

## Noteworthy Decision Summary

**Decision:** WCAT 2004-02507-RB    **Panel:** Sherryl Yeager    **Decision Date:** May 13, 2004  
Larry Campbell  
James Howell

***Worker, who suffered from chronic pain, was not entitled to medical marijuana as a section 21 of the Workers Compensation Act health care benefit to control his pain because its effectiveness in reducing his symptoms was questionable, and it would delay his recovery and create unwarranted risk of further injury***

The worker suffered from chronic pain syndrome and requested that the Workers; Compensation Board (Board) provide him with medical marijuana under section 21 of the *Workers Compensation Act* (Act) for pain relief. The Board denied his request and the worker appealed.

The phrase “may consider reasonably necessary” in section 21 provides the Board significant discretion to determine what health care benefits it will provide to assist an injured worker’s recovery. Section 21 and policy item #78.10 of the *Rehabilitation Services and Claims Manual* (RSCM) establish that while patient choice is a consideration, the Board has the ultimate authority to determine what manner of health care it will sponsor. The mere fact that a physician issues a prescription is not sufficient to trigger the Board to provide a medication or treatment. The Board has the authority to deny a worker health care benefits even if they are prescribed by a physician, if the Board has determined there is no demonstrable efficacy in the requested mode of treatment. According to the Board president’s statement, clinical trials have found medicinal marijuana to have inadequate efficacy for pain control compared with newer medications, and the risks associated with use outweigh the benefits. The president’s statement also noted marijuana was not an appropriate treatment for benign pain from a claims perspective. A physician had authorized the worker to possess marijuana for pain control under the Health Canada access regulations for pain control, notwithstanding that the worker failed to meet the criteria for such approval. Although item #78.10 of the RSCM allows the Board discretion to provide alternative treatment to a worker, the primary focus of the policy and the Act is to provide treatment that promotes recovery, and excludes choices that delay recovery or create unwarranted risk of further injury. The panel found the effectiveness of marijuana at reducing the worker’s pain to be questionable because he continued to be bedridden while consuming large quantities of it for pain relief. There was not even reliable anecdotal evidence that marijuana use controlled the worker’s symptoms, because his own evidence was that the most significant improvement in his symptoms occurred after surgery and cessation of morphine use, not after consumption of marijuana. Also, an addiction specialist opined that there was no proven efficacy for marijuana for pain control, and that the drug would worsen the symptoms for an individual with chronic pain syndrome. Like the College of Physicians and Surgeons, the specialist felt that the risks of consuming smoked marijuana outweighed the benefits. The panel found that if law and policy were strictly interpreted, there would be an obligation on the Board in this situation to deny the worker access to smokable marijuana, as the medical opinion indicated this drug would delay his recovery and create an unwarranted risk of further injury. The Board appropriately exercised its discretion in denying the worker’s request for this drug.

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## Introduction

The worker appealed six decision letters of officers of the Workers' Compensation Board (Board) dated July 18, 2000, November 27, 2000, August 8, 2001, August 22, 2001, October 9, 2001 and December 27, 2001.

The letter of July 18, 2000 advised the worker that a case manager had recalculated his wage rate based on additional earnings information he had provided for 1995 and 1996. The case manager determined the worker's wage rate would be based on his one-year pre-injury average earnings in 1996 and 1997, rather than a three-year average. New information for 1996 resulted in an increase in the worker's wage rate to \$369.47 gross per week, less a deduction for the Family Maintenance Enforcement Program (FMEP).

The letter of November 27, 2000 advised the worker that the Board would not provide him with an adjustable bed. The Board would also no longer provide him with taxis to and from medical appointments.

The letter of August 8, 2001 advised the worker that the case manager concluded his headaches, right shoulder and neck pain were not accepted under his claim as they were due to a 1999 motor vehicle accident. The Board did not accept depression resulting from the compensable injury because the worker had a prior history of this condition. The Board would provide pain management/drug withdrawal counseling during his vocational rehabilitation planning and no further narcotics. Finally, the letter advised the worker that three specialists had provided differing medical opinions on the likely outcome of further lumbar surgery. The surgery would not occur until early 2002. Therefore, effective August 19, 2001 the case manager considered the worker medically stable and no longer entitled to temporary wage loss benefits. The Board would reopen his claim for these benefits when he had the surgery.

The letter of August 22, 2001 advised the worker that he would not receive vocational rehabilitation benefits as he refused to participate in a job search because he believed he was not medically plateaued. As he would have a permanent functional impairment because of his compensable injury, he was entitled to further assistance in the future if

he chose to participate in actively seeking employment.

The letter of October 9, 2001 advised the worker's representative that the Board would not provide the worker a wheelchair or massage therapy. The Board would not approve the worker's request to cover his \$1,100 weekly marijuana use for pain control.

The letter of December 27, 2001 advised the worker that his wage loss benefits were suspended as of December 16, 2001 for non-compliance with his drug treatment program as he refused to stop marijuana use. The case manager advised the worker that his wage loss benefits would be reinstated when he was compliant with treatment.

### **Issues(s)**

- 1) Was the worker's long-term disability wage rate correct?
- 2) Was the worker entitled to further health care benefits, in particular an adjustable bed, the use of a taxi to attend appointments and treatment, narcotic medications, medical marijuana, massage therapy, and a wheelchair?
- 3) Was the worker at a medical plateau as of August 19, 2001?
- 4) Were the worker's right shoulder condition, neck pain, headaches and depression a result of his compensable injury?
- 5) Was the worker entitled to vocational rehabilitation benefits after August 22, 2001?
- 6) Were the worker's wage loss benefits appropriately suspended on December 16, 2001?

The accident employer was no longer in business. The appropriate employers' organization, the Construction Association, declined to participate in the appeal. The Workers' Compensation Appeal Tribunal (WCAT) panel therefore invited a representative from the Employers' Advisers Office to participate in the appeal solely in relation to the issue of whether the Board should provide marijuana to the worker for medical purposes, in particular pain control.

### **Jurisdiction**

These appeals were filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003 WCAT replaced the Appeal Division and Review Board. As a Review Board panel had not considered these appeals before that date, they have been adjudicated as WCAT appeals. (See the *Workers Compensation Amendment Act (No. 2)*, 2002, section 38.)

These appeals were heard by a three member panel in accordance with section 238(5) of the *Workers Compensation Act* (Act), which enables the chair of WCAT to appoint a three member panel if the chair determines that a matter requires this manner of consideration. The decisions of panels appointed under section 238(5) do not constitute precedent decisions under section 250(3) of the Act.

## **Background and Evidence**

The worker was 36 years old and employed as a framer when he sustained a herniation to his L4-5 disc on March 3, 1997 while lifting a truss. The Board initially denied his claim for compensation, a decision upheld by the Review Board on appeal. The worker appealed this finding to the Appeal Division. While awaiting the appeal determination the worker underwent a discectomy on May 25, 1997. He also sustained several soft tissue injuries in a serious motor vehicle accident in March 1999.

The Appeal Division commissioners found on June 2, 1999 that the worker's disc herniation resulted from his work activities in March 1997. The commissioners noted that the worker had pre-existing degenerative disc disease, and the Board would have to determine if the 1999 motor vehicle accident affected his compensable injury.

The worker told a Board case manager on June 28, 1999 that he continued to have numbness down his right leg from his back to his foot. He injured his neck, right shoulder, back, and both legs in the motor vehicle accident. He was using Demerol two or three times a week prior to his motor vehicle accident for back pain, but after the accident he required this medication three times daily. The numbness in his right leg was also worse since the accident.

Following the discectomy in May 1997 the worker had little follow-up or medical treatment. He next returned to the doctor on April 17, 1998 and was diagnosed with recurrent sciatica secondary to degenerative disc disease and the previous discectomy.

