United States Department of Labor
Employees' Compensation Appeals Board

N.M., Appellant	)	
and	)	**Docket No. 08-205**
	)	**Issued: September 2, 2008**
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, Bremerton, WA, Employer	)	

Appearances:
John Eiler Goodwin, Esq., for the appellant
No appearance, for the Director

Oral Argument July 16, 2008

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 30, 2007 appellant filed a timely appeal from a November 17, 2006 decision of the Office of Workers' Compensation Programs denying his occupational disease claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established that he sustained occupational asthma in the performance of duty due to accepted workplace exposures. On appeal, he, through his attorney, asserts that the Office did not provide Dr. William C. Stewart, the impartial medical examiner, with a complete, accurate statement of accepted facts.

FACTUAL HISTORY

On December 8, 2004 appellant, then a 57-year-old insulator, filed an occupational disease claim (Form CA-2) asserting that he sustained occupational asthma and increasing

shortness of breath due to workplace exposures to fiberglass, silicates, welding smoke, polychlorobenzenes, rubber, dusts, gases, fumes and smoke from "burning out" submarines from 1991 through January 14, 2004. Employing establishment health monitoring program records demonstrate that beginning in February 1992, appellant worked in an environment with arsenic, asbestos, cadmium, chromium, lead, polychlorobenzenes, respiratory hazards and solvents. A position description specified that appellant fabricated and installed "all types of insulating materials," applied "vapor sealing compounds" and mixed "loose materials into cement or plaster form for trowel application." The position entailed exposure to dust, fumes, smoke, gases, silica and asbestos. Appellant was issued protective clothing and an air feed respirator on or before May 2003. He retired from the employing establishment effective April 1, 2005.

In a December 20, 2004 letter, the Office advised appellant of the type of additional evidence needed to establish his claim, including a detailed history of work exposures and a rationalized report from his attending physician explaining how and why those exposures would cause the claimed respiratory condition.

Appellant submitted a February 2005 statement describing exposure to smoke from welding and burning, fiberglass and calcium silicates. He alleged that the smoke and fiberglass particles were "visible in the air and [on] all surfaces," particularly in the shops. Appellant asserted that respirators were not required although he often wore one.

The employing establishment controverted the claim, asserting that appellant "greatly exaggerated" his exposures. The employing establishment acknowledged that while asbestos and fiberglass dusts were present in appellant's work environment, safety precautions in place since 1991, including wetting equipment, ventilators, protective clothing and respiratory devices, would have minimized his actual exposure. The employing establishment noted that the Office had denied appellant's claim for asbestosis under a separate file number.[1]

Appellant submitted medical evidence.[2] Annual pulmonary testing as part of an employing establishment industrial hygiene program showed an abnormally increased rate of decline in forced expiratory volume and forced vital capacity from 1990 to 2004. A July 8, 1999 chest x-ray was abnormal, with linear parenchymal fibrosis and pleural thickening.[3]

In an April 9, 2002 report, Dr. R.A. Deedman, an attending family practitioner, diagnosed bronchitis with reactive airway disease. In a December 15, 2003 report, he diagnosed occupational asthma. Dr. Deedman explained in a January 4, 2004 report that appellant's shortness of breath improved markedly during a three-month absence following left knee arthroscopy in September 2003. He opined that appellant's "respiratory difficulties (low blood oxygen and low peak flow readings) [were] related to occupational asthma. It appears that the

[1] The asbestosis claim is not before the Board on the present appeal.

[2] Appellant submitted February and March 2003 reports related to an episode of viral bronchitis. On November 16, 2004 report Dr. R. W. Martin, an attending cardiologist, ordered additional tests.

[3] Appellant also submitted spirometry reports without interpretation from April 2001 to March 2003, pulmonary function test reports from 2003 and 2004 and screening chest x-rays from July 15, 1999 to November 2004, which were within normal limits.

fumes and gases generated by his work with fiberglass have contributed significantly to his respiratory ailments." Dr. Deedman recommended that appellant "should no longer work around fiberglass insulation, dusts, fumes and gases." He submitted periodic progress notes through October 2004.[4]

In a September 17, 2002 note, L. Herring, a physician's assistant at the employing establishment's health clinic, related appellant's account of working with fiberglass and asbestos. Appellant did "not wear a respirator as he [felt] uncomfortable doing so" due to shortness of breath.

