Noteworthy Decision Summary

Decision: WCAT-2007-02958 **Panel**: Randy Lane **Decision Date:** September 27, 2007

Heart Attack – Arising Out of and In the Course of Employment – Section 5(1) of the Workers Compensation Act – Items #30.70 and #15.10 of the Rehabilitation Services and Claims Manual, Volume II

This decision is noteworthy because it provides an analysis of whether a worker's heart attack arose out of and in the course of his employment.

The worker was diagnosed with a myocardial infarction (a heart attack). Prior to suffering the heart attack, the worker had been involved in removing heavy wire cables and wire straps from a log tow. The Workers' Compensation Board, operating as WorkSafeBC, accepted the myocardial infarction as a personal injury. The employer requested a review of this decision by the Review Division who allowed the review and denied the acceptance of this condition. The worker appealed to WCAT.

The worker's appeal was allowed. Item #30.70 of the *Rehabilitation Services Claims Manual*, *Volume II* (RSCM II) provides guidance as to whether claims for heart-related conditions are adjudicated as personal injuries under section 5 of the *Workers Compensation Act* (Act) or as occupational diseases under section 6 of the Act. Whether adjudicated under section 5 or 6, the issue is whether there is a causal link between the worker's employment and his heart attack. Were the work activities of causative significance?

In this case, the worker had a pre-existing condition (coronary artery disease). The presence of such disease did not preclude the worker from suffering a work-related heart attack. While the worker had "quite mild" symptoms prior to the employment activities, the panel found that they were indicative of a pre-existing deteriorating condition. A critical question was whether there was some exceptional strain or other exceptional circumstance in the course of the worker's employment as outlined in policy item #15.10[1] of the RSCM II. The panel found that the worker's employment activities were part of his usual employment. He stated that work activities can amount to an exceptional strain or other exceptional circumstance, even if they are not atypical. The panel found that the worker's work activities were of causative significance because the worker was involved in very heavy work during the second half of his twelve hour shift on a warm day. While he had a pre-existing heart condition, the panel found that the worker would not have suffered the heart attack but for his work activities.

[1] The board of directors of the Workers' Compensation Board has enacted policy item #C3 16.00 to replace items #15.00 and #15.10. The new policy item #C3-16.00 is applicable to all claims for injuries occurring on or after July 1, 2010. This decision applies the old policy in force prior to July 1, 2010.

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Panel: Randy Lane, Vice Chair

Introduction

The worker has appealed to the Workers' Compensation Appeal Tribunal (WCAT) from the February 7, 2007 decision of a review officer with the Workers' Compensation Board, operating as WorkSafeBC (Board). The review officer varied an August 4, 2006 Board decision which determined the worker's heart attack arose out of and in the course of his employment.

The appeal was initiated by a March 13, 2007 notice of appeal which was followed by a July 19, 2007 submission from the worker's union representative. The employer's representative provided an August 10, 2007 submission to which the worker's union representative provided an August 28, 2007 rebuttal.

By letter of June 14, 2007 the worker was advised that the appeal would proceed by way of written submissions. That decision does not bind me if I consider that an oral hearing is necessary. The rule in item #8.90 of WCAT's *Manual of Rules of Practice and Procedure* (MRPP) provides that WCAT will normally conduct an appeal on a read and review basis where the issues are largely medical, legal, or policy based, and credibility is not an issue. I have reviewed the issues, evidence and submissions on the worker's file and have concluded that this appeal may be determined without an oral hearing. The issue before me is primarily legal and medical in nature.

Issue(s)

At issue is whether the worker's heart attack on June 30, 2006 arose out of and in the course of his employment.

Jurisdiction

WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law, and discretion arising or required to be determined in an appeal before it (section 254 of the *Workers Compensation Act* (Act)). It is not bound by legal precedent (subsection 250(1) of the Act). WCAT must make its decision on the merits and justice of the case, but, in so doing, it must apply a policy of the board of directors of the Board that is applicable in the case.

This is an appeal by way of rehearing, rather than a hearing *de novo* or an appeal on the record. WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal.

Background

On June 30, 2006, the worker, then a 46-year-old tug mate, was working on a log tow in the sun. His application for compensation indicates he was removing heavy wire cables and straps off the log tow. At approximately 4:30 p.m. he experienced a sudden onset of anterior chest pressure with pain into his neck and jaw. He became nauseated, diaphoretic, and experienced shortness of breath.

