedent for a finding of permanent sequelae to toxic exposure to processing chemicals. In this regard, she relies on appellate decisions of workers’ compensation tribunals in other jurisdictions as well as a decision of the former Appeal Division of the Board.

The Appeal Division decision involves a radiographer who was exposed to the same types of chemicals to which the MRI technologists were likely exposed and the Appeal Division found that the worker likely had developed multiple chemical sensitivities as a result of her occupational exposure. The Appeal Division in that case, however, was dealing with an appeal of decisions made by the Board and the Review Board specifically denying acceptance of multiple chemical sensitivities. The Appeal Division clearly had the jurisdiction to address multiple chemical sensitivities.

With one exception, there is no documentation indicating that the Board was requested to adjudicate the issue of multiple chemical sensitivity nor was evidence submitted to the Board that would support such a diagnosis.

This poses issues with respect to the jurisdiction of WCAT. The decisions that form the basis of the appeals address the compensability of specific symptoms and/or conditions. These decisions date back to 1998, at which time some of the symptoms reported by the technologists had not yet developed and/or had not been reported to the Board. For the most part, those symptoms which had been reported were adjudicated on the basis that they occurred in relation to specific occupational exposures. The submission now is that a wide range of symptoms are present in both occupational and non-occupational settings due to a process of sensitization to occupational substances and cross-sensitization to various unknown and non-occupational substances. In other words, it is submitted that the technologists have developed multiple chemical sensitivities.

There are certain circumstances in which WCAT may consider a new diagnosis for a condition or symptom complex that has been adjudicated by the Board under a different diagnosis. In that situation, neither the symptoms nor the mechanism of injury have changed but new information has become available suggesting a more appropriate diagnosis. Generally, WCAT considers that it has the jurisdiction to decide whether the condition was work related albeit the change in diagnosis.

In this case, however, the decision letters (with one exception) address whether the workers have developed respiratory and/or skin conditions and eye irritation as a result of exposure to film processing chemicals which are recognized as causing those types of symptoms. Those decisions are based on specific histories of exposures, knowledge

of the symptoms which may develop as a result of such exposures, and a temporal relationship between exposure and the onset of symptoms of that nature. This is different in kind from adjudicating a multiple chemical sensitivity disorder which involves reactivity to a wide variety of unknown substances resulting in multiple organ dysfunction and which is “undiagnosable with any degree of certainty” and “the pathophysiology is unknown” as stated by the authors of the May 2004 report.

Generally, WCAT also has jurisdiction to address a diagnosis which has been made prior to the initial adjudication by the Board despite the Board not having addressed that diagnosis. In *WCAT Decision #2003-02677*, which may be viewed at the WCAT website under *Noteworthy Decisions*, the panel explained the basis on which it would consider an alternative diagnosis for the worker’s condition as follows:

...in the decision letter, the case manager dealt with only one of the diagnoses on file. The case manager did not address the matter of cervical radiculopathy secondary to degenerative disc disease. The panel considers that WCAT has jurisdiction to consider not only the condition of bursitis/tendonitis but also cervical radiculopathy, since the worker initiated a claim for a symptom complex that could have been caused by either condition or both in combination, and the medical reports clearly identified both conditions.

In the current appeals, there was no alternative diagnosis of multiple chemical sensitivity when the decisions were made regarding entitlement to compensation in 1998. In this regard, I note that the medical legal opinions of Dr. Stark speak to the conditions of the technologists in 2005 and the May 2004 report speaks to their conditions in 2004.

It may be that the technologists have developed conditions involving multiple symptoms to unknown substances as permanent sequelae of their occupational exposures in 1994/95 and afterwards. This is a question, though, that is adjudicated as an issue of compensable consequences.

In view of all of the above, I do not consider that I have the jurisdiction to decide whether an individual technologist has developed multiple chemical sensitivity as a result of her occupational exposure, except where that matter appears to have been considered at the time the decision was made that forms the basis of the appeal.

