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Ms. Christina Wendel
Senior Policy Analyst
Policy and Regulation Division
Workers' Compensation Board
P.O. Box 5350, Station Terminal
Vancouver, B.C. V6B 5L5

Dear Ms. Wendel:

Re: Nerve Entrapments and Tendinopathies of the Arm, Neck and Shoulder

Introduction

The BC Building Trades appreciates the opportunity to participate in the stakeholder consultation regarding changes to the activity-related soft tissue ("ASTD") policy regime. Given the significant number of ASTD claims made every year, benefits paid, work days lost, and the high level of overturns at the Review Division and Workers Compensation Appeal Tribunal ("WCAT"), this is a matter of great importance for workers and employers alike.

While the Board's stated objective of consolidating and clarifying adjudicative guidance of ASTD claims as well as updating occupational risk factors seems reasonable enough, a closer analysis reveals more serious changes. As a result, we have serious concerns.

Discussion

In the process of our review of Dr. Bionka's study of causal relationships between work-related activities and the development of nerve entrapments and tendinopathies ("Systematic Review"), we have unearthed a range of shortcomings in the Board's proposal.

Other General Adjudicative Guidance

One of the problems emerges in the context of *7.1.3 Other General Adjudicative Guidance*. Specifically, on page 12-13 the Board states that:

> Having all general guidance moved into the introductory policy would be more effective and may result in more consistent adjudication. It would also allow for policies on specific ASTDs to be more concise.
>
> **In addition if all general guidance is moved into the introductory ASTD policy, it follows that two current policies could be deleted: disablement from vibrations, and unspecified or multiple tissue disorders.** These policies do not contain any specific risk factors or adjudicative guidance in addition to what would be in the introductory ASTD policy. If these policies are deleted, claims relating to these conditions would continue to be adjudicated and may still be accepted on a case-by-case basis under the introductory ASTD policy. [Bolding added.]

While we concur that disablement from vibrations (RSCM Policy Item #27.34) does not contain any specific risk factors or adjudicative guidance in addition to what will be set out in the proposed introductory ASTD policy, that is not the case for unspecified or multiple tissue disorders (RSCM Policy Item #27.35). On the contrary, it appears that valuable adjudicative guidance will be eliminated if Policy Item #27.35 is deleted as proposed. Consequently, unless this language is reiterated in another section of the paper - verbatim or close thereto - we suggest that it be left as is.

Carpel Tunnel Syndrome

Another issue arises in the context of *7.2.2 Carpel Tunnel Syndrome*. We do not agree with the Board's assertion that the *Systematic Review* and underlying studies provide a basis for the risk factors for carpel tunnel syndrome being updated with respect to force, repetition, and hand-arm vibration. We have three significant reasons for opposing this proposal.

To begin with, while increased specificity may sometimes assist in identifying a work-related injury, it can just as easily obfuscate it. In this particular case we think that this is precisely what

will happen. The proposed elimination of the existing language and inclusion of specific identifiers will narrow the "lens" through which WCB officers evaluate CTS claims.

Secondly, as cogently argued by James Sayre, former legal advocate with the Community Legal Assistance Society, "all three of these 'updates' would impose a cookie cutter approach which would apply the same precise measurements to all workers, whether young or old, big or small, male or female" thereby ignoring the individual differences in vulnerability between workers. The proposal would also "enhance the position of the medical advisors by requiring detailed measurements which the worker's treating physician won't have the expertise or interest to make".

Thirdly, the research studies upon which the proposed specific CTS risk factors are based possess serious methodological deficiencies. To begin with, under the rubric of *force*, the Board is proposing to delete virtually all of the existing language and replace it with the following:

> Force: exertion of pinch-grip force or performance of precise motions while holding a tool or part weighing in excess of 1 kg, more than 10 times per hour

The above language is based solely on the research findings of one study, namely, *Occupational and Personal Risk Factors for Carpel Tunnel Syndrome in Industrial Workers* by Roquelaure Y. et al. This case-control study examined 65 cases of workers with CTS and 65 referent workers without CTS in three manufacturing plants where televisions, shoes and automobile brakes were made. Generally, Roquelaure et al. found a significant association between exposure to force and CTS; more specifically, handling of loads of more than 1 kg for at least 10 times per hour was a risk factor for CTS. The problem with using these findings to create a risk factor is that, as already mentioned, this is only one study, and equally importantly, it is a case-control study which is known to possess serious limitations.

