

Noteworthy Decision Summary

Decision: WCAT-2006-03608 **Panel:** Deirdre Rice **Decision Date:** September 20, 2006

Role of Board Medical Advisor – Ability of Workers Compensation Board operating as WorkSafeBC to use internal guidelines – Work simulation – de Quervain’s tenosynovitis – Section 6(3) and Schedule B of the Workers Compensation Act – Item #27.12 of the Rehabilitation Services and Claims Manual, Volume I

The role of a Board Medical Advisor (BMA) is to provide medical expertise, not to interpret and apply policy of the Workers Compensation Board operating as WorkSafeBC (Board). The Board may not rely on internal guidelines where to do so would result in ignoring binding Board policy. In general, it is possible to duplicate a worker’s job in a work simulation.

The worker, a housekeeper, filed a claim for right wrist and hand pain and swelling. The Board accepted her claim for wrist and elbow tendonitis. The worker returned to work and three months later developed severe right wrist pain. The Board refused to reopen the claim as there was nothing to connect the current symptoms to the previous condition. The worker appealed the decision to the former Workers’ Compensation Review Board (Review Board). On March 3, 2003 both the Review Board and the Appeal Division of the Board were replaced by WCAT and the worker’s appeal was transferred to WCAT.

The worker provided a report by a hand specialist who diagnosed the worker with de Quervain’s tenosynovitis of the right wrist. The first WCAT panel referred the claim back to the Board to undertake further investigation and adjudication. Following an assessment in which the worker demonstrated the way in which she carried out her work duties, the Board again denied the claim as it determined the worker had not been exposed to the risk factors for de Quervain’s tenosynovitis listed under schedule B of the *Workers Compensation Act* (Act). The worker requested a review by the Review Division of the Board, which confirmed the Board decision. The worker appealed to WCAT.

The worker submitted the results of the assessment were not reliable because it was brief and did not capture all of the worker’s work activities or the ways in which she would carry out those duties and because the worker used a broom rather than a mop. However, the panel noted the worker had not challenged the accuracy of the assessment and knew this was an opportunity to demonstrate the way in which she carried out her job. The panel concluded the assessment provided an accurate review of the worker’s functions at work and her exposure to risk factors. The panel also noted that, in general, it is possible to duplicate a worker’s job in simulations.

The worker submitted that the BMA had set the threshold for causation of de Quervain’s tenosynovitis higher than the Act and Board policy required. The panel noted that the role of a BMA is to provide medical expertise and, if a BMA gave an opinion on whether the circumstances of a particular worker met those set out in Board policy, the BMA would be usurping the role of the adjudicator. The panel concluded the BMA was correct in quoting the risk factors for de Quervain’s tenosynovitis identified in the medical literature.

The worker additionally submitted the Board had relied on its ergonomic guidelines rather than on the content of the policy with respect to de Quervain’s tenosynovitis in item #27.12 of the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I). The panel acknowledged it

would be an error for the Board to apply another reference (including its own guidelines or a medical text) if this resulted in the Board ignoring the RSCM I. However, in this case, the worker's circumstances did not meet the criteria in Schedule B to the Act and thus the presumption in section 6(3) did not apply.

Based on the BMA's opinion that the worker did not engage in activities that placed strain on the tendons affected by de Quervain's tenosynovitis, the panel denied the worker's appeal.

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Panel: Deirdre Rice, Vice Chair

Introduction

In September 2001, the worker, a housekeeper, filed an application for compensation for right wrist and hand pain and swelling which occurred at work on August 31, 2001 and which caused her to stop working. The Workers' Compensation Board (Board) denied the claim in a December 7, 2001 decision. However, in a May 16, 2005 decision (*WCAT Decision #2005-02523-RB*), a panel of the Workers' Compensation Appeal Tribunal (WCAT) referred the claim back to the Board to undertake further investigation and adjudication.

Following a June 22, 2005 meeting with the worker during which the worker demonstrated the way in which she carried out her work duties, a Board case manager denied the claim in a July 8, 2005 decision. The case manager determined that the worker's claim would not be accepted under section 5 of the *Workers Compensation Act* (Act) because the worker's condition had not been caused by a single or repeated incident or accident, and that the claim would also not be accepted under section 6 of the Act because the worker was not exposed to risk factors sufficient to have caused her condition.