## **Reasons and Decision**

In the decision letter of September 11, 1998 the Board officer stated the BMA’s opinion that the evidence was consistent with, rather than supportive of, the worker having developed a sensitivity to chemicals at work. The officer accepted the worker had developed occupational asthma, skin dermatitis, laryngitis and sinusitis as a result of exposure to film processing chemicals. However, the officer stated that these reactions

were temporary, only occurred when the worker was exposed to unbagged films and perfume in the workplace, and that they had not occurred after September 1997.

The worker's allergic reactions subsequent to September 1997 were not accepted by the Board because it did not have and did not obtain medical evidence that would support the existence of ongoing reactions.

The reason for distinguishing between evidence that is "consistent with" and evidence that is "supportive of" the development of a chemical sensitivity is not clear. However, the BMA subsequently provided an opinion that the worker had developed sensitivity to film processing chemicals. That is consistent with all of the other medical opinion evidence.

According to the MSDS information, respiratory and skin reactions are associated with exposures to glutaraldehyde and hydroquinone. These chemicals are also sensitizers and all of the physicians who have provided opinion evidence have noted that an individual who becomes sensitized to a chemical will develop reactions to minute quantities and repeated reactions are likely to result in chronic conditions.

There are no policies that deal specifically with the development of a chemical sensitivity due to occupational exposures. The policies dealing with compensation for asthma and dermatitis address situations that are most analogous to the development of a chemical sensitivity in that they deal with the existence and/or development of an underlying condition which results in either respiratory or skin reactions under certain conditions that would not elicit these reactions in individuals who do not have this underlying condition.

The policies currently in effect with respect to these conditions are currently under review and are the subject of a public consultation. The discussion papers pertaining to this review are accessible on the internet at [www.worksafebc.com](http://www.worksafebc.com). It is not known whether any policy changes will result from this review process and if there are changes, the nature of those changes. As previously noted, the policies applicable to these appeals are those in effect at the time that the workers developed symptoms due to their occupational exposures.

With respect to the worker's asthma, the evidence is that she developed this condition subsequent to her exposures in late 1994/95 and that it was caused by her occupational exposure. Dr. Yeung, Dr. Stark and the BMA were all of the opinion that the worker's asthma was caused by her exposures at work. The decision letter of September 11, 1998 is unclear in that it states that the worker's asthmatic and other symptoms are temporary, yet she is referred to the Disability Awards Department for assessment of a PFI for asthma. It does appear that there is objective evidence of permanent impairment due to occupational asthma and the worker is entitled to a PFI assessment for that condition.

According to memo #29, the worker was denied a permanent disability award because she was not disabled from working.

Section 6(1) of the Act provides that compensation is payable under Part 1 of the Act where a worker is disabled from working due to an occupational disease that is due to the nature of the employment.

Section 23(1) of the Act provides that the impairment of earning capacity for pension purposes must be estimated from the nature and degree of the injury, or in other words, from the degree of physical impairment.

Item #26.30 of the RSCM provides that no compensation, other than health care benefits, is payable to a claimant who suffers from an occupational disease, (with certain exceptions that do not apply here), unless the claimant is thereby disabled from earning full wages at the pre-injury job.

In this case, the worker had been disabled from working due to asthmatic reactions and she had received wage loss benefits for four days as a result, but the disability awards officer considered that the worker was not entitled to a permanent disability award, despite a period of temporary total disability, because the worker had returned to her usual occupation. However, the Act does not require that a claimant suffer an actual loss of earnings for entitlement to a permanent disability award under section 23(1); it requires only that the disability be likely to impair earning capacity.

The requirement in item #26.30 of the RSCM that the claimant must be disabled from earning full wages at the pre-injury job before compensation is payable refers to the threshold test for entitlement to compensation under section 6(1). It does not have the effect of restricting permanent disability awards for occupational disease to cases where there is an actual loss of earnings. Such an interpretation of the policy is inconsistent with section 23(1) of the Act. In this regard, I agree with the reasoning in *Appeal Division Decision #92-0658*, 8 WCR 145. This is also consistent with the memorandum referenced in the representative's submission.

The worker is entitled to a PFI assessment for occupational asthma and, if there is objective evidence of a compensable degree of permanent impairment, she is entitled to a permanent disability award.