A case-control study design is an observational study in which two existing groups differing in outcome are identified and compared on the basis of some supposed causal attribute. These research methodologies/designs are commonly used because they require fewer resources than many other designs, but they provide less evidence for causal inference than other experimental studies. While case-control studies have led to important discoveries and in certain situations may have greater statistical power than cohort studies, they are observational and thus do not

provide the same level of evidence as randomized controlled trials. Moreover, results may be confounded by other factors (in some cases they have given the opposite answers to better studies); it can be more difficult to establish the timeline of exposure to disease outcome; and, most importantly, it is difficult to obtain reliable information about an individual's exposure status over time using a case-control study. For all these reasons case-control studies are placed low in the hierarchy of evidence.

With respect to the matter of *repetition*, the Board, again, is proposing to delete virtually all of the existing language and replace it with the following:

> Repetition: where the work cycle time is less than 10 seconds, or where more than 50% of the work cycle is spent performing the same wrist movements

Similar to the issues raised above with respect to force, the proposed change is based on the study by Roquelaure et al., a case-control study (the limitations of which have been discussed) and one other study by Chiang HC et al. entitled *The Occurrence of Carpel Tunnel Syndrome in Frozen Food Factory Employees.* This latter study was published in 1990, that is, more than 23 years ago. Such an old study does not meet the Board's stated objective of "updating occupational risk factors for specific ASTDs in accordance with *current* medical/scientific evidence". We are equally troubled by the fact that Chiang's research was drawn from a group of workers in a frozen food factory, one of the industries with the highest prevalence for CTS according to Dr. Warren's Systematic Review. Finally, Chiang's et al. research results are the product of a cross-sectional study. A cross-sectional study is a descriptive study in which disease and exposure status are measured simultaneously in a chosen population. Essentially, these kinds of studies provide a picture of the frequency and characteristics of a disease in a population at a particular point in time. Because exposure and disease status are measured at the same point in time, it may not be possible to distinguish whether the exposure preceded or followed the disease, and, as a result, cause and effect relationships cannot be obtained with any degree of certainty.

We find many of the problems pointed to above with respect to force and repetition apply to the proposed risk factors for *hand-arm vibration.* Specifically, with the exception of the Nathan et

al. cohort study, the Board has relied upon the same weak research to support this change as they have to justify their risk factors in relation to force and repetition.

Last but certainly not least, we are opposed to the Board Medical Advisors' proposed revision of non-occupational risk factors. Regarding the scientific validity of the proposed changes, the Board says only that the "changes are based on advice from WorkSafeBC MAs [Medical Advisors], and are consistent with some of the risk factors set out in the general policy in Prince Edward Island". Yet the changes appear to be far reaching, that is, they add a list of medical conditions that would be deemed non-occupational or personal risk factors as well as delete a significant portion of the existing language, some of which gives decision-makers latitude to interpret medical data. The fact that the Board Medical Advisors have advanced this proposal does not provide us with a great deal of confidence in the supporting evidence. And let us not forget that we are talking about a factor that can be used (and oftentimes is!) by the decision maker to deny compensation, even if the overall evidence supports causation.

Given the problems with the proposed changes set out in *7.2.2 Carpel Tunnel Syndrome* of the discussion paper, we suggest the existing language be sustained.

General Risk Factors

Every workers' advocate who has appealed a Board decision denying a worker's ASTD injury is fully aware of the importance of effectively scrutinizing the listed risk factors and, when relevant, using them to prove their case. Similarly, Board decision-makers who canvass the existing list of risk factors can obtain significant guidance when evaluating whether the injury is causally connected to the workplace. Not surprisingly, then, the *content* of the expressed risk factors is critically important to all parties – workers, employers, and the Board.

