U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SCOTT J. KERNS and U.S. POSTAL SERVICE,
POST OFFICE, Atlanta, GA

Docket No. 00-855; Submitted on the Record;
Issued March 2, 2001

DECISION and ORDER

Before WILLIE T.C. THOMAS, A. PETER KANJORSKI,
PRISCILLA ANNE SCHWAB

The issue is whether residuals of the accepted employment injury have ceased.

On March 29, 1992 appellant, a city carrier, filed an occupational disease claim asserting that, while working as a mail processing supervisor, he was exposed to dust, which caused an infection and loss of vision in his left eye. He reported that he first realized that his diagnosed glaucoma was caused or aggravated by his employment on or about July 15, 1988.

The Office of Workers' Compensation Programs accepted appellant's claim for an aggravation of open angle glaucoma, left eye. He received compensation benefits.

A conflict in medical opinion subsequently emerged between an Office referral physician, Dr. Terry W. Taylor, a Board-certified ophthalmologist, and appellant's attending physician, Dr. Douglas G. Day. Dr. Taylor reported on December 23, 1994 that the March 1992 infection had resolved. Although appellant's vision continued to deteriorate, this was due to his preexisting glaucoma. In Dr. Taylor's opinion, dust did not contribute to appellant's problem.

In a supplemental report dated April 7, 1995, he clarified that appellant's current impairment in the left eye was due to the normal progression of glaucoma. Dr. Taylor reported that he had never known dust to be an aggravating condition of glaucoma. Further, the decision to operate on the eye in 1992 preceded the incident that took place in March 1992. From what Dr. Taylor could tell from the record, there was no evidence of any infection with the filtering bleb or in the eye itself.

Dr. Day, an ophthalmologist and glaucoma specialist, reported on September 26, 1995 that he agreed with the majority of Dr. Taylor's findings but disagreed with his opinion on the relationship between appellant's working environment and his left eye infection. Dr. Day stated that appellant's glaucoma surgery in 1980 placed him at risk for more serious infections called endophthalmitis. Appellant subsequently developed separate episodes of low-grade bleb

infection in October 1990, which ultimately caused a failure of his first surgical procedure and necessitated a second. Later, in October 1994, appellant had a second infection of his filtering bleb once again in the original surgical site from 1980.

Dr. Day reported that, as long as appellant was exposed to foreign materials or a dusty environment, he would be prone to contracting further infections. Dr. Day explained that the dusty environment did not cause any worsening of appellant's glaucoma or loss of eyesight, but it did put appellant at particular risk for severe infection to the eye and could ultimately cause loss of sight or loss of the eye itself.

To resolve the conflict between Drs. Taylor and Day, the Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. David W. White, a Board-certified ophthalmologist. On June 24, 1996 Dr. White reviewed appellant's records, appellant's history and reported findings, which he stated were consistent with long-standing open angle glaucoma with marked progression to legal blindness in the left eye. Dr. White then concluded:

> "As I did not examine the patient soon after his alleged injury on March 13, 1992, I cannot comment as to the extent of this injury or its relationship to his glaucoma. I see nothing in the records describing the nature of this injury.
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> "As far as the discussion of his having 'recurrent eye infections in the left eye' supposedly related to a dusty environment, I have never advised a patient to attempt a 'dust free environment,' as there is no evidence that dust in the air is related to infections in the eye.
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> "My overall impression is that this condition is unrelated to his employment unless documentation can be obtained showing an incontrovertible relationship of his alleged injury on March 13, 1992 to an exacerbation of his glaucoma. There is plenty of evidence in the record pointing to advanced glaucoma with progression of optic nerve damage and visual field loss prior to March 13, 1992."

In a decision dated August 15, 1996, the Office found that Dr. White's opinion represented the weight of the medical evidence and established that appellant's condition and impairment were unrelated to his federal employment. The Office denied benefits on the grounds that appellant's condition was not work related.

