

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

---

In the Matter of STUART M. COLE and DEPARTMENT OF LABOR,  
MINE SAFETY & HEALTH ADMINISTRATION, Richlands, VA

*Docket No. 02-611; Submitted on the Record;  
Issued October 10, 2002*

---

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,  
A. PETER KANJORSKI

The issue is whether appellant has pneumoconiosis causally related to his employment.

On June 4, 1987 appellant, then a 49-year-old coal mine safety inspector, filed a claim for an occupational disease for pneumoconiosis.

Appellant submitted a report dated May 15, 1984, from Dr. J.P. Sutherland who set forth a history that appellant worked in coal mines for 15 years and in mine safety for 13 years and that he was not a smoker. He concluded that appellant had chronic obstructive lung disease caused by exposure to coal dust and that this condition disabled him to do coal mining work. In separate reports, Dr. Sutherland stated that chest x-rays taken on June 5 and September 16, 1986 showed 2/2 pneumoconiosis. In a report dated May 4, 1987, Dr. Donald L. Rasmussen, a Board-certified internist, stated that pulmonary function, blood, gas and treadmill exercise studies indicated a marked impairment in respiratory function. Dr. Rasmussen concluded:

“[Appellant’s] pulmonary impairment [is] sufficient to render him totally disabled for resuming his former coal mine employment. The pattern of impairment in this case including the slight restrictive impairment, the barely normal total lung capacity, reduced single breath diffusing capacity and the impairment in gas exchange progressing during incremental exercise are consistent with an interstitial type lung disease of which coal workers’ pneumoconiosis is an example. This is especially pertinent in [appellant’s] who is a lifelong nonsmoker.”

An Office of Workers’ Compensation Programs medical adviser reviewed the medical evidence on September 8, 1987 and concluded that it showed pneumoconiosis causally related to appellant’s federal employment and total disability for his previous job.

By letter dated September 16, 1987, the Office advised appellant that it had accepted that he sustained pneumoconiosis in the performance of his duties.

Appellant stopped work on September 23, 1987 and used sick leave until February 5, 1988. On February 8, 1988 the Office began payment of compensation for temporary total disability.

On May 18, 1992 appellant returned to work as a physical science technician, a surface position. By decision dated August 24, 1992, the Office found that this position represented his wage-earning capacity; the Office reduced his compensation to that for partial disability.

In a report dated November 4, 1992, Dr. Sutherland stated that appellant could return to mine inspection work. By letter dated February 10, 1993, the employing establishment advised appellant that it would not consider his request to return to duty as an underground coal mine inspector, as this would not be in his best interest.

On February 3, 1994 appellant filed a claim for a schedule award.

On July 17, 1996 the Office referred appellant, prior medical reports and a statement of accepted facts to Dr. Mitchell Wicker, Jr., a Board-certified internist, for a second opinion as to whether he had a pulmonary condition causally related to his federal employment and on the extent of the permanent impairment of his lungs. In a report dated August 7, 1996, Dr. Wicker stated: "On my examination today, I find no evidence of any supportable claim of pneumoconiosis. I find no evidence of desaturation of [appellant's] blood gases and find no basis of any disability at this time." In a report dated September 3, 1996, Dr. Wicker stated that a chest x-ray on August 7, 1996 showed no evidence of pneumoconiosis.

On January 8, 1997 the Office referred appellant, the case record and a statement of accepted facts to Dr. Bruce Broudy, who is Board-certified in pulmonary diseases, to resolve the conflict of medical opinion as to whether appellant had pneumoconiosis and whether he was disabled for the position of coal mine inspector. In a report dated January 29, 1997, Dr. Broudy set forth appellant's history and his findings on physical examination, pulmonary functions studies and a chest x-ray, which he stated showed no evidence of pneumoconiosis. Dr. Broudy concluded:

"The evidence does not support a claim that [appellant] has coal workers' pneumoconiosis. The evidence does indicate that he would retain the respiratory capacity to perform his previous work or his current work or work requiring similar effort. I believe [appellant] is capable from a respiratory standpoint of returning to work eight hours per day as a mine inspector. The results of the spirometric studies are virtually normal and the diffusing capacity is normal. The blood gases show no evidence of any abnormality and show no desaturation with exercise. He was able to exercise for nine and one-half minutes under the Bruce protocol which is fairly good.... There were no significant findings on physical examination to suggest significant pulmonary disease or pulmonary disability. The results of the lung function testing including blood gases, diffusing capacity and spirometry suggest that the dyspnea is nonpulmonary in origin."