The worker attended a hospital emergency department. The attending nurse noted that the worker had experienced a similar episode six years earlier which had been diagnosed as "gas behind heart."

On July 1, 2006 the worker was seen by Dr. M, a specialist in internal medicine, who noted the worker advised him he had experienced an episode of chest pain upwards of six years ago while he was exerting himself. That episode lasted upwards of one hour. The worker did not think any confirmation of cardiac disease was made when he was admitted to hospital at the time of that episode. In the three to six months prior to June 30, 2006 the worker had a decline in exercise capacity and had noticed some exertional symptoms. The symptoms were "quite mild."

Dr. M recorded that the worker was uncertain of any definite risk factors for development of early coronary disease. He denied any family history of coronary artery disease. He thought he might have been told in the past his blood pressure had been somewhat elevated and that possibly he had high cholesterol. The worker underwent an angiogram on July 4, 2006 which established the existence of mild-to-moderate diffuse disease with stenoses in his arteries ranging from 20% to 70%.

On July 7, 2006 the worker was seen by Dr. D, a cardiologist, who noted the worker had a possible history of hypertension and hypercholesterolemia. He documented that the worker had been seen earlier that month with exertional chest pain and positive troponin. Dr. D noted the worker indicated he had a "similar episode about six years ago with normal-work up at that time."

On July 7, 2006 Dr. G, the worker's attending physician, completed a return-to-work plan. The plan was accompanied by a job description, prepared by the employer, of the employment activities of tug mates. The description indicated a tug mate would work 12 hours per day, split into two six-hour watches, plus occasional overtime. The tour of duty is usually two to three weeks at sea followed by two to three weeks leave, depending on the tug. A mate stands watch with one deck-hand and is in charge of the vessel while the master is off watch, including navigation and safe operating of the tug.

Mates assist in handling all lines, wires, and winches associated with making the tow suitable for transportation, whether it is a barge or log tow.

In her July 28, 2006 claim log entry a case manager documented the following information supplied by the worker concerning his work activities and his medical history:

> The claimant is employed with [employer's name] as a tug mate. The claimant works 13 days at a time, seven hours a day split into two six hour watches with occasional overtime. The tug mates assist in making tows suitable for transportation, whether it is a barge or log tow. They handle all lines, wires, winches, associated with making the tow ready for transport.
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> On June 30, 2006 at approximately 4 pm, the claimant was in the course of his second shift of that day, from noon to 6 pm. He described his work activities as follows: he was removing heavy wire cables and wire straps from the log tow. These wires and straps are put on log tows to prevent loss of logs. The claimant also advised in conversation July 27, 2006 that it was a very hot day, and that the work is physically demanding. He would be pulling on fifty to eighty pounds at any given time. At approximately 4 pm he developed shortness of breath with acute chest pain and nausea. He reported to his supervisor and was taken to [a local hospital] which was approximately five minutes away as the work was done in the …area.
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> The claimant was admitted to hospital for five days and underwent a cardiac catheterization. He had experienced a myocardial infarction.
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> The claimant has being doing this job since 2002 and prior to that was a fisher for approximately 20 years.
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> The claimant described himself as very fit and healthy with no known history of risk factors such as hypertension or elevated cholesterol. He is a lifelong non-smoker.
>
> [all quotations in this decision are reproduced as written, save for changes noted]

In her August 11, 2006 claim log entry the case manager documented that she confirmed the worker's evidence with the tug captain who was with the worker at the time of the incident:

> The employer confirmed information submitted by the worker, indicating he was involved with physically demanding work on the afternoon of June 30, 2006. It was a hot day, over 30 degrees celsius, and the claimant was performing physically demanding activities. He was, with a deck hand, removing steel cables which weighed over 50 pounds. He was working at the rear end of the log tow when he began to develop symptoms of shortness of breath and chest pain. This is approximately a quarter of a mile long, and he subsequently walked to the head end of the log tow to advise the Captain. Fortunately, the tug was close to a hospital and there was prompt medical attention given.

