Noteworthy Decision Summary

Decision: WCAT-2005-04407 **Panel**: Susan Marten **Decision Date:** August 22, 2005

Hernia – Pre-operative and post-operative wage loss benefits – Conflicting medical opinions – Policy item #15.20 of the Rehabilitation Services and Claims Manual, Volume II (RSCM II)

This decision is noteworthy as an example of an analysis of whether a worker is eligible for pre-operative and post-operative wage loss benefits in relation to the repair of a hernia.

The worker sustained a hernia while working as a ship fitter and underwent surgical repair ten weeks later. The worker attempted light duties prior to the surgery but was unable to perform these due to persistent discomfort.

The Board accepted the worker's claim for a ventral hernia and paid wage loss benefits for three weeks after surgery but did not pay pre-operative wage loss benefits. The worker requested a review by the Review Division of the Workers' Compensation Board (Board) which confirmed the Board decision. The worker appealed to the Workers' Compensation Appeal Tribunal.

There was substantial disagreement between the worker and the employer as to the availability of light work. There had been significant labour relations conflicts and the worker had received a 10-day suspension. However, he did not serve the entire suspension as he was laid off due to a lack of work. The employer said the worker had not returned to work after his surgery and had refused many call-back opportunities. The worker submitted that light duties had not been made available and he had been required to undertake physically demanding duties that were not appropriate. He said the Board had not adequately followed up to ensure he was not at risk.

The panel noted that policy item #15.50 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) addresses the adjudication of claims for hernia based on the Board's understanding of their biological characteristics. It states that there is usually no urgency to the hernia operation, except where there are threatening complications. In most cases there is no need to stop working while awaiting surgery. Pre-operative wage loss will not normally be paid unless medical information is provided by the attending physician indicating the complication that restricts the worker's ability to continue working. Where an attending physician's report certifies a pre-operative disability, other objective evidence, such as a medical opinion regarding the worker's condition, may be sought to either verify or dispute that opinion. Usual recovery times for hernia surgical repair are based on medical protocols and procedures adopted by the Board. Item #15.50 contains an internet link to the Board's "Simple Herniorrhaphy Post-op Rehabilitation Guidelines", which provide that a return to work will commence between 11 and 28 days after the surgery. Deviations from the guidelines may occur based upon the specifics of individual cases and surgeon preference.

The panel noted that as the worker had performed modified light duties and had been suspended and laid off, items #34.32, #34.11, and #35.21 in the RSCM II could apply as they generally describe the considerations that can be made in such situations. The panel concluded, however, that item #15.50 was most applicable to the worker's claim, as it specifically sets out the Board's policy with regard to hernia claims. The panel concluded the worker was not entitled to pre-operative wage loss benefits. The panel accepted the Board medical advisor's assessment

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
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and thus concluded suitable work was available to the worker. There was insufficient evidence of complications in the particular circumstances of the worker's case. The panel also determined the worker was not entitled to the payment of pre-operative wage loss benefits after he was suspended from work or after his layoff occurred.

With respect to post-operative wage loss benefits, the panel concluded the worker was entitled to benefits for six weeks. There was evidence the worker was at greater risk as his hernia was recurrent. Thus, he required a further two to three weeks of restrictions on lifting. The worker's appeal was allowed in part.

WCAT Decision Number: WCAT-2005-04407
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Introduction

The worker sustained a hernia while lifting a heavy gate on April 7, 2004 in the course of his employment as a ship fitter. The worker underwent a surgical repair on June 22, 2004.

By decision dated May 31, 2004, an officer at the Workers' Compensation Board (Board) advised the worker that his claim was accepted for a ventral hernia and pre-operative wage loss benefits would not be paid.

By decision dated July 9, 2004, a Board officer advised the worker that his wage loss benefits would be concluded on July 13, 2004.

The claim file indicates the worker was paid wage loss benefits from June 22 to July 13, 2004.

Review Division Decisions #20339 and *#21629* confirmed the above decisions. The worker appeals the review officer's decisions.

Issue(s)

Whether the Board appropriately determined the worker's entitlement to wage loss benefits.

