United States Department of Labor
Employees' Compensation Appeals Board

GEORGE L. DARBY, Appellant	)	
and	)	**Docket No. 04-420**
	)	**Issued: October 5, 2004**
SMALL BUSINESS ASSOCIATION, Lubbock, TX, Employer	)	

Appearances:
George L. Darby, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On December 8, 2003 appellant filed a timely appeal from the October 23, 2003 merit decision of the Office of Workers' Compensation Programs, which found that he suffered no residuals of an employment-related aggravation of his gastrointestinal condition. The Board has jurisdiction to review this decision.[1]

ISSUE

The issue is whether the Office met its burden of proof to establish that appellant suffers no residuals of an employment-related aggravation of his gastrointestinal condition.

FACTUAL HISTORY

The Office's May 12, 1998 decision well describes the history of this case. Briefly, the Office accepted that appellant's duties as a Deputy District Director caused him stress and aggravated both his gastritis and coronary artery disease. After obtaining evidence that his

[1] 20 C.F.R. §§ 501.2(c), 501.3.

gastrointestinal and coronary conditions had returned to the baseline pathology of a normal progression, as though the work exposure never occurred, the Office terminated appellant's compensation benefits on January 9, 1993. In its May 24, 1996 decision,[2] the Board noted that the Office properly terminated compensation benefits and that the burden of proof had shifted to appellant to establish continuing disability related to the accepted aggravations. A conflict later arose when appellant submitted medical opinion evidence supporting that the accepted aggravations were permanent. The Office referred him to an impartial medical specialist to resolve the conflict. On May 12, 1998 the Office found that the opinion of Dr. Majid A. Syed, a Board-certified internist specializing in cardiovascular diseases, established that appellant no longer suffered any work-related aggravation of his coronary condition, but because a conflict still existed on whether he suffered from a work-related aggravation of his gastrointestinal condition, the Office remanded the case to an impartial medical specialist in gastroenterology.

In a November 17, 2000 decision, the Office found that the weight of the medical evidence, as represented by the November 2, 2000 opinion of Dr. William Gregory Hodges, a Board-certified internist specializing in gastroenterology, established that appellant suffered no residuals from a work-related aggravation of his gastrointestinal condition. Appellant requested reconsideration, but the Office delayed a decision on the request more than 90 days and thereby jeopardized his right to a Board review of the merits of his case. So, on June 4, 2003, the Board remanded the case for an appropriate merit decision on the gastrointestinal issue.[3]

In an October 23, 2003 decision, the Office found that the Dr. Hodges's November 2, 2000 opinion represented the weight of the medical evidence and established that appellant suffered no work-related aggravation of his gastrointestinal condition.[4]

LEGAL PRECEDENT

Section 8123(a) of the Federal Employees' Compensation Act provides: "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."[5] 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 upon a proper factual background, must be given special weight.[6]

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[2] Docket No. 96-48 (issued May 24, 1996).

[3] Docket No. 02-316 (issued June 4, 2003).

[4] The Board notes that the Office appeared to address appellant's coronary artery disease. This issue was settled by the hearing representative's decision on May 12, 1998. The Board remanded the case on June 4, 2003 for further action solely on the gastrointestinal question. Dr. Hodges was a gastroenterologist who at no point expressed an opinion on coronary disease. For these reasons, the Office's October 23, 2003 decision properly relates only to appellant's gastrointestinal condition.

[5] 5 U.S.C. § 8123(a).

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

ANALYSIS

The Office based the termination of appellant's compensation benefits on the opinion given by Dr. Hal L. Green, an internist and Office referral physician. He reported that appellant's chronic acid peptic disease had returned to the baseline pathology to be expected for the normal progression of that underlying condition "had the work-related exposure never occurred." A conflict later arose when Dr. Stephen A. Pierce, appellant's internist, reported that employment had permanently aggravated appellant's peptic ulcer disease. Also, Dr. Edward J. Leins, an osteopath and appellant's family physician, reported that working conditions had severely and permanently aggravated his peptic ulcer disease. The Office properly referred appellant to an impartial medical specialist under section 8123(a) of the Act. The issue on appeal is whether Dr. Hodges's November 2, 2000 opinion is sufficiently probative to resolve whether appellant suffers from an employment-related aggravation of his gastrointestinal condition.