A CT scan on December 30, 1998 indicated a possible recurrent herniation at L4-5 with displacement of the thecal sac and lateral entrapment of the right L5 nerve root. A repeat CT scan on July 16, 1999 indicated similar findings. A claims adjudicator determined on August 24, 1999 that although the motor vehicle accident had caused additional soft tissue injuries, the worker's compensable injury continued to temporarily disable him. The worker continued to receive wage loss benefits pending further medical investigation.

Neurosurgeon Dr. Chan assessed the worker in September 1999 and believed surgery to remove scar tissue and the recurrent herniated disc would relieve his pain complaints, although a muscular component would remain. Dr. Chan also expressed concerns that the worker's addiction to narcotic medication would prolong his muscular pain and recovery.

The worker had a second discectomy and removal of adhesions in December 1999. He reported his symptoms improved to virtually complete resolution of the nerve-related pain in the right leg, although there was residual stiffness and discomfort in his lower back.

#### *Wage rate*

The Board was served with a notice of attachment against the worker on October 13, 1998 for \$10,268.61 in arrears plus \$200 in monthly maintenance from the FMEP. In August 1999, another notice of attachment was served on the Board for a second payer for a sum of \$13,110 in arrears and \$250 monthly maintenance.

A decision letter dated August 4, 1999 advised the worker his wage rate was \$196.94 per week based on his earnings information provided to that date and two FMEP payments would be deducted from his benefits. The worker did not appeal this decision letter.

The worker and the employer provided additional earnings information to the Board for the periods from 1994 to 1997. The case manager ultimately determined the worker's income from employment in 1996 was \$16,589, in 1995 was \$14,260, and in 1997 was \$3,024. His earnings from January 1, 1996 to March 2, 1997 equaled \$19,613, creating a weekly wage rate of \$369.47. The case manager believed this was the most accurate reflection of the worker's income, which averaged \$15,000 a year and issued the decision letter of July 18, 2000 advising the worker of this increase and the continued FMEP deductions.

In February, 2002 the worker submitted his reassessed 1996 income tax return showing earnings of \$26,589, which combined with the 1997 earnings equaled \$29,613, spread over 428 days, for a wage rate of \$484.32 per week. The case manager adjusted the worker's wage rate accordingly and advised him of this change by decision letter dated March 6, 2002. The worker did not appeal this decision letter.

### *Health Care Benefits*

In March 2000 the worker reported continuing myofascial pain in his neck and ongoing problems with his right rotator cuff that were attributed to the non-compensable March 1999 motor vehicle accident. The worker was attending private physiotherapy for these complaints, although the Board provided therapy for his low back. The worker advised his case manager that he required transportation by taxi to attend physiotherapy, as he did not have a vehicle. The case manager noted that the worker was able to attend his sessions for his neck and shoulder treatments despite not having a vehicle and told him the Board would not provide a taxi. Nonetheless, in May 2000, the case manager approved the use of a taxi to ensure the worker attended at the occupational rehabilitation program. The worker reported numerous financial problems, difficulty with non-compensable medical conditions and stress were interfering with his ability to attend the program.

In June 2000 the occupational rehabilitation program discharged the worker as not fit to return to work, with a recommendation he attend a pain program. The program staff was concerned about the worker's pain magnification and poor compliance with treatment. The physiotherapist noted that the worker's range of motion was restricted; however passive range of motion tests produced an improvement. The worker reported pain with all tests, and the therapist observed muscle guarding during the assessments. The worker was seen demonstrating full flexion when reaching to pick up items from the ground in the gym.

In August 2000 the worker had an MRI and assessment by neurosurgeon Dr. Matishak, who believed the worker had a residual and/or recurrent disc herniation at L4-5. Dr. Matishak requested a referral to orthopedic surgeon Dr. Domnisse for consideration of a revision laminectomy with fusion.

At this time the worker provided his case manager a written "prescription" for an adjustable bed from his physician, Dr. Smith, dated November 9, 2000. On November 23, 2000 the Board medical advisor provided the opinion that an adjustable bed was not required for the worker's compensable injury. He also believed there were no objective findings that would prevent the worker from taking public transportation.

The case manager issued the decision letter of November 27, 2000 to the worker, advising that the Board would not provide a hospital bed or taxi fare for medical or treatment program appointments.

*Medical Plateau (1)*

In his November 23, 2000 opinion the medical advisor stated that the suggested laminectomy surgery would be consistent with the compensable injury, but he wanted to review the consultation report prior to providing a definitive answer. The medical advisor stated that if there was no further surgery, the worker was stabilized, or at a medical plateau. Dr. Dommissse assessed the worker on December 11, 2000 and provided the opinion he had chronic pain with perineural fibrosis, and surgery would only relieve 40% of his symptoms. He requested a second opinion from the Visiting Specialists Clinic, where a third neurosurgeon, Dr. Gittens, assessed the worker on July 26, 2001. Dr. Gittens believed the worker had chronic pain that was unlikely to be relieved by any further surgical procedures. He recommended the worker be educated in pain management and control, and possibly receive dorsal column stimulation.

Upon receipt of Dr. Gittens' consultation report the case manager determined the worker was medically stable, based on the November 23, 2000 opinion of the medical advisor that the worker would be at a medical plateau if no surgery occurred. The participants in a Board team meeting determined wage loss benefits would conclude effective August 19, 2001. As the worker would have a permanent functional impairment, referral to Vocational Rehabilitation Services and Disability Awards was appropriate. The team also agreed the worker's narcotic use was excessive and he required drug and alcohol counseling.

The case manager issued the decision letter of August 8, 2001 advising the worker that his temporary wage loss benefits would conclude effective August 19, 2001, and be reinstated when he had the surgery in 2002 at the earliest. The letter also advised the worker that the Board would not accept his headaches, right shoulder and neck pain and depression under the claim. The case manager determined the depression pre-existed the compensable injury, and the other conditions were related to the 1999 motor vehicle accident.

The worker confirmed on August 16, 2001 that his depression pre-dated his compensable injury and he accidentally submitted a reimbursement request for this medication. The worker reported an inability to participate in household and recreational activities since the motor vehicle accident. He also had pain in his right shoulder, all levels of his spine, and headaches following the motor vehicle accident.

A medical advisor provided the opinion on August 20, 2001 that the worker may have pre-existing depression, however it was common for this condition to result from chronic back pain, and Effexor and/or other antidepressants would be appropriate until the depression resolved.

The medical advisor made a second entry on the same date after a discussion with the Board psychologist and client services manager. They agreed that if surgery was not performed, supportive pain management counseling with a component of weaning the worker from his narcotic medication would be appropriate. The medical advisor then discussed the client's progress with his physician, Dr. Smith, and learned of the pending surgery, which the worker had signed consent for on January 28, 2001. The medical advisor believed that referral to pain and drug counseling was appropriate regardless of the pending surgery.

### *Vocational Rehabilitation*

On August 22, 2001 the worker met with a Board vocational rehabilitation consultant to conduct an initial vocational assessment. The worker advised he was medically unable to seek employment, believed he required further medical treatment and refused to participate in vocational rehabilitation. The vocational rehabilitation consultant issued the decision letter of August 22, 2001 advising the worker that his vocational rehabilitation benefits were concluded due to his refusal to participate. If he wished to seek employment he could contact the Board in the future.

The vocational rehabilitation consultant met the worker again in September 2001. The worker reiterated that he was physically incapable of conducting a job search and would not participate in the vocational rehabilitation process. The consultant determined the worker's file would remain closed.