Jurisdiction and Procedural Matters

The appeals are brought under section 239(1) of the *Workers Compensation Act* (Act), which permits appeals from Review Division findings to the Workers' Compensation Appeal Tribunal (WCAT).

Section 250 of the Act provides that WCAT must make its decision based on the merits and justice of the case but in so doing, must apply relevant policies of the board of directors of the Board. Section 254 gives WCAT exclusive jurisdiction to inquire into, hear, and determine all matters of fact, law, and discretion required to be determined in an appeal before it. This is therefore a rehearing by WCAT.

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The worker's claim was accepted for a hernia occurring in April 2004. The worker's entitlement is adjudicated based on the provisions of the Act after the amendments made by the *Workers Compensation Amendment Act, 2002* (Bill 49), effective June 30, 2002. Applicable published policy is found in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II). I have considered the worker's appeals according to the law and policy in effect at the time of the decisions appealed.

The worker is represented by a consultant hired by his union. The employer is participating in the appeal. The worker did not request an oral hearing. After reviewing the evidence and guidelines for considering an oral hearing in item #8.90 of WCAT's *Manual of Rules of Practice and Procedure* (MRPP), I conclude that an oral hearing is not required to ensure a full and fair consideration of the issues in the appeal.

The submissions of the worker's representative do not indicate any disagreement with the acceptance of the claim for a ventral hernia. I have therefore not addressed that issue, in accordance with the provisions of MRPP #14.30 that provides a WCAT panel will normally restrict its decision to the issues raised by the appellant.

The employer's representative provided a submission that was received after the deadline for receipt of a submission. He provided reasons for the late submission, which included an apology and explanation that the volume of appeals generated was difficult to manage, the delay was brief, the panel needed to have access to both the worker and employers' perspective on the appeal, and the integrity of the process was not compromised by the delay. MRPP item #10.20, "Late Submissions or New Evidence Submitted with Rebuttal" provides that a WCAT panel may decide not to consider the material, if a party submits material after the due date has passed. The panel will advise the parties, either by letter or in the decision, if the evidence or submissions have been excluded from consideration. I have considered the reasons provided. While I acknowledge the concern about the volume of appeals and that the delay was not lengthy, the time frames set out in WCAT's procedures are intended to ensure an appeal decision is issued within the statutory time lines as much as is possible. I have excluded that evidence from my consideration.

Documents have been placed on the worker's claim file since disclosure was provided on these appeals. I find I am able to render my decision on the basis of the information in the documents disclosed. I therefore do not find it necessary to disclose the additional claim file documents. I have not relied on that information in my decision.

Background and Evidence

I have read and considered all the information on the claim files and that presented on appeal. The worker's history is set out in the Review Division decision and I will not reiterate all that information. The review officer set out the policies that he considered applicable. I have considered those policies as well as those discussed below. What follows is a summary of the evidence relevant to the issues identified above.

The worker's application for compensation stated that he did not work on April 13, 16, 19, 21, and 23, 2004. He did not work after April 26, 2004 on the advice of his doctor. He provided a faxed statement in May 2004 that described his symptoms and activities between April 7 and May 3, 2004 and is further discussed below.

On April 7, 2004, the attending physician (Dr. Fothergill) stated the worker had a probable tear at an umbilical hernia repair site. He had an umbilical hernia repair in December 2003. He was on bed rest and not medically capable of working at his full duties full time, but could return to work in 7 to 13 days.

A November 2003 operative report of a left inguinal hernia and umbilical hernia repair described that exploration of the internal inguinal ring revealed an indirect hernia with weakness and a direct hernia on the floor of the inguinal canal.

The claim file contains a physical demands analysis of the job of fitter, faxed in April 2004, which indicated, in part, that a fitter was required to lift up to 10 pounds on an occasional basis (6% to 33%) and undertake activities such as bending, stooping, twisting, stair climbing, and reaching on a frequent basis (34% to 66%). Steel could be transported by hand if the pieces were small, by cart if they were manageable, and by forklift if they were too large. A piece could be put into place by hand or by crane or chain pulley if they were too heavy for lifting.