In an April 3, 2003 report, Dr. W.F. Nelson, an attending family practitioner diagnosed congestive heart failure and a history of sleep apnea. In an April 16, 2003 report, Dr. Nelson noted appellant's history of pleural thickening and asbestos exposure. He diagnosed shortness of breath "most likely secondary to pulmonary hypertension and possibly to asbestosis."

In a November 10, 2004 report, Dr. William L. Boyan, an attending Board-certified internist specializing in pulmonary medicine, described appellant's history of asbestos exposure while in the Navy prior to beginning work at the employing establishment and in his current position. Appellant participated in demolishing "multiple submarines with constant exposure to asbestos, heavy metals and fiberglass insulation.… When he works in or around fiberglass, he gets wheezing and profoundly short of breath." Pulmonary function tests revealed increasing restriction. Based on pulmonary function testing,[5] Dr. Boyan opined in a December 7, 2004 report that appellant had occupational asthma with particular sensitivity to fiberglass, although "other agents could be problematic." He cautioned that even "trivial exposure to fiberglass, such as sitting near another person with fiberglass debris on his clothes, [would be] unhealthy and dangerous." Dr. Boyan explained in a January 4, 2005 report, that serial pulmonary function tests showed decreased pulmonary function over the past 14 years. He diagnosed occupational asthma with consequential mild pulmonary hypertension. Dr. Boyan explained that appellant's clinical history was typical for occupational asthma and that there was "no other explanation" for his condition after extensive testing.

In a December 8, 2004 report, Dr. G.W. Duckworth, an attending Board-certified family practitioner, noted appellant's history of "allergic reactions to fiberglass and possibly other agents." He diagnosed occupational pneumonopathy related to occupational exposures.

In a May 6, 2005 statement of accepted facts, the Office stated that "[u]nprotected exposure to asbestos and dust created by fiberglass [was] unlikely due to the extremely controlled work environment at the [employing establishment]." The employing establishment noted that appellant smoked tobacco for 17 years before quitting in 1985 and had "significant

[4] A November 1, 2004 chest x-ray showed probable parenchymal scarring in the left lower lobe. A December 13, 2004 computed tomography scan showed a diminishing left posterior basal pleural parenchymal band.

[5] In a November 18, 2004 report, Dr. Boyan noted that pulmonary function tests that day showed forced vital capacity at 3.44 liters, 73 percent of predicted value, with total lung capacity at 72 percent of predicted volume. He diagnosed mild restrictive airway disease and mild diffusion impairment, with voluntary ventilation at 88 percent of predicted value.

exposure to asbestos, fiberglass, dust and fumes while serving" in the United States Navy from 1966 to 1989.

The Office obtained a second opinion from an Office medical adviser. In a May 10, 2005 report, the Office medical adviser reviewed the medical record and commented that the etiology of appellant's conditions was complicated by past tobacco use, bronchitis, obesity, sleep apnea and pulmonary hypertension. He commented that while "inhalation of excessive amounts of any particulate material can result in acute and temporary upper airway irritation, fiberglass [was] a synthetic, relatively inert fiber and in general is an unlikely cause of occupational asthma … [or] any long-lasting respiratory symptom or disease." The medical adviser opined that additional testing and evaluation were needed to determine the cause of appellant's condition.

By decision dated May 19, 2005, the Office denied appellant's occupational disease claim on the grounds that fact of injury was not established. It found that appellant did not establish that he was exposed to fiberglass, fumes and gases as alleged. The Office noted that the employing establishment stated that appellant could not have been exposed to fiberglass or asbestos as safety protocols were in place during his employment.

In a February 15, 2006 letter, appellant requested reconsideration. He submitted additional evidence.[6]

In a January 7, 2005 report, Dr. Boyan stated that after extensive pulmonary and cardiac evaluations, occupational asthma was the only explanation for appellant's condition. He noted appellant's longtime, "significant exposure to innumerable chemical compounds," in particular fiberglass. Dr. Boyan explained that appellant had "occupational asthma evidenced by his history of worsening breathing at work and absence of any other explanation. This [was] supported by the cardiopulmonary exercise test which show[ed] ventilatory limitation to exercise." He opined that the length and severity of appellant's occupational exposures caused chronic obstructive lung disease that was no longer fully reversible.