### *Health Care Benefits*

On September 26, 2001 the worker attended at the Board office and spoke to his case manager. He presented a zip lock bag of what he advised was marijuana and a letter from his physician dated 9-11-00 (November 9, 2000 or September 11, 2000) prescribing him marijuana. Dr. Smith stated in the letter that the worker's lumbar nerve entrapment pain was "by his report" helped by marijuana use, and if that was available to him for pain relief he should be eligible for that type of help. The worker advised that his marijuana cost \$1,100 every two weeks and requested the Board pay for this.

The worker's representative wrote the Board September 27, 2001 requesting a decision letter accepting depression, impaired gastrointestinal tract, impaired sexual, urinary, and large bowel function, and impaired sleep, memory and concentration. The letter also requested the Board provide the worker a wheelchair, marijuana (six to eight joints daily), and the medications Losec, Effexor, Morphine Sulphate, Morphine Contin, the forthcoming lumbar fusion surgery, and massage therapy.



On October 1, 2001 a medical advisor provided the opinion that he would not support prescribing marijuana for the worker's pain. He had discussed the issue with Dr. Smith, who advised that at the time he issued the prescription he supported the worker's request. However, he had since come to believe the worker required counseling to reduce his narcotic and marijuana use and agreed it would be inappropriate for the Board to fund this drug. The medical advisor also provided an excerpt from the Board's "Ask the President" feature regarding marijuana use. The president stated that clinical trials found cannabis had inadequate efficacy for pain control compared with newer medications, and the risks associated with its use outweighed the benefits. From a claims perspective, marijuana was not an appropriate treatment for benign pain, however it might be considered for the occasional cancer claim where the worker required palliative care.

The case manager issued a decision letter to the worker's representative on October 9, 2001 advising that several of the items he requested were addressed in the decision letter of August 8, 2001. The medication Losec was approved. However, the Board would not provide a wheelchair, massage therapy or marijuana to the worker.

### *Suspension of Benefits*

A psychologist interviewed the worker in October 2001, and provided the opinion that the worker met the DSM-IV criteria for Adjustment Disorder with Depressed Mood, and the Board Psychology Department's criteria for chronic pain syndrome.

The worker underwent an initial assessment with drug and alcohol treatment specialist Dr. Coleman on November 5, 2001. Dr. Coleman recommended the worker be assisted through withdrawal, followed by admission to an addiction treatment centre, then a work hardening program with clearly defined functional goals.

The worker missed his first scheduled appointment with the addiction specialist psychologist in October. The worker advised the psychologist's office that he had stopped taking all pain medication and wanted to meet, however then missed two further appointments without explanation. The psychologist therefore closed the worker's file.

On November 22, 2001 the worker told his case manager that he was willing to try the treatment program. The case manager determined the worker's claim would be reopened for section 29 wage loss benefits as participation in the treatment program would take him out of the job force.

On December 17, 2001 Dr. Coleman advised the Board that the worker was refusing to abstain from marijuana. The worker cancelled his appointment with Dr. Coleman to discuss this issue and did not rebook another one.

On December 21, 2001 Dr. Smith issued a letter to the Compassion Club advising he no longer was able to recommend the use of marijuana for medical reasons by the worker.

The case manager relied on policy #78.13 of the *Rehabilitation Services and Claims Manual, Volume I* (RSCM) to suspend the worker's benefits for refusal to submit to treatment and advised the worker of this decision by letter dated December 27, 2001.

#### *Medical Plateau (2)*

Following the suspension of his benefits, the worker continued to see Dr. Matishak, who believed the worker remained disabled because of his low back pain and kept him on the waiting list for the recommended surgical laminectomy and fusion. During the waiting period, Dr. Matishak prescribed marijuana to the worker.

The worker underwent this surgery in April 2003. The operative report of Dr. Matishak indicated there was significant synovium exiting from the facet complex on the right at L4-5 and adherent to the dura. This was excised and scar tissue removed, a discectomy completed and a bone graft and steel rods inserted to stabilize the spine. During his recovery the worker used Demerol for pain control.

There was conflicting information in the file regarding the worker's pain levels following surgery. In May 2003 Dr. Smith advised the Board medical advisor that the worker had reported his pain was resolved. In June 2003 the worker told a case manager that frequent Demerol was not "holding" his pain. Dr. Smith advised that he was concerned by this information, and that he did not know that the worker was using marijuana prescribed by Dr. Matishak.

On August 11, 2003 Dr. Matishak's consultation report noted the worker was no longer on pain medications, but was using marijuana "primarily for pain control."

## Pre-hearing Submissions

The employers' advisor representative submitted a package of information to WCAT on September 11, 2003, regarding the prescription of medical marijuana, and a medical-legal opinion from addiction medicine specialist Dr. Baker regarding the worker's use of this drug for pain control. Dr. Baker believed that due to the toxicity associated with inhaling the smoked plant, and lack of standardized dosing of this route of administration, smoked marijuana for any purpose other than brief, terminal compassionate use by a dying patient could not meet the tests of safety and efficacy demanded of other approved, prescribed medications.

Dr. Baker reviewed the worker's Board file as part of the formation of his opinion. He advised that marijuana was contraindicated for the worker for several reasons, including his refusal to comply with drug treatment. He believed the worker's heavy use of opiates and marijuana perpetuated and exacerbated his depression and chronic pain syndrome. He recommended the worker undergo abstinence-based treatment, cognitive behavioural therapy, antidepressant medication and an active aerobic exercise program.

Also included in the submission were policy statements from several health professional organizations, a review of the efficacy of medical marijuana for pain control issue conducted by the Alberta Workers' Compensation Board (Alberta Board), and a memo from the B.C. Board's Evidence-Based Practice Group (EBPG).

The College of Physicians and Surgeons of B.C. position statement dated July 9, 2001 on the marijuana medical access regulations published by Health Canada reminded its members that while patients may benefit or claim benefit from smoking marijuana, only physicians familiar with this agent should consider prescribing it for their patients. The statement noted that Health Canada regulations did not take into account the requirement for physicians to follow evidence-based protocols and guidelines in providing care for their patients. The College concluded the statement with the comment that marijuana had not been subjected to investigative protocols and the pre-public release requirements for all new drugs.

The Alberta Board's 2002 review of the scientific literature concluded "scientific evidence of the effectiveness of marijuana as a therapy for chronic pain, however, does not currently exist." The review also found that there had been "significant advances in approved therapies since the 1970s and 1980s, and herbal marijuana did not appear to provide treatment options not currently available with approved pharmaceutical drugs." The authors raised concerns about the negative risks associated with smoked marijuana, including cognitive impairment, cancers, and impaired motor skills. The

authors concluded there was “presently insufficient evidence to treat marijuana as a ‘prescribable’ drug.”

The Board’s EBPB updated the review and found its conclusions were still supported by the medical literature. In a memo circulated to Board staff on June 4, 2003 the senior medical advisor stated that it was the Board’s position there was “insufficient evidence to support the concept marijuana is a prescribable drug,” and officers should not approve any such requests. Requests for pharmaceutical grade cannabinoid derivatives for cancer or HIV-related claims could be considered, but required input from a senior medical advisor.

The worker’s representative provided a written submission at the outset of the oral hearing. Included in the package was a report dated August 18, 2003 prepared by Dr. Vaisler, an orthopedic surgeon, for the lawyer who represented the worker regarding his 1999 motor vehicle accident. Dr. Vaisler noted that prior to the motor vehicle accident there were no plans for further surgery. Although the radiological examinations indicated there was no change in the worker’s back because of the motor vehicle accident, the accident did result in a significant exacerbation of the worker’s pain and his intake of narcotic analgesics. Dr. Vaisler believed it was more likely than not that the worker sustained a significant soft tissue musculoligamentous injury to his low back, which was very susceptible to reinjury as a result of the pre-existing disc protrusion. Dr. Vaisler stated that the motor vehicle accident resulted in an acceleration of the need for further surgery and contributed to the worker’s narcotic dependence. The worker had advised that his back pain significantly improved as a result of the 2003 surgery, but he continued to display marked restriction of movement with perceived pain at the extremes. Dr. Vaisler expected the worker’s symptoms would continue to improve over the next year, but intermittent mechanical low back pain and physical restrictions would remain.

