BC NURSES' UNION
Standing up for health care

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Via Email: Lori.Guiton@worksafebc.com

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WorkSafeBC
Policy, Regulation & Research Division
PO Box 5350, Stn. Terminal
Vancouver, BC V6B 5L5

Attention: Lori Guiton (Director, Policy, Regulation & Research)

Dear Lori Guiton:

Re: Covid-19 (SARS-CoV-2) and its compensable consequences discussion – Occupational Disease Recognition and Related Policy and Practice

Introduction

The BC Nurses' Union is presenting this Paper to the Policy, Regulation and Research Department (PRRD) to support our call for changes to compensation policy and practices regarding Covid as an occupational disease. The BC Nurses' Union (BCNU) represents more than 50,000 members in the British Columbia (BC) healthcare industry. Because our members are on the frontlines of the healthcare system, it is long accepted that they are at a higher risk of both contracting Covid-19 and suffering from Long Covid than the wider public. As the unified voice of nurses working in healthcare, significant weight should be attached to our position and recommendations on this issue.

The BCNU has advocated for members directly on appeals of Covid-19 and Long Covid claim entitlements with comprehensive submissions on the related law and policy to the Review Division (RD) and Workers Compensation Appeal Tribunal (WCAT). As frontline advocates for injured workers, we have concerns that WorkSafeBC's Long Covid decisions often fail to reflect the realities and lived experience of our members. Treatment and return-to-work processes that may be appropriate for other conditions contradict the best practices and recommendations from leading experts in the field. The ratings of permanent impairment often do not reflect the actual degree of functional impairment. Acknowledging the evolving understanding of this complex occupational disease and its compensable consequences, we believe there are significant changes that can be made now to policy and practice that would reflect the current state of medical knowledge. To support our call for changes to policy, practice and guidance on adjudicating and rating impairment we reference current medical science on this subject, including expert evidence and appeal decisions that changed impairment ratings. This submission provides BCNU's perspective on the policies and practices governing how Long Covid claims are handled by the Board. We write to advocate for Long Covid entitlement decisions being fair, individualized, lawful and reflective of the current medical knowledge. We also have great respect for the complex considerations at hand. Our goal is to assist WorkSafeBC in identifying solutions that uphold workers' rights, while ensuring clarity and consistency in the compensation system.

Recognition as an Occupational Disease

Viral pathogens are recognised as an occupational disease under Item 20 of Schedule 1 of the *Workers Compensation Act* (the Act). However, this recognition is not specific to Covid-19, and it is limited to specific timeframes where a public health emergency is enacted. As we know on July 26, 2024, the public health emergency for Covid-19 was rescinded. This change has led to there no longer being a presumption of work relatedness for Covid-19 and its compensable consequences, therefore shifting the burden to the worker to prove their work posed a significantly greater risk of infection than the public. This is a high bar for our members who in some cases have had multiple infections of Covid-19.

There is now no recognition of Covid-19 (as a viral pathogen or otherwise) as an occupational disease. Chapter 4 of the RS&CM II provides that occupational diseases my be recognized under Schedule 1 and as a result would have a rebuttable presumption. Occupational diseases may be recognized by regulation under section 138 of the Act and policy item C4-25.10, this policy provides in part:

> To assist in adjudicating the merits of occupational disease claims, to facilitate efficiency and consistency in the decision-making process and to establish an institutional memory (with the additional benefit of providing the working community with confirmation that the Board is aware that a disease may arise as a result of employment activities), the Act provides a means by which the Board may designate or recognize a disease as an "occupational disease".
>
> There are levels of designation or recognition based on the available medical and scientific evidence and on the Board's experience in dealing with these diseases. The manner in which a disease is designated or recognized is primarily based on the strength of medical and scientific knowledge about the role employment may have in its causation.
>
> The following are the various ways in which an occupational disease may be designated or recognized:
>
> - by inclusion in Schedule 1;
> - by regulation of general application;
> - by order dealing with a specific case; or
> - under section 138(4), as being a disease that is peculiar to or characteristic of a particular process, trade or occupation, on the terms and conditions and with the limitations set by the Board.