The worker asked the Board's Review Division to review this decision. In a January 4, 2006 decision (*Review Decision #R0055198*), a review officer confirmed the July 8, 2005 decision.

The worker has appealed the Review Division decision to WCAT with the assistance of her union representative. The employer is participating in the appeal, and is also represented.

Issue(s)

The issue is whether the worker's deQuervain's tenosynovitis arose out of and in the course of her employment as a housekeeper or, alternatively, is due to the nature of her employment in that capacity.

Jurisdiction

This appeal was filed with WCAT under section 239(1) of the Act. As the condition for which the worker seeks compensation arose before June 30, 2002, her entitlement to benefits is to be determined under the provisions of the Act that preceded changes

contained in the *Workers Compensation Amendment Act, 2002*. WCAT panels are bound by published policies of the Board pursuant to the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63). Policy relevant to this appeal is set out in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I).

Background and Evidence

The worker is currently 40 years old and began working in the employer's hospital on a part-time casual basis in 1991. In the summer of 1998 she began working almost full time. In December 1998 she noticed a gradual onset of right wrist pain. The pain was worse with heavy mopping, and it progressed into her right forearm and upper arm and to the right side of her neck.

The worker stopped working in April 1999. She filed a claim for compensation for her condition, which was diagnosed by Dr. Chua, her family physician, as a strain to her right wrist, arm, thumb and shoulder.

The Board retained an ergonomic analyst who attended the worker's workplace on May 6, 1999 and performed an ergonomic assessment. The ergonomic assessment indicated that the worker's position as a housekeeper involved a number of tasks that contained risk factors for elbow sprain/strain, including mopping, wet ragging, and handling full garbage bags.

Mopping required handling a mop, weighing approximately eight kilograms, to wash floors in 20 to 30 patient rooms and hallways. The worker applied force on the wrist flexors, extensors, supinators, and pronators of the right forearm in a way that the evaluator said could stress the muscle insertion points at the elbow. The force load posed the most risk, followed by repetition.

Wet ragging/dusting, toilet brushing and scrub brushing involved handling a small wet rag, long-handled scrub brush, toilet brush and feather duster in the right hand to wipe surfaces. It required multi-plane wrist movements, which affect the muscle insertion points at the elbow. Force was low and repetition was high, with the fingers constantly grasping the rag or handle, and the wrist angles were significant in all planes. The main risk was the overall repetition. By itself the task posed only a low risk for elbow strain, yet it contributed to the cumulative trauma posed by the heavier mopping and garbage handling tasks.

Handling garbage involved lifting bags from containers, carrying them to an indoor dumpster, and throwing them into the dumpster. The lifting and carrying activities involved medium force static activity.

Based on the results of the ergonomic assessment, the Board accepted the worker's claim for a right wrist and elbow tendonitis. Over the next year, the worker underwent a variety of investigations and treatment, including an activity-related soft tissue disorder

(ASTD) program and a rehabilitation pain program. In May 2000, she returned to work via a graduated return-to-work program. After that, she worked mainly as a hospital cleaner and occasionally as a laundry worker.

The worker went off work again on August 31, 2001 when she developed severe right wrist pain part way through her shift. Dr. Chua diagnosed a right wrist sprain.

In the December 7, 2001 decision, a Board case manager considered both whether the worker's 1999 claim should be reopened and whether a new claim should be established. The case manager concluded that the weight of evidence did not support that the worker's current pain was related to the April 16, 1999 work activity for which the claim was initially accepted and that the myofascial pain a Board medical advisor found when he examined the worker on July 21, 2000 was not related to her work activity. Since there was no repetitive strain injury diagnosis, the case manager also concluded that the claim could not be accepted under section 6 of the Act. Further, there was insufficient evidence to demonstrate that the worker sustained a traumatic injury on August 31, 2001. The worker appealed this decision, leading to *WCAT Decision #2005-02523-RB*.