Also included in the worker’s submission were copies of documents signed by Dr. Matishak indicating the worker required medical marijuana under Category 1 of the Marijuana Medical Access Regulations (the access regulations) for treatment of lumbar spinal stenosis and back and leg pain and weakness. Dr. Matishak also signed a form under Category 2 of the access regulations indicating the worker had a severe pain due to a spinal cord injury with resulting muscle spasms and a severe form of arthritis and required 15 grams of smoked marijuana per day. He signed these forms on May 23, 2003. The worker also applied for a license to produce marijuana under the access regulations on June 7, 2003.

## Oral Hearing

At the outset of the oral hearing, the worker's representative protested the participation of a representative of the Employers' Advisers Office on the basis that he was not advised of the panel's reasons for allowing the representative standing. He argued that section 246(2)(1) of the Act did not apply, as the decisions under appeal pre-dated the legislative changes.

The representative of the Employer's Advisers Office submitted that the panel had authority to invite participants and the worker's representative had received six weeks notice of that decision.

The panel made a preliminary decision that the representative would continue to participate in the hearing, and the panel would consider the worker's representative's arguments post-hearing.

## *Wage Rate*

The worker said that he did not appeal the decision letter of August 4, 1999 because he was "messed up" by his pain and medications and was in bed. He believed it would be more appropriate to base his wage rate on a three or five year average of his earnings prior to the injury.

## *Medical Plateau*

The worker believed he was still temporarily disabled after December 2001, and his MRI proved he was in pain. He said his third surgery improved his back pain by 50%. His chief complaint was spasms that pulled and tightened his muscles from his waist down to his buttocks and up into his thoracic region. Surgery improved these spasms by 70%, which he believed proved he was not at a plateau in August 2001. The worker said that the lengthy delay for his surgery was due to hospital wait lists. He said that on a scale of one to ten, his pain level at the time of the hearing was a three, while prior to the surgery it was a ten.

### *Narcotics*

The worker told the panel that he took Demerol for the first two years after his compensable injury. He began seeing Dr. Smith shortly after his motor vehicle accident in July 1999, who switched him to morphine as he was concerned about the side effects of Demerol. The worker denied any morphine use prior to the motor vehicle accident. He said that he quit using morphine during the Board sponsored drug addiction program and has not used prescription medications for pain control since, other than Demerol for a monitored period following his 2003 surgery.

### *Medical Marijuana*

The worker said he began using marijuana after his first surgery, and used more when he was also on morphine. Before his injury he used marijuana on an infrequent basis. The worker said that morphine and Demerol made him angry and after stopping these medications he had a significant improvement in his mood, but the biggest factor in his change in mood was the improvement in his pain following his most recent surgery. The only medication he used at the time of the hearing was marijuana, which he said did not “mess me up” in any way. Dr. Smith initially approved his use of this drug after he provided him the appropriate forms from Cannabis Canada. Dr. Smith’s written approval allowed him to obtain his user number from the federal government and a card from the Compassion Club that permitted him to possess and purchase marijuana. He required a different number to grow his own supply, which Dr. Matishak approved, but he was awaiting confirmation from Health Canada at the time of the oral hearing. The worker said it did not matter whether Dr. Smith revoked his prescription, as he still had his number and his papers.

The worker said that while he was awaiting surgery in 2001 and 2002, marijuana was enough to keep him sustained and keep his mind occupied while he was bedridden by his pain. He believed marijuana provided relief from the spasms in his back, allowed him to sleep longer and deeper, and eased off the stomach pain he had from morphine use. He also said his stomach pain had subsided following surgery. Marijuana also relieved his constipation resulting from morphine use. He did not believe there were any adverse side effects from marijuana, which also improved his mood in that it mellowed him out, relaxed his body and state of mind.

The worker said that after the Board suspended his benefits in 2001 he began growing his own marijuana. From approximately September 2000, when he obtained his Compassion Club card on the advice of his lawyer following a possession charge, until his benefits were suspended, he purchased his marijuana on the street or through the club. The worker said that the street price was \$80 an ounce, while the Club price was

\$280 an ounce. He estimated he was using one-half of a pound every two weeks, which cost \$1,000 on the street. He spent \$2,000 at the Compassion Club. The worker said that he purchased the more expensive marijuana from the Club because if he had the Compassion Club card and stickers on the bag of marijuana the police would not arrest or charge him with possession. The police did attend his home at one point and because he had his card, they removed his marijuana plants but did not confiscate his growing equipment.

The worker said that it took him a year to convince Dr. Matishak to sign the Health Canada forms for him to possess and grow marijuana for pain control. The worker said marijuana also improved his depression. He denied any addiction to marijuana, and said he only used it when he needed it for pain. He did not think it would be a problem for him to wean himself off it. Although Dr. Matishak approved him to use 15 grams of marijuana a day, he was only using 7 grams daily at the time of the oral hearing.

#### *Additional Health Care Benefits*

The worker said he purchased an \$1800.00 adjustable bed with a vibrator in order to avoid using drugs for pain control. It raised his head and legs and relieved the pressure on his back. Both he and his doctor thought it would be useful in relieving his symptoms. The worker said he was in bed up to 90% of the day prior to his 2003 surgery. At the time of the oral hearing, several months after that surgery, he was in bed 30% of the day and part of the night. The worker said he did not get a full night's sleep due to pain, although this had also improved following his surgery.

The worker said that at the time he was requesting a taxi to his medical appointments in 2000 he did not have a car and it was a one-mile walk to the nearest bus stop. From there it was a ten-mile bus ride to his doctor's office. In August 2000 he moved to a new residence, which was seven to ten miles from the nearest bus stop.

The worker said that he no longer required a wheelchair, however he did prior to his surgery as his legs would give out and he had to be moved in a wheelchair. He was only able to walk for five or ten minutes, on flat ground. He could not climb stairs without assistance.

He did have a prescription from Dr. Smith for massage and attended a massage therapist once, but the treatment provided only momentary relief.

### *Limited Acceptance of the Claim*

The worker said his pain, prolonged recovery, and difficulties with the Board were contributing to his depression in 2001. He believed his right shoulder problems, neck and headaches were more related to the motor vehicle accident than to his compensable injury. The worker agreed with the contents of Dr. Vaisler's report.

### *Vocational Rehabilitation Benefits*

The worker said that he could not look for work in August 2001 because he could not get out of bed. He told the panel that he was aware of the Board's policy regarding active participation from workers as an essential part of vocational rehabilitation, and advised that he wanted to return to work.

### *Suspension of Benefits*

The worker said that he stopped all morphine use by the time of his last visit to the treatment program. He was only using marijuana, ten joints a day, which the doctors also wanted him to quit. He missed the appointments with the counselor and addiction specialist because his back pain prevented him from getting out of bed. He said that he advised the doctors' offices of this at the time.

The worker said the program was reducing his morphine use by 5 mg increments, which he found very difficult, so he quit cold turkey. He was not refusing to stop morphine use, and did not believe stopping marijuana would promote his recovery. The worker disputed his need for drug and alcohol counseling, and said his physician had never advised him this was necessary.

He said that when his benefits were suspended, he had stopped using morphine and his head was spinning. He knew he still needed surgery and therefore did not approach the addiction doctors and request continued treatment.

