United States Department of Labor
Employees' Compensation Appeals Board

BETTY J. SUMNER, Appellant	)	
and	)	**Docket No. 05-134**
	)	**Issued: April 6, 2005**
TENNESSEE VALLEY AUTHORITY, PARADISE FOSSIL PLANT, Drakesboro, KY, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant
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 October 13, 2004 appellant timely filed an appeal from a July 12, 2004 decision by a hearing representative of the Office of Workers' Compensation Programs, finding that appellant had not established that her pulmonary condition was causally related to factors of her employment. The Board has jurisdiction over the merits of this case pursuant to 20 C.F.R. §§ 501.2(c) and 501.3.

ISSUE

The issue is whether appellant met her burden of proof in establishing that her pulmonary condition was causally related to factors of her employment.

FACTUAL HISTORY

On July 26, 2002 appellant, then a 67-year-old retired human resource manager, filed a claim for pneumoconiosis which she related to her employment. She indicated that she first learned she had an occupational lung disease on May 31, 2002 when she read a chest x-ray

report. In an accompanying statement, appellant indicated that she began work at the employing establishment in May 1961, as a personnel clerk. Appellant became a project manager secretary in 1965 then returned to a clerk position in 1970. She became an administrator for another power plant of the employing establishment and an administrative supervisor at a third power plant. She returned to the employing establishment in 1990 as a human resource manager until December 31, 1992, when she retired. Appellant noted that, when she began working at the employing establishment, she was in temporary buildings and was moved to the powerhouse in the 1970s. She stated that all during her employment she was exposed to coal dust, fly ash and flue gas and was occasionally exposed to asbestos. Appellant commented that there would be dust on her desk every day. Considerable dust was tracked into the office. She noted that all the coal storage at the employing establishment was in front of the powerhouse, requiring her to walk past it every day. Appellant indicated that she had noticed shortness of breath for the prior two to three years with exertion. She stated that she had never been a smoker and had never been hospitalized for pulmonary conditions.

Appellant submitted several reports from Dr. Glen Baker, a Board-certified pulmonologist. In a June 22, 2002 report, Dr. Baker indicated that appellant complained of shortness of breath, primarily with greater than normal exertion, for the prior two to three years. He noted that appellant had no history of cough, sputum production or wheezing, nor any nocturnal symptoms. He commented that appellant's breathing was worse primarily with exertion but also with exposure to various dusts, odors and fumes. Dr. Baker reported that he had no history of tuberculosis, asthma, pneumonia or hemoptysis. He indicated that pulmonary function studies showed appellant's forced vital capacity (FVC) was 97 percent of the predicted value before use of a bronchodilator and 96 percent of the predicted value after the bronchodilator. The forced expiratory volume in one second (FEV_1) was 100 percent of the predicted value in both tests. Dr. Baker stated that appellant had normal pulmonary function studies with no significant change following administration of bronchodilators. He diagnosed occupational pneumoconiosis, category 1/0, with possible asbestosis or coal dust exposure, based on an abnormal x-ray and history. Dr. Baker stated that appellant had a Class 1 impairment of the lungs as the pulmonary function studies were greater than 80 percent of the predicted values.

In an October 31, 2002 letter, Nancy L. Branham, a manager of claims at the employing establishment, stated that the office building in which appellant worked was a clean, typical office environment. She noted that the office wing had a separate air conditioning and heating units with filters not connected with any part of the power plant. Ms. Branham concluded that appellant had no exposure to coal dust or other dust or fumes at the employing establishment. She pointed out that the employing establishment had received a large number of claims from former employees of the employing establishment alleging pneumoconiosis submitted by one attorney and supported by medical evidence from two physicians, including Dr. Baker. Ms. Branham stated that on each claim the diagnostic impression was occupational lung disease regardless of contrary medical findings or nonwork exposures. She noted that appellant's spirometry was completely normal and her pulmonary function values were essentially 100 percent of the predicted value for her age and body habitus which indicated no evidence of pneumoconiosis or did not expose appellant to dust that could cause occupational pneumoconiosis. Ms. Branham contended that appellant's claim had to be denied because there was no fact of injury.

The Office referred appellant to Dr. Kenneth Anderson, a Board-certified internist specializing in pulmonary diseases, for an examination and second opinion. In a January 14, 2003 report, Dr. Anderson noted that appellant had been exposed to construction dust, including coal dust, fumes, soot, asbestos and smoke stack emissions. He reported the results of appellant's pulmonary function tests, indicating that the FVC was 98 percent of the predicted value, the FEV_1 was 96 percent of the predicted value and the FVC/FEV_1 ratio was 83 percent of the predicted value. He indicated that the diffusion level of carbon monoxide in appellant's blood (DLCO) was 64 percent of the predicted value. Dr. Anderson stated that chest x-rays, examined by a B-reader, showed a profusion of 0/1 with no pleural changes. He noted that appellant had cardiomegaly and apical pleural capping, unrelated to pneumoconiosis. Dr. Anderson indicated that appellant's current symptoms included an occasional cough. He commented that the x-rays could suggest pneumoconiosis but the profusion was not to the level of 1/1. He found no pleural abnormalities. Dr. Anderson pointed out that the pulmonary function tests were normal but the diffusion capacity of carbon monoxide was abnormal which could be related to early pneumoconiosis. He stated, however, that appellant did not have symptoms to such a diagnosis. He noted that the diffusion capacity of carbon monoxide could be determined as a Class 2 impairment. Dr. Anderson commented that other abnormalities that could contribute to an abnormal DLCO could be searched for, pointing out that asbestosis could cause an abnormal diffusion defect when the pulmonary function are otherwise normal.