In that claim log entry the case manager documented the basis for her acceptance of the worker's claim:

> Heart disease is recognized by regulation of general application as an occupational disease. There is, however, no evidence that this work activity as a tug mate would cause such a condition, and no suggestion from any source on the claim that this is the case. It is the worker's contention that the heart attack resulted from the physically demanding work activities.
>
> If the condition arising out of and in the course of the employment and is "attributed to a specific event or cause or series of specific events or causes …" this would be treated as a personal injury and consequently, adjudicated under Section 5 of the Act.
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> Policy item #15.10 deals with situations where a worker has a pre-existing deteriorating condition. According to a WorkSafeBC Occupational Physician, the heart attack would be caused by underlying heart disease. Policy Item #15.10 notes that if an organ of the body is deteriorating as a result of disease and has reached a point where it is likely to become disabling, the "final breakdown" might be triggered by a specific activity. However, if "it is only chance or coincidence whether it happened at work, at home, or elsewhere …" the disability is not considered compensable.
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> The worker's activities precipitated the acute symptoms, and can be assessed as physically demanding or an exceptional circumstance. The causative significance of the work activity is such that it likely precipitated the heart attack.
>
> The claim has been accepted under Section 5(1) of the *Workers Compensation Act (the "Act*") for the heart attack. When recovered from the heart attack, there is no WCB responsibility for the underlying pre-existing heart disease.

The case manager issued an August 4, 2006 decision to the employer which advised the claim had been accepted. She noted a Board physician indicated that heart attacks arise from pre-existing coronary artery disease. The question for review was whether the worker was subject to some exceptional strain or other physically demanding activity that could have triggered the heart attack. She considered that the worker's heart attack was precipitated or triggered by his work-related activities.

The employer requested a review of the August 4, 2006 decision. Its representative provided a November 22, 2006 submission. Among other matters, the representative referred to information from Environment Canada which indicated that the temperature at the Vancouver International Airport at 4:00 p.m. on June 30, 2006 was 24.9˚C with a wind speed of 13 kilometres. The worker was notified of the employer's review request, but he did not indicate he wished to participate.

The review officer sought a medical opinion from the Review Division medical advisor. He noted in his February 1, 2007 request that, while there was no question the worker's work activities which immediately preceded the heart attack were physically demanding, there was no evidence the work activity was in any way unaccustomed. He also referred to the fact that three to six months prior to the heart attack the worker had experienced a decrease in exercise tolerance and some exertional symptoms.

In his February 6, 2007 medical opinion Dr. P outlined general considerations with respect to heart attacks:

> The relationship between physical activities and a cardiac event is still a bit controversial. At this point, it is generally accepted that strenuous isometric activities can play a role in precipitating a MI [myocardial infarction]. High level aerobic activities can also be problematic. In the case of this man, it is accepted that he was doing heavy work when he developed the MI symptoms.
>
> We know that an MI occurs in persons who have atherosclerosis of the coronary arteries. This causes the arteries to become progressively obstructed. At some point the stenosis can be severe and this is often the point at which a patient develops symptoms such as shortness of breath, loss of exercise tolerance and chest discomfort.
>
> One day, the already severely narrowed blood vessel becomes suddenly obstructed. It is believed that it can be caused by a plaque that dislodges itself upstream and plugs the remaining opening in the coronary artery. Another mechanism of injury is that of a platelet embolus doing the same thing, or alternatively a platelet thrombus develop on a ruptured plaque and rapidly obstruct the lumen of the blood vessel. It is thought that some

> mechanical stimulus (increased blood pressure, increased heart rate) can precipitate this kind of event.
>
> Without some kind of intervention (coronary bypass, angioplasty) this event is practically unavoidable.

He then addressed the worker's specific case:

> In the case of this man, it is possible that he would have sustained the MI that day even if he was not doing anything at all. We will never know for sure. If we assume that the activities had a role to play, the question becomes: when would he have had his MI if it were not for the strenuous activities? We know that he had some symptoms for about three to six months. With hindsight we know now that they probably were a harbinger of the cardiac event. Given the natural history of the disorder, this means that the MI was going to happen fairly soon, probably within the next few months, perhaps even within the next few weeks, even if he had done no physical work.
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> I read that this was a hot day yet the temperature was recorded at 24 degrees Celsius. Nevertheless, if he was working in the sun it could have felt hot. I do not think that this matters much unless he was severely dehydrated and there is no indication that he was. In any event, this would not change the rationale for the above opinion.