### **Submissions**

The worker's representative submitted that the worker's use of marijuana for pain control was strong evidence he had not reached a medical plateau. He also submitted that the Board's decision to place the worker back on wage loss benefits during the period he was receiving drug treatment was inconsistent with its position that the worker



was medically plateaued. He argued that the worker's significant reported improvement in his pain following the fusion surgery was evidence of his potential for improvement. The worker's representative also referred to pages 7 to 10 of Dr. Vaisler's report, noting the finding of neurofibrosis and argued this went to the question of medical plateau, and suggested Dr. Vaisler's use of the word "significant" implied the condition was severe.

He argued that it was illegal to suspend the worker's wage loss benefits because of medical marijuana use, as there was no evidence this was delaying recovery of the worker's back injury.

The worker's representative submitted that the Board was discriminating against the worker because he used marijuana for pain relief, which was a breach of basic human rights and freedoms, the B.C. Human Rights Code and the Canadian Charter of Rights and Freedoms. He intended to forward notice of this to the provincial and federal attorney-generals. (No documentation of the notification of the Charter challenge to these agencies was provided to WCAT 30 days in advance of the hearing, or afterwards. Therefore in accordance with item 3.60 of the *WCAT Manual of Rules, Practices and Procedures* (MRPP) the panel proceeded with its decision without considering Charter arguments.)

The worker's representative argued that Dr. Matishak's decision to sign the Health Canada documents should receive significant weight, as it was not a decision made lightly or carelessly. The worker's representative argued that the Board had an anti-marijuana use policy agenda, evidenced by the medical advisor contacting Dr. Smith regarding his prescription.

He further argued that marijuana was being "demonized." There was no section in the RSCM regarding marijuana, or mention of it in the narcotics policy. The generally accepted view is that marijuana is a narcotic and under the jurisdiction of the Controlled Substances Act. Therefore this was a federal issue and not within the jurisdiction of the B.C. government. He argued that marijuana was well-recognized as a sleep, depression, and chronic pain treatment. The federal government appeared to be in the process of approving marijuana for use.

The employers' advisor submitted that policy #77.30 of the RSCM regarding prescription narcotics and addictive drugs does not discuss marijuana because marijuana is not a prescribed medication found in the Compendium of Pharmaceutical Sciences. She supported the opinion of Dr. Coleman regarding the worker's drug use, and his decision to stop treatment for the worker's refusal to discontinue his marijuana use. She noted Dr. Coleman was an addiction specialist. She argued marijuana was an addictive, non-prescribed drug of unproven efficacy.

She relied on the position of the College of Physicians and Surgeons that its members should be cautious about prescribing medications without knowing their impact and the Alberta Board's policy paper contained in her pre-hearing submission. She asked the panel to place significant weight on Dr. Baker's opinion, as he was an expert in addictive medicine.

The employers' advisor submitted that WCAT should prefer medical expertise when weighing medical opinions. Dr. Smith's letter of support for the worker to receive marijuana did not cite any reasons for the worker's requirement of this drug. Both Dr. Coleman and Dr. Baker believed the worker had a chronic pain syndrome, and complete withdrawal of drugs would allow for recovery and gainful employment.

She argued that the decision of the medical advisor to deny marijuana was soundly researched and reflected the opinion of the Board's EBPG on the subject. The representative also noted that medical marijuana is available to the worker through other avenues than the Board.

### **Post-hearing Submissions**

Following the oral hearing the panel provided the worker's representative opportunity to respond to the pre-hearing submission of the employers' advisor and he did so in writing on October 15 and 17, 2003. Only arguments pertinent to the issues before the panel will be summarized here.

The worker's representative repeated his protest against the presence of a representative of the Employers' Advisers Office at the hearing as an attempt by the provincial government to improperly influence the WCAT in order to establish a precedent decision prohibiting medical marijuana.

He argued that Dr. Baker's opinion was of limited value because he had not examined the worker and was not independent or objective. He believed Dr. Baker's comments regarding the availability of cannabinoids in pill form supported a finding the worker should be provided this drug by the Board. He also argued that Dr. Baker's comments on addictive drugs perpetuating chronic pain syndrome were general and not specific to the worker.

The worker's representative noted that section 21 of the Act regarding the provision of medical treatment did not restrict itself to prescription medications. There was no policy in the RSCM regarding medicinal marijuana use, and therefore WCAT was not bound by any policy on this issue. Policy #77.30 of the RSCM did not list marijuana as a

narcotic or drug of addiction. The worker's ability to stop his other medications supported a conclusion he was not in danger of further disablement due to drug use. He argued Dr. Matishak was a specialist who treated the worker and his opinion should be preferred over Dr. Baker.

The worker's representative also submitted that the WCAT panel should have invited marijuana advocacy groups and Health Canada to intervene in the hearing. He referenced and attached a number of recent legal decisions regarding the legality and supply of medicinal marijuana. He also attached the worker's recent approval from Health Canada to possess and grow medicinal marijuana for a spinal cord injury and severe arthritis.

The worker's representative also requested a number of findings regarding acceptance of conditions and benefits that had not yet been adjudicated by the Board and will not be dealt with in these findings.

### **Findings and Reasons**

At the outset of the oral hearing, the worker's representative protested the participation of the Employers' Advisers Office on the basis that he was not provided the panel's reasons for allowing the representative to have standing. He argued that 246 (2)(i) of the Act did not apply, as the decisions under appeal pre-dated the legislative changes. The worker's representative characterized the participation of the employers' adviser as the participation, submissions and arguments of the "B.C. government." He requested the following findings:

- 1) That it was unlawful for the WCAT to have provided the Government of B.C. with party status, with no notice and opportunity to be heard by [the worker] and without his consent.
  
- 2) That it was unlawful for the WCAT to have allowed the Government of B.C. to file a 148-page submission on [the worker's] counsel only two days before the hearing;
  
- 3) Unlawful for the WCAT not to have provided notice and opportunity to be heard to Health Canada, Compassion Clubs, Hemp B.C., the B.C. Marijuana Party, the Vancouver Legal Assistance Society, WCB Advocates Group, the B.C. Federation of Labour and the Official

Opposition.

[reproduced as written]

In his October 17, 2003 amended submission, the worker's representative contended that:

...the Government of BC (Ministry of Labour) has improperly influenced or consulted with the WCAT (Ministry of Labour) to provide it standing here in order to attempt to establish a precedent decision, on behalf of the WCB and/or BC government with these goals;

- (a) to prohibit s. 21 assistance for medicinal marihuana,
- (b) to prohibit s. 21 assistance for all "non-prescription" medications: and,
- (c) to establish a useful precedent for all MSP/Pharmacare/welfare disability medication and other BC government insured health care and/or pharmaceutical services under all statutory and/or contractual insurance plans or schemes under provincial jurisdiction.

[reproduced as written]

The panel considers to be groundless the assertion that the participation of the employers' adviser in this appeal resulted from any outside influence or consultation with WCAT, whether or not directed or motivated by a political agenda. Neither is it accurate to equate the participation of the employers' adviser as tantamount to the participation of the provincial government. The employers' advisers are appointed pursuant to section 94 of the Act, as are the workers' advisors. Both agencies are neither beholden to government, nor obliged to espouse its views, but rather they are directed by statute to represent the positions and interests of their respective clients, in this case the larger community of employers.

In the circumstances of this appeal, the accident employer was no longer in business and the appropriate employers' organization, The Construction Association, declined an invitation to participate in the proceedings. WCAT invited the employers' adviser to participate in the hearing with respect to a single issue, namely whether the worker was entitled to have the Board pay for his acquisition of medical marijuana for pain relief. It took this step to ensure that the panel received both a worker's and an employer's perspective on a novel issue, to assist the panel to fully consider the merits of the appeal and arrive at a reasoned conclusion.

