U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GARY F. BEAMAN and U.S. POSTAL SERVICE,
MAIN POST OFFICE, Des Moines, IA

Docket No. 01-466; Submitted on the Record;
Issued December 19, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has a disabling medical condition causally related to his exposure to chemicals in the course of his employment.

On July 26, 1993 appellant, then 46 years old, filed a claim for an occupational disease for allergic encephalopathy and neuropsychiatric deficit caused by environmental exposures in his employment as a maintenance technician. Appellant contended that he was exposed to "solvents and cleaning compounds, ink and petroleum products, paper dust, paint, insecticides, copy machine chemicals, dyes, battery room gases and chemicals, wood stain and carpentry products, etc." Appellant alleged that these exposures caused "fatigue, mental confusion, skin rashes and hives, respiratory and vision problems, stomach problems, severe aches and pains in joints and muscles, rectal problems, headaches, memory loss, problems coping with supervision at work, emotional and control problems, ear problems, speech problems, depression, anxiety attacks, night sweats, kidney stones and urinary tract problems, angina pain, cramps, prostatitis, hemorrhoids and sleep disturbance."[1]

Appellant began working at the employing establishment on July 24, 1978. On February 25, 1992 he filed an application for disability retirement. On May 27, 1992 the employing establishment assigned appellant light duty with physical limitations. Effective February 2, 1993 appellant's disability retirement was approved, based on an October 20, 1992 report from an employing establishment physician, Dr. James L. Blessman, who concluded that "on a physical basis he is not disabled," but that "his emotional status currently precludes him from gainful employment."

[1] In claims dated August 15, 1989 and August 29, 1990, appellant attributed most of these problems to stressful interactions with his supervisors. These claims were denied by the Office of Workers' Compensation Programs in October 19, 1989 and December 10, 1990 decisions. Appellant also filed a claim with the Department of Veterans Affairs in which he attributed many of these conditions to his exposure to Agent Orange in Vietnam. In another claim, the Office accepted that appellant sustained bilateral conjunctivitis in a May 8, 1990 arc welding incident.

In a report dated April 25, 1992, Dr. Gaylord Nordine, a Board-certified psychiatrist, noted that appellant had not had a "full neuropsychological evaluation subsequent to his closed head injury during the 1970's," and diagnosed "organic mood disorder associated with previously undermanaged traumatic brain injury." In an August 11, 1992 report, Dr. Nordine stated that appellant had "severe impairment of executive functions of the mind including planning, new learning and interference control. He is paranoid, easily agitated and functions erratically under limited stress conditions." In a September 25, 1992 report, Dr. Greg Lamberty, a psychologist, diagnosed post-traumatic stress disorder, and stated that "the 'organic' personality characteristics reported by the patient are certainly consistent with the long-term adjustment problems often encountered in victims of TBI [traumatic brain injury]."

In a report dated June 15, 1993, Dr. Vernon P. Varner, a Board-certified psychiatrist, set forth a history that appellant had "progressively developed severe muscle pain (myalgia), migratory arthritis, persistent constipation, hives, airway restriction, headaches, memory blanks, marked irritability and inability to control his anger in work settings. Again, an adequate history reveals that he worked around a great deal of chemicals while in the employing establishment including, at least, dyes, solvents, inks and multiple other chemicals." Dr. Varner stated that the only abnormality in the comprehensive laboratory data done at his office was one elevated liver enzyme, that in May 1993 he sent a sample of appellant's blood to Antibody Assay Laboratories in Santa Ana, California, and that the impression was that appellant had "autoimmunity to his own nerve myelin ... as well as positive antiparietal cell antibodies" and "antibodies to trimetallic anhydride" suggesting a problem with indoor air pollution. Dr. Varner stated that this information and the "dramatic improvement with simple diet avoidance of foods that cause problems" led him to a "clinical impression that the 'inner head injury syndrome' that Dr. Nordine diagnosed was really secondary to an escalating immune response to a contaminated work environment while working at the [employing establishment]." Dr. Varner stated that many of appellant's symptoms experienced while working had abated since he stopped: speech articulation problems, word finding problems, episodes of sudden confusion, feeling that his environment was weird or strange or out of place, profound memory gaps that would last five minutes or longer, a marked mental decline, staring spells, profound suicidal ideations, rapid onset of sudden depression, episodes of extreme and intense anger for reasons that were not clear, and difficulty staying awake. Dr. Varner diagnosed "chemical hypersensitivity (to multiple chemicals)" and stated that appellant's "neuropsychiatric deficit and problems are directly related to the work environment in the [employing establishment]. By work environment, I am talking about the quality of air and his exposure to chemicals as well as dust and other agents. I do believe that he is disabled from the work setting because of this problem." In a report dated November 9, 1993, Dr. Varner stated that appellant's "disabling neuromuscular and musculoskeletal symptoms are directly caused by his workplace exposure," and that his "ongoing neuropsychiatric problems are complicated by the fact that when he gets exposed to trace amounts of the substances that he has become hypersensitive to from his work setting exposure, he regenerates symptoms of pain, aching, and swelling with tingling and numbness in arms and hands and to some degree in legs and feet that would be associated with the irritant nature of the exaggerated immune response…."