The Office then found a conflict of medical opinion between Dr. Boyan, for appellant and the Office medical adviser, for the government. To resolve the conflict, it appointed Dr. Stewart, a Board-certified internist specializing in pulmonology, as the impartial medical examiner. The record indicates that the Office sent Dr. Stewart a statement of accepted facts and a copy of the medical record for his review. The record contains a March 30, 2006 memorandum entitled "Statement of Conflict of Medical Opinion." The memorandum notes that Dr. Boyan believed that appellant's "symptoms [were] most provoked by fiberglass exposure at work." The memorandum does not contain additional information regarding appellant's occupational exposure to fiberglass, dust, fumes or other substances.

In a May 15, 2006 report, Dr. Stewart provided a history of injury and treatment. He related appellant's complaints of dyspnea, wheezing, cough and retrosternal chest pain. Dr. Stewart noted that appellant smoked ¼ of a pack of cigarettes daily from 1968 to 1985, while serving on submarines that were filled with second hand smoke. While working as an insulator at the employing establishment beginning in 1991, he was exposed to "a number of potential

[6] Appellant also submitted a copy of Dr. Deedman's January 14, 2004 letter, previously of record.

pulmonary irritants," including airborne fiberglass dust, welding and paint fumes, dust and fumes from insulating cement, "particulate matter from the fiberglass and rock wool, fumes from paint and fumes from cutting torches and power saws, all in the close confines of a ship. Filters, respirators and suction ventilation were in use at times, but were difficult to use effectively." On examination, Dr. Stewart noted diminished breath sounds, mild cough and pitting edema of the ankles. He stated an impression of "functionally significant dyspnea … [of] multifactorial … etiology." Dr. Stewart also diagnosed chronic bronchitis due to smoking, "infection, allergies or a variety of inhaled gases or particulate irritants. It [was] in essence a nonspecific pulmonary reaction to chronic pulmonary irritation, manifest by cough, shortness of breath, mucus production and wheeze." He noted that appellant's exposure to cigarette smoke for 17 years triggered his chronic bronchitis. Dr. Stewart also diagnosed restrictive lung disease due to obesity, obstructive sleep apnea, mild pulmonary hypertension and esophageal regurgitation.

Dr. Stewart commented that if appellants' description of his exposures was accurate, the work environment "most certainly aggravated the chronic bronchitis. In contradiction, the [employing establishment] describe[d] an extremely controlled work environment." He noted that, while fiberglass was a pulmonary irritant, it was not known to cause lung disease. "Serial pulmonary function studies … [did] not demonstrated any progression in loss of function from 1991 to 2004."

By decision dated November 17, 2006, the Office affirmed as modified the May 19, 2005 decision. It accepted that appellant was exposed to "dust created by fiberglass, fumes and gases while working as an Insulator." However, the Office found insufficient rationalized medical evidence to establish a causal relationship between the accepted exposures and the claimed respiratory condition. It noted that the Office medical adviser stated that appellant had other respiratory abnormalities and that fiberglass, an inert material, was unlikely to cause asthma. Dr. Stewart opined that appellant's controlled work environment did not contribute to his condition.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[7] has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an "employee of the United States" within the meaning of the Act; that the claim was filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged; and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[8] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[9]

[7] 5 U.S.C. §§ 8101-8193.

[8] *Joe D. Cameron*, 41 ECAB 153 (1989).

[9] *See Irene St. John*, 50 ECAB 521 (1999); *Michael E. Smith*, 50 ECAB 313 (1999).