Although we accept that future panels who address issues concerning medical marijuana may consider this decision, our findings on the worker's entitlement to

provision of, or funding for medical marijuana, is limited to the particular facts of this case. This is not a precedent panel, and of course, our findings are not binding on future panels addressing similar issues.

The primary objection of the worker's representative to the participation of the employers' adviser was based on his argument that section 246 (2)(i) of the Act did not apply, as the decisions under appeal predated the legislative changes. Sections 246(1) and (2)(i) of the Act provide as follows:

- 246(1) Subject to any rules, practices or procedures established by the chair, the appeal tribunal may conduct an appeal in the manner it considers necessary, including conducting hearings in writing or orally with the parties present in person or by means of teleconference or videoconference facilities.
- (2) Without restricting subsection (1), the appeal tribunal may do one or more of the following:
  - (i) request any person or representative group to participate in an appeal if the tribunal considers that this participation will assist the tribunal to fully consider the merits of the appeal.

There was no similar provision in the former legislation with respect to the Review Board. The former section 90(2) of the Act permitted the Review Board to deem an employers' organization to be a worker's employer for the purposes of an appeal where the actual employer had ceased to exist, but there was no express power granted to invite participation in an appeal in other circumstances.

Section 38(1), of the Workers Compensation Amendment Act (No. 2), 2002, part of the transition provisions of Bill 63, expressly contemplates a form of retrospective application by directing that pending Review Board proceedings "must be completed as **proceedings pending before the appeal tribunal**" [emphasis added]. The appeal tribunal does not operate in a procedural vacuum; of necessity it encompasses the procedures and practices provided for it by the same legislation that created it and this includes the ability to request that a representative group participate in an appeal.

It is a presumption of the common law that procedural legislation is presumed to have immediate application. This principle is codified by sections 36 (1)(b) and (c) of the Interpretation Act, R.S.B.C. 1996 c. 238 that provide:

- (b) every proceeding commenced under the former enactment must be continued under and in conformity with the new enactment so far as it may be done consistently with the new enactment,
- (c) the procedure established by the new enactment must be followed as far as it can be adapted in the recovery or enforcement of penalties and forfeitures incurred under the former enactment, in the enforcement of rights existing or accruing under the former enactment, and in a proceeding relating to matters that happened before the repeal,

As noted in Sullivan and Driedger on the *Construction of Statutes, Fourth Edition*, at p. 584, whether a statutory provision is procedural or substantive, depends not on the label, but on the effect. “If the effect of the provision is to alter the legal significance of the facts of a case, it is not purely procedural.” We find that the statutory provision in question that gives WCAT the discretion to request participation in an appeal has no effect upon the substance of the worker’s appeal. It does not alter the legal significance of the facts of the appeal, but is merely intended to ensure that the issues arising from those facts are fully canvassed and is therefore purely procedural. The panel finds it was within the jurisdiction of WCAT to request the participation of the employers’ advisor.

The other procedural disputes of the worker’s representative regarded the timing of the pre-hearing submission from the employer’s advisor, the decision of the panel that Dr. Baker was not required to attend for cross-examination, and the involvement of other interested parties as interveners.

On the first issue, the worker’s representative was provided additional time following the oral hearing to respond in writing to the submission, although it was disclosed prior to the hearing. There are no strict timelines for submissions in the legislation or procedural manuals for appeals of Review Board matters heard by WCAT. Dr. Baker provided an opinion regarding the efficacy of medical marijuana in general, and for this worker in particular, based on a review of his clinical records and information in the Board file. The worker’s representative could have replied to Dr. Baker’s comments and/or could have sought an alternate medical opinion in support of his position. WCAT panels operate in a non-adversarial forum and regularly weigh medical evidence and opinions without the benefit of cross-examination of those providing the opinion. The panel finds there was no prejudice to the worker resulting from the timing of the submission or the absence of Dr. Baker at the oral hearing.

Regarding the invitation for other interest groups to attend the hearing, the panel notes that the issue under appeal was solely whether the worker was entitled to

reimbursement of expenses for medical marijuana under existing Board policy and the Act. There is no jurisdiction or reason for the panel to examine the question of the legality of marijuana possession, which these groups would undoubtedly address. Counsel represented the worker's interests. The panel findings, as mentioned previously, deal strictly with matters pertaining to workers' compensation benefits and are not binding on other WCAT panels, much less other provincial agencies or federal programs. The panel finds no requirement for other agencies to participate in the appeal.

### *Wage Rate*

Regarding the worker's long-term wage rate, the panel finds there are no issues within its jurisdiction to consider under the January 18, 2000 decision letter. The worker did not appeal the August 4, 1999 decision letter advising him of his provisional eight-week wage rate and that FMEP payments for two payers would be deducted from his benefits. As this was the first instance a decision on the FMEP was conveyed to the worker, if he disputed his obligation to make these payments he should have appealed the August 4, 1999 decision letter.

Nor did the worker appeal the March 6, 2002 decision letter advising him that his wage rate was increased for a second time to reflect evidence of self-employment earnings subsequently reported to the Board. As the wage rate in the March 6, 2002 decision letter altered the decision in the letter under appeal in the worker's favour, and the worker did not appeal the 2002 letter, the panel has no remaining jurisdiction on the issue of the wage rate from the July 18, 2000 decision letter. Although the worker's representative advised he was unaware of these decision letters, they were included in the disclosure of the worker's file. We deny the worker's appeal.

### *Health Care Benefits*

Section 21 of the Act establishes that the Board may provide health care benefits and treatments that "it may consider reasonably necessary" at the time of the injury and after to assist in treatment of a disability.

Item #78.10 of the RSCM provides that the Board determines all questions regarding the necessity, character and sufficiency of health care to be furnished. The Board uses its control over treatment to promote recovery and exclude choices by workers or doctors that may delay recovery or create an unwarranted risk of further injury. Where coverage for a non-standard treatment program, medical appliance or other health care benefit expense is contemplated, prior approval of the Board is suggested. A medical

advisor should determine whether a requested treatment is appropriate for Board approval.

### *Adjustable Bed*

Item #77.29 of the RSCM relates to the provision of miscellaneous items as health care expenses pursuant to section 21 of the Act. This policy states in part that a healthcare expense must either be for the provision of medical treatment for the compensable injury, or an item to assist in carrying out the normal functions of daily living that the injury has rendered the worker incapable of performing. The panel finds that the evidence does not support that the adjustable bed was for medical treatment or to allow the worker to perform activities of normal living. While the worker may have found the bed more comfortable, the evidence does not support the medical necessity of its use. The panel denies the worker's appeal on this issue.

### *Taxi Transportation*

Item #82.10 of the RSCM sets out Board policy with respect to eligibility for transportation. This sets out, in part, that transportation expenses may be paid within 24 kilometres of a worker's residence where the worker is required to travel by taxi and has received prior authorization from the Board. The question to be answered is whether the worker required transportation by taxi.

The worker's evidence at the hearing related primarily to the distance that he had to walk to access public transportation, the distance that he had to travel, and that he moved to a residence even further from access to public transportation. The panel finds that the key question is whether there was medical evidence of an inability to take public transportation as opposed to the effects of the worker's choices about residential location and access to transportation.

The medical evidence from the worker's physicians does not set out medical reasons why the worker would be incapable of taking public transit. The Board medical advisor noted in his opinion of November 23, 2000 that there were no objective findings that would prevent the worker taking public transportation. The panel finds that while it may have been inconvenient for the worker to access public transportation, the medical evidence does not support a conclusion that the worker required taxi transportation due to the effects of the compensable injuries. We deny the worker's appeal on this issue.