An Office medical adviser reviewed Dr. Varner's reports on April 20, 1995 and stated that the studies from Antibody Assay Laboratories "must be considered suspect," and that, if all the records regarding appellant were available, "it could be clearly documented that this

individual's mood disorder substantially predated any employment that he may have had in federal service for the postal department." The Office medical adviser concluded that Dr. Varner's reports did "not substantiate, based upon signs, symptoms, as well as diagnostic studies, that this individual does have an organic mood disorder."

The Office obtained appellant's medical records from the Veterans Administration, which showed a head injury in a motor vehicle accident on July 7, 1968 with a concussion and whiplash, vasomotor rhinitis on May 4, 1971, gastritis with esophageal reflux on May 5, 1971 and October 1, 1976, and a notation of appellant's acknowledgement of "a fairly steady use of 'pot' and alcohol" in a November 13, 1984 assessment for post-traumatic stress disorder. A computerized tomography scan of appellant's brain on April 27, 1993 was described as negative. In a report dated January 5, 1994, Dr. Sharon Koele, a Board-certified psychiatrist, stated that appellant had experienced poor concentration and low mood since his motor vehicle accident in 1968, that he had been anxious since his military service in Vietnam, and that he had sufficient symptoms to diagnose post-traumatic stress disorder.

Other medical records were obtained by the Office. Dr. Theodore W. Rooney, an osteopath, noted migratory polyarthralgias and symptoms suggestive of prostatitis in a June 27, 1993 report. In a report dated November 6, 1985, Dr. D.J. Straubinger, an osteopath, stated that appellant's pulmonary problems were related to his years of smoking cigarettes. In a report dated December 3, 1985, Dr. Donald R. Shumate, a Board-certified internist, stated that appellant had difficulty with his lungs that dated to childhood and that allergy tests in the 1960's were positive for dust and feathers. In a January 21, 1986 report, Dr. Shumate stated that appellant had noticed a very definite relation between emotional stress and chest tightness, coughing and shortness of breath. Appellant was hospitalized from February 4 to 14, 1991 for major depression, post-traumatic stress disorder, panic disorder and severe alcohol dependency. In a report dated June 18, 1991, Dr. Walter Eidbo, a Board-certified surgeon, stated that he treated appellant on April 27, 1990 for an allergic reaction to a welding compound and for an anxiety reaction, on August 3, 1990 for an allergic reaction to dust and on October 29, 1990 for "more anxiety attacks." All skin tests were negative in a March 31, 1992 allergy evaluation; idiopathic urticaria and angioedema were diagnosed and a history of allergy shots in appellant's teens was noted.

In a report dated February 27, 1995, Dr. Charles J. Rudolph, an osteopath, provided a list of toxic metals and other substances to which appellant was exposed at the employing establishment, and stated that a provocative 24-hour urine collection on December 16, 1994 showed that he was excreting lead at a toxic level. Dr. Rudolph stated that, on February 7, 1995, after approximately 10 treatments with EDTA (ethylenediaminetetraacetic acid), appellant's lead and aluminum levels were still high, "indicating that there was still a significant toxic exposure to lead and aluminum."

On March 29, 1995 the Office referred appellant, his medical records and a statement of accepted facts to Dr. Allen Parmet, who is Board-certified in preventive medicine, for a second opinion evaluation of his condition and its relationship to his employment. Dr. Parmet referred appellant to Dr. Bruce Geller, a Board-certified neurologist, and Dr. Rosalyn E. Inniss, a Board-certified psychiatrist, for evaluations in their specialties.