With respect to the worker's sinusitis, I accept, based on Dr. Stark's medical reports and medical-legal opinion and the BMA's opinion, that the worker has developed compensable chronic rhinosinusitis due to her occupational exposures.

Turning to the dermatitis, it is not clear from the medical evidence whether the worker has a permanent dermatitis. It appears that she develops rashes and hives as an

allergic reaction to certain exposures but it also appears that these symptoms resolve. Although, I accept that the worker has likely developed a permanent skin sensitivity which results in symptoms when she is exposed to various substances, there is insufficient medical evidence to find that she has symptoms which do not resolve and which might constitute a permanent functional impairment.

The same applies to the worker's laryngitis; I accept that the worker likely has a permanent respiratory system sensitivity which results in laryngitis. But, it appears that this is a recurring problem and there is insufficient medical evidence to find that she has symptoms which do not resolve and which might constitute a permanent functional impairment.

The policies state that compensation is not payable solely on the basis that a worker has developed an allergy or sensitivity to substances due to occupational exposures. If there is evidence of permanent objective impairment, the worker may be entitled to a permanent disability award but repeated reactions to substances are not considered objective evidence of permanent impairment. In this case, I accept that the worker has permanent sensitivities which result in symptoms of dermatitis and laryngitis when she is exposed to various substances.

The worker may be entitled to temporary total or partial disability benefits when she has a disabling allergic reaction to substances in the workplace. At those times that the worker has a disabling allergic reaction or requires health care for an allergic reaction, sufficient information must be provided to the Board to establish entitlement to benefits at that time. A finding that the worker has a permanent sensitivity does not result in automatic entitlement to benefits for every period of subsequent disability. There must always be evidence of disability and that the disability is due to a workplace exposure.

With respect to the costs of medication, none of the decisions appealed to WCAT deny the worker the costs of medication. In the decision letter of September 11, 1998 the Board officer states the worker is entitled to health care benefits for occurrences of occupational asthma, skin dermatitis, laryngitis and sinusitis between 1995 and September 1997. The worker's representative states that the worker has not been reimbursed for any of the costs of medication since 1995. However, I was unable to find documents indicating that the worker had submitted receipts for medication or that the Board had refused to pay for medications.

With respect to the worker's asthma, it has been accepted that the worker has occupational asthma and it appears that she has been using medication for this condition on a regular basis since pulmonary function tests first revealed asthma in 1995. Policy at item #73.20 of the RSCM I states that "Coverage for necessary health care continues for as long as the worker continues to experience the effects of a compensable injury or occupational disease, notwithstanding that he or she may not be disabled from working or may be retired from the workforce." Accordingly, the worker is entitled to reimbursement for the costs of medication to treat her occupational asthma

on an ongoing basis. The reimbursement is dependent on the worker submitting receipts for the medications.

I have also concluded that the worker has a chronic rhinosinusitis which she uses medication to treat on an ongoing basis. The worker is also entitled to reimbursement for the costs of medication to treat that condition on submitting appropriate receipts.

With respect to specific allergic reactions of laryngitis and hives or rashes after September 1997 – the reimbursement of medication expenses is dependent on whether the allergic reaction was compensable. Although I find that the worker has permanent sensitivities, only allergic reactions to occupational exposures are compensable in keeping with the policies set out above. As a result, each exposure which results in an allergic reaction requiring treatment or time off, must be reported to the Board. I believe that the worker is aware of this and I note that several claims have been opened since 1997 for compensation with respect to specific exposures reported by the worker.

Turning to the decision respecting preventative vocational rehabilitation assistance, at the oral hearing the worker's representative submitted that the worker was entitled to preventative vocational rehabilitation assistance in the future should the need arise. I note that the written submissions do not refer to this remedy and there is no submission respecting vocational rehabilitation assistance. Since it was raised in the oral hearing, however, and the appeal of the decision letter dated February 29, 2000 which addressed vocational rehabilitation assistance has not been withdrawn, I will address that issue.