In his February 7, 2007 decision the review officer reviewed the evidence on file and the submissions. He cited subsection 5(1) of the Act and item #15.10 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II). He provided the following analysis in support of his decision that the worker's heart attack did not arise out of and in the course of his employment:

> There is no dispute that the worker has confirmed underlying CAD [coronary artery disease] and that ultimately, this is the cause of the majority of heart attacks. Policy item #15.10 describes the circumstances under which claims of this nature can be accepted, notwithstanding the existence of the pre-existing condition. Acceptance of this claim depends on whether the evidence supports that the worker was performing an activity that involved an exceptional strain. Further, the evidence would have to show that the pre-existing condition was such that the worker could have gone months or years without problems were it not for the work-related activity.

According to the Oxford English Dictionary, 'exceptional' is an adjective meaning "unusual; not typical". There is no question that the worker was performing a physically demanding activity immediately prior to experiencing symptoms subsequently confirmed as an MI. However, there is nothing to suggest that there was anything unusual or atypical in this work activity. It is worth noting that the example provided in policy item #15.10 describes fright and an unusual strain caused by a load slipping. There is no evidence of any occurrence of this nature in the matter before me.

In addition, I find the opinion of the Review Division Medical Adviser to be persuasive, especially in light of the absence of a contrary opinion. The worker's physicians did not overtly comment on the possible relationship between the worker's employment and the MI and the Case Manager did not obtain a medical opinion prior to accepting the claim.

The worker reported to his treating specialist that he had experienced symptoms for a 3-6 month period prior to the MI. The Review Division Medical Adviser has described this as a "…harbinger of the cardiac event." Given the presence of the pre-existing symptoms, I find, as did the Medical Adviser, that the worker would not likely have escaped the MI regardless of the work activity. I find that the significance of the work activity was slight, thus leading to a conclusion that the MI resulted from the pre-existing, deteriorating CAD. As a result, I allow the employer's request.

Submissions

As part of the appeal, the worker's union representative provided a July 19, 2007 statement from the worker and a June 24, 2007 opinion from Dr. M. WCAT also obtained the representative's June 13, 2007 letter to Dr. M requesting a medical opinion. The representative provided Dr. M with a copy of Dr. P's opinion. That material was provided to the employer's representative who made a brief September 24, 2007 submission.

In his statement the worker discusses his general work activities and, in particular, his activities of June 30, 2006. Dismantling the tow, which he undertook on June 30, 2006 "requires a high intensity of physical exertion." It was a hot, sunny, summer day. He was wearing a work shirt, jeans, life vest, gloves, and rubber steel-toed caulk boots. The work involved carrying and pulling heavy cables and boom chains (weighing approximately 80 pounds) that hold the log boom together, while walking up and down the tow. After a couple of hours of working under those conditions, the worker started to experience the symptoms that were later diagnosed as a heart attack caused by physical labour.

Regarding the 2000 incident, the worker indicates the symptoms started out as pressure in his chest, like the acid reflux symptoms that he has suffered from for years. The pressure was worse than usual so he admitted himself to hospital where he was tested for "heart issues." After an electrocardiogram and blood work, heart issues were ruled out. The final diagnosis was an acute case of acid reflux in which gases trapped behind the heart cause pressure and pain. He indicates that incident "was not at all similar in any fashion to what I experienced on June 30, 2006." He reiterated that his exertional symptoms experienced in the three to six months prior to June 30, 2006 were mild.

In his June 24, 2007 opinion Dr. M noted that two questions had been put to him. He described the first question and his answer as follows:

> The first question is "was it likely that your work activities on June 30, 2006 caused or significantly accelerate the occurrence of you myocardial infarct?". There is no way to be completely certain that this was the case but it certainly is well within the realm of possibility.
>
> You were clearly working to very high work load on the log boom in very hot weather, although your coronary artery disease would have developed over many years prior to the infarct on June 30, 2006 the stress of that day almost certainly lead to demand ischemia and potentially plaque rupture. It is difficult to be complete certain that you indeed had a plaque that ruptured. On your angiogram we did see a 70%% stenosis and this could have been a source of simply demand ischemia given your high workload. Given the high potential for a recurrent event even if you were under similar high workload I have advised you not to return to that type of work.