In a report dated May 22, 1995, Dr. Geller noted that appellant "complains of nearly every symptom imaginable that one can ask a patient if it is a symptom from which he or she suffers," and that, on a list of 23 possible neurologic symptoms, appellant checked boxes to indicate he suffered from every symptom except convulsions. Dr. Geller stated that his review of appellant's medical records revealed tests that were "not generally recognized or scientifically accepted medical or neurologic tests and have not been recognized as clinically significant or clinically valid." Dr. Geller stated that, in his opinion, all the results from Antibody Assay Laboratories could be discounted, as they were "not at all indicative of the type of standard neurologic testing," which he described, "or of the neurologically accepted testing techniques … which are performed in the laboratories usually used by reputable neurologists." Dr. Geller stated that appellant's neurologic examination was normal, as were his EEGs (electroencephalograms), and concluded: "In summary, I find no evidence of any objective neurologic abnormality on examination of [appellant] by standard neurologic examination techniques. My review of the records indicates that no significant neurologic abnormality is present nor has been documented according to the scientific basis of medicine as generally practiced in the United States or as generally produced by experienced neurologists in this community, that would in any way allow a diagnosis of a disorder named 'multiple chemical sensitivity' to be applied to any neurologic aspects of [appellant's] case."

In a report dated July 15, 1995, Dr. Inniss recounted appellant's childhood and adult history, and stated that appellant's records "clearly chart a pattern of concerns about his health and his body over a number of years," an "escalation not only in symptoms experienced but his efforts and distress as he seeks redress for them" and "a pattern of problems in his interpersonal relationships both personal and professional extending over a number of years. Anxiety and alcohol use is noted, it is viewed as a problem by several other clinicians as well as others who have contact with [appellant] but seldom viewed as a problem by [appellant] himself." Dr. Inniss stated that psychological testing showed preoccupation with body functions and health and "a high susceptibility for psychosomatic reactions. This is seen in individuals for whom the presence of physical signs and symptoms serves purposes other than the expression of physical discomfort." In her interview of appellant, Dr. Inniss noted, "obsessive preoccupation with the issue of his health," and stated that, on the Yale-Brown obsessive compulsive list, appellant "checked an unbelievable number of positive symptoms, both past and present," which the doctor listed. On mental status examination, Dr. Inniss noted that appellant claimed a memory loss but gave a detailed account of his illness, that there was "marked circumstantiality and tangentiality," that appellant believed supervisors at the employing establishment had "set out to purposely harm him," and that he felt that his depression began with his head injury in the military service and had never resolved but had become less severe once he left the employing establishment and was no longer exposed to chemicals. Dr. Inniss concluded:

> "This man easily meets the criteria for somatization disorder, however, if one looks at his long-standing history of obsessive compulsive behaviors dating from childhood or adolescence a far more appropriate diagnosis would be of OBSESSIVE COMPULSIVE DISORDER. Statistically there is a 50 [to] 60 percent occurrence of major depression in untreated OCD, he meets the criteria for this as well. He also meets criteria for SCHIZOTYPAL PERSONALITY DISORDER on Axis II. ….

"It is highly likely that his current somatic preoccupations are an extension as well as a manifestation of lifelong untreated obsessive compulsive disorder. I must conclude that his current difficulties are not work related. In addition there is a component of [appellant's] personality and identity that is based on the multiple signs and symptoms he allegedly experiences and his quest for disability for the same. Until his OCD is treated, the treatment of this will also hit the depression that he experiences. There will be no clear idea as to whether the somatization disorder is valid or exists without the OCD to drive it." (Emphasis in the original.)

In a report dated August 21, 1995, Dr. Parmet set forth appellant's history and reviewed the prior medical evidence, commenting that it was "not possible to determine body burden of lead without obtaining either blood or bone lead levels." Dr. Parmet set forth appellant's findings on examination, and stated that appellant's encephalopathy was probably from his June 1968 head injury in a motor vehicle accident. Dr. Parmet concluded:

"1. Based on objective physical findings, laboratory studies and patient interviews, he meets the diagnosis of OBSESSIVE COMPULSIVE DISORDER with SCHIZOTYPICAL PERSONALITY DISORDER and Somatization Disorder. Status post closed head injury with concussion (severe) – 1968. Specifically, there is no objective evidence whatsoever to support a diagnosis of multiple chemical sensitivity, allergic encephalopathy, 'inner head injury syndrome,' or any other toxic condition or work-related disorder. Some of his behavioral symptoms may relate to his head injury from the motor vehicle accident in 1968. (Emphasis in the original.)

"2. The current condition is caused by [appellant's] long-standing and untreated obsessive compulsive personality since childhood. This has allowed for an evolution into an untreated disorder with secondary somatization and blossoming of schizoid personality. This is a preexisting condition and would have been exacerbated in any structured environment.