…

> If the Board concludes that a disease is more likely to occur in connection with a particular employment covered by the Act than elsewhere, it may be added to Schedule 1. On the other hand, if the Board concludes that a disease is only sometimes due to the nature of a particular employment covered by the Act, and it does not appear that the disease is more likely to occur in connection with any particular employment than elsewhere (it is not something specific to that employment), the Board may designate or recognize the disease under section 138(2), by regulation of general application without the rebuttable presumption afforded by inclusion in Schedule 1.
> …
>
> **D. RECOGNITION BY REGULATION OF GENERAL APPLICATION**
>
> The Board may designate or recognize a disease as an occupational disease "by regulation of general application" (section 138(2)). In these circumstances, the Board is satisfied from the expert medical and scientific advice it receives that there is a greater incidence of the particular disease than there is in the general population, but without connecting it to a particular employment or providing a rebuttable presumption that the occupational disease is due to the nature of any employment in which the worker was employed.
>
> The Board has designated or recognized the following as occupational diseases by regulation of general application:
>
> - Bronchitis
> - Bursitis (other than the forms of bursitis mentioned in Item 13 of Schedule 1 of
> - the Act)
> - Campylobacteriosis (diarrhea caused by Campylobacter)
> - Carpal Tunnel Syndrome

- Chicken Pox
- Cubital Tunnel Syndrome
- Disablement from vibrations
- Emphysema
- Food poisoning
- Giardia Lamblia Infestation
- Head lice (Pediculosis Capitis)
- Heart Disease
- Hepatitis A
- Herpes Simplex
- Hypothenar Hammer Syndrome
- Legionellosis
- Lyme Disease
- Meningitis
- Mononucleosis
- Mumps
- Plantar Fasciitis
- Radial Tunnel Syndrome
- Red Measles (Rubeola)
- Ringworm
- Rubella
- Scabies
- Shigellosis
- Staphylococci infections
- Streptococci infections
- Tendinopathy (other than the forms of tendinopathy mentioned in Item 14 of
- Schedule 1 of the Act), including:
- Epicondylopathy (lateral and medial
- Stenosing Tenosynovitis (Trigger Finger)
- Thoracic Outlet Syndrome
- Toxoplasmosis
- Typhoid
- Vinyl Chloride induced Raynaud's Phenomenon
- Whooping Cough
- Yersiniosis

Several of the above contagious diseases are not likely to meet the section 136 requirement to be ". . . due to the nature of any employment in which the worker was employed . . ." except for hospital employees, or workers at other places of medical care.

Covid-19 is as deserving of being recognized by regulation as any of the occupational diseases currently listed. This is particularly true for healthcare workers and others in which there is greater exposure to the disease than would be experienced by the general public. Covid should be included in the occupational diseases recognized by regulation.

The third level of recognition is by order dealing with a specific case. The policy provides that this level of recognition is appropriate where there is

- Weak or complete absence of medical and scientific information which causally associates such disease with employment
- Adjudication should be considered without "institutional memory" for decision-makers or an explanation for others that the disease may be due to the nature of some employment

- allows an avenue of recognition for unique, meritous, individual disease claims. As the Board repeatedly encounters such claims for a particular disease, it may determine that a higher level of designation or recognition is warranted for that disease.

The BCNU submits that Covid-19 and conditions that are a compensable consequence of Covid-19 should now be recognized by regulation. This is clearly the appropriate place under compensation law and policy.

Covid-19 and Long Covid should be explicitly recognized by regulation and policy as occupational diseases for healthcare occupations. There are examples for this recognition being codified in legislation and policy. In an analysis of 181 jurisdictions, 98 have recognised Covid-19 as an occupational disease. Of those 181 jurisdictions, 17% had presumptive policies for healthcare workers. Notably France and Spain have designated Covid-19 as an occupational disease and 34 of the 50 United States have presumptions in place for first responders and healthcare staff[1].

In a study published by UNI Global Union titled Covid-19: An Occupational Disease: Where Frontline Workers Are Best Protected[2] states the following rationale for Covid-19 being designated an occupational disease:

> For COVID-19, the link to the workplace has become a major issue of contention because community viral loads have been high, and some cases are asymptomatic until the appearance of long-COVID symptoms. Presumptive language is therefore the best policy as it enables workers to get immediate access to benefits, but too few governments have these policies on their books.