On December 19, 2001, the worker was examined by orthopedic specialist Dr. Serink. The worker reported pain over the radial aspect of her right wrist and that, if she did any repetitive work, the area would swell. Dr. Serink found localized tenderness over the abductor pollicis and the extensor pollicis brevis tendon. The pain was most acute with ulnar deviation. Finkelstein's test was positive. Dr. Serink diagnosed a chronic tenosynovitis of the right wrist involving the tendon of the abductor pollicis and the extensor pollicis brevis. He suggested day surgery to explore the tendons.

The Board denied coverage for the surgery.

In an August 3, 2002 medical-legal letter he prepared in support of the worker's appeal, Dr. Chua said the worker had not fully recovered from her April 16, 1999 right wrist injury when a second injury occurred on August 31, 2001. Dr. Chua said that this second injury aggravated the worker's earlier symptoms and that, subsequently, as a result of his referral of the worker to orthopedic specialist Dr. Caines for a second opinion, the worker's condition was diagnosed as deQuervain's tendonitis. Dr. Caines confirmed this diagnosis in a June 5, 2002 report, which was also introduced as an exhibit to the WCAT proceeding.

In his August 3, 2002 letter, Dr. Chua described deQuervain's tendonitis as an overuse syndrome, caused by lifting, an activity that the worker had to do regularly in her work as a housekeeper. Dr. Chua said the worker had been totally disabled since August 31, 2001, and it was difficult to say when she would recover sufficiently from her injuries to return to her normal duties.

In a December 6, 2004 report (also an exhibit to the WCAT proceeding), hand specialist Dr. Gropper said the clinical diagnosis was persistent radial wrist pain with the possibility of mild to moderate deQuervain's tenosynovitis of the right wrist.

In *WCAT Decision #2005-02523-RB*, the panel concluded that, even though her condition was not diagnosed as chronic deQuervain's tenosynovitis until several months after she went off work, the worker's symptoms on August 31, 2001 were related to that condition. Given that none of numerous physicians who examined the worker in 1999 and 2000 was able to diagnose deQuervain's (for which Finkelstein's manoeuvre is a simple and easy test), the panel concluded that the worker developed her deQuervain's at some point after May 2000. The panel concluded that the worker's 1999 condition was not a significant cause of her deQuervain's condition and that the symptoms on account of which she went off work in August 2001 were not related to the 1999 work injury or claim.

The panel began her consideration of whether the worker's deQuervain's condition was due to the nature of her job following her return-to-work in May 2000 by reviewing the relevant provisions of the Act and Board policy. The panel noted that tendonitis/tenosynovitis is one of several conditions generally referred to as ASTDs, and that the Board views ASTDs that develop over time as diseases, and those that develop from trauma as personal injuries. Since the worker's right thumb/wrist condition developed over time, the panel said that it was considered to be a disease.

The panel wrote as follows:

The ergonomics assessment that was done in May 1999, and on the basis of which the Board accepted the 1999 claim, assessed risk factors for elbow strain/sprain. It did not address the awkwardness, frequency, repetitiveness, or force aspects of the work tasks relative to the thumb extensor and thumb abductor tendons along the thumb side of the wrist. Further, it described different hand positions and movements for mopping than those the worker described at the hearing.

There are no medical opinions on file from a Board medical advisor or the worker's physician, or any other specialist, linking or dispelling a link, between the worker's work activities and her diagnosed de Quervain's condition.

In the result, I have insufficient evidence on which to determine whether it is likely that the worker's diagnosed de Quervain's condition was due to the nature of her employment over the period from May 2000 to August 2001.

[all quotations typed as written unless otherwise indicated]

The panel therefore referred the matter back to the Board, as permitted by section 38(2) of Bill 63, with directions that the Board:

- arrange for an ergonomic assessment of the work tasks the worker performed over the period from May 2000 to August 2001, in order to assess risk factors for right deQuervain's tenosynovitis;
- obtain such medical opinions as may be appropriate; and,
- thereafter, adjudicate whether the diagnosed deQuervain's tenosynovitis was due to the nature of the worker's employment.

Since the employer had contracted responsibility for cleaning out, a job site visit at the worker's workplace was not possible. However, the case manager arranged for an assessment of the manner in which the worker carried out her job duties through a simulation at the Board's office. During the simulation, the case manager took a series of photographs of the worker engaged in her simulated work activities.