### *Narcotic Medication*

Item #77.30 establishes that Board responsibility for narcotic analgesics will be limited to a post-surgical period of eight weeks. Extensions are considered in extenuating circumstances, such as where a worker has sustained a permanent functional impairment and will require regular intermittent and limited narcotics for pain relief. The worker provided evidence at the oral hearing that his narcotic medication made him moody and upset his stomach, and was not controlling his pain. This raises the question of why the Board would continue to provide medication that was not assisting the worker, and was in fact producing intolerable side effects. More importantly, the worker's physician, in addition to the Board medical advisor and the consulting physicians at the treatment centre, believed the worker had an addiction to this medication that required treatment. In those circumstances, it would behoove the Board to cease providing this type of medication.

At the oral hearing, the worker indicated he had not taken any narcotic medication after the time he began the drug treatment program until his surgery in 2003. There is therefore no outstanding expense for this type of medication, other than if the Board did not provide the Demerol prescribed by Dr. Matishak for a short period after the 2003 surgery. The Board was aware of and monitored that drug use at that time. We find that this was a reasonable treatment protocol for this worker. We find the worker was entitled to reimbursement for the cost of Demerol, if he was not already so compensated, for his post-surgical period only.

### *Wheelchair*

Policy #77.24 of the RSCM establishes that wheelchairs are issued to workers who are permanently disabled and unable to walk.

There was no medical evidence presented to support the worker's request for a wheelchair. Although the worker stated at the oral hearing that prior to his surgery he required a wheelchair because of falls, there was no supporting documentation from his physician regarding the need for a wheelchair. Nor was there evidence the worker sustained a spinal cord injury with resulting paralysis. We find the worker was not entitled to a wheelchair.

### *Massage Therapy*

There was insufficient evidence presented at the hearing that the worker found massage therapy beneficial for symptom relief. We find the worker was not entitled to this treatment.

### *Medical Marijuana*

The worker's representative argued that, as the worker's physicians prescribed him medical marijuana, the worker had federal authorization to possess it, and his evidence was that it effectively treated his pain when narcotic medication did not, the Board should provide it to him.

The panel considers the phrase "may consider reasonably necessary" in section 21 of the Act provides the Board significant discretion to determine what health care benefits it will provide to assist an injured worker's recovery. This is further illustrated in Item #78.10 of the RSCM, which directs that "all questions as to the necessity, character, and sufficiency of health care to be furnished shall be determined by the Board." The policy goes on to state that where coverage for a non-standard treatment program, medical appliance or other health care benefit expense is contemplated, prior approval of the Board is suggested. A medical advisor must consider whether the treatment is appropriate.

In summary, the law and policy regarding health care benefits establishes that while patient choice is a consideration, the Board does have the ultimate authority to determine what manner of health care it will sponsor. The mere fact a physician issues a prescription is not sufficient to trigger the Board to provide a medication or treatment. Current examples of this include the Board's practice not to sponsor pulse signal and craniosacral therapy or prolotherapy for musculoskeletal conditions, and sonocur (Extracorporeal Shock Wave Therapy (ESWT)) for treatment of epicondylitis. These are legal treatment modalities that are often recommended by physicians who advocate in favour of them. The Board's EBPG has concluded through clinical trials and analysis of existing scientific research that these treatment modalities are ineffective and issued recommendations that the Board not support them. This process creates the accepted practice for officers of the Board when adjudicating entitlement to benefits, creating a consistency in approach to all injured workers.

The case manager determining the worker's entitlement to medical marijuana consulted a Board medical advisor, who in turn referred to the Board president's statement noting that clinical trials found medicinal marijuana had inadequate efficacy for pain control

compared with newer medications and the risks associated with use outweighed the benefits. The president's statement also noted marijuana was not an appropriate treatment for benign pain from a claims perspective. This statement was supported by the findings of the Alberta Board's review of the scientific literature, which the EBPG updated and relied on in the June 4, 2003 memo advising there was insufficient evidence to support the concept marijuana was a prescribable drug.

There is no published Board policy specifically on the issue of medicinal marijuana, and considering the above reasoning, the panel finds there is no requirement for such a policy in order for the Board to determine entitlement to this as a health care benefit. The panel considers the June 4, 2003 memo of the EBPG constitutes an attempt to establish consistent practice in regard to this issue.

The worker did not provide any scientific studies or evidence in support of his position that he was entitled to reimbursement for medicinal marijuana. He did provide the Board with the "prescription" of Dr. Smith in 2000 for marijuana, which was based entirely on the worker's self-report of efficacy for pain control. The prescription pre-dated the creation of the Health Canada access regulations. In addition, Dr. Smith revoked this approval for the use of marijuana at the time the worker was requesting reimbursement, and therefore the panel affords his "prescription" no weight.

Dr. Matishak's authorization for the worker to possess marijuana was filed under Category 1 and 2 of the Health Canada access regulations. However, the worker was not terminally ill, did not have a spinal cord injury, nor was he diagnosed with a severe form of arthritis, which are the criteria for those categories. While the panel has concerns about the categorization under which the worker received his authorization to possess this drug, this is not the material issue, which is whether the Board should pay for it.

Policy #78.10 allows the Board discretion to provide alternative treatment to a worker, however the primary focus of the policy and the Act is to provide treatment that promotes recovery, and excludes choices that delay recovery or create unwarranted risk of further injury.

It could be argued that one individual's reactions to a drug or treatment are extra-ordinary enough to warrant deviating from accepted Board practice. Although the worker insisted at the oral hearing that marijuana controlled his pain, emotions, settled his stomach and mood, he also stated to physicians and at the oral hearing that the surgery reduced his pain significantly and eased his muscle spasms by 70%. He gave evidence that his mood and stomach problems had greatly improved since he quit using morphine. He stated that he was in so much pain prior to his surgery that he could not

get out of bed, both during the time he was taking morphine and after he quit this narcotic medication cold turkey and used only marijuana. The panel finds the effectiveness of marijuana at reducing the worker's pain is therefore questionable if he continued to be bedridden while consuming large quantities of it for pain relief. From the worker's evidence, the most significant improvement in his symptoms followed his stopping morphine use and undergoing surgery, not after consuming marijuana. The panel finds therefore there is not even reliable anecdotal evidence that marijuana use controlled this worker's various symptoms.

Additionally, Dr. Baker provided the opinion that there is no proven efficacy for marijuana for pain control, and in fact this drug would worsen the symptoms for an individual with chronic pain syndrome, such as the worker. He believed the risks outweighed the benefits of consuming smoked marijuana. The College of Physicians and Surgeons of B.C. also holds this opinion. The College indicated its members should exercise extreme caution in prescribing this drug to patients. The panel finds that if law and policy were strictly interpreted, there would be an obligation on the Board in this situation to deny the worker access to smokable marijuana, as the medical opinion indicates this drug would delay his recovery and create an unwarranted risk of further injury.

The panel finds the Board has the authority to deny a worker health care benefits even in the event they are prescribed by a physician, if the Board has determined there is no demonstrable efficacy in the requested mode of treatment. We find the Board appropriately exercised its discretion in denying the worker's request for this drug. We deny the worker's appeal.

### *Medical Plateau*

The determination of whether a worker's condition has ceased to be temporary, for the purposes of sections 29 and 30 of the Act is based upon Board policy item #34.54 of the RSCM. The policy sets out, among other things, that the primary criterion is whether there is likely to be a significant change in the worker's condition in the upcoming 12 months.