Long Covid should also be considered for designation as an occupational disease. We recognise that WorkSafeBC often accepts Long Covid as a compensable consequence of COVID-19, though our experience has shown that long covid cases face skepticism and an underappreciation for the impact of symptoms due to the inherently subjective nature of workers reporting of symptoms and their medical assessment in addition to the evolving nature of medical knowledge on the subject.

Because Covid-19's is no longer as prevalent in the community as it was during the declared public health emergency, its symptoms vary so much, testing is now less common than it was. An article titled Post-Covid-19 condition symptoms among emergency department patients tested for SARS-CoV-2 infection, states the following on the subject[3]:

> In 2024, fewer people are seeking or being offered diagnostic testing for SARS-CoV-2 now that the virus is less virulent and endemic. As a result, people who were never tested for SARS-CoV-2 infection may develop WHO PCC [post-COVID-19 condition] criteria without ever being diagnosed with SARS-CoV-2.

We are concerned that this leads to undiagnosed Covid-19 in our members, creating difficulties when they develop Long Covid symptoms as they never had a confirmed diagnosis, or claim, for Covid-19. Many workers who develop Covid-19 will simply stay home, not get tested or seek medical attention, and return to work when their symptoms resolve. We submit that recognizing Long Covid as a standalone occupational disease would recognize that certain workers, such as nurses, who are at significantly greater risk of exposure to Covid-19 are also at significantly greater risk of developing Long Covid. This would allow those workers to receive compensation without first proving that they had a specific Covid infection.

We submit that the Board should consider adding Covid-19 and Long Covid to the occupational disease schedule and acknowledge similar post-viral syndromes as part of Long Covid's spectrum will ensure nurses get the support they need.

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[1] UNI Global Union. (2021). *COVID-19: An Occupational Disease Where Frontline Workers Are Best Protected.* https://uniglobalunion.org/wp-content/uploads/covid-19_an_occupational_disease.pdf

[2] *Ibid.*

[3] Lone, N. I., et al. (2024). *Post-COVID-19 condition symptoms among emergency department patients tested for SARS-CoV-2 infection.* Nature Communications. https://www.nature.com/articles/s41467-024-52404-4

There is also a high correlation between Long Covid and Myalgic Encephalomyelitis/Chronic Fatigue Syndrome ("ME/CFS"). A 2024 journal article titled: The persistence of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) after SARS-CoV-2 infection: A systematic review and meta-analysis, speaks to the overlap of diagnostic criteria for Long Covid patients with ME/CFS as follows[4]:

> We identified 13 eligible studies that reported a total of 1973 LC patients. Our meta-analysis indicated that 51% (95% CI, 42%-60%) of LC patients satisfied ME/CFS diagnostic criteria, with fatigue, sleep disruption, and muscle/joint pain being the most common symptoms. Importantly, LC patients also experienced the ME/CFS hallmark symptom, post-exertional malaise.

Given this strong association between the Long Covid and ME/CFS we submit the Board should also recognize ME/CFS as a compensable consequence of Long COVID, which itself is a compensable consequence of COVID.

Current Science and Medical Knowledge

Now that we are five and half years on from the onset of Covid -19, there has been an evolution in knowledge about the virus and Long Covid. Given what we now know and based upon our significant representation experience in these claims, apparent gaps have emerged in how WorkSafeBC handles claims for Covid-19 and its compensable consequence of Long Covid.

The effects of Covid -19 and Long Covid have now been established to be often debilitating, wide ranging, complex and varied despite improvements in assessment and treatment.

In their 2022 report, The Office of the Chief Science Advisor states that "PCC (Post Covid Condition) is not a homogeneous disease, as different individuals can present different sets of symptoms", and speaks to the complexity and challenges in diagnosis[5].

