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R.N., Appellant)	
)	
and)	Docket No. 08-1196
)	Issued: January 12, 2009
TENNESSEE VALLEY AUTHORITY,)	
PARADISE FOSSIL PLANT, Drakesboro, KY,)	
Employer)	
)	

Case Submitted on the Record

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

The issue is whether appellant sustained pneumoconiosis in the performance of duty.

FACTUAL HISTORY

On September 10, 2002 appellant, then a 71-year-old carpenter, filed an occupational disease claim alleging that he sustained pneumoconiosis causally related to his federal employment.¹ He first learned of his condition on July 25, 2002 when he received a chest x-ray report from Dr. Glen R. Baker, an attending Board-certified pulmonologist and a certified B reader.² Appellant worked at the employing establishment from 1966 to 1991 and was exposed to coal dust and flue gas daily. He was exposed to asbestos on occasion when he tore down scaffolds that had been used by insulators. In the latter years of his employment, appellant used a paper mask and sometimes wore a respirator. He had experienced shortness of breath for the past two years. Appellant smoked cigarettes for 50 years. The employing establishment advised that there was no specific evidence that appellant was exposed to coal dust or asbestos although he might have been exposed to asbestos at .01 to .02 fibers per cubic centimeter on rare occasions (1 to 3 times during employment for 8 to 12 hours) and he might have been exposed to coal dust at a concentration of .3 milligrams per cubic meter. The Office accepted the employing establishment's statement regarding appellant's exposure to coal dust and asbestos although he alleged a higher exposure. Appellant's employing establishment chest x-rays and pulmonary tests dated 1982 to 2002 were reported as normal.

In an August 23, 2002 report, Dr. Baker provided a history that appellant was exposed to coal dust daily during his 25 years at the employing establishment as well as other dust, odors and fumes of uncertain etiology and asbestos. He had experienced difficulty with his breathing for the past one to two years but denied significant coughing sputum production, wheezing or nocturnal symptoms. Appellant smoked at the rate of one pack of cigarettes a day for 50 years. Dr. Baker provided findings on physical examination, the results of pulmonary function testing and diagnosed mixed occupational pneumoconiosis, category 1/0, with a history of coal dust and asbestos exposure, cardiomegaly and probable aortic stenosis. Pulmonary function studies were normal but Dr. Baker opined that appellant had a Class I pulmonary impairment based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* and was totally disabled from working in any dusty environment.

On August 27, 2004 the Office referred appellant, together with a list of questions and statement of accepted facts to Dr. Kenneth C. Anderson, a Board-certified pulmonologist and a certified B reader.

In reports dated September 24 and October 25, 2004, Dr. Anderson provided findings on physical examination and stated that a chest x-ray was consistent with mixed dust pneumoconiosis at a profusion rate of 1/0. He noted that appellant had a 40-year history of smoking, quitting in May 2004. Dr. Anderson opined that his left lower lung abnormality and

¹ *Dorland's Illustrated Medical Dictionary* defines pneumoconiosis as a lung condition characterized by deposition of large amounts of dust or other particulate matter and the subsequent tissue reaction, usually seen in workers in certain occupations and in residents of areas with excessive particulate matter in the air. Types of pneumoconiosis range from nearly harmless forms to destructive or fatal conditions and are usually named for the implicated substance such as asbestosis or silicosis. *Dorland's Illustrated Medical Dictionary* 1461 (30th ed. 2003).

² The National Institute for Occupational Safety and Health (NIOSH) has a program to certify physicians to interpret pulmonary x-rays. Physicians so certified are referred to as B readers.

pleural thickening most likely developed after heart surgery on July 13, 2004. Appellant's pulmonary function tests revealed only early obstruction, small airways dysfunction and hyperinflation which were most likely due to his history of cigarette smoking. Dr. Anderson discussed the results of other pulmonary function tests and found that appellant had a Class II pulmonary impairment with 10 to 25 percent whole person impairment. He recommended that appellant limit his exposure to dust.