He described the second question and his answer as follows:

> The second question was "was it likely that you could have survived months or even years without experiencing a myocardial infarct other than for your work activities on June 30, 2006?" Again, this is a difficult question to be completely certain about. Your amount of myocardial damage was small (your troponin did not rise as high as I would expect for a complete occlusion of a coronary artery) and as such I feel that you infarct again may have been due to demand ischemia. Demand ischemia would have come about from a high workload that you were doing on June 30, 2006.
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> I do think it likely that your activities on June 30, 2006 contributed to your myocardial infarct. However, admittedly there is no way to be completely certain of this. Giving you young age and otherwise good health, I think it

> safest that we have you avoid getting back into very strenuous situation as you were in on that day.

In his July 19, 2007 submission the worker's union representative notes Dr. M's opinion, the worker's statement, and the August 11, 2006 claim log entry by the case manager. He notes item #15.10 of the RSCM II and submits the worker was involved in unusual and not typical duties on the afternoon of his heart attack. He submits that Dr. P's qualifications make his opinion questionable as he appears to be a general practitioner, as opposed to Dr. M who is a specialist. Dr. P did not examine the worker. Dr. P's opinion does not support the Review Division's application of item #15.10. He contrasts Dr. P's opinion that the worker was going to suffer a myocardial infarction probably within the next few months, perhaps even within the next few weeks with the language of item #15.10 which refers to a worker who could well have survived without disability for months or years. The Review Division misapplied Dr. P's opinion.

The worker's union representative notes Dr. M's August 23, 2006 report documents that the worker undertook a treadmill test to determine if ischemia could be induced. There were no adverse symptoms and the worker's exercise capacity was found to be quite good. The union representative submits that this is some confirmation the ischemia that occurred on June 30, 2006 was likely because of the unusual working conditions rather than less severe forms of physical exertion such as the treadmill test. Dr. M's opinion is much more consistent with what is required by item #15.10.

With regard to Dr. M's response to the first question put to him, the employer's representative indicates she does not feel that "Dr M. is completely convinced the work activities were the causation of the MI." She draws attention to Dr. M's use of the word "may" in his response to the second question and contends Dr. M's response "does not provide a definitive causation of the MRI." She contends that Dr. M is a credible internal medicine specialist who cannot definitively state the cause of the worker's myocardial infarction.

She reviews Dr. P's opinion. She notes the temperature and wind speed information provided earlier and observes that the worker was performing work that was part of his normal daily activities. She draws attention to the worker's earlier episode, his signs in the three to six months prior to June 30, 2006, and a history of hypertension and elevated cholesterol. She submits the worker has continued to have intermittent episodes of exertional chest pain and that in a January 7, 2007 claim log entry Dr. Y, a Board medical advisor, related the chest pain to the worker's pre-existing condition.

In rebuttal, a worker's union representative contends that the employer's representative's submissions are misconceived. He notes that item #97.00 of the RSCM II requires only that there be a preponderance of evidence; it does not require absolute certainty. It is unlikely most claims would never succeed of the standard suggested by the employer's representative were applied.

Reasons and Decision

Item #30.70 of the RSCM II provides guidance as to whether claims for heart-related conditions are adjudicated as injuries under section 5 of the Act or diseases under section 6 of the Act:

> Heart-related conditions which arise out of and in the course of a person's`employment and which are attributed to a specific event or cause or to a series of specific events or causes are generally treated as personal injuries. They are therefore adjudicated in accordance with the policies set out in Chapter 3. If the heart-related condition of a worker is one involving a gradual onset and is not attributed to a specific event or cause or to a series of events or causes, the claim will be adjudicated under section 6 of the *Act*. (See policy items #15.10 and #15.15).

Regardless of whether the appeal is analyzed with respect to whether the worker's heart attack arose out of and in the course of his employment under subsection 5 (1) of the Act or whether it was due to the nature of his employment under subsection 6 (1) of the Act, the issue raised by this appeal is whether there is a causal link between the worker's employment and his heart attack. Item #14.10 of the RSCM II makes this point very clearly. While that item occurs in chapter 2 which concerns compensation for personal injuries, the following passage has application to claims for injuries and diseases:

> To be compensable, however, the evidence must warrant a conclusion that there was something in the employment that had **causative significance** in producing the injury. A speculative possibility that this might be so is not enough.
>
> [emphasis added]

That point is reinforced by the following language found at item #15.00 regarding natural causes:

> An injury is not compensable simply because it happened at work. It must be one arising out of and in the course of employment. If it happened at work that usually indicates that it arose in the course of the employment. But it must also have arisen "out of" the employment. This means that there must have been something in the employment relationship or situation that had **causative significance** in producing the injury.
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> But if the injury was one arising out of purely natural phenomena – the internal workings of the human body – the employment situation may then be an irrelevant coincidence, and if so, the injury is not compensable

[emphasis added]

Item #15.10 provides policy regarding deteriorating conditions:

> There may be cases where an organ of the body is deteriorating, possibly through disease, and it has reached a critical point at which it is likely to become a manifest disability. Some immediate activity might trigger the final breakdown. But if it had not been one thing it would most likely have been another, so that it is only chance or coincidence whether it happened at work, at home, or elsewhere. The disability is one that the worker would not have escaped regardless of the work activity, and hence the causative significance of the work activity is so slight that the disability is treated as having resulted from the deteriorating condition. The disability is the result of natural causes and is not compensable. A Board decision illustrates the point:
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> > "An office worker goes to work at an office that is located above a store. He walks up one flight of stairs to his office and has a heart attack at the top. The evidence indicates a deteriorating condition of his heart. It indicates that a heart attack would not be unexpected and could be brought on by any activity at all. The disability is the result of natural causes and is not compensable."
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> On the other hand, there may be other cases where the deteriorating condition was such that, in the absence of some **exceptional strain or other exceptional circumstance, it was not likely to reach a critical point and become a disability about the time of the work injury. The worker could well have survived without disability for months or years if something exceptional in the course of his employment had not triggered the disability.** Here the employment situation had substantial causative significance and the disability is compensable. An illustration of the point comes from a Board decision which stated in part:
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> > "A transportation worker is moving a 300 lb. load up a flight of stairs when the load slips, causing fright and strain. The worker has a heart attack. Again the medical evidence indicates a deteriorating condition of the heart. But it supports a conclusion that the worker could well have survived for months or years without a heart attack had it not been for this unusually strenuous experience. Here the employment situation appears to have had causative significance and the heart attack is compensable."

> It is sometimes said that an event at work "triggered" the disability. This does not, however, determine whether the disability is compensable. The circumstances, including the condition of the worker, must be investigated in such cases to determine which of the above applies.
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> [emphasis added]

In the following passage, item #26.22 of the RSCM II (which includes a discussion of section 99 of the Act) emphasizes the need for affirmative evidence of a causal link before a claim may be accepted:

> Therefore if the weight of the evidence suggesting the disease was caused by the employment is roughly equally balanced with evidence suggesting non-employment causes, the issue of causation will be resolved in favour of the worker. This provision does not come into play where the evidence is not evenly weighted on an issue.
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> If the Board has no or insufficient positive evidence before it that tends to establish that the disease is due to the nature of the worker's employment, the Board's only possible decision is to deny the claim.

The evidence establishes that June 30, 2006 was a warm day. While the employer's representative contends the worker's representative submitted that the temperature was over 30°C, the employer's representative errs in that assertion. The suggestion that the temperature was over 30°C is found in an August 11, 2006 claim log entry which documents information from the tug captain. I accept the information provided by the employer's representative that it was 24.9°C at the Vancouver International airport at the time in question. The worker was not working at the Vancouver International Airport at the time of his heart attack, and while there is some question as to whether it would have been warmer or cooler than 24.9°C at the worker's work location, I accept the evidence of the worker and the tug captain that it was very warm.

That the worker had a pre-existing condition is not in doubt. As noted by Dr. M, the worker's coronary artery disease would have developed over many years prior to the heart attack. The presence of such disease does not preclude the worker from having suffered a heart attack arising out of and in the course of his employment. As established by item #15.10 the issue is whether the pre-existing condition was deteriorating and, if so, the nature of that deterioration and whether there was an exceptional strain or other circumstance.

I do not consider that a determination of whether the worker may have had a similar episode some six years prior to his June 2006 attack resolves the issue before me. Dr. P's analysis does not attach significance to the 2000 episode. As well, while Dr. M's

July 1, 2006 consultation report establishes that the worker had an episode of chest pain some six years earlier, Dr. M did not place any significance on that episode.