"3. There is no specific work-related exacerbation of [appellant's] preexisting condition. Simply by living in any structured environment [appellant] would have found his untreated obsessive compulsive disorder worsening. I believe that [appellant] has a temporary condition which is amenable to appropriate therapy. The persistence of his symptoms are due to the fact that first of all, the underlying condition stems from childhood and secondly, that it remains untreated and therefore will not respond to simple removal from work."

* * *

"5. With respect to the diagnosis made by Dr. Varner and the immune studies done by the Antibody Assay Laboratories of Santa Ana, California, these tests are not valid and have not been standardized or compared by any independent means. Scientific studies over the past 10 years have conclusively demonstrated that these studies are completely unable to differentiate patients who claim to have 'multiple

> chemical sensitivity syndrome' and those who have no complaints whatsoever. These tests are highly profitable for the performing laboratory, but do not provide any diagnostic information. In addition, treatment programs that [appellant] has been undergoing in Kansas City consist of chelation therapy using calcium EDTA. This treatment is valid only for heavy metal poisoning such as lead, and even then only at lead levels in excess of 40 µg/dl. At levels less than 40 µg/dl, calcium EDTA therapy has been demonstrated to have adverse effects by removing small amounts of stored lead from the bone and distributing them to the brain. This 'alternate therapy' is clearly not to [appellant's] advantage since his blood lead levels, which have *only* been measured by my laboratory, demonstrated a normal blood lead of 3 µg/dl. The treatment programs of the Environmental Center in Texas as well have no proven efficacy and overall are simply manifestations of and contributions to [appellant's] ongoing obsessive compulsive disorder."

By decision dated October 31, 1995, the Office found that "the evidence of file fails to establish that the claimed condition, allergic encephalopathy/neuropsychiatric, or disability is causally related to the accepted activities or employment factors."

By letter dated November 15, 1995, appellant requested a hearing.

Additional medical evidence was obtained from the Veterans Administration. In a report dated October 21, 1995, Dr. Peggy Baker, a Board-certified psychiatrist, diagnosed a psychological condition affecting a physical disorder. She noted that a magnetic resonance imaging (MRI) scan of appellant's brain and an EEG showed no deficit in cognitive function or structural abnormalities. In a report dated October 25, 1995, Dr. Donald F. McBride, an internist, diagnosed a psychological disorder with delusional and obsessive thinking with multiple somatic complaints without confirmed anatomical abnormalities.

In a report dated December 12, 1995, Dr. David A. Schwartz, who is Board-certified in internal medicine and in preventive medicine, stated that toxic levels of heavy metals were found by Dr. Rudolph but that blood and urine levels for heavy metals were normal at the Mayo Clinic. Dr. Schwartz concluded that it was doubtful that appellant's chronic fatigue and chronic pain were causally related to his exposure to heavy metals. In a report dated March 4, 1996, Dr. Laurence Fuortes, who is Board-certified in internal medicine and in preventive medicine, stated: "I believe whatever the etiology [appellant] is clearly disabled. I do not think this gentleman's presentation is typical or even suggestive of a metal or solvent neurotoxicity syndrome. He appears to have features consistent with somatization and an obsessive component."

A prehearing conference was held on July 23, 1996 and a hearing was held on March 26, 1997.

Appellant submitted additional medical evidence.

In a report dated March 7, 1997, Dr. Raymond Singer, a psychologist, set forth appellant's history of a closed head injury and of toxic exposures in Vietnam and as a

maintenance worker at the employing establishment, describing appellant's occupational exposures and specific incidents of acute exposure. Dr. Singer stated: "Findings were consistent with organic brain dysfunction from chemical toxicity. In my review to date, which is incomplete, [appellant's] neuropsychological function deteriorated after exposure to toxic chemicals while working at the [employing establishment]." In a March 24, 1997 report, Dr. Singer described the psychological testing he performed, and diagnosed "organic brain dysfunction, exacerbating a possible preexisting personality disorder." Dr. Singer stated that appellant did not meet the criteria for a diagnosis of obsessive compulsive disorder, as he did not attempt to ignore or suppress thoughts, and that he did not have a history of many somatic complaints before age 30, which was required for a diagnosis of somatization disorder. Dr. Singer stated that the most likely explanation for appellant's neuropsychological disorder was his very troubled childhood, his experience in Vietnam, and his exposure to toxic substances at the employing establishment. Dr. Singer stated that appellant's "exposure seems excessive and unprotected, especially for a person with a preexisting sensitivity to chemicals from prior exposures or head trauma," that no other cause of his illness was found on multiple doctors' examinations, and that "the exposures at the [employing establishment] seem to have sent him over the edge of brain dysfunction. At this time, he definitely shows the signs and symptoms of brain damage upon neuropsychological examination and testing." Dr. Singer concluded:

> "At this point in my analysis, I will say that [appellant] was probably functioning fairly well when he began his work with the [employing establishment], and that he deteriorated during his work with that employer. When examining for effects of toxic substances, the most likely substance affecting a person would be the substances to which the person was exposed when the deterioration occurs. Herbicides and other military exposure *may* have played a role in [appellant's] current condition by setting up a sensitivity to toxic chemicals, leading to a greater likelihood of deterioration in the future. Brain cells do not regenerate, so brain damage is cumulative.
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> "Multiple chemical sensitivity (MCS) is a real disorder that is quite prevalent in the USA. Many people have this disorder to some degree. It is primarily diagnosed by symptoms. Many people with neurotoxicity have symptoms of MCS. There is some controversy about MCS because it is difficult to prove that a person has this disorder. Some of the difficulty in proof is due to the high costs to corporate interests associated with proof of MCS. Doctors who align themselves with the status quo may be very reluctant to diagnose a condition that can be very costly to corporate profits, unless the proof is overwhelming."

In a report dated May 2, 1997, Dr. Varner described appellant's exposures to chemicals in the military service and at the employing establishment, and reviewed prior medical reports. Dr. Varner stated that appellant did not suffer from somatoform disorder, obsessive compulsive disorder, or schizotypal personality disorder, and that even two hours per day of exposure to solvents and other chemicals "would be certainly enough exposure over 16 years to lead to clear chemical hypersensitivity and to explain his left cerebral deficit as well as explain his lung disease and as it relates to the development of autoinflammatory processes associated with solvents to his migratory joint symptoms." Dr. Varner diagnosed multiple chemical sensitivity, and explained the mechanisms of central nervous system and organ damage due to exposures to

chemicals. In a report dated May 7, 1997, Dr. Randolph stated that he agreed with Dr. Singer that "there is some degree of organic brain syndrome." In a report dated May 7, 1997, Dr. William J. Rea, who is Board-certified in surgery and in thoracic surgery, set forth a history that appellant was "apparently well until 1979, when he first developed his symptoms," noted "significant exposure to solvents and petrochemicals," and stated that a chemical panel revealed elevated levels of petrochemicals and that skin testing showed a positive response to natural gas, propane gas, and chlorine. Dr. Rea stated that appellant did not exhibit any type of obsessive compulsive disorder, and concluded that appellant was "suffering from neurotoxicity due to his chemical exposures during his work at the [employing establishment]."

By decision dated July 3, 1997, an Office hearing representative found that the newly submitted medical evidence created a conflict of medical opinion with the reports of Dr. Parmet's group, and that other substances needed to be added to the list of appellant's exposures in the Office's statement of accepted facts.

On December 31, 1997 the Office referred appellant, the case record, and an amended statement of accepted facts to Dr. H. William Barkman, a Board-certified internist, to resolve the conflict of medical opinion on the diagnosis and cause of appellant's condition.

Dr. Barkman referred appellant for a pulmonary function study, which was done on February 13, 1998 and showed a borderline obstructive defect, and normal blood gases and maximum ventilatory volume. A progressive exercise test on February 11, 1998 showed systemic hypertension. In a report dated February 12, 1998, Dr. Debra Kelsh, a Board-certified psychiatrist to whom Dr. Barkman referred appellant for an evaluation, set forth appellant's history, complaints and findings on mental status examination. Dr. Kelsh concluded:

> "This patient is not a malingerer nor do I believe he suffers from a factitious disorder. I believe [appellant] has attempted to relate his symptoms and history as truthfully as he can, even in view that this was a completely artificial setting, in that, he was not coming here seeking a psychiatric evaluation himself but rather as part of a process that has great meaning and importance for him. There is little doubt that this patient did suffer from an alcohol abuse problem; however, I doubt that this has any impact on his current symptoms. He also apparently has suffered some type of mood disorder; again, probably not significant enough to account for his current disability. He also has some anxiety symptoms. Symptoms of PTSD were not delved into. He has had that diagnosis in the past and may have that as well. I do not believe, however, that his anxiety disorder consisting mostly of isolated panic attacks, accounts for his current symptoms.
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> "This patient certainly did meet the criteria of somatization disorder. He has had pain symptoms, gastrointestinal symptoms, sexual symptoms and some neurological symptoms since his early 20's. His symptoms have caused him great social and occupational disability. His diagnosis was coded as Provisional in that somatization disorder cannot be diagnosed if these symptoms can be accounted for by a general medical condition. It is precisely this question that is being evaluated by his other doctors; *i.e.,* to determine if his exposure to solvents in the past could in fact account for these symptoms."