Dr. Fothergill indicated on April 14, 2004 that the worker was improved and working at light duties.

Dr. Klein, a physician at the same address, indicated on April 27, 2004 that the worker was medically capable of working at his full duties full time, but also estimated it would be up to six days before he returned to work in any capacity. He required modified duties and light lifting and could persist if he tolerated those duties. He otherwise might need time off work if appropriate duties were not available. He had a tender obvious midline hernia without incarceration. Dr. Klein diagnosed a ventral supraumbilical hernia and probable complications from the last hernia repair.

Dr. Lam, general surgeon, indicated on May 3 and June 7 that the worker was not medically capable of working at his full duties full time. His pre-operative history described that the worker tried light duties, but was off work for the past week because of the persistent discomfort. He required an urgent repair so that he could return to his full work capacities.

On May 20, 2004, Dr. F, Board medical advisor, provided recommendations for the worker's restrictions in physical activity, which included that he avoid climbing, as well as carrying, lifting, pushing, or pulling more than 10 kilograms.

The June 22, 2004 operative report described that a fairly large ventral hernia, approximately 3 to 4 centimetres above the umbilicus, was dissected out.

Dr. Klein's July 14, 2004 report described that the worker's wound had healed well externally. He still had twinges of discomfort. The internal healing was likely progressing apace. He suggested the worker continue to avoid heavy lifting for the next two to three weeks and not lift over 30 pounds. He could lift much less in awkward positions. The worker considered that only work in the shop would qualify as light duties, which appeared problematic for his company. There were significant employer/employee relations conflicts. It was reasonable to limit his heavy lifting for another 2 to 3 weeks.

Dr. Fothergill provided a report, dated September 15, 2004, in support of the worker's appeals. Dr. Fothergill stated that she noted the worker was managing at light duties on April 14, 2004, which involved making templates and grinding. It subsequently appeared that the light duties were no longer available. The worker was not capable of doing any lifting subsequent to the April 2004 injury. Lifting increased the intra-abdominal pressure and led to the risk of the hernia becoming incarcerated. Dr. Klein recommended that the worker avoid heavy lifting for six weeks post surgery, which had always been the standard advice. The worker's case involved a recurrent abdominal hernia of significant size and it seemed this advice was even more critical. Dr. Fothergill was aware that the Board guidelines had recently changed, but neither the surgeon nor Dr. Klein was aware of that change. The guidelines stated that individual circumstances may need special consideration. She supported the advice given to the worker. He had a recurrent hernia and caution with heavy lifting was appropriate. He would have been fit to return to work on August 3, 2004.

The September and October 2004 submissions of the worker's representative to the Review Division stated, in brief, that the employer did not have light duties available. The worker was required to undertake physically demanding duties that were not light or appropriate. The physical demands of those duties were not made known to his physicians and it was not clear whether that information was sent to the Board. No physical examination was conducted. The Board erred by not conducting a work site assessment and monitoring to ensure the worker was not put at risk, not consulting with the treating physicians, and not following their recommendations. The Board failed to perform a suitable job demands analysis upon which a post-operative return to work decision should be based. The worker should not be penalized for following his physician's advice.

The November 2004 submission of the employer's representative to the Review Division stated, in brief, that the worker was not suffering a loss or a potential loss. The worker's representative overstated the modified duties being carried out during the graduated return to work. The worker had a variety of options and preferred and chose his modified duties. He did not identify or refuse modified duties. The family physician was

aware of the modified duties. The worker received a 10-day suspension that was unrelated to the compensable injury. He did not serve the entire suspension, as he was laid off due to a lack of work. The employer rehired the worker on May 18, 2004, but he did not return to work. The employer called the union to ask why they did not dispatch the worker. The dispatcher indicated the worker was on compensation benefits and it was their policy not to dispatch workers in such circumstances. To date, the worker had not returned to work and refused many call back opportunities. The loss or potential loss was not a result of the injury but a result of the union's dispatch practices and/or the worker's option to deny available suitable work. The absence from work was a result of strained industrial relations and "piggybacking" upon a compensation issue.