In a report dated May 23, 1997, Dr. Frank J. Sutherland, an osteopath, diagnosed chronic obstructive pulmonary disease with bronchospasms, pneumoconiosis and pulmonary fibrosis.

On June 10, 1997 the Office issued a notice of proposed termination of compensation on the basis that the acceptance of pneumoconiosis was in error as supported by new evidence showing that he did not have coal workers' pneumoconiosis.

In a letter dated July 3, 1997, appellant stated that he had applied for at least 14 posted positions and had been rejected by the employing establishment even though he met the requirements for these positions.

By decision dated September 8, 1997, the Office rescinded its acceptance of pneumoconiosis and terminated appellant's compensation effective September 14, 1997.

By letter dated September 26, 1997, appellant requested a hearing and submitted a report dated October 31, 1997 from Dr. Yasir Hatahet, a Board-certified internist who stated that pulmonary function studies showed two ventilatory abnormalities, "namely moderate volume restriction, which could partly be due to obesity and partly due to an interstitial process such as industrial pneumoconiosis. The other abnormality is moderate obstructive disorder, which in the absence of smoking history has to be related to underlying, subclinical asthmatic bronchitis."

At a hearing before an Office hearing representative on November 18 1998, appellant submitted reports from Dr. Michael S. Alexander, a Board-certified internist and Dr. Enrico Cappiello, a Board-certified radiologist, stating that Dr. Broudy's January 29, 1997 chest x-ray showed pneumoconiosis. Dr. Cappiello also stated that August 7 and September 29, 1997 chest x-rays showed pneumoconiosis. In a report dated May 26, 1998, Dr. Hatahet stated that a recent pulmonary function study showed a restrictive disorder and air flow limitation and that surface coal mining was likely to result in further significant dust exposure and "may worsen appellant's lung condition, which makes it unlikely that he will be able to obtain such employment." In a report dated October 19, 1998, Dr. Anne Marie Hynes stated that appellant had coal workers' pneumoconiosis and chronic asthmatic bronchitis and that he would "never be able to do the work he was trained for. His lungs are already damaged and further exposure would result in a continued decline in lung function which would be accelerated from normally expected decline.... He will never be able to work in environments that are injurious to his respiratory health."

By decision dated February 19, 1999, an Office hearing representative found that the opinion of Dr. Broudy constituted the weight of the medical evidence and justified the Office's termination of appellant's compensation. The Office hearing representative also found that there was no evidence that Dr. Cappiello was a certified B reader and that "even with his credential established, there was no other diagnostic testing presented in support of these imaging findings such as blood gas testing results."

By letter dated January 13, 2000, appellant requested reconsideration and submitted additional evidence. In a report dated June 18, 1999, Dr. Rasmussen stated that pulmonary function studies and a treadmill exercise study "indicate at least moderate impairment in respiratory function. This degree of impairment would render [appellant] totally disabled for resuming his former coal mine employment or his former underground coal mine inspecting work." Dr. Rasmussen stated that appellant had "x-ray abnormalities consistent with pneumoconiosis, although not typically classic for coal workers' pneumoconiosis."

Dr. Rasmussen concluded, “[b]ased on [appellant’s] history and his number of positive x-rays it is medically reasonable to conclude that he does have coal workers’ pneumoconiosis which arose from his coal mine employment.” Dr. Afzal Ahmed, a Board-certified radiologist and certified B reader, Dr. Larry Westerfield, a Board-certified diagnostic radiologist and certified B reader, Dr. Thomas E. Miller, a Board-certified radiologist and certified B reader, Dr. Edward Aycoth, a diagnostic radiologist and certified B reader and Dr. Cappiello, who is a certified B reader, indicated that a chest x-ray taken on July 16, 1999 showed pneumoconiosis.

An Office medical adviser reviewed the medical evidence on February 7, 2000 and stated that appellant “had provided a number of B reader certifications from various physicians who have interpreted chest x-rays as showing densities that, using the ILO classification, permit [the Office] to accept that the diagnosis of pneumoconiosis is valid. It can be accepted that a portion of such lung field abnormalities occurred because of [his] federal work duties.”