In a July 23, 2003 decision, the Office denied appellant's claim for compensation on the grounds that she had not established that the claimed medical condition was related to her established work-related events.

Appellant requested a hearing before an Office hearing representative which was conducted on May 3, 2004. She subsequently submitted a May 7, 2004 report from Dr. Baker, who noted that appellant had a repeat pulmonary function studies. He indicated that her FEV_1 and FVC were normal but the diffusion capacity was decreased to a 61 percent and 64 percent in two different measurements. Dr. Baker concluded that appellant fell into a Class 2 impairment equaling 10 to 25 percent of the whole body. He commented that the impairment was due to lower diffusion capacity and probably related to her exposure to coal dust, rock dust and asbestos for a long period of time.

In a July 12, 2004 decision, the Office hearing representative found that Dr. Anderson's report formed the weight of the medical evidence. The hearing representative also found that appellant had not established a causal relationship between her pulmonary condition and the factors of her employment.

LEGAL PRECEDENT

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed;[1] (2) a factual statement identifying the employment factors alleged to have caused or contributed to the presence or

[1] *See Ronald K. White*, 37 ECAB 176, 178 (1985).

occurrence of the disease or condition;[2] and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[3] The medical evidence required to establish causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant,[4] must be one of reasonable medical certainty[5] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[6]

ANALYSIS

Appellant gave a history of exposure to coal dust, asbestos and other material at the employing establishment. The Office accepted that appellant had established compensable factors of employment, however, denied her claim because she had not established a causal relationship between her condition and the accepted factors of employment.

Dr. Baker, in his reports, noted that appellant's pulmonary function tests were normal but the diffusion capacity was reduced to 61 or 64 percent of the predicted value. He related appellant's test findings and pulmonary condition to her exposure to the dust and asbestos at work. The Office hearing representative found Dr. Baker's reports to be speculative and stated that Dr. Anderson's report constituted the weight of the medical evidence. However, he also noted that appellant had normal pulmonary function tests and a diffusion capacity of 64 percent of the predicted value. Dr. Anderson stated that appellant's diffusion capacity could be related to possible early pneumoconiosis, although she was not experiencing symptoms of this condition. He commented asbestosis could cause an abnormal diffusion capacity when the pulmonary functions tests were otherwise normal. Therefore, Dr. Anderson concurred with Dr. Baker that appellant had an abnormal diffusion capacity that could be related to her exposure to coal dust or asbestos at work. The reports of both physicians are speculative but both suggested a causal relationship between her pulmonary condition and her exposure to coal dust and asbestos at the employing establishment. Although the medical evidence of record is insufficiently rationalized to establish that the accepted factors of employment caused or contributed to appellant's pulmonary condition, the uncontradicted evidence of record supports her claim and, therefore, is sufficient to require further development of the record. On remand the Office should refer appellant, together with the statement of accepted facts and the case record, to an appropriate

[2] *Jerry D. Osterman*, 46 ECAB 500, 507 (1995); *Walter D. Morehead*, 31 ECAB 188, 194 (1979).

[3] *George V. Lambert*, 44 ECAB 870, 876-77 (1993); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[4] *Durwood H. Nolin*, 46 ECAB 818, 821-22 (1995); *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[5] *Dennis M. Mascarenas*, 49 ECAB 215, 217-18 (1997); *Morris Scanlon*, 11 ECAB 384, 385 (1960).

[6] *Arturo A. Adams*, 49 ECAB 421, 425-26 (1998).

medical specialist for an examination. The medical specialist should be requested to give a diagnosis of appellant's pulmonary condition and provide his rationalized opinion on whether her pulmonary condition was causally related to coal dust, asbestos or other airborne particles at the employing establishment. After further development as it may find necessary, the Office should issue a *de novo* decision.

CONCLUSION

The record contains sufficient medical evidence in support of appellant's claim of an employment-related pulmonary condition as to require further development of the record by the Office.

ORDER

IT IS HEREBY ORDERED THAT the decision of the hearing representative of the Office of Workers' Compensation Programs, dated July 12, 2004, be reversed and the case remanded for further development as set forth in this decision.

Issued: April 6, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member