

CLAIM HISTORY AND APPEAL PROCEEDINGS:

On April 3, 2006, the Worker filed a claim for chronic obstructive pulmonary disease (COPD) with the Board. He claimed that it resulted from second-hand tobacco smoke from his employment in a toll booth.

On November 1, 2006, a Board Adjudicator found that she could not relate the Worker's COPD to his employment given: his smoking history, a no smoking policy of the Employer, and that the degree of the Worker's COPD would not be explained by occasional exposure to second-hand smoke.

On January 15, 2007, a Board Hearing Officer confirmed the Adjudicator Decision.

This decision addresses the Worker's appeal of the Hearing Officer Decision. He argues that the no smoking policy was not enforced, and that he feels that second-hand smoke caused his COPD.

ISSUES AND OUTCOMES:

Is there sufficient evidence of occupational second-hand smoke exposure to infer causation?

No. While plausible, there is insufficient evidence to establish causation.

ANALYSIS:

In order for the Worker to prove causation, it is not necessary for him to show that workplace exposures are the sole or most important cause of his COPD. Instead, all that need be proven is that the exposures were a contributing cause in the sense that, "but for" the exposures, the COPD would not have occurred when it did, or that the exposures contributed to it to a material degree.

I do not need to rely solely on medical opinions when deciding whether there is a link between the workplace exposures and the COPD. I can use common sense and logic to draw conclusions from proven facts (reasonable inferences). I must decide disputed issues in the Worker's favour if the possibilities supporting his position are at least as strong as the possibilities against it.

However, speculation, even if plausible, does not establish causation.

The Worker testified that he complained about smoking at the toll plaza on many occasions, but that the Employer never acknowledged this. He testified that information from the Employer that he had a home welding shop was wrong. He feels that second-hand smoke exposures caused his illness. He testified that the employee who provided information to the Board did not work on his shift. He testified that smoking occurred during the night shift, and he could smell the smoke when he entered the booth during the day shift. He testified that he quit smoking some ten to fifteen years ago. He is disappointed with how the Employer has treated him.

On his claim form, the Worker wrote that he quit smoking in 1980 after smoking about five cigarettes a day for 15 years. He first sought treatment for his condition in 1991.

On October 4, 2006, the Employer wrote that the Worker started at the toll plaza on November 14, 1997. On June 7, 2002, his employment became part-time. He resigned on July 26, 2005. They wrote that after an investigation they were unable to find proof of smoking in the workplace. They wrote that the Worker had extended periods off-work due to his diabetes and shortages of work. They indicated that the no smoking policy was enforced by both them and the Department of Transportation and Public Works.

On January 2, 2002, and May 31, 2002, the Worker's family doctor wrote notes asking that the Worker not be exposed to second-hand smoke in the workplace.

On March 22, 2006, Dr. Berghuis, family physician, wrote that the Worker had been treated for COPD symptoms for the past few years. He stated that diagnostic testing was consistent with chronic lung changes.

On October 26, 2006, Dr. Marche, Board physician, reviewed the Worker's file. It was her view that the Worker's significant COPD was not related to occasional occupational second-hand smoke.

On February 7, 2007, Dr. Berghuis wrote that the Worker's exacerbation of COPD may be related to his old smoking, second-hand smoke after quitting, or a virus.

I accept the Worker's testimony that there was some occupational exposure to second-hand smoke despite the Employer's policy against smoking in the booths. The Worker complained to both his Employer and doctor about this well before putting in a claim.

However, I find the exposures to be occasional in nature and of low intensity - mostly from walking into a booth that had been smoked in before his arrival.

Dr. Berghuis wrote that the Worker's exacerbation of COPD might be related to his smoking history, second-hand smoke or a virus, but he does not discuss likelihoods. Dr. Marche felt that occasional exposure to second-hand smoke would not account for the Worker's COPD.

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Considering the low level intensity of occupational exposure, the speculative nature of Dr. Berghuis's report, and Dr. Marche's years of experience in occupational medicine, I am unable to infer on an as likely as not basis that occupational exposure is a cause of the Worker's current COPD.

CONCLUSION:

The appeal is denied. I am unable to relate the Worker's current COPD symptoms to occupational second-hand smoke.