On November 12, 2004 an Office medical adviser reviewed appellant's file and found that the pulmonary function tests demonstrated no impairment due to his pulmonary condition.

In a June 28, 2005 report, Dr. Baker stated that appellant had mixed pneumoconiosis based on his 25-year exposure to asbestos, coal dust and other fumes, odors and dust of unknown etiology during his federal employment and was totally disabled. He discussed his disagreement with Dr. Anderson's report.

By decisions dated December 15, 2004 and February 22, 2006, the Office denied appellant's claim on the grounds that the evidence did not establish that his pneumoconiosis was causally related to factors of his federal employment. By decisions dated September 8, 2005 and December 20, 2006, it remanded the case for further development of the medical evidence. On December 20, 2006 the Office hearing representative directed the Office to amend the statement of accepted facts to reflect that appellant was exposed to coal dust at .3mg/m³ (milligrams per cubic meter) rather than 1.3mg/m³ as stated in the statement of accepted facts first sent to Dr. Anderson. The hearing representative directed the Office to obtain another report from Dr. Anderson with a rationalized opinion as to whether appellant had pneumoconiosis causally related to his federal employment. It corrected the statement of accepted facts and asked Dr. Anderson to provide a reasoned opinion on whether appellant had pneumoconiosis causally related to his federal employment, considering all pertinent corrected evidence, including x-rays, gas studies, electrocardiograms, pulmonary function tests, physical performance tests, a physical examination and his medical and work history. The Office advised Dr. Anderson that it did not have a standard definition of pneumoconiosis and, therefore, the presence of that condition could not be determined based on profusion.

In reports dated November 20, 2005 and January 24, 2006, Dr. Anderson stated that appellant had a Class 1/0 impairment based on pulmonary function study tests and findings on physical examination. He noted that appellant had an abnormal chest x-ray at a profusion of 1/0. Dr. Anderson opined that, if pneumoconiosis was defined as a profusion of 1/0, then appellant had this condition. If it was defined as a profusion of 1/1, then he did not have pneumoconiosis. He noted that appellant's chest x-rays supported chronic obstructive pulmonary disease, but pulmonary function tests were not consistent with pneumoconiosis.

On February 23, 2007 Dr. Anderson provided a detailed report discussing appellant's prior exposure to substances at work, findings from prior diagnostic test results, his findings on examination, the results of pulmonary function tests performed on February 23, 2007 and the results of x-rays. He noted that pulmonary function tests demonstrated obstructive lung defect and early chronic obstructive pulmonary disease and chest x-rays revealed small opacities with a profusion of 1/0. Dr. Anderson stated that appellant's dyspnea (shortness of breath) appeared to be out of proportion to the radiographic and pulmonary function test findings. He noted that

appellant did not have the chronic cough or sputum production that would be expected with coal workers' pneumoconiosis. Dr. Anderson ordered a high resolution computerized tomography (CT) scan which was performed on March 14, 2007 by Dr. Leslie K. Tutt, a Board-certified diagnostic radiologist. In a March 20, 2007 supplementary report, Dr. Anderson stated that the CT scan report indicated no evidence of pulmonary fibrosis, only extensive century lobular emphysema. No intralobular septa or honeycombing was found, only postinflammatory scarring. Based on appellant's testing and physical examination, Dr. Anderson opined that appellant did not have pneumoconiosis causally related to his federal employment.

On April 6, 2007 the Office denied appellant's claim on the grounds that the weight of the medical evidence rested with Dr. Anderson and established that appellant did not have pneumoconiosis causally related to his federal employment. Appellant requested an oral hearing that was held on October 30, 2007. By decision dated January 16, 2008, the Office hearing representative affirmed the April 6, 2007 decision.

LEGAL PRECEDENT

To establish that an injury was sustained in the performance of duty in a claim for an occupational disease claim, an employee must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.³ Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical 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 employee.⁴

ANALYSIS

Appellant alleged that he developed pneumoconiosis as a result of exposure to coal dust and asbestos during his federal employment. The employing establishment provided data as to specific levels of his exposure to coal dust and asbestos and this data was accepted by the Office.