The March 19, 2005 submission of the worker's representative to WCAT stated, in brief, that the worker returned to work on a restricted, light-duty basis in accordance with the medical clearance from his attending physician. The light duties initially assigned were reasonable, within his restrictions, and involved no lifting. However, he was then assigned to more physically demanding duties that involved strenuous overhead exertion, lifting, climbing while carrying medium to heavy weights, and awkward physical postures, all of which definitely aggravated the hernia injury. The worker advised his supervisor those duties were not suitable. His physician reassessed him and advised him to restrict himself to light duties and not engage in any lifting. Neither the employer nor the Board informed the treating physician of the more physically demanding duties or obtained medical clearance to assign the worker to such duties. The supervisor assigned the worker to an overhead zip cut that required him to work from a height while positioned on a ladder and hold onto ceiling pipes with one hand and use a 5 to 10 pound grinder with the other hand. The worker advised that assignment was beyond his capability and was then assigned to another job that required him to be fully bent over while grinding on the ground. At that point, his attending physician advised him to refrain from all work duties.

The representative submitted the Review Division failed to appreciate that the content of the worker's light duties changed, the increased physical demands aggravated his hernia injury, and the treating physician's advice was to refrain from any lifting. More detailed evidence was now provided to WCAT after a further review with the worker. The worker performed light duties that were within the medical restrictions and acted appropriately in stopping work when the assignments went beyond his medical clearance. The advice of the treating physician was reasonable. With regard to post operative wage loss, the Review Division erred in assuming that appropriate light duties were available. Dr. Fothergill's opinion should be given substantial weight.

Reasons and Findings

Section 5(1) of the Act provides that an injury is to be considered compensable, if it arose out of and in the course of the worker's employment.

Sections 29(1) and 30(1) of the Act provide that wage loss benefits are paid for a temporary total or temporary partial disability that results from the injury.

The Board has specific published policies with respect to the adjudication of claims for herniae, based on its understanding of the biologic characteristics of herniae. The board of directors' *Resolution #2004/05/18-03* (publicly accessible at www.worksafebc.com) amended the policy on hernia claims. The Board's May 31, 2004 decision was made before the policy change and the July 9, 2004 after that change. My consideration of the worker's appeal is in accordance with the amended policy, as the resolution was effective June 1, 2004 and applies to all decisions, including appellate decisions made on or after that date.

RSCM II policy item #15.50, as of June 1, 2004, states that there is usually no urgency to the hernia operation, except where there are threatening complications. In most cases there is no need to stop working while awaiting surgery. Pre-operative wage loss will not normally be paid unless medical information is provided by the attending physician indicating the complication that restricts the worker's ability to continue working. Where an attending physician's report certifies a pre-operative disability, other objective evidence, such as a medical opinion, regarding the worker's condition may be sought to either verify or dispute that opinion. Usual recovery times for hernia surgical repair are based on medical protocols and procedures adopted by the Board.

A housekeeping amendment was made to this policy item on December 1, 2004 to add an internet link to the Board's "Simple Herniorrhaphy Post-op Rehabilitation Guidelines." Those guidelines provide that a return to work will commence between 11 and 28 days after the surgery. Deviations from the guidelines may occur based upon the specifics of individual cases and surgeon preference.

Policy item #34.32 describes the Board's policy concerning strike or other lay-off on the day following injury. It provides general guidelines where a job was not available during a period of disability, or for some reason, a worker cannot or will not be returning to the prior job upon recovery. Where the injury disables a worker beyond the date of injury and results in an actual or potential loss of earnings, wage loss benefits are paid. Where no actual or potential loss of earnings occurs, the requirements of section 5(2) will be deemed to have not been met. This policy discusses the situation of a partially disabled worker who continued at light work and is laid off due to a lack of work. The general expectation is that the worker would, if not injured, have immediately sought new employment and the Board should not speculate as if and when it would have been found. If there is evidence to rebut this general expectation, the Board may conclude there was no actual or potential loss. These considerations apply only at the point of the original lay off.