The worker received a variety of specialist opinions on the potential efficacy of a third lumbar surgery. Dr. Matishak recommended this surgery, and Dr. Dommissé believed that it could relieve a portion of the worker's pain. The case manager concluded, as Dr. Matishak predicted the worker's surgery would not occur before 2002, that the worker was plateaued in August 2001 as no significant change would occur within one year. However, the Board also recognized that the worker's depression was at least, in part, related to his compensable injury and surgeries, and, in addition, that the worker

had a chronic pain condition for which treatment was recommended. This resulted in the worker's referral to the pain management program and the addiction program.

In the course of a compensation claim, decisions are often made on a prospective basis. The actual timing or occurrence of future conditional events cannot be known with certainty, but decisions must be made based upon the likelihoods of events occurring. In this instance, the case manager relied upon the nine month-old opinion of a Board medical advisor that if no surgery was planned the worker was plateaued. The logical corollary of this is that if surgery was planned, the worker was not plateaued. The determination of plateau was, at that time, guided by policy but could not fetter the discretion of the Board officer to determine the matter based on the evidence and the merits of the individual claim.

Dr. Matishak believed the worker had pain from a physical source. Until the planned surgery occurred, the physical source of the chronic pain would not be addressed. While a pain program might have assisted the worker in coping with his ongoing problem, it would not result in a resolution as long as the physical cause remained. It appears that the Board officer, at the time of the August 8, 2001 decision, was engaged in speculation about precisely when the worker's surgery might occur. The panel finds no good evidence on which a conclusion rested that the surgery was, for example, more likely to occur in September 2002 rather than in July 2002. If one were hewing to the literal reading of the policy, one date would result in a loss of entitlement to temporary disability benefits whereas the second would retain such entitlement. In the absence of evidence upon which to base a determination of the likely surgical date, the panel finds that the Board officer simply engaged in speculation in determining to end the worker's temporary disability benefits.

In addition, the panel finds that the policy did not provide such a stricture that a literal reading was justified in any event. The decision about plateau requires the exercise of judgment based upon the evidence. In this case, the evidence from the medical advisor was that if surgery was planned the worker was not plateaued.

Similarly, if the worker required treatment for his narcotic addiction and chronic pain, which the Board determined he did and for which the Board resumed payment of temporary disability benefits for in November 2001, then how could he be plateaued? Indeed, the treatment for which benefits would have been paid was actually a precursor to the actual treatment of the worker's pain. Yet that precursor treatment was, in the Board's opinion, as set out in the suspension of benefits under the December 27, 2001 letter, considered reasonably essential to promote the worker's recovery. If the essential precursor treatment would lead to an expected recovery, via the subsequent narcotic treatment program, and as both of these would occur less than one year after

the August 8, 2001 letter, then there was no logical basis to conclude the worker was plateaued.

Given the opinion of the Board medical advisor with respect to the potential surgery, and the Board's determination that the worker required further treatment of his narcotic addiction problems, the panel finds that the worker was not plateaued at the time of the August 8, 2001 decision and he was entitled to temporary disability benefits under section 29 of the Act. The panel finds that the worker remained temporarily disabled in the period between August 2001 and the reopening of his claim at the time of surgery in April 2003.

#### *Limited Acceptance of the Claim*

Regarding the issue of whether the worker's right shoulder and neck pain, headaches and depression were a consequence of his compensable injury, the worker acknowledged that the physical complaints were related to his motor vehicle accident in 1999. This was supported by Dr. Vaisler's letter of August 18, 2003. We find insufficient medical evidence to support a conclusion the worker's right shoulder and neck pain and headaches resulted from his 1997 compensable injury.

Although the worker had a pre-existing history of depression, the Board medical advisor provided an opinion that it would not be unusual for an individual with chronic low back pain to suffer a degree of depression. The panel finds the evidence supports a conclusion that the worker's pre-existing depression was aggravated as a consequence of his compensable injury. We make no finding regarding whether this condition was temporary or permanent. We allow in part the worker's appeal of the August 8, 2001 decision letter.

#### *Vocational Rehabilitation*

Regarding the issue of whether the worker was entitled to vocational rehabilitation benefits, this is rendered moot by our findings above that the worker had not reached medical plateau when his benefits were terminated. We deny the worker's appeal of the August 22, 2001 decision letter.

#### *Suspension of Benefits*

Section 57 of the Act provides, in part, that the Board may reduce or suspend compensation where a worker refuses to participate in medical or surgical treatment

which the Board considers, based on expert medical opinion, is reasonably essential to promote recovery. Item #78.13 of the RSCM sets out Board policy with respect to section 57(2) of the Act. This item provides, in part, that subsection 2(b) is not intended to exclude all patient choices and even where the terms of the subsection are satisfied, the adjudicator is not bound to reduce or suspend compensation: there is discretion.

In determining application of section 57, the three major factors are refusal by the worker, the presence of an expert medical opinion, and the reasonably essential nature of the treatment.

The basis for the worker's referral for treatment was the Board medical advisor's recommendation that supportive pain counseling and weaning of the worker off narcotic medications was appropriate regardless of whether surgery took place. The treatment referral was made and the worker met with Dr. Coleman. The worker did cease his use of narcotic medication, but continued with marijuana. In this matter, the worker was supported by Dr. Matishak, though not by Dr. Smith.

If the primary focus of treatment was to wean the worker from narcotic medications and provide pain counseling, then that purpose was achieved. The worker did not explicitly refuse to participate in treatment but made a patient choice that the panel finds is within the realm contemplated by Board policy. The evidence does not support that the worker's use of marijuana was in and of itself a bar or impediment to his recovery from the compensable injury.

Finally, given that surgery was required in any event, it is difficult to say that the proposed treatment would have been reasonably essential to promote recovery. In the absence of the surgical amelioration of the physiological aspect of the worker's pain, reduction in medication or pain management would be at best peripheral to, rather than essential for, the worker's recovery.

The panel finds that the worker made a choice, for which he had some medical support, and that this choice did not constitute refusal *per se* to participate, as the primary objective of treatment – cessation of prescription narcotic medication – had been achieved. The panel finds that while there was expert medical opinion that the treatment would benefit the worker, the evidence does not support a conclusion that the treatment was reasonably essential to promote the worker's recovery.

The panel allows the worker's appeal on this issue. The worker was entitled to ongoing temporary disability benefits, in accordance with the panel's finding regarding plateau.

The panel allows the worker's appeal of the December 27, 2001 decision letter.

### **Conclusion**

We confirm the decision of the Board set out in the letter dated July 18, 2000.

We confirm the decision of the Board set out in the letter dated November 27, 2000.

We vary in part the decision of the Board set out in the letter dated August 8, 2000. The worker is entitled to wage loss benefits from August 19, 2001 through to his surgery in 2003, and thereafter for a period to be determined by the Board. He is also entitled to narcotic medications, in particular Demerol, only for treatment of post-surgical pain in 2003, if not already provided.

We confirm the decision of the Board set out in the letter dated August 22, 2001. The decision was, however, rendered moot by our finding regarding the August 8, 2001 decision letter.

We confirm the decision of the Board set out in the letter dated October 9, 2001.

We vary the decision of the Board set out in the letter dated December 27, 2001. The worker's benefits were inappropriately suspended and he is entitled to further wage loss benefits as set out above.

The worker's representative requested reimbursement of legal costs. The *Workers Compensation Act Appeal Regulation 7(2)*, stipulates that WCAT may not order the Board to reimburse a party's expenses arising from a person representing the party, or the attendance of a representative of the party at a hearing or other proceeding. We deny this request.



The worker also requested reimbursement of travel costs to attend the oral hearing. We award these costs in accordance with Board tariffs.

Sherryl Yeager  
Vice Chair

Larry Campbell  
Vice Chair

James Howell  
Vice Chair

SY/lja