The Board's proposal with respect to risk factors is essentially twofold: first, to express specific risk factors with respect to carpel tunnel syndrome, radial tunnel syndrome, and lateral and medial epicondylitis in keeping with the medical literature in the Systematic Review; and secondly, to replace the existing general risk factors with fewer and more specific risk factors. With respect to this latter issue, the Board states its rationale as follows:

> WorkSafeBC staff have advised that many of the definitions in the current policy on risk factors are too general and lack the specificity to be usefully applied in practice. To address this issue, it is proposed that the risk factors be updated based on definitions set out in the Occupational Health and Safety Regulation and associated guidelines, input from a WorkSafeBC Senior Ergonomist, WorkSafeBC MAs who specialize in ASTD treatment and assessment, and an existing WorkSafeBC practice directive on ASTDs.

Contrary to the Board's assertion, we do not think that the current "risk factors are too general and lack the specificity to be usefully applied in practice". While there may be elements of improvement in some of the proposed changes, we think much of the existing language provides useful guidance to decision-makers. Paradoxically, it is the *lack of specificity* in the context of general risk factors that ensures their efficacy. That is to say, the existing comprehensive, albeit generic, risk factors provide decision-makers and advocates with the necessary "tools" to scrutinize a wide range of potential stresses and strains arising in workplace activities and their potential causal connections to ASTD. As already discussed in the context of carpal tunnel syndrome above, the proposal to replace these general comprehensive risk factors with more specific and far fewer risk factors narrows the "aperture" through which a potential workplace injury can be viewed and, therefore, analyzed. This does not serve the interests of workers.

Consider: The goal is to identify an ASTD condition arising from a workplace incident. In order to do so decision-makers must analyze the activities, the workplace, the worker, the environment, and all matters related thereto in as comprehensive manner as possible. If the guidelines they employ are too specific they will not aid in the process of interpretation; they will detract from it. Remember: Risk factors are guidelines that must be applied with a degree of judgement. The real problem with the existing risk factors is not the current guideline, but rather the WCB investigators who oftentimes fail to *read* and, even more importantly, *apply,* the relevant risk factors. In other words, there has too oftentimes been a self-imposed narrowing of the aperture of assessment. Clearly, providing a *shorter list* of risk factors for investigators to consider is *not* the remedy.

When we compare and contrast the risk factors of the existing *RSCM* Policy Item #27.40 with the proposed language set out in Policy Item #27.00, Section 5 on risk factors, we find that much has been left out. This is not too surprising given that the existing seven and half pages of risk

factors have been reduced to two pages! Although we are not suggesting that every word be put "back in its place", *where* the existing risk factor is important, *where* it has been deleted without any reference in the new language, and, most importantly, *where* the analysis of a worker's condition will be narrowed as a result of its absence, *we are* suggesting the existing language be included in the overall revision.

With this principle in mind, we suggest that the following existing risk factors be included in the generic risk factor list in their entirety:

- Location
- Magnitude/Intensity
- Local Mechanical Stresses
- Shock (impact loading)
- Grip Type
- Vibration
- Extremes of Temperature
- Unaccustomed Activity
- Ergonomic Aspects
- Work Organization
- Work Behaviour
- Cognitive Demands
- Age
- Moderate to Heavy Smoking

With respect to awkward postures, the new policy should indicate that, as noted in the existing policy, "some postures may adversely affect the physiologic function of the arm as a result of impingements, occlusion of blood flow and the like. Postures to watch include: overhead reaching and lifting; postures involving static shoulder loads; sustained shoulder abduction or flexion; sustained flexion or extension of the wrist; and sustained ulnar deviation of the wrist".

Conclusion

While the BC Building Trades would like to believe that any changes proposed by the Board would not negatively impact our members, past experience does not support such a belief. We are all empiricists when it comes to law and policy. Workers have been under attack since the legislative and policy changes in 2002, and we must remain forever vigilant to ensure the "historic compromise" is not further compromised. Not surprisingly, then, we take little comfort in the Board's statements about the proposed changes to the ASTD regime not having a significant impact on the number of claims accepted or denied. On the contrary, there *is* good reason to think that the proposed changes will have a significant impact on the number of claims denied and this submission sets out some of those reasons.

In closing, the BC Building Trades appreciates the opportunity to review the Board's ASTD policy proposal. We respectfully submit our counter proposal.

Sincerely,

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Workers' Advocate

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