RSCM II policy item #34.11, at the time of the case manager's decision, stated that where a worker accepts selective/light employment, benefit entitlement will be determined under section 30 of the Act. A worker must be capable of undertaking some form of suitable employment and, within reasonable limits, agree to the arrangement. The work must be safe, and the attending physician must be apprised of the nature of

the work and conclude it will neither harm the worker nor slow recovery. The work must be productive and not token or demeaning. If the attending physician is unable or unwilling to provide the required advice, a Board medical advisor must make the necessary determination. The Board will intervene to determine if an offer of light employment is suitable if the worker and employer disagree over the terms of the return to work, intervention is requested, and/or the Board adjudicator considers that further inquiry is required. That evaluation will include a review of the physical requirements and detailed medical information outlining the worker's medical requirements and physical restrictions.

RSCM II policy item #35.21 provides guidelines for determining what a worker "could earn" under section 30(1) of the Act. This policy similarly provides that the occupations not endanger the worker's recovery, be reasonably available over the short-term, and be one the worker is medically capable of performing. If the economy is the major factor in a worker's employment problems, compensation is based upon the difference between the pre-injury wage rate and the wage rate of the jobs that would have been available if not for the economic down-turn. Where a remaining disability makes a worker less viable as a potential candidate for employment in competition with other non-disabled workers, benefits may be paid on the basis that the work is not reasonably available.

In this case, there are some differences in the description of the worker's light duties in the worker's May 2004 statement, the submissions of the worker's representative, and the submission of the employer's representative. There are also differences in the information in the reports from the worker's attending physicians about the nature of the work he could do.

That said, the information subsequently presented by the worker's representative in the submissions to WCAT is generally consistent with the information provided by the worker. However, where differences exist, I prefer the evidence in the worker's May 2004 statement about the tasks he did. I do so because the worker's statement is his own direct evidence and was provided closer in time to the events. I therefore accept that the worker did not undertake a fire watch assignment, as noted by the worker's representative in his March 2005 submission.

The worker's statement described his activities between April 7 and May 3, 2004. In brief and in part, the worker stated that he was very sore on April 13, phoned to see his doctor, and was told to rest. His duties on April 14 and 15 included a light job that required a lot of reaching with a cutting torch. He probably could have worked on the afternoon of April 16, but thought he should take his doctor's advice and rest. He cut some angle bar on April 20, carried them for 150 feet or so, and did a lot of stair climbing. He then pulled cables and worked on the front car ramp. He built 2 ladders that weighed over 60 pounds on April 22 and took them to the ship to install them. He had to carry and manually lift them up to another deck. He dragged cable extension

cords. He measured the plates and went to a shop to lay them out. He welded at the top of the ship with a lot of stairs and ladders on April 26. He was asked to do an overhead zip cut in a very awkward position. He did not feel comfortable and informed the supervisor, who assigned him to grinding all afternoon on material that was heavy to turn over. He was bent over and grinding for about one hour when he felt his hernia pop out.

The worker informed the case manager on April 30 and May 17, 2004 that he missed time from work between April 7 and 26, as his stomach was too sore and he would attend at a hospital or see his doctors. He wanted to work at light duties, but was told there was no light duty program. He only refused one job that involved undertaking a zip cut for an overhead wheelhouse repair.

The employer's representative informed the case manager on May 17, 2004 that the worker was suspended on April 27 due to absenteeism and laid off on May 7, 2004. The worker had a lot of absences. He was arriving late and leaving early and probably exhibiting the same pattern with no relation to the work injury, disability, and work duties. There was a light duty program. The worker was on light duty and was told to do only what he could do. The worker only declined one job that involved a zip cut.

The employer's safety coordinator and another individual advised that the worker did not refuse modified duties. He was disciplined while on modified duties due to his extremely poor timekeeping. He was late almost every day for several months. He left early to see his doctor, and at times did not show up without clear communication with the employer. The worker was told on the morning of April 27 that he was suspended.