* * *

> "In conclusion, this patient is clearly disabled by his somatic symptoms as he experiences them. The fact that he has suffered in the past from an alcohol abuse problem and mood and anxiety symptoms should not be used as evidence that this patient's symptoms are completely psychiatric and, therefore, cannot be accounted for by a general medical condition. Many patients diagnosed in the past with somatization disorder have later been found, when adequate medical testing and knowledge becomes available, to in fact, suffer from a medical condition."

In a report dated July 10, 1998, Dr. Barkman set forth appellant's history and his findings on physical examination and laboratory studies, which showed a slight elevation in serum glucose and two liver enzymes (AST and ALT), normal cholinesterase, and a blood lead level of 1.2, which Dr. Barkman indicated was a negative result. Dr. Barkman then described his assessment:

> "1. Labile hypertension. He was noted on admission to be hypertensive at the time he felt he was beginning to have one of his typical reactions. His history and physical findings are most consistent with a panic attack. During his comprehensive cardiopulmonary exercise test he revealed significant hypertension, and the test had to be aborted.
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> "2. Somatization disorder. He has multiple medical complaints without specific objective findings. Historically, he feels this is related to chemical exposures. The odors will trigger these symptoms. However, there is no exposure data or objective medical data to establish a correlation between his work-related chemical exposures and his somatization disorder. Historically, he apparently developed this disorder during his employment at the postal service. His prior records reveal that he has had multiple psychiatric diagnoses made over the years; however, there is a theme of somatization disorder in more than one evaluation. He has been advised in the past to recognize this as psychiatric illness and to seek appropriate therapy. He has rejected the recommendations and continues to do homework and seek care from a variety of practitioners. Certain laboratory tests conducted over a period of time are consistent with exposure but do not establish a diagnosis of a chemical toxicity.
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> "3. Borderline chronic obstructive pulmonary disease. He is an ex-cigarette smoker and his pulmonary functions reveal minimal abnormalities. Given a negative methacholine and no bronchospasm after exercise, there is no objective evidence to establish a diagnosis of asthma.
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> "4. Obesity. His slightly elevated serum glucose and labile hypertension may be associated with his weight and conditioning level.
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> "5. Elevated AST and ALT. Historically, he has had prior elevation of isolated liver enzymes. These elevations have been noted in the past but no definitive

diagnosis has been established. Currently, as these are nonspecific and given his current list of medications and no occupational exposures since 1993, I do not believe these are related to workplace exposures."

By decision dated July 24, 1998, the Office found that the weight of the medical evidence, represented by the findings and conclusions of Dr. Barkman, supported that appellant had no condition related to factors of his employment.

By letter dated August 21, 1998, appellant requested a hearing, and requested that the Office "subpoena data and documentation to help substantiate my claims for exposure and injury." In another lengthy submission, appellant requested subpoenas for material safety data sheets, all records from the Occupational Safety and Health Administration, all his clock rings and discipline records, all safety violations, and all heating, ventilation and air conditioning records. Appellant also stated that his list of claimed conditions should be expanded to include chronic pain syndrome, central neurotoxicity, rhinosinusitis, heavy metal toxicity, systemic candiasis, chronic fatigue syndrome, organic brain dysfunction, autoimmune disease, and labile hypertension. Appellant alleged that he was exposed to tear gas used as a protective device in an employing establishment safe he opened using a grinding tool.

Following a hearing held on April 20, 1999, appellant submitted additional evidence. In a report dated December 9, 1998, Dr. Rod Zeitler, a Board-certified internist at the Veterans Administration, stated that appellant was totally disabled to his symptoms, but that it was difficult to establish an etiology or diagnosis. In a report dated May 18, 1999, Dr. Eidbo stated that appellant was not totally physically disabled but that his chronic severe anxiety reaction made him unable to perform his work mentally. In a report dated May 21, 1999, Dr. Zeitler stated that appellant appeared to respond to environmental stimuli, including multiple somatic complaints, that his symptoms kept him from working, and that work exposures seemed to have been the trigger.

By decision dated July 13, 1999, an Office hearing representative found that the evidence failed to establish a medical condition causally related to appellant's exposure to chemicals, and that appellant's request for a subpoena was appropriately denied, as there was no evidence that the employing establishment did not provide all relevant exposure information.