By decision dated February 8, 2000, the Office rescinded its February 19, 1999 decision and found that the evidence established that appellant had employment-related pneumoconiosis. The Office reinstated appellant’s compensation for loss of wage-earning capacity, retroactive to September 14, 1997.

On March 21, 2000 the Office referred appellant, prior medical reports and a statement of accepted facts to Dr. John Forehand, who is Board-certified in allergy and immunology and is a certified B reader, for a second opinion whether he had a pulmonary condition causally related to his federal employment and on the extent of the permanent impairment of his lungs. In a report dated May 29, 2000, Dr. Forehand stated that his findings on examination included a normal chest x-ray that showed no evidence of coal workers’ pneumoconiosis, a normal spirogram without evidence of significant airflow obstruction or mechanical restriction, a normal transfer factor and normal arterial blood gas studies at rest and with exercise. Dr. Forehand stated that Dr. Rasmussen’s June 18, 1999 arterial blood gas study showed very unusual responses and concluded that appellant had no evidence of any work limiting respiratory disease which would prevent him from returning to his last coal mining job and no evidence of any lung disease caused or aggravated by his employment in the coal mining industry.

On July 20, 2000 the Office referred appellant, the case record and a statement of accepted facts to Dr. Subramaniam Paranthaman, who is Board-certified in pulmonary diseases and is a certified B reader, to resolve a conflict of medical opinion whether appellant had a pulmonary condition causally related to his federal employment. In a report dated August 25, 2000, Dr. Paranthaman set forth appellant’s history, symptoms and findings on physical examination. He stated that a chest x-ray showed “no evidence of coal workers’ pneumoconiosis” and that a spirogram was normal. Dr. Paranthaman concluded:

“Though [appellant] has worked in the coal mines approximately 31½ years, his chest x-ray does not show any significant dust accumulation. He has symptoms of chronic bronchitis, but there is no significant airway obstruction in spirogram. [Appellant] uses bronchodilator medications very sparingly, namely Albuterol once every two months and Lufyllin once a week. His resting blood gases show minimal reduction in pO<sub>2</sub> but this reduction in pO<sub>2</sub> may be due to other causes, such as obesity and his age, rather than due to lung problems. In other words,

though [appellant] has a history compatible to chronic bronchitis, this does not produce any significant impairment either clinically or in pulmonary function testing.

“As per A[merican] M[edical] A[ssociation], *Guides to the Evaluation of Permanent Impairment* 4<sup>th</sup> Edition, page 162, table 8, he belongs to class I or no impairment of the whole person (FVC equal or more than 80 percent of the predicted, FEV<sup>1</sup> equal to more than 80 percent of the predicted, FEV<sup>1</sup>/FVC is equal to or more than 70 percent and DLCO equal to or more than 70 percent of the predicted). Arterial blood gas analysis is not included as a criteria for classification of respiratory impairment because the arterial blood gases may be outside the normal range for reasons other than pulmonary disease. Example; altitude in which the sample is taken, obesity or breath holding. In addition, for the purpose of evaluating permanent impairment, hypoxemia must be documented on two occasions at least four weeks apart unless the pO<sub>2</sub> level is less than 60 mm/Hg. Exercise induced hypoxemia rarely occurs when the DLCO is greater than 60 percent of the predicted value as per guidelines.

“To conclude, though [appellant] has been exposed to coal dust for sufficient duration that can cause coal workers’ pneumoconiosis, he does not have radiological evidence of coal workers’ pneumoconiosis. He has chronic bronchitis which may be related to coal dust exposure, but has not produced any functional impairment on objective measurements. In other words, there is no objective evidence to state that federal employment has caused, aggravated or precipitated or accelerated a pulmonary condition.”

On November 27, 2000 the Office issued a notice of proposed termination of compensation on the basis that the weight of the medical evidence did not support employment-related pneumoconiosis and did not establish any disability or permanent impairment.

By decision dated January 10, 2001, the Office terminated appellant’s compensation on that date on the basis that the weight of the medical evidence did not support employment-related pneumoconiosis and did not establish any disability or permanent impairment.