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; (2) factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; 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. The medical evidence required to establish causal relationship is generally 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, must be one of reasonable medial certainty 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.[10]

Section 8123 of the Act provides that, 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.[11] In situations where 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.[12] However, in a situation where the Office secures an opinion from an impartial medical examiner for the purpose of resolving a conflict in the medical evidence and the opinion from such examiner requires clarification or elaboration, it has the responsibility to secure a supplemental report from the examiner for the purpose of correcting the defect in the original opinion.[13]

ANALYSIS

The Office accepted that appellant was exposed to "dust created by fiberglass, fumes and gases" while working at the employing establishment. However, it denied appellant's occupational disease claim on the grounds that the medical evidence did not establish a causal relationship between those exposures and the claimed asthma condition. The Office accorded the weight of the medical evidence to Dr. Stewart, a Board-certified internist specializing in pulmonology. Where a case is referred to an impartial specialist to resolve a conflict of medical opinion, the specialists' opinion is accorded special weight if sufficiently rationalized and based

[10] *Solomon Polen*, 51 ECAB 341 (2000).

[11] 5 U.S.C. § 8123; *see Charles S. Hamilton*, 52 ECAB 110 (2000).

[12] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Barry Neutuch*, 54 ECAB 313 (2003); *David W. Pickett*, 54 ECAB 272 (2002); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[13] *Nancy Keenan*, 56 ECAB 687 (2005); *Roger W. Griffith*, 51 ECAB 491 (2000); *Margaret M. Gilmore*, 47 ECAB 718 (1996).

on a complete, accurate factual and medical history.[14] In this case, the Board finds that Dr. Stewart's opinion was not based on a complete, accurate history of occupational exposures.

The record indicates that the Office provided Dr. Stewart with a May 6, 2005 statement of accepted facts. Regarding appellant's occupational exposures, this statement notes only that unprotected "exposure to asbestos and dust created by fiberglass was unlikely" due to safety protocols. However, the employing establishment did not assert that appellant could not have been exposed. Appellant asserted in September 2002, that he could not wear the respirator provided due to shortness of breath, indicating some period of direct exposure. Dr. Stewart did not address this issue in his report. Also, Dr. Boyan, an attending Board-certified internist specializing in pulmonology, opined on December 7, 2004 that as appellant was hypersensitive to fiberglass, even "trivial exposure … such as sitting near another person with fiberglass debris on his clothes, [would be] unhealthy and dangerous." Dr. Stewart did not discuss whether such brief periods of exposure caused or aggravated the claimed occupational asthma.

Also, the statement of accepted facts does not set forth the variety of substances to which appellant was exposed. The Board notes that the employing establishment's industrial hygiene surveys state that, from February 1992 onward, appellant worked in environments contaminated by arsenic, asbestos, cadmium, chromium, fiberglass, lead, polychlorobenzenes, other respiratory hazards and solvents. His position description also noted exposure to vapor sealing compounds, cement and silica. Yet, the statement of accepted facts provided to Dr. Stewart mentions only asbestos and fiberglass. As the critical issue in the case is the causal relationship between appellant's occupational exposures and the claimed asthma, Dr. Stewart's accurate knowledge of those exposures is crucial to obtaining an accurate medical opinion; but the statement of accepted facts provided to Dr. Stewart is incomplete.

The Board finds that the Office is now obligated to obtain a supplemental report as to whether appellant sustained a respiratory condition to the accepted occupational exposures.[15] The Board directs the Office to obtain additional information from the employing establishment regarding the precise nature of the safety equipment appellant used, the safety protocols used and any industrial hygiene reports documenting the presence and concentration of arsenic, asbestos, cadmium, chromium, fiberglass, lead, polychlorobenzenes and solvents. The Office shall also obtain appropriate information from the employing establishment regarding the precise periods and duration of appellant's exposure to these substances. It should then prepare a new statement of accepted facts with a complete, accurate history of appellant's occupational exposures. The Office should provide Dr. Stewart with the new statement of accepted facts and request a supplemental, clarifying report on the issue of causal relationship. This report shall address the effect of appellant working without a respirator and the role of transient exposures to fiberglass dust as described by Dr. Boyan. Following this and all other development deemed necessary, the Office shall issue an appropriate decision in the case.

[14] *Darlene R. Kennedy*, *supra* note 12.

[15] *See, e.g., Elmer K. Kroggel*, 47 ECAB 557 (1996) (the Board remanded the case for the Office to obtain a supplemental report from the impartial medical specialist).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 17, 2006 is set aside and the case remanded for further development consistent with this decision.

Issued: September 2, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board