By letter dated July 10, 2000, appellant requested reconsideration, and submitted additional medical evidence from Dr. Rea and from physicians to whom Dr. Rea had referred appellant. Dr. Theodore R. Simon, who is Board-certified in nuclear medicine, stated that an October 4, 1999 brain scintigram was "consistent with neurotoxicity as seen in the presence of all four components, 'salt and pepper' pattern, shunting to the soft tissues, temporal asymmetry and a mismatch between the early and late phases. The degree of involvement is moderate." In an October 5, 1999 report, Dr. Daniel M. Martinez, a Board-certified otolaryngologist, stated that posturography on that date was abnormal, indicating "vestibular pattern insufficiency which may be related to a chemical toxicity since if it were due to a peripheral lesion in the past, compensation would have already occurred and the posturography tracings would have been normal." In a report dated October 6, 1999, Dr. Nancy A. Didriksen, a psychologist, set forth appellant's history, complaints and findings on psychological testing. She stated that "the results of neuropsychological testing clearly demonstrate impairment in the specific areas most

frequently impaired in neurotoxically-exposed individuals," that personality and behavioral test results argued strongly against malingering, and that neurocognitive test results, the brain scan by Dr. Simon, and "the findings of other professionals who are familiar with neurotoxic effects" also argued "against malingering and/or somatization disorders of any kind."

In a report dated December 6, 1999, Dr. Rea noted that, some of appellant's symptoms, initially chronic sinusitis or chronic respiratory infections, began in 1967, and that appellant may have been exposed to chemicals during his military service. Dr. Rea reviewed the findings of Drs. Martinez and Didriksen, and stated that it was "evident that he has multi-organ system dysfunction." Dr. Rea then stated:

> "It has been in my medical experience that toxic chemical exposures will affect many organ systems and produce a complex medical condition. His immune system is deregulated as shown by the skin testing results, which show sensitivities to several chemicals. More specifically he skin tested positive and symptoms were provoked when he skin tested several common chemicals. It is well known in the profession, a patient who has a strong sensitivity to a particular substance will cross react with other antigens. This patient exists in a hypermetabolic and hyper-reactive state. This state has a tendency to deplete his nutrient pools, consequently impairing detoxification and resulting in the patient's susceptibility to accumulation of chemicals."

In a report dated July 6, 2000, Dr. Rea diagnosed "chemical exposure, toxic encephalopathy, peripheral neuropathy, toxic effect solvents, chemical sensitivity, food sensitivity and inhalant sensitivity." Dr. Rea stated that appellant's original chemical exposure may have occurred in Vietnam, and that his "preexisting condition was aggravated by his current exposure while working at the [employing establishment]. I would categorize this as a permanent aggravation."

By decision dated September 11, 2000, the Office found that the weight of the medical evidence remained with the impartial medical specialist, Dr. Barkman, and did not establish that appellant had "a chemical toxicity or organic brain syndrome which was caused or aggravated by factors of Federal employment."

The Board finds that the weight of the medical evidence establishes that appellant does not have a disabling medical condition causally related to his exposure to chemicals in the course of his employment.

There was a conflict of medical opinion in this case on the question of whether appellant had a disabling medical condition causally related to his exposure to chemicals in the course of his employment. In a report dated June 15, 1993, Dr. Varner, a Board-certified psychiatrist, diagnosed "chemical hypersensitivity (to multiple chemicals)" and attributed appellant's neuropsychiatric problems to his exposure to chemicals and dust at the employing establishment. In a report dated March 24, 1997, Dr. Singer, a psychologist, attributed appellant's neuropsychological disorder in part to his exposure to toxic substances at the employing establishment.

Contrary to these opinions from appellant's attending physicians, the Office's referral physician, Dr. Parmet, who is Board-certified in preventive medicine, concluded, in a report dated August 21, 1995, that "there is no objective evidence whatsoever to support a diagnosis of multiple chemical sensitivity, allergic encephalopathy, 'inner head injury syndrome,' or any other toxic condition or work-related disorder." Dr. Parmet disputed the reliability of the immune studies done for Dr. Varner, and concluded that they "do not provide any diagnostic information." In concluding that appellant had no employment-related condition and that his symptoms were due to an obsessive compulsive disorder, Dr. Parmet relied on the reports of Dr. Geller, a Board-certified neurologist who found "no significant neurologic abnormality," and Dr. Inniss, a Board-certified psychiatrist who diagnosed somatization disorder and obsessive compulsive disorder.[2]