That Dr. Y may consider the worker's ongoing episodes are due to his pre-existing condition also does not determine the matter before me. The issue is the cause of his myocardial infarction on June 30, 2006.

That the worker had experienced symptoms in the three to six months prior to June 30, 2006 is established by the evidence on file. Both Dr. M and Dr. P were aware of the existence of such symptoms. Dr. P considered the symptoms were probably a harbinger of the cardiac event. While Dr. M's June 24, 2007 opinion does not address the significance of those symptoms, his July 1, 2006 consultation report establishes he was aware of them.

While the worker had "quite mild" pre-June 30, 2006 symptoms, I find that they are indicative of a pre-existing deteriorating condition. What was the nature of that condition? Dr. P considered the worker's heart attack was going to happen within the next few months and possibly within the next few weeks even if he had done no work. On the other hand, Dr. M considered that the worker's activities contributed to his heart attack.

While the employer's representative attaches significance to what she appears to consider to be tentative language in Dr. M's opinion, I consider that, taken as a whole, Dr. M expressed an opinion that the worker's activities were of causative significance. He indicated the worker's physical stress certainly led to demand ischemia. As well, he thought it likely the June 30, 2006 activities contributed to the worker's myocardial infarction. The use of the word "may" in Dr. M's opinion does not undermine those statements by Dr. M. It appears that the word "may" concerns whether the myocardial infarction was due to demand ischemia or a plaque rupture; Dr. M thought that it may have been due to demand ischemia rather than a plaque rupture.

I accept that some tentative language appears in Dr. M's opinion; however, I consider that that language is consistent with Dr. M not being absolutely certain. As noted by the worker's representative, absolute certainty is not required. Given the terms of subsection 250(4) of the Act the issue is whether the evidence supporting an occupational cause for the worker's heart attack is evenly balanced with there not being an occupational cause. Thus the issue is whether the possibilities are evenly balanced. A critical question is whether there was some exceptional strain or other exceptional circumstance. I do not consider that any exceptional nature of the June 30, 206 activities is established by how the worker may have performed at an exercise test undertaken several months after the heart attack. The evidence and argument do not persuade me that such a test is especially relevant to whether the activities of June 30, 2006 were exceptional.

In reviewing this aspect of the case, the review officer attached significance to whether the worker's work activities were unusual or atypical. While the worker's representative submitted that the tug captain confirmed that the activities were unusual and not typical, I am not satisfied that is the case. The captain confirmed the actual activities; however, he did not address whether they were unusual or typical. I find that the evidence establishes that the activities engaged in were part of his usual employment. The evidence does not establish that the activities were atypical.

Yet, that the work activities were not atypical does not resolve the matter. I consider that activities can amount to an exceptional strain or other exceptional circumstance, even if they are not atypical. I consider that the language of item #15.10 uses the expressions "some exceptional strain", "other exceptional circumstance" and "something exceptional in the course of employment," as equivalent to the test of substantial causative significance. As established by other aspects of policy, the issue is whether the employment was of causative significance. I consider that it would be most unusual if, despite the fact the evidence established work activities were of causative significance, a claim would have to be denied on the basis the work activities in question were not atypical. I do not consider that narrow interpretations of the expressions "exceptional strain," "other exceptional circumstance," and "something exceptional in the course of employment" are consistent with the basic question which underlies these cases: were the work activities of causative significance?

After having reviewed the matter, I find that the worker's heart attack arose out of and in the course of his employment. I am persuaded by Dr. M's opinion that the worker's work activities were of causative significance. He was involved in very heavy work during the second half of his 12 hour shift on a warm day. While he had a pre-existing heart condition, I am satisfied that he would not have suffered a heart attack but for his work activities on June 30, 2006.

Conclusion

The worker's appeal is allowed. I vary the review officer's February 7, 2007 decision. I find that the worker's heart attack arose out of and in the course of his employment.

I consider that reimbursement of $150.00 associated with Dr. M's report would be appropriate. Item #13.23 of WCAT's MRPP provides that WCAT will generally order reimbursement of expenses for attendance of witnesses or obtaining written evidence, regardless of the results in the appeal, where (1) the evidence was useful or helpful to the consideration of the appeal or (2) it was reasonable for the party to have sought such evidence in connection with the appeal. Dr. M's report was useful in the consideration of this appeal.

Randy Lane
Vice Chair

RL/jm