The Office provided Dr. Hodges with appellant's case file and a statement of accepted facts. He examined appellant on October 27, 2000. After relating his history, symptoms and findings on physical examination, Dr. Hodges offered a diagnosis and opinion:

> "Chronic dyspeptic symptoms in a man with a documented history of peptic ulcer disease but no significant ulceration on multiple subsequent exam[ination]s. The duodenal ulcer in 1991 was almost certainly a consequence of nonsteroidal use as he had been taking Naprosyn for arthritic pain. While he may have been under considerable stress at work, there is no reason to believe this was a contributing factor in the development of his ulcer and subsequent hemorrhage. He was treated appropriately and subsequent endoscopy confirmed healing of the ulcer so that this would certainly not explain any ongoing symptoms. Subsequent endoscopic exam[ination]s in 1992, 1996 and 1998 have all revealed multiple, small, superficial erosions in either the stomach or duodenal bulb. These lesions are typical of those seen in patients taking aspirin (as he was doing) and are unlikely to account for any clinical symptoms. Furthermore, there is no reason to believe that stress, either past or present, would cause such lesions. His current symptoms of abdominal gas and bloating are entirely consistent with functional dyspepsia. I do not believe that further diagnostic studies are warranted at this time. While the symptoms of functional dyspepsia may well be more troublesome under stressful circumstances, his symptoms have continued despite the fact that he has not worked since 1991 so that it would be difficult to implicate work-related stress, particularly in relation to his ongoing symptoms. In summary, I do not believe that either the previous ulcer or [appellant's] ongoing symptoms have been a result of work-related stress suffered in 1990 or 1991. Furthermore, while his ongoing symptoms are certainly troublesome, I do not believe they are sufficient to result in long-term disability."

On November 2, 2000 Dr. Hodges addressed the specific questions posed by the Office:

> "After careful review of the exhaustive records and lengthy consultation with the patient, it is my opinion that neither his initial duodenal ulcer nor his ongoing

gastrointestinal symptoms have been a result of work-related stress he may have suffered in 1990 or 1991. Furthermore, while his ongoing symptoms are certainly troublesome, I do not believe that they are sufficient to result in long-term disability. I believe his current symptoms represent functional dyspepsia and I would not recommend any further diagnostic evaluation at this time given the extensive workup he has undergone previously.

"With reference to the specific questions for determination, I find no evidence in my review of the records that he had 'gastritis' in June 1991 or that such a problem is currently active and disabling. He has been found on three subsequent endoscopic exams (in 1992, 1996, and 1998) to have multiple superficial erosions in either the stomach or duodenum which are characteristic of lesions found in patients taking aspirin as he was doing. Regarding the second question of determination, I do not believe that work-related stress played any role in his initial presentation with a bleeding ulcer which was almost certainly a consequence of the use of Naprosyn for arthritic pain which is widely recognized as a common cause of ulcers. While the symptoms of functional dyspepsia may be more troublesome under stressful circumstances, there is no reason to believe that work-related stress suffered 9 or 10 years ago would in any way contribute to ongoing symptoms at this time."

The Board finds that Dr. Hodges's opinion is based on a proper factual background and is sufficiently well reasoned that it must be accorded special weight in resolving the conflict between Dr. Green and Drs. Pierce and Leins. Convincing are the endoscopic examinations that confirmed healing of the duodenal ulcer appellant had in 1991 and that found multiple superficial erosions characteristic of lesions in patients taking aspirin, as he was doing. Although appellant indicated that he took nothing but a single enteric-coated aspirin "on occasion" since the diagnosis of his ulcer, Dr. Hodges reported: "Significantly, a careful review of the records suggests that the patient was taking aspirin in some form, usually Ecotrin, at the time of each of these last three endoscopic examinations." Regardless, he explained that the pinpoint erosions found on endoscopic examination were unlikely to account for any clinical symptoms. Dr. Hodges has thus, presented what appears to be a sound medical case that appellant's ongoing gastrointestinal symptoms are not the result of any stress he experienced at work some 9 or 10 years earlier but are merely characteristic of chronic dyspepsia. His opinion represents the weight of the medical evidence and resolves the relevant conflict.

CONCLUSION

The Board finds that Dr. Hodges's November 2, 2000 opinion is sufficiently probative to establish that appellant suffers no residuals of an employment-related aggravation of his gastrointestinal condition.

ORDER

IT IS HEREBY ORDERED THAT the October 23, 2003 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 5, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member