By letter dated June 1, 2001, appellant requested reconsideration and submitted additional evidence. Drs. Cappiello and Aycoth stated that April 12, 2000 and April 21, 2001 chest x-rays showed pneumoconiosis. In a report dated April 21, 2001, Dr. Glen Ray Baker, Jr., who is Board-certified in pulmonary diseases, set forth appellant’s history, symptoms and findings on examination. He stated that an April 21, 2001 chest x-ray showed coal workers’ pneumoconiosis, that pulmonary function testing showed a mild obstructive ventilatory defect and that an arterial blood gas study showed mild resting arterial hypoxemia. Dr. Baker concluded that appellant had coal workers’ pneumoconiosis based on his abnormal x-ray and a significant history of dust exposure and that he had a Class II impairment, using the 5<sup>th</sup> edition of the A.M.A., *Guides*. Dr. Baker stated: “[appellant] is a nonsmoker and has obstructive airway disease, chronic bronchitis and resting arterial hypoxemia. It is thought that these symptoms are caused predominantly by his coal dust exposure.” In a report dated April 23, 2001, Dr. Baker reviewed several x-rays that were interpreted as showing pneumoconiosis and stated that the

most significant finding was “the report from Dr. Rasmussen with the resting arterial hypoxemia present on exercise, which confirms his complaints of shortness of breath and dyspnea on exertion.” Dr. Baker concluded:

“It is my opinion that [appellant] suffers from coal workers’ pneumoconiosis. This is based on his long history of coal dust exposure, multiple x-rays read by other doctors as positive and the presence of resting arterial hypoxemia with exercise, abnormal diffusion capacity and abnormal pulmonary function studies as well as his general medical history and physical examination. He should have no further exposure to coal dust, rock dust or similar noxious agents.”

By decision dated July 19, 2001, the Office found that the additional evidence was insufficient to warrant modification of its previous decision. With regard to Dr. Baker’s report, the Office found: “[s]ince Dr. Baker does not mention Dr. Paranthaman’s report or provide any evidence directly related to the impartial medical examination that would diminish its probative value, his report is insufficient to overcome the special weight given to Dr. Paranthaman.”

The Board finds that the case is not in posture for decision due to an unresolved conflict of medical opinion.

The Office initially accepted appellant’s claim for pneumoconiosis on September 16, 1987 based on a May 4, 1987 report from Dr. Rasmussen, a Board-certified internist. After appellant filed a claim for a schedule award, the Office referred appellant to Dr. Wicker, a Board-certified internist, who concluded that he did not have pneumoconiosis. This created a conflict of medical opinion, which the Office, pursuant to section 8123(a) of the Federal Employees’ Compensation Act,<sup>1</sup> resolved with a referral to Dr. Broudy, who is Board-certified in pulmonary diseases and who concluded, in a January 29, 1997 report, that appellant did not have pneumoconiosis. The Office then rescinded its acceptance of appellant’s claim for pneumoconiosis.

Appellant then submitted reports from several B readers who concluded that recent x-rays, including Dr. Broudy’s, showed that appellant had pneumoconiosis. Based on these reports, the Office rescinded its rescission and reinstated appellant’s compensation. The Office created a second conflict of medical opinion when it obtained a report from Dr. Forehand, a Board-certified allergist and immunologist and a B reader, concluding that appellant did not have pneumoconiosis. The Office resolved this conflict with the report of Dr. Paranthaman, who concluded that appellant did not have pneumoconiosis. Based on this report, the Office terminated appellant’s compensation.

Appellant has now created another conflict of medical opinion by submitting the report of Dr. Baker, who, like Dr. Paranthaman, is Board-certified in pulmonary diseases. Dr. Baker’s conclusion that appellant has employment-related pneumoconiosis is as supported as Dr. Paranthaman’s conclusion that he does not and Dr. Baker, as supported by the opinions of

---

<sup>1</sup> 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.”

two B readers interpreting chest x-rays, is an equally qualified medical specialist. Under these circumstances, referral to an impartial medical specialist is required.<sup>2</sup>

The July 19 and January 10, 2001 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded to the Office for action consistent with this decision of the Board.

Dated, Washington, DC  
October 10, 2002

Willie T.C. Thomas  
Alternate Member

Michael E. Groom  
Alternate Member

A. Peter Kanjorski  
Alternate Member

---

<sup>2</sup> Federal (FECA) Procedure Manual, Part -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.11a (April 1993).