On February 14, 1997 Dr. Day prepared a supplemental report, which stated as follows:

> "Concerning the issue of whether or not [appellant] was subject to increased risk for ocular infection due to being in a dusty environment, and whether or not this contributed to his having endophthalmitis, there are no definitive studies detailing whether or not patients in a pristine environment vs. patients in a dusty environment are at more risk for ocular problems. It is well known that patients who have had glaucoma surgery are at higher risk for endophthalmitis, which [is] a total infection of the eye. The risk rate following glaucoma surgery is quoted at anywhere from two percent to nine percent over a lifetime, with infections often

> occurring many months or years following the operation due to chronic irritation or chronic exposure to various pathogens that can cause infections. There are numerous factors which may contribute to increased risk for endophthalmitis, among them: chronic mechanical irritation by the eyelids, from either repetitive blinking or rubbing of the eyes, which is thought to weaken the structure of the surgery site; also additional disruption of the eye surface secondary to prolonged drying of the eye surface may cause breakdown of the natural protective layer of the eye, causing increased access of pathogens to the intraocular contents.
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> "[Appellant] was in an environment in which both chronic irritation due to exposure to dust and chronic exposure of airborne particles and/or pathogens led to an increased chance for developing ocular infection in a patient who was already at relatively high risk for ocular infections due to his prior glaucoma surgery. I feel that this had a strong influence on his episodes of eye infections, one of which was quite severe and without prompt treatment would have led to complete loss of eyesight."

In a decision dated June 18, 1997, an Office hearing representative found that Dr. White, the referee medical specialist, had provided only minimal rationale to support his opinion, and that Dr. Day, appellant's physician, had subsequently provided convincing rationale to support that a dusty environment would lead to eye infections. The hearing representative set aside the Office's August 15, 1996 decision and remanded the case for another impartial medical opinion on whether appellant continued to have a condition related to his employment.

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Judith M. Piros, a Board-certified ophthalmologist. On October 8, 1997 Dr. Piros reported that she had examined appellant and had reviewed his chart extremely carefully so that she could best try to address the questions put forth by the Office. She stated that appellant had reported to her office in 1972.

When he was in the military he was involved in a motor vehicle accident, and as a result of that examination he was found to have glaucoma in both eyes, greater in the left. In 1975 he underwent a glaucoma filtering procedure at Duke University. In 1981 he began working at the employing establishment. In 1992 he was noted to have scarring of the previous filtration site and Dr. Day determined that a reoperation was necessary. This determination was based on elevated intraocular pressure initially in December 1991 and then in February 1992.

After reporting her findings on examination, Dr. Piros addressed the Office's questions as follows:

> "In reference to the questions which you pose to me: Question 1: Is the employee still suffering a condition of the left eye causally related to the dust exposure at work? I would have to answer, 'no,' since [appellant] is not currently working; the condition which he is suffering from is a chronic progressive disease which in some patients will just progress regardless of the treatment chosen, and [appellant's] eyes at the time of my examination were completely quiet and uninflamed. Question 2: Was the surgery in 1992 related to the dust exposure at

the employee's job? I [ha]ve been unable to find any documented evidence in the glaucoma literature that would indicate that dust exposure in any way caused failure of a filtration bleb following glaucoma surgery. Failure of a filtration bleb is a fairly common occurrence, especially in those patients who had the filtration surgery especially in those patients who had the filtration surgery done prior to antimetabolite therapy, which really did not become popular until 1990 or 1991. It is also much more common in the African-American population. So, I honestly do not feel that any dust exposure at his job would have caused his previous bleb to have failed. Question 3: Does the employee currently suffer any permanent visual impairment of the left eye. This would be consistent with the A[merican] M[edical] A[ssociation], *Guides* [*to the Evaluation of Permanent Impairment.*] In all honesty, I feel that [appellant] has a particularly aggressive form of glaucoma, but currently with his intraocular tensions being as well controlled as they are I do not feel that he will have any further progression of his glaucoma at this time."