On June 8, 2004, the worker informed the case manager that the union said he was on the seniority list to be hired but he did not return to work as there were no light duties. He was told there were no light duties at the meeting about his suspension. He worked at other jobs during past lay offs. The case manager requested information on those jobs. The employer advised the case manager on June 9, 2004 that the call back should have included the worker but the worker never showed and the union did not dispatch him. The dispatch indicated he did not call the worker as he was injured.

On July 13, 2004, the case manager indicated that the worker either told the union he could not work or the union just did not provide the worker's name to the employer. Workers below the worker's seniority level were hired. Work was available but not taken.

I agree with the case manager that the worker's entitlement to pre-operative wage loss benefits is considered under section 30 of the Act. The available evidence supports a temporary partial disability at that time. The worker undertook light duties during some of this time. There are varying reasons provided about why he did not work as of April 27, 2004.

I conclude the available evidence supports the case manager's conclusions with regard to the payment of pre-operative wage loss benefits. I accept Dr. F's assessment of what were the reasonable pre-operative restrictions. Although the worker's representative indicated no suitable job analysis was undertaken, a job description and physical demands analysis are on the claim file. I consider the analysis undertaken by Dr. F was appropriate and in accordance with policy item #15.50, which provides that pre-operative wage loss is generally not paid and other evidence may be sought to verify or dispute the attending physician's opinion. There is also evidence that the nature of the worker's tasks were changing and I consider the balance of the evidence in this case indicates a review by a Board medical advisor was appropriate.

I conclude policy item #15.50 is more applicable to the worker's claim, because that policy specifically sets out the Board's policy with regard to hernia claims. I reach this conclusion because the worker did undertake modified light duties and was suspended and laid off and policy items #34.32, #34.11, and #35.21 generally describe the considerations that can be made in such situations. I have generally considered those policies, but again consider the specific policy on hernia claims to be more applicable to the particular circumstances of the worker's claim. The adjudicative principles in policy item #15.50 are based upon the Board's present understanding of the biologic characteristics of herniae, which sets out that a medical opinion can be sought about the payment of pre-operative wage loss benefits. Here, Dr. F set out that there were restrictions and I conclude the available evidence supports that suitable work was available. I consider that the worker was able to decline work that he considered unsuitable, did so, and the more likely reason for stopping work was the suspension. Generally, I do not consider the light duties were token or demeaning. I agree with the case manager's May 28, 2004 log entry that the April 27, 2004 medical report (Dr. Klein) indicates the physician was aware of the modified duties and the concerns expressed by the worker and continued to indicate that the worker could undertake modified and light duties. In addition, the reports of the attending physicians differ at times. Although Dr. Fothergill indicated in her April 14, 2004 chart note and her September 2004 report that the worker should not undertake any lifting, Dr. Klein's April 27, 2004 report indicated the worker would require modified duties and light lifting.

I place significant weight upon Dr. Klein's assessment, which was provided one day after the worker stopped working and was based upon his examination of the worker at that time. I again consider that the assessment of a Board medical advisor was appropriate in the particular circumstances of the worker's case.

In addition, although the worker stated he did not work on April 13, 16, 19, 21, and 23, 2004 and indicated he undertook tasks that involved more than making templates and grinding, he did not apparently seek medical attention between April 14 and 27, 2004. He described tasks that involved more than making templates, including the duties he described on April 20, 22, and 26, 2004. He stated he built and carried 2 ladders that weighed over 60 pounds on April 22 and was asked to do a zip cut in an awkward position on April 26, and did grinding in a bent over position. I acknowledge that the worker's assignment included tasks that involved awkward postures. I acknowledge that duties that included climbing and lifting 60 pounds were more than assessed by Dr. F; however, I again place significant weight upon the fact that Dr. Klein continued to indicate he could work on April 27, 2004. Dr. Klein expressly noted Dr. Fothergill's notes and that the worker indicated the light duties were too heavy. There is also the evidence of the worker's suspension, which I agree is a non-compensable issue.