In response to the report from Dr. Parmet and his consulting physicians, appellant submitted additional medical evidence disputing their conclusions. In a report dated March 24, 1997, Dr. Singer, a psychologist, stated that appellant did not meet the diagnostic criteria for obsessive compulsive disorder or for somatization disorder. Dr. Singer attributed appellant's organic brain dysfunction in part to his exposure to toxic substances at the employing establishment. In a report dated May 2, 1997, Dr. Varner stated that appellant did not suffer from somatoform disorder or obsessive compulsive disorder, and attributed appellant's left cerebral deficit, his lung disease and his migratory joint symptoms to his exposure to chemicals at the employing establishment. In a report dated May 7, 1997, Dr. Rea, who is Board-certified in surgery and in thoracic surgery, concluded that appellant was "suffering from neurotoxicity due to his chemical exposures during his work" at the employing establishment.

To resolve this conflict of medical opinion, the Office, pursuant to section 8123(a) of the Federal Employees' Compensation Act,[3] referred appellant, the case record and a statement of accepted facts to Dr. Barkman, a Board-certified internist, who conducted additional studies including a blood study, a pulmonary function study, and a progressive exercise test, and referred appellant to Dr. Kelsh, a Board-certified psychiatrist, who concluded that appellant "certainly did meet the criteria of somatization disorder," and explained why. Based on these reports, his review of the prior medical evidence, and his findings on physical examination, Dr. Barkman concluded that appellant's "multiple medical complaints without specific objective findings" were due to a somatization disorder. Dr. Barkman noted that appellant had had "multiple psychiatric diagnoses made over the years," with "a theme of somatization disorder in more than one evaluation." Dr. Barkman stated that certain laboratory tests over a period of time were consistent with exposure but did not establish a diagnosis of chemical toxicity, and that there was

[2] Though not from physicians to whom the Office referred appellant, other medical reports negate a causal relation of appellant's conditions to his exposure to chemicals in his employment. Dr. Nordine, a Board-certified psychiatrist, and Dr. Lamberty, a psychologist, attributed appellant's organic mood disorder to his head injury in the military service in 1968. Dr. Schwartz and Dr. Fuortes, both of whom are Board-certified in internal medicine and in preventive medicine, concluded that it was doubtful that appellant's chronic fatigue and chronic pain were related to his exposure to heavy metals or solvents. Dr. Staubinger concluded in 1985 that appellant's pulmonary problems were related to cigarette smoking.

[3] 5 U.S.C. § 8123(a) states in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."

no definitive diagnosis established in connection with appellant's "elevation of isolated liver enzymes," which he did not believe was related to employment exposures, given appellant's medications and no occupational exposure since 1993.

In situations where there are 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.[4]

The July 10, 1998 report of Dr. Barkman is sufficiently well rationalized to be given special weight. This report was based on an accurate factual background. The statement of accepted facts provided to Dr. Barkman stated that appellant was exposed to ink, petroleum products, paper dust, paint, wood stains, battery room gases, trichloroethane, phosgene, Stoddard solvent, propane and acetone. The employing establishment confirmed that appellant was exposed to these substances in the course of his employment, and the case record contains material safety data sheets on these substances. The employing establishment acknowledged that a safe that appellant cut open was equipped with a tear gas deterrent, but denied that tear gas was released. There is no evidence that it was.

The medical evidence submitted by appellant subsequent to Dr. Barkman's report is not sufficient to outweigh that report or to create a new conflict of medical opinion. Dr. Simon's statement that an October 4, 1999 brain scintigram was "consistent with neurotoxicity" does not indicate what else it might be consistent with, nor does it attribute the neurotoxicity to appellant's exposures at the employing establishment as opposed to those in the military service. Dr. Martinez's conclusion that appellant's vestibular pattern insufficiency "may be related to a chemical toxicity" is speculative, and Dr. Didriksen's statement that "the results of neuropsychological testing clearly demonstrate impairment in the specific areas most frequently impaired in neurotoxically-exposed individuals" does not contain a definite statement on causal relation.. Although Dr. Rea had further information in the form of the reports he obtained from Drs. Simon, Martinez and Didriksen, his December 6, 1999 and July 6, 2000 reports reiterate the conclusions of his May 7, 1997 report, which helped create the conflict of medical opinion resolved by Dr. Barkman. A new report from a physician on one side of a conflict of medical opinion is generally insufficient to overcome the weight of the impartial medical specialist's report or to create a new conflict with the report of the impartial medical specialist.[5]

[4] *James P. Roberts*, 31 ECAB 1010 (1980).

[5] *Dorothy Sidwell*, 41 ECAB 857 (1990).

The September 11, 2000 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
December 19, 2002

Alec J. Koromilas
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member