In a supplemental report dated November 19, 1997, Dr. Piros stated as follows:

"I honestly do not feel that dust exposure is in any way responsible for the difficult course [appellant] has had with his glaucoma. Glaucoma in and of itself is an extremely difficult disease and has a very high incidence of failure of filtering blebs. One series which I most recently found reported less than 75 percent success of trabeculectomies in controlling the pressure in African-American patients. Thus, I feel that the visual loss that [appellant] has is not a result of his dust exposure, but rather is a result of the extremely difficult nature of the disease from which he suffers, that being glaucoma."

In a decision dated December 4, 1997, the Office found that the weight of the medical evidence rested with the opinion of the impartial medial specialist, Dr. Piros, and established that appellant's glaucoma was not related to his prior work exposure.

Appellant requested reconsideration and submitted a May 13, 1998 report from Dr. M. Bruce Shields, Sears Professor and Chairman of the Department of Ophthalmology and Visual Science at the Yale University School of Medicine. Dr. Shields reported that he concurred with each of the points made by Dr. Day in his letter of February 14, 1997 and that any additional comments would only be redundant. "In summary, I agree with Dr. Day that, while it is not possible to prove a cause-and-effect between the environmental exposure and the ocular infection, the former clearly has an influence on the latter."

In a decision dated September 10, 1998, the Office reviewed the merits of appellant's claim and denied modification of its prior decision.

On September 10, 1999 appellant requested reconsideration and submitted a disability retirement form and an August 31, 1999 report from Dr. Day, who reported that appellant continued with the diagnosis of chronic open angle glaucoma and would need life-long treatment. He reported no other change in appellant's clinical condition and no change in the clinical assessment of appellant's risk for injury or hazard to self or others which would arise from the performance of essential duties of a position similar to the one from which he retired.

In a decision dated September 28, 1999, the Office again denied modification of its prior decision.

The Board finds that this case is not in posture for decision.

When there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[1]

To resolve the conflict between the Office referral physician, Dr. Taylor, and appellant's attending physician, Dr. Day, the Office ultimately referred the case to Dr. Piros. She explained that appellant was not suffering a condition of the left eye causally related to his dust exposure at work. The opinion of Dr. Piros is sufficiently well rationalized and is based on a proper factual background. Ordinarily, her opinion would be accorded special weight in resolving the outstanding conflict.[2] However, in her October 8, 1997 report, Dr. Piros stated that appellant had reported to her office in 1972.

It is well established that a physician previously connected with the claim or the claimant may not serve as a referee medical examiner. In *Beverly Wetzel*,[3] the Board found that a physician who had made the original interpretation of the claimant's electrocardiogram following the claimant's collapse and hospitalization, and whose associates had interpreted subsequent cardiograms, did not meet the test of a referee medical examiner within the meaning of 5 U.S.C. § 8123(a). Further, the Office's procedure manual, citing Board precedent, states that physicians who may not be used as referees include "physicians previously connected with the claim or the claimant, or physicians in partnership with those already so connected."[4]

Although the Office took reasonable precautions to ensure impartiality when making the referral to Dr. Piros, once the physician's possible connection with appellant was apparent, it became incumbent upon the Office to inquire whether Dr. Piros or her associates were in fact previously connected with this claim or with appellant. If a previous connection exists, Dr. Piros may not serve as the referee medical specialist in this case, and the Office must select an appropriate physician to fill the role, notwithstanding any difficulty in locating a willing expert in the field.

Accordingly, the Board will set aside the Office's September 28, 1999 decision and remand the case for further development of the evidence. Following such further development

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[1] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[2] Dr. Shields offered no independent medical reasoning to explain how environmental exposure influences ocular infection. His report, while supportive of appellant's claim, must itself be considered redundant to the reports submitted by Dr. Day and is insufficient to establish a new conflict in medical opinion.

[3] 26 ECAB 181, 184 (1974).

[4] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500.4.b(3)(b) (March 1994).

as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to continuing benefits.

The September 28, 1999 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this opinion.

Dated, Washington, DC
March 2, 2001

Willie T.C. Thomas
Member

A. Peter Kanjorski
Alternate Member

Priscilla Anne Schwab
Alternate Member