The Public Health Agency of Canada reports a wide variety of symptoms of Long Covid, effecting different bodily systems, and capacities. These include fatigue, trouble sleeping, shortness of breath, general pain and discomfort, cognitive problems, and mental health symptoms[6]. The Office of the Chief Science Advisor states common manifestations of Covid-19 are described by as effecting the respiratory, nervous, cardiovascular, gastrointestinal, skin, musculoskeletal, and endocrine systems[7] and states the following regarding Long Covid's clinical manifestations:

> PCC symptoms can be grouped into three general categories. In the first, some symptoms, such as cardiovascular ones, are well studied and part of other diseases. In the second category, symptoms are less well clinically and biologically defined, and include myalgia (muscle aches and pain) and cognitive deficits such as "brain fog". The third category regroups neuro-cognitive symptoms. Symptoms occur in different combinations or clusters and may interfere with daily life and regular activities. Common symptoms include debilitating fatigue which may worsen after activity, shortness of breath, "brain fog" and cardiac problems including heart palpitations.
>
> PCC symptoms also overlap with other medical conditions, including post-intensive care syndrome, which can develop as a result of being hospitalized. Furthermore, PCC can have a similar symptom profile as other poorly understood post-infection chronic conditions like myalgic

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[4] Dehlia, A., & Guthridge S. (2024). The Journal of Infection. The persistence of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) after SARS-CoV-2 infection: A systematic review and meta-analysis https://pubmed.ncbi.nlm.nih.gov/39353473/

[5] Office of the Chief Science Advisor of Canada. (2022). *Post-COVID-19 Condition in Canada: What we know, what we don't know, and a framework for action.* https://science.gc.ca/site/science/en/office-chief-science-advisor/initiatives-covid-19/post-covid-19-condition-canada-what-we-know-what-we-dont-know-and-framework-action

[6] Public Health Agency of Canada (PHAC). (2024). *Post COVID-19 condition (long COVID).* https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/symptoms/post-covid-19-condition.html

[7] *Supra note 5.*

> encephalomyelitis/chronic fatigue syndrome (ME/CFS) and fibromyalgia (FM), which are characterized by fatigue and generalized pain.
>
> Studies are also providing accumulating evidence that acute COVID-19 increases the risk for other health conditions, such as autoimmune and neurological disorders, stroke, heart failure, diabetes mellitus and liver injury. Other system deregulations not necessarily considered as part of the PCC spectrum are also being reported, like changes to the auditory and vision systems.

Further complexities with assessing Long Covid are spoken to by the Public Health Agency of Canada:

> Symptoms can vary in severity and can sometimes disappear and reappear without having another diagnosis to explain them.[8]

In the BCNU Update Magazine titled "the Long Haul, for some BCNU members, COVID-19 has brought life-changing consequences, our members state the following about their personal experience dealing with the effects of Long Covid[9].

> "What if this is for the rest of my life?"
>
> "The whole thing had affected my cognitive, emotional and physical state."
>
> "The exhaustion was crazy – all I did was sleep."
>
> "If I'm not given the time, the proper job and possibly part-time hours, I will have no choice but to leave the profession."
>
> "As my signs and symptoms progressed, changed and new ones appeared, it just never went away entirely. Today I still have trouble with random heart palpitations, random tachycardia, extreme fatigue and delayed onset muscle fatigue and weakness."
>
> "I worry that I may have permanent disabilities that impact my capacity to continue a 12-hour physical job."
>
> "I anticipate a full recovery, that is my goal. But I'm not sure I will ever have the mental or cognitive endurance to withstand the pressures of nursing as I did before."

This has led to concerns about how rapidly return to work plans expect our members to return to their duties. Alberta based study of primarily health care workers found that of the workers with Long Covid who completed a WCB based rehabilitation program, only 53% were able to return to work afterwards and of these 93% required modified duties[10]. Long Covid does not always follow a linear recovery trajectory, and our members have reported being pushed into return-to-work programs.

Permanent Disability Ratings

When it comes to Long Covid, we have observed WorkSafeBC's permanent partial disability processes and decisions struggle to fairly account for our members impairment. Numerous Review Division ("RD") and Workers Compensation Appeal Tribunal ("WCAT") decisions have contemplated the appropriateness of the Boards reliance on the AMA Guides to the Evaluation of Permanent Impairment (the "AMA Guides") to quantify our members disablement for compensable consequences of Covid-19.