The findings of the assessment, which was conducted on June 22, 2005, are set out in an ASTD pre-site evaluation report and in a June 22, 2005 claim log entry. The claim log entry includes a comprehensive description of the worker's work duties and the manner in which she completed them.

The results of the assessment were reviewed by a Board medical advisor. The medical advisor said that, based on the text *Occupational Hand and Upper Extremity Injuries and Diseases* (Second Edition, 1998) by M.L. Kasdan, the risk factors considered to be associated with deQuervain's from a work-relatedness perspective were: more than 2,000 forceful manipulations per hour and repeated radial and ulnar deviation, especially when the thumb is also forcefully exerted. The medical advisor said that, based on the evidence provided, it was less than 50% likely from a medical perspective that there was an association with the work activities described and the development of right deQuervain's tenosynovitis. He also said that there had been insufficient risk factors identified which were capable of stressing the deQuervain tendons of the thumb. In particular, forceful work across the thumb was not required and, while upper limb activities occurred, the thumb was used in a supportive role only, without need for awkward thumb postures, without repetitive thumb movement and without repetitive wrist movement. As a consequence, the medical advisor concluded that the worker's symptoms could not be explained on the basis of a work-related activity based soft tissue disorder.

The case manager relied in part on this opinion in reaching the conclusions set out in the July 8, 2005 decision. The case manager noted that the worker had described her

symptoms as being gradual in their onset and was unable to link her injury to a specific incident. He therefore said that the claim was not acceptable under section 5 of the Act. The case manager also wrote:

As a cleaner you perform a wide variety of tasks that are not repetitive as defined by the Board ergonomic guidelines i.e. tasks do not repeat within a 30 second cycle and no one task requires 10 wrist movements per minute continuously for 120 minutes. The work involves sedentary to light force and does not require frequently repeated or sustained awkward wrist or thumb postures. At the time of the onset of symptoms the work was not unaccustomed. Finally, you report no change in your symptoms since you stopped work in August 2001. The persistence of symptoms over a prolonged period in the absence of any work activity suggests that work is not the cause of your condition.

Based on his comparison of the worker's job demands with the Board's ergonomic guidelines, the case manager found that there were insufficient risk factors with respect to force, awkward posture and repetition to meet the requirements of section 6(3) or section 6(1) of the Act. Accordingly, the claim was disallowed.

In *Review Decision #R0055198*, the review officer found that there was no evidence that the worker's right deQuervain's tenosynovitis was caused by a specific event or trauma or a series of specific events or traumas or that it resulted from a sudden strain placed on the tendons as described in policy item #27.12 of the RSCM I. The review officer therefore concluded that the worker's claim was more appropriately adjudicated under the occupational disease provisions of the Act than under section 5(1).

The review officer noted that section 6(3) of the Act presumes that an occupational disease listed in Schedule B to the Act will be caused by work if the criteria in Schedule B are met. Schedule B lists deQuervain's tenosynovitis as an occupational disease if the affected tendons perform tasks involving two or more of the following:

1. frequently repeated motions or muscle contractions that place a strain on the affected tendons;
2. significant flexion, extension, ulnar deviation or radial deviation of the affected hand or wrist; or
3. forceful exertion of the muscles utilized in handling or moving tools or other objects with the affected hand or wrist.

The combination of two or more of these activities must represent a significant component of the employment. The review officer acknowledged the position of the worker's representative that the work simulation in 2005 was very brief and did not capture all of the worker's work activities or the ways in which she would carry out those

duties on a regular basis. However, the review officer concluded that there was sufficient information to assess the worker's exposure to relevant occupational risk factors in the job description on file, the information about the worker's simulated work activities and the information provided from the 1999 ergonomic assessment.

The first process listed in Schedule B is defined in policy item #27.12 as frequently repeated motions that are repeated at least once every 30 seconds; or ones that are repeated and where at least 50% of the work cycle is spent performing the same motions or muscle contractions. The review officer accepted the evidence from the 1999 ergonomic assessment that the worker's job of housekeeping involved many different duties, and concluded that the worker's tasks were varied and self paced. Although the 1999 assessment found that the worker was subject to repetitive grasp, the review officer concluded that this grasp, although perhaps significant with respect to an elbow strain, was not a significant risk factor for deQuervain's tenosynovitis. Therefore, the review officer concluded that the first process listed in Schedule B was not present in the worker's employment activities.