I conclude the worker is not entitled to the payment of pre-operative wage loss benefits after he was suspended from work or after his layoff occurred. Again, I consider the balance of the evidence supports that it is more likely the worker did not continue at work because of the suspension. I again refer to Dr. Klein's April 27, 2004 report, which noted tenderness and no incarceration and continued to clear the worker for work that involved modified duties and light lifting. I prefer Dr. Klein's written comments to the indication elsewhere on the form that the worker could return to work in one to six days, but even if I preferred that estimate I would also note the worker's suspension was for a ten-day period. I also do not consider the evidence supports the payment of benefits for the time the worker was apparently not dispatched, either during the time of his suspension or after, including before the May 2004 recall to work and then when the recall occurred. I again conclude the available evidence supports the worker continued to be able to undertake the modified duties, as assessed by Dr. F. While I note there is evidence the worker had worked for other employers, I conclude the available evidence does not support there was an actual or potential loss or that he was a less viable candidate for employment.

With reference to Dr. Fothergill's June 21, 2004 report that the worker was advised to continue to avoid lifting and to continue with only the lightest of duties, I again prefer Dr. F's assessment and Dr. Klein's assessment on April 27, 2004 that the worker could continue to work and the hernia was not incarcerated. Policy item #15.50 also provides that pre-operative wage loss will not normally be paid unless medical information is provided by the attending physician indicating the complication that restricts the worker's ability to continue working and I find insufficient evidence of such complications in the particular circumstances of the worker's case.

I also do not consider the evidence supporting different findings on an issue is evenly weighted, such that the provisions of section 250(4) are applicable.

I have reached a different conclusion with reference to the payment of post-operative wage loss benefits. I conclude the available evidence supports the payment of wage loss benefits for temporary partial disability until August 3, 2004. I found Dr. Fothergill's comments about the nature of the worker's recurrent hernia compelling. I agree with her comments that the individual circumstances must be considered and note it is in keeping with the Board's guidelines. Deviations from the guidelines may occur based upon the specifics of individual cases and surgeon preference. Dr. Fothergill's assessment accords with Dr. Klein's July 14, 2004 assessment that the worker needed a further two to three weeks of restrictions on lifting. The Board officer did not have this evidence available at the time of his July 9, 2004 decision. Dr. F's comments concerned the pre-operative restrictions. The worker's representative relies upon Dr. Fothergill's report. Dr. Fothergill does not indicate the worker was temporarily totally disabled, and states she agrees with Dr. Klein's advice on July 14, 2004. Dr. Klein's report concerns restrictions on the worker's lifting abilities and I do not consider the balance of the evidence support a continuing temporary total disability after July 13, 2004. I do, however, consider those comments support a continuing temporary partial disability and I accept the attending physician's reasons for payment to August 3, 2004 for a continuing temporary partial disability to that date.

I acknowledge the comments of the employer's representative to the Review Division that there was available suitable work. I have concluded above that suitable duties were available with reference to the payment of pre-operative wage loss benefits. That said I found Dr. Klein's specific comments on July 14, 2004 about the progress of the worker's post-operative healing compelling. Dr. Klein also indicated the worker should do no lifting over 30 pounds in a normal position and should be restricted to lifting much less in any awkward position. Dr. Klein indicated that the worker advised that only light duties in the shop would meet those criteria. I conclude the balance of the evidence supports the payment of temporary partial disability benefits to August 3, 2004 according to the criteria described by Dr. Klein and minus any days and/or hours the worker may have worked to August 3, 2004. Although I make no findings on these matters, it may be necessary for the Board to determine what would be the much less lifting restriction in any awkward position, if the light duties in the shop and/or in other available positions met those criteria between the date the worker's benefits were concluded and August 3, 2004, and, whether the temporary partial benefits should be paid at the full benefit rate, if no such work was available.

Conclusion

I confirm *Review Division Decision #20339.* I vary *Review Division Decision #21629*. I conclude the worker is entitled to the payment of temporary partial benefits until August 3, 2004 according to the criteria set out above and minus any days and/or hours that he may have worked.

I note the Review Division indicated that any expenses associated with Dr. Fothergill's September 15, 2004 report should be paid. No other expenses were apparent or requested and none are awarded.

Susan Marten
Vice Chair

SM/gw