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[8] *Supra note 6.*

[9] BC Nurses' Union. (2021). *The Long Haul.* **Update Magazine (Spring 2021).** https://www.bcnu.org/news-and-events/update-magazine/2021/spring-2021/the-long-haul

[10] Magnusson, K., et al. (2022). *Return-to-Work Following Occupational Rehabilitation for Long COVID: Descriptive Cohort Study.* https://pmc.ncbi.nlm.nih.gov/articles/PMC9484483/

Many of our members' RD and WCAT decisions revise entitlements upward significantly and recognise that the AMA guides do not fit some conditions which are compensable consequences of Covid-19. The RD and WCAT decision makers then use the discretion under RSCM C6-39.00 to more fairly account for workers disablement, in light of the absence of a more fitting set of guidelines and policy guidance. The decision maker discretion in these cases can involve very technical analysis and the creative use of other tools to arrive at what we have accepted to be reasonable outcomes for workers, who often suffer from debilitating symptoms for years post Covid-19 infection.

The table below sets out the vast spectrum of ratings between Board, RD and WCAT decision makers, which we speak to above:

Reference	WorkSafeBC	RD	WCAT
A2400249	2%	4%	18%
A2400698	1%	1%	15%
A2401223	5.5%	7%	13.5%

We submit that this shows the Board under-recognizes our members' level of functional impairment. In many cases, this is an issue stemming from a lack of guidance and at the Board level and on review and appeal decision makers have to reach quite far to arrive at fair outcomes. We are also concerned that our members and others are not in a position to understand the level of complexity in these ratings, often do not appeal, and are drastically undercompensated.

We also provide the following RD cases to further demonstrate the nature of the case issues, analysis and outcomes: R0332144, R0309147, R0318367, R0308099, R0313299.

In representing one of our members, (WorkSafeBC File #25090707), BCNU received an Independent Medical Examination (IME) from internal medicine expert and Covid-19 specialist Dr. Richard Arsenault. In the IME Dr. Arsenault states the following about the Boards use of the AMA Guides to assess brain fog in a Long Covid case, and the resulting entitlement decision:

> 340 - The absence of a listing in the Schedule should not require the "shoe-horning" of patients' limitations and disability into a category that does not capture the full, and often devastating, impact of an injury. Further, it should not be exploited as an opportunity to devalue the patient's disability and loss of earning potential. Common sense should prevail in making a decision.
>
> 390 - I have a hard time understanding how a patient who can only work 70% of what they did before getting injured can be considered to have a disability of 1 to 2%. Having been involved in a number of WorkSafeBC cases related to Long COVID and ME/CFS, the 1 to 2% attribution of disability is ascribed to patients who are completely disabled and unable to work at all – even part-time – is common. This is especially disappointing for nurses and doctors who contracted COVID while risking their health taking care of patients with COVID.

We understand that the legislation and policy permit discretion and the use of other resources to decide workers permanent disability ratings. However, we submit that surely the spirit of that discretion and flexibility is to address novel and emerging medical conditions rather than those that have been pervasive for over 5 years. It is clear at this point that further guidance on the application of this discretion is necessary.

We submit that given the complexity of the compensable consequences of Covid-19, their significant impact on workers and the noted issues in Board permanent disability rating decisions, the Board should consider developing policy and practice guidance that is consistent with the current medical knowledge.

Policy item C6-39.00 provides in part:

> **B. DECISION-MAKING PROCEDURE UNDER SECTION 195(1)**
> Section 195(1) assessments are undertaken once a worker's condition has stabilized as permanent.

> The Board is responsible for ensuring that the necessary examinations and other investigations are carried out with respect to the assessment and making a decision on a worker's entitlement to permanent partial disability benefits.
>
> Section 195(1) evaluations may be conducted by the Board or a Board-authorized External Service Provider. The Board sets protocols and procedures for these evaluations. The Board determines whether the evaluation will be referred to an External Service Provider based on the nature of the condition and other relevant criteria as set out in the protocols. The Board may proceed to assess the permanent disability benefits without a section 195(1) evaluation if there is sufficient medical evidence already available.