The second process listed in Schedule B, significant wrist flexion, extension and deviation, is defined in policy item #27.12 of the RSCM I as moving or holding the hand in greater than 25 degrees of flexion or extension or greater than 10 degrees of deviation. The review officer accepted that the worker was exposed to some awkward wrist postures in her work and, consequently, found that the second listed process was present in the worker's employment activities.

However, the review officer determined that the third process of forceful exertion of the thumb and wrist muscles was not present in the worker's cleaning activities. Instead, based on the 2005 simulated work assessment, the review officer concluded that the worker was primarily exposed to sedentary to light level force. Further, although the 1999 ergonomic assessment noted that wet mopping required force on tendons and muscles of the right forearm, the assessment did not state that the worker's thumb tendons were subject to force.

Since the worker was not significantly exposed to the criteria listed in Schedule B, the review officer found that the worker's claim does not satisfy Schedule B and was not compensable under section 6(3) of the Act.

The review officer also concluded that the worker's condition was not compensable under section 6(1) of the Act. The officer noted that the Board considers ASTDs such as deQuervain's tenosynovitis work-related if the worker is subject to the required threshold of exposure to risk factors including force, awkward postures and repetition, and then noted that the worker had submitted that the case manager and Board medical advisor had set the threshold higher than the Act and Board policy required.

The officer wrote:

I have compared the worker's occupational exposure to risk factors to the risk factors set out in policy item #27.40. This policy provides definitions of risk factors. I note that awkward postures are defined as postures where the joints are held at or near the end range of motion for that joint, repetition is defined as the cyclical use of the same body tissues and that task variability allows the affected tissue to return to a resting state for recovery. I find that the task variability and the self paced nature of the worker's activities allowed for the affected tissues to return to a resting state for recovery. Although there was fleeting exposure to force and awkward postures there is no evidence that this was prolonged or sustained or that it occurred for a significant period of the worker's shift. After comparing the worker's described job activities to policy item #27.40, I conclude that the worker was not exposed to the magnitude, frequency and duration of risk factors that is required by Board policy to conclude that a worker's condition is work related.

Policy item #27.40 states that the importance and effect of particular factors in the circumstances of any individual claim is a matter of individual judgment exercised having regard to the medical and other evidence available. I have therefore considered the evidence that research indicates 2000 forceful thumb manipulations per hour are required to cause deQuervain's tenosynovitis. I have not based my decision on this evidence; however, I consider it one piece of evidence that policy suggests should be considered.

Similarly the fact that the worker's symptoms did not resolve during the four years that the worker was not working is only one piece of evidence suggesting a non-work related cause. However, I have not attached significant weight to this evidence.

Basically my decision rests on a comparison between the worker's occupational activities which as noted above, I find sufficient information on the claim file to assess and the Board policy setting out the required exposure to risk factors. Like the Board Officer and the MA [medical advisor], I conclude that the worker's exposure to risk factors was not sufficient to cause deQuervain's tenosynovitis. I note that there is no medical opinion contradicting the Board MA's opinion.

I conclude that the worker's right hand was not exposed to sufficient occupational risk factors to cause deQuervain's tenosynovitis.

Submissions

In the submissions she prepared in support of the worker's appeal, the worker's representative argued that:

- The 2005 review of the worker's activities cannot be considered a detailed assessment of the worker's work activities and associated risk factors. Further, in general, it is not possible to duplicate a worker's job in simulations.
- The May 13, 1999 ergonomic report provided a detailed assessment of all of the worker's main work activities which she actually performed at her workplace.
- The presumption under section 6(3) of the Act applies because the 1999 ergonomic assessment report details significant force, repetitive and awkward postures, including gripping, significant wrist flexion, extension and "forceful exertion of the thumb and wrist muscles."
- While a case manager may have had some training in ASTD evaluation reports, it is questionable whether that training would match the credentials of an occupational therapist such as the one who carried out the 1999 ergonomic assessment report. [The panel notes that the 1999 assessment was in fact carried out by an ergonomic analyst.]
- The conclusions of both the case manager and review officer to the effect that there was no evidence of any prolonged or sustained exposure to force or awkward positions were contradicted by the evidence of the 1999 ergonomic assessment report, which clearly detailed moderately repetitive and moderately forceful movements of wrist extension and flexion, pronation and supination during wet mopping, with the force load posing the most risk followed by repetition. This assessment report constitutes expert evidence which documents significant risk factors associated with the worker's work activities.
- The review officer's statement that repetitive grasp is not a significant risk factor for deQuervain's tenosynovitis was not supported.
- The case manager erred in relying on current Board ergonomic guidelines, as the criteria of "no more than 10 awkward wrist movements per minute continuously for 60 to 120 minutes. No more than 20 finger movements per minute continuously for 50 to 120 minutes" (as set out in the June 22, 2005 claim log entry) is not found in the published binding policy of the Board.
- The criterion identified by the Board medical advisor (more than 2,000 forceful manipulations per hour and repeated radial and ulnar deviation) is also not found in the published binding policy of the Board. Little weight should be attached to

the medical advisor's opinion as it was based on the medical advisor's interpretation of the medial literature rather than on an assessment of all the risk factors to which the worker was exposed. Moreover, any remaining value to the medical advisor's report was weakened by fact that the information on which the report was based was "not the best evidence." In particular, the medical advisor relied on the conclusions reached by the case manager following the very brief simulated ergonomic assessment with no apparent consideration or acknowledgement of the evidence of work activities and related risk factors contained in the 1999 ergonomic assessment report.

- The review officer erred by relying on the Board medical advisor's opinion and, since the medical advisor based his opinion on the "wrong criteria" and "incomplete factual evidence regarding the worker's risk factors," the fact that there was no medical opinion contradicting the medical advisor's opinion is of no consequence.
- The medical evidence provides a link between the diagnosis of the worker's condition and the repetitive nature of her work activities, and the ergonomic assessment done in 1999 confirms significant awkward wrist postures associated with those activities. Given the 1999 ergonomic assessment report, and the fact that there was no compelling evidence that non-occupational factors played a role in the onset of the worker's deQuervain's tenosynovitis, the worker's work activities played a significant role in producing the condition.

The employer's representative submitted that if the 1999 assessment was relevant to determining the compensability of the worker's deQuervain's tenosynovitis, then the WCAT panel would not have requested that the Board undertake a new ergonomic assessment. The representative submitted that the Board medical advisor's opinion should be accepted as expert evidence, and that the Review Division decision should be confirmed.

In reply, the worker's representative reiterated her position that little weight can be attached to Board medical advisor's opinion because it "ignores" the 1999 ergonomic assessment which documented moderately forceful movements of wrist flexion, extension, pronation and supination during wet mopping. The representative said that there was also no explanation for "inconsistencies" between the "expert ergonomic assessment" and the case manager's conclusions in 2005, the latter of which were based on a simulation that had, in part, been carried out with different tools. The representative also said that decisions under the Act must be based on law and policy and that, since it was clear that the Board medical advisor's opinion was based on medical literature rather than the policy in items #27.12 and #27.20 of the RSCM I, it should be accorded little weight. Finally, the representative submitted that, should the

panel determine that further medical evidence was required, the panel should consider referring the matter to an independent health professional, as provided by section 249 of the Act.

Reasons and Findings

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*, I conclude that an oral hearing is not required to ensure a full and fair consideration of the issues in the appeal. The outcome of the appeals turns on an assessment of the extent of the worker's exposure to the risk factors that are relevant to her diagnosed condition. The worker's representative has taken issue with the brevity of the 2005 work simulation and suggested that the results are not reliable. However, I am satisfied that there is sufficient reliable information on the claim file about the worker's work duties in 2000 through 2001, and the manner in which she performed them, to allow me to assess the relevant exposure and to determine whether the requirements of the Act and Board policy are met. I have therefore based my decision on the information in the claim and appeal files.

The parties do not take issue with the conclusion of the case manager and review officer that the worker's deQuervain's tenosynovitis is not compensable under section 5(1) of the Act. I agree that, for the reasons provided in their decisions, the worker did not sustain a personal injury that arose out of and in the course of her employment in August 2001.