Dr. Baker, a Board-certified pulmonologist and a B reader, provided a history that appellant was exposed to coal dust and asbestos daily during his 25 years at the employing establishment. He had experienced difficulty with his breathing for the past one to two years but denied significant coughing sputum production, wheezing or nocturnal symptoms. Appellant

³ See *Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994).

⁴ *I.J.*, 59 ECAB ____ (Docket No. 07-2362, issued March 11, 2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

smoked at the rate of one pack of cigarettes a day for 50 years. Dr. Baker provided findings on physical examination, the results of pulmonary function testing and diagnosed mixed occupational pneumoconiosis. Pulmonary function studies were normal, but Dr. Baker opined that appellant had a Class I pulmonary impairment and was totally disabled.

Dr. Anderson, also a Board-certified pulmonologist and a certified B reader, provided findings on physical examination and stated that a chest x-ray was consistent with mixed dust pneumoconiosis at a profusion rate of 1/0. He noted that appellant had a decades-long history of smoking. Dr. Anderson opined that appellant's left lower lung abnormality and pleural thickening most likely developed after heart surgery on July 13, 2004. Appellant's pulmonary function tests revealed only early obstruction, small airways dysfunction and hyperinflation which were most likely due to his history of cigarette smoking.

On December 20, 2006 the Office hearing representative directed the Office to amend the statement of accepted facts to correctly reflect that appellant was exposed to coal dust at 3mg /m³ rather than 1.3mg/m³ as stated in the statement of accepted facts first sent to Dr. Anderson. The hearing representative directed the Office to obtain another report from Dr. Anderson with a rationalized opinion as to whether appellant had pneumoconiosis causally related to his federal employment.

On February 23, 2007 Dr. Anderson provided a detailed report discussing appellant's exposure to substances at work, findings from prior diagnostic test results, findings on examination, the results of pulmonary function tests and the results of x-rays. He noted that pulmonary function tests demonstrated obstructive lung defect and early chronic obstructive pulmonary disease. Chest x-rays revealed small opacities with a profusion of 1/0. Dr. Anderson stated that appellant's shortness of breath appeared to be out of proportion to the radiographic and pulmonary function test findings. He noted that appellant did not have the chronic cough or sputum production that would be expected with coal workers' pneumoconiosis. To better diagnose appellant's condition, Dr. Anderson ordered a high resolution CT scan which was performed on March 14, 2007 by, a Board-certified diagnostic radiologist. He stated that the CT scan report indicated no evidence of pulmonary fibrosis intralobular septa or honeycombing, only extensive centrilobular emphysema and postinflammatory scarring. Based on appellant's test results and physical examinations, Dr. Anderson opined that appellant's pneumoconiosis was not causally related to his federal employment.

Both Dr. Baker and Dr. Anderson are Board-certified specialists in pulmonary diseases and both physicians examined appellant. However, Dr. Anderson's medical opinion included the results of an additional diagnostic test, a high resolution CT scan. Further, it is not clear whether Dr. Baker reviewed the corrected data regarding the degree of appellant's exposure to coal dust at work. Additionally, Dr. Anderson provided a more thorough analysis of appellant's findings on physical examination and test results and explained how this medical evidence was not consistent with work-related pneumoconiosis. He noted that chest x-rays supported early obstructive pulmonary disease but pulmonary function tests were not consistent with pneumoconiosis. Appellant's shortness of breath was out of proportion to x-rays and pulmonary function test findings and he did not have the chronic cough or sputum production that would be expected with coal workers' pneumoconiosis. The Board finds that the Office properly found that the opinion of Dr. Anderson represented the weight of the medical evidence and that

appellant failed to establish that he sustained pneumoconiosis causally related to his federal employment.

CONCLUSION

The Board finds that appellant failed to meet his burden of proof in establishing that he sustained pneumoconiosis in the performance of duty.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 16, 2008 is affirmed.

Issued: January 12, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board