Covid-19 related conditions are complicated. We have yet to see LTDS refer a PPD assessment to an in-person medical assessment. The LTDS officers may obtain a medical opinion by file review and apply a table usually from the AMA Guides to make a rating. The results of these ratings are incredibly poor. It is the BCNU's position that in any Covid-19 related permanent impairment the condition will be so complex that there will not be sufficient medical evidence already available to rate the impairment. The Board should not proceed to assess permanent disability benefits without the direct assessment by a medical expert with relevant qualifications and experience.

Interjurisdictional Comparison

The Ontario Workplace Safety and Insurance Board (WSIB) recognized the challenges in rating post-COVID (long COVID) impairments and issued an administrative practice document for post-COVID condition PPD assessment[11]. The WSIB guidance includes direction on the nature of severity and number of Long Covid symptoms, when to use the AMA Guides and when to use other alternatives, and acknowledges some of the same issues as our previously cited RD and WCAT decisions. It also includes direction on when to use their impairment assessment policy for rating mental and behavioral health disorders, something RD decisions have opted to do to arrive at fair ratings on review. The WSIB practice guidance states the following, in part:

> The number of symptoms experienced by someone with a post-COVID condition may range from one to multiple symptoms as in the examples above and can range in severity from mild to severe. People that present with this diagnosis and have symptoms that are severe enough to be measured on specific objective tests, would meet the threshold for impairment of one or more body areas/ systems outlined in the AMA Guides. These people would receive a permanent impairment rating for those specific body areas/ systems.
>
> On the other hand, there are people with mild post-COVID conditions who demonstrate mild symptoms or groups of symptoms that impact their activities of daily living yet would not meet the threshold for impairment outlined in the AMA Guides. Instead, using the AMA Guides these mildly symptomatic people with definite limitations in daily living activities could receive a 0 percent permanent impairment rating, which is not considered a fair assessment of their degree of impairment.
> …
> In cases where certain mild post-COVID condition symptoms (or groups of symptoms) would not meet specific impairment criteria in the AMA Guides, the impact of these mild symptoms on the person's ability to carry out activities of daily living would be assessed using the rating scale in the Assessing Permanent Impairment Due to Mental and Behavioural Disorders policy.
>
> A permanent impairment rating using the scale in the Assessing Permanent Impairment Due to Mental and Behavioural Disorders policy does not suggest that this is a rating of psychiatric or psychological functioning. The scale is being used because it best captures the holistic impact of

[11] Workplace Safety and Insurance Board (WSIB Ontario). (2023). *Administrative Practice Document: Permanent Impairment Rating Guidelines for Post-COVID Conditions (Long COVID).* https://www.wsib.ca/en/administrative-practice-document-permanent-impairment-rating-guidelines-post-covid-conditions-long

the post-COVID condition on this person's activities of daily living as detailed in the AMA Guides and policy.

The WSIB appears to have had a similar basis for their recent policy guidance as what concerns we have expressed in this document. We submit that WorkSafeBC as a large and progressive organisation should follow WSIB's lead in this area yet continue beyond where they have and consider consulting experts in the development of a rating system dedicated to Long Covid and the compensable consequences of Covid-19.

Conclusion

WorkSafeBC's handling of Covid-19 and Long Covid claims leaves substantial gaps that impede our members' income, and health through inconsistent recognition, inadequate impairment ratings, and policies that fail to reflect medical realities. By recognizing Covid-19 and Long Covid as occupational diseases, strengthening adjudication guidance, and reforming rating practices, WorkSafeBC can provide fairer and more consistent outcomes.

We call for WorkSafeBC to prioritize these changes, and through consultation with experts chart a path towards the improvements laid out in this discussion paper.

The BCNU thanks WorkSafeBC for the opportunity to provide this input.

Yours truly,

British Columbia Nurses' Union

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This submission has been developed in alignment with the BC Nurses' Union Strategic and Operational Plans, reviewed and approved by the BCNU OH&S Department, Director Mellissa Muir and Manager Sue Bateman.