The worker's representative has submitted that the presumption in section 6(3) of the Act applies to the worker's circumstances, based on her understanding that the exposure to risk factors documented in the 1999 ergonomic assessment meets the threshold set by Schedule B to the Act. I do not agree. First, as noted by the previous WCAT panel, the 1999 assessment was conducted for the purpose of identifying whether the worker was exposed to risk factors for elbow strain/sprain. In this regard, contrary to the submission of the worker's representative, the report did not document "forceful exertion of the thumb and wrist muscles." I agree with the WCAT panel's conclusion that the assessment did not address the awkwardness, frequency, repetitiveness, or force aspects of the work tasks relative to the thumb extensor and thumb abductor tendons along the thumb side of the wrist. It is these latter factors that are relevant to determining whether the worker's work duties placed strain on the tendons affected by deQuervain's tenosynovitis.

Second, it is clear from the worker's testimony to the WCAT panel that the value of the 1999 ergonomic assessment is further limited by the fact that it considered the worker's work activities in a different job than the one that she was performing in 2001. In

particular, in 2001, the worker was no longer responsible for transporting garbage bags to a dumpster. This garbage handling function was the medium force static activity which the 1999 evaluator identified as requiring wrist extension.

Third, it is clear from the evidence on the claim file that the worker was no longer using the same body motions when wet mopping as those which gave rise to the 1999 conclusion that this work applied force on the wrist flexors, extensors, supinators and pronators of the right forearm. Rather, as stated by the case manager in the June 22, 2005 claim log entry, the worker demonstrated that, when holding the handles of brooms and mops, she maintained a neutral wrist position, and placed her thumbs along the handle in a supportive posture. Further, sweeping and mopping was done without wrist or thumb movements. Instead, the worker's upper body moved or her shoulders adducted and abducted subtly. The pictures the case manager took are consistent with this description. This description is also more consistent with the description the worker provided of her wet-mopping activities at the WCAT hearing than with the description of that activity in the 1999 ergonomic assessment report. As the WCAT panel noted, the report described different hand positions and movements for mopping than those the worker described at the hearing. At the hearing, the worker said that she held the mop handle with her right hand, placed her left hand on the top of the handle, and, using her body and shoulders, mopped in a circular fashion. In light of this, I conclude that the review officer's conclusion that the worker's situation met the second criterion in Schedule B cannot stand.

The worker's representative has suggested that the results of the 2005 work simulation are not reliable because of the brevity of the assessment and because it did not capture all of the worker's work activities or the ways in which she would carry out those duties. Further, the representative noted that, as stated in the caption to the picture that shows the worker demonstrating her dry mopping technique, the worker used a broom rather than a mop. I note that the worker has not taken issue with the accuracy of the case manager's description of the way in which she carried out the work activities that she did demonstrate during the work simulation. Additionally, the pictures which capture these activities are of the worker, who knew that this was an opportunity to demonstrate the way in which she carried out her job. The "inconsistencies" between the description of the worker's activities in the 1999 ergonomic assessment and the 2005 simulation can be explained by the fact that the worker had changed the way that she held a mop and that her job had also changed between the two dates.

I find that the June 22, 2005 description of the worker's work duties and the way in which she carried them out is accurate. The pictures showing the worker engaged in various tasks are consistent with those descriptions. Further, since the worker's primary work activities were canvassed in the 2005 simulation, I am satisfied that the June 22, 2005 claim log entry and the related pictures provide an accurate review of the worker's functions at work and a reliable basis upon which to assess the worker's

exposure to risk factors. I am satisfied that the Board medical advisor based his June 22, 2005 opinion on an accurate summary of the worker's principal work activities and the way in which she carried out those duties.