In this case, the employer has made substantial efforts to accommodate the conditions that the worker has developed as a result of her occupational exposures. Steps have been taken to practically eliminate exposure to x-ray films by implementing digital film processing and taking various other precautionary measures to avoid any exposures to film. Despite these measures, there are instances when the worker is exposed to film in the course of her employment with this employer. Despite attempts by the employer to establish a fragrance-free workplace, there are also unavoidable exposures to perfume. By and large, however, the incidence of exposure to perfume and film processing chemicals and other chemicals to which the worker has been sensitized has been substantially reduced through the efforts of the employer.

The steps taken by the employer to accommodate this worker and her co-workers has resulted in a unique workplace in which the worker is able to function albeit with some difficulties. As I understand the position of the worker, there is a concern that she is limited in employment opportunities, present and future, because of her compensable conditions and sensitivities. In addition, earlier submissions expressed a concern that the employer might undergo organizational changes resulting in the elimination of the MRI unit.

Section 16 of the Act provides that the Board may take measures “To aid in getting injured workers back to work or to assist in lessening or removing a resulting handicap...”

Item #86.30 of the RSCM I discusses preventative vocational rehabilitation assistance. It states:

Preventative rehabilitation is intended to provide assistance to workers who can return to their old jobs, but have been medically deemed to be at undue risk of:

1. permanent disability due to vulnerability, or
2. increased permanent disability.

Cases involving occupational disease or prior claims for the same injury (mainly joints and backs) are the primary focus of preventative rehabilitation.

Once eligibility for preventative assistance has been established, the rehabilitation process set forth in #87.00 applies.

Section 16 provides the Board with discretion to provide certain types of assistance to injured workers. Since the worker has continued to work in the same occupation with the pre-injury employer, there is no basis for the Board to exercise this discretion at this point. In the future, a situation may arise where the worker is not able to continue working at her pre-injury employment and she may request the Board, at that time, to provide vocational rehabilitation assistance. It is not possible to foresee the situations in which it may be appropriate for the Board to exercise that discretion and WCAT does not have the jurisdiction to direct the Board to exercise its discretion by providing any vocational rehabilitation assistance requested by the worker in the future.

Accordingly, I agree that the worker was not entitled to preventative vocational rehabilitation in February 2000. That does not preclude the Board from exercising its discretion under section 16 of the Act should that be deemed appropriate at some point in the future.

## **Expenses**

Item #13.22 of WCAT's *Manual of Rules of Practice and Procedure* states that WCAT will generally order reimbursement of the party's expenses to attend the oral hearing under section 7(1)(a) of the *Workers Compensation Act Appeal Regulation* (Appeal Regulation) if the party was successful on the appeal.

The worker is entitled to her expenses for a full day of wage loss to attend the hearing on November 15, 2005.

In addition, I found Dr. Stark's report of January 6, 2005 useful in considering the appeals of all six MRI technologists. Therefore, under section 7 of the Appeal Regulation, I direct the Board to reimburse the expenses related to Dr. Stark's report, according to the Board's schedule of fees, bearing in mind that this report includes six medical legal opinions.

I also found the report by Dr. Yassi and Dr. Oullette, dated May 2004, of assistance and direct the Board to reimburse the expenses related to that report, according to the Board's schedule of fees.

## **Conclusion**

I vary the decisions of March 27, 1996 and September 11, 1998 as follows:

- The worker has occupational asthma and chronic rhinosinusitis as a result of her exposures to film processing chemicals. She is entitled to health care benefits for treatment of those conditions, including the costs of medications.
- The worker has developed a permanent sensitivity to film processing chemicals which results in respiratory, sinus and skin irritations including dermatitis, laryngitis and sinusitis.

I vary the decision of January 14, 2000. The worker is entitled to a permanent functional impairment assessment with respect to her occupational asthma. The fact that she is not currently disabled from working does not disentitle her to a permanent disability award if there is evidence of a permanent functional impairment.

I confirm the decision of February 29, 2000 that the worker was not entitled to preventative vocational rehabilitation assistance at that time.

WCAT does not have the jurisdiction to make a decision as to whether the worker has developed multiple chemical sensitivities due to her occupational exposures.

Marguerite Mousseau  
Vice Chair



MM/gw