In this regard I note that I do not agree with the position that, in general, it is not possible to duplicate a worker's job in simulations. That proposition may well hold true in circumstances where a worker carries out a highly specialized function or uses specialized tools and equipment. However, the worker's job as a housekeeper is not of this nature. Further, the worker participated fully in the assessment, as demonstrated by the series of photographs. With the exception of the fact that the worker's representative pointed out that a broom rather than a dry mop was made available, the worker has not taken issue with the adequacy of any of the equipment that was provided during the assessment. The fact that a broom was used rather than a mop was specifically noted in the caption to the relevant photograph, which reads, "Worker demonstrates dry mopping technique. NB worker is simulating dry mop[p]ing with a broom consequently the movement is less fluid than if she was using a dry mop." More importantly, the worker has not taken issue with any of the case manager's comments regarding the placement of her hands, fingers, right thumb or wrists, nor has she taken issue with any of the specific conclusions the case manager reached regarding the type of grip and body motions used in performing her various work duties. I do not consider the fact that a broom was used instead of a dry mop is a sufficient basis for discounting the validity of the case manager's observations, as recorded in the June 22, 2005 claim log entry.

It is apparent that the Board medical advisor based his opinion entirely on the case manager's comments in that claim log entry and the photographs taken during the work simulation. The 1999 assessment report is not on the 2001 claim file and there is no indication that it was available to the medical advisor. In light of the conclusions I have reached in relation to that report, this does not provide a basis for discounting the medical advisor's opinion. Further, I do not consider that the Board medical advisor can be faulted for the fact that, rather than referencing Board policy, he quoted the risk factors for deQuervain's tenosynovitis that are identified in the medical literature. The role of a Board medical advisor is to provide medical expertise. The interpretation and application of Board policy is beyond that expertise, and a Board medical advisor who purported to determine whether the circumstances of a particular worker meet those set out in Board policy would be usurping the role of the adjudicator. I am satisfied that the Board medical advisor properly confined himself to giving advice that is within his expertise – namely, whether the work activities described by the case manager were scientifically relevant to the development of the worker's deQuervain's tenosynovitis.

The Board medical advisor concluded that they were not, for two reasons. First, he concluded that the described work activities did not meet the threshold set out in the medical text he relied on. In addition, however, he also concluded that there were insufficient risk factors identified which were capable of stressing the deQuervain's tendons of the thumb. In particular, the medical advisor concluded that forceful work

across the thumb was not required and that the thumb was used in a supportive role only, without need for awkward thumb postures, without repetitive thumb movement, and without repetitive wrist movements. In short, the description provided by the case manager did not identify activities that would place strain on the tendons affected by deQuervain's tenosynovitis.

This second conclusion is, in my view, determinative of the worker's appeal. The conclusions reached by the case manager, which I accept as reliable, confirm that the worker does not meet the criteria in Schedule B. The medical advisor's opinion, which was based on the case manager's review of the worker's demonstration of how she carried out her work functions in 2001, confirms that the worker was not engaged in activities that could, from a scientific perspective, be causally relevant to the condition for which she seeks compensation.

I acknowledge that Dr. Chua thought that the worker's deQuervain's tenosynovitis was due to "an overuse syndrome, caused by lifting." However, Dr. Chua's August 3, 2002 letter was not based on a comprehensive review of the worker's activities, and the pictures showing the positioning of the worker's hands and wrists were not available to him. I prefer and accept the Board medical advisor's opinion.

I also acknowledge the concerns of the worker's representative regarding the case manager's reliance on the Board's ergonomic guidelines rather than on the content of the policy in the RSCM I. In a circumstance where relying on such non-binding guidelines would result in ignoring the binding requirements of the RSCM I, it is not open to the Board to apply another reference (whether that other reference is the Board's guidelines or a medical text such as that identified by the Board medical advisor). However, that circumstance does not arise in this case. The worker's circumstances do not meet the criteria in Schedule B to the Act and, therefore, the presumption in section 6(3) does not apply. Further, the medical evidence does not support a conclusion that the worker was engaged in activities which placed strain on the tendons affected by deQuervain's tenosynovitis, nor does it support a conclusion that her work activities can otherwise be considered of causal relevance to the development of this condition.

Conclusion

The appeal is denied. The worker's deQuervain's tenosynovitis did not arise out of and in the course of her duties as a housekeeper, nor is it due to the nature of her duties in that position. The Review Division's January 4, 2006 decision is confirmed.

No expenses were requested, and it does not appear from a review of the file that any reimbursable expenses were incurred in relation to this appeal. I therefore make no order regarding expenses of this appeal.

Deirdre Rice
Vice Chair

DR/dw