United States Department of Labor
Employees' Compensation Appeals Board

S.S., Appellant	)	
and	)	**Docket No. 08-2386**
	)	**Issued: June 5, 2008**
DEPARTMENT OF THE NAVY, LONG BEACH NAVAL SHIPYARD, Long Beach, CA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 2, 2008 appellant filed a timely appeal from the Office of Workers' Compensation Programs' hearing representative decision dated August 18, 2008, which affirmed the denial of his occupational disease claim and his request for a subpoena. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over these issues.

ISSUES

The issues are: (1) whether appellant has met his burden of proof to establish that he sustained an injury in the performance of duty; and (2) whether the Office hearing representative properly denied appellant's request for a subpoena.

FACTUAL HISTORY

On January 12, 2007 appellant, then a 67-year-old retired production controller and machinist, filed an occupational disease claim alleging that he developed asbestosis due to asbestos exposure at work. He first realized the disease was caused or aggravated by his

employment in November 2004. Appellant was last exposed to conditions alleged to have caused his condition in 1993. He retired in May 1993.

In support of the claim, appellant and the employing establishment submitted various personnel and health records.[1] This included a notification of personnel action, a periodic health evaluation from November 18, 1985, naval asbestos surveillance reports, respirograph charts dating from 1985 to 1992, appellant's employment history; appointment affidavits and a position description. In response to Office questions, appellant indicated that he was not exposed to any other toxic substances affecting the lung. He noted that he had smoked cigarettes since 1958 and stopped in January 2005. Appellant became aware of his lung condition in November 2004.

Appellant submitted several chest x-rays. A December 20, 2004 chest x-ray read by Dr. Vijitha Reddy, a Board-certified diagnostic radiologist, noted diffuse emphysematous changes involving the lungs bilaterally with a large bulla and bilateral pleural thickening involving the lower lobes and two pleural plaques involving the upper lobes suggestive of prior asbestos exposure or related to old granulomatous disease. In a February 9, 2005 report, Dr. Lisa Langmo, a Board-certified diagnostic radiologist, noted that a chest x-ray showed progression of infiltrate in the left upper lobe and an improvement in the subcutaneous emphysema in the right hemithorax. An April 27, 2005 report from Dr. Wayne A. Windham, a Board-certified diagnostic radiologist, revealed a stable appearance of emphysematous changes. In July 7, 2005 and June 16, 2006 reports, Dr. Donald Breyer, a Board-certified diagnostic radiologist, diagnosed emphysema in the upper lung zones and noted bilateral changes of calcified chest wall pleural plaque and calcified left diaphragmatic pleural plaques. He opined that "these findings are very strongly suggestive of asbestos-related pleural disease.

In a June 9, 2006 report, Dr. Richard Bordow, Board-certified in internal medicine and pulmonary disease, advised that appellant had a history of working around asbestos fiber dust for most of his life and while working between 1957 and 1974. Appellant also smoked one pack of cigarettes a day between the ages of 18 to 65 years. Dr. Bordow reviewed appellant's pulmonary function studies and found evidence of severe airflow obstruction that was bronchospastic in nature. He opined that appellant had a 47-year history of cigarette smoking and long-term asbestos exposure. Dr. Bordow diagnosed advanced chronic obstructive pulmonary disease (COPD) that was secondary to cigarette smoking. He also diagnosed asbestos pleural disease secondary to asbestos exposure and noted that appellant had a history of resection of blebs due to smoking and COPD. Dr. Bordow stated:

> "[Appellant's] asbestos exposure was particularly worrisome because he has a history of heavy cigarette smoking and the combination of these two factors markedly increases his risk for cancer, even without asbestosis. Because of these combined exposures, [appellant] has a markedly elevated risk for the development of primary lung cancer in view of the exposure and additionally for the development of other cancers of the pleura, upper airways, gastrointestinal tract and kidneys."

[1] The employing establishment advised the Office that it was unable to provide a comment from a knowledgeable supervisor as the base where appellant worked was closed in 1996.

The Office referred appellant to Dr. Leonard Cosmo, Board-certified in internal medicine, for a second opinion. In an April 17, 2007 report, Dr. Cosmo reviewed appellant's history and medical treatment. He diagnosed COPD and noted appellant's long history of heavy tobacco abuse. Dr. Cosmo found that diagnostic studies revealed severe COPD, or bullous emphysema, which was severe enough to require surgery. There was no significant pulmonary asbestos-related disease or any evidence of any pulmonary asbestos-related fibrosis or scarring. Dr. Cosmo explained that there were no significant parenchymal abnormalities to suggest an asbestos-related lung disorder. While pleural plaques were present which confirmed exposure to asbestos, there was a lack of objective documentation to support pulmonary asbestos-related lung disease. Dr. Cosmo opined that appellant's pulmonary function test was more consistent with an obstructive airflow limitation which was a result of tobacco-induced COPD. He explained that, if there was the presence of severe asbestos-related lung disease with fibrosis or scarring, appellant would have a restricted airflow pattern. Dr. Cosmo opined that the predominant diagnosis was COPD, which was due to his long history of smoking. He opined that there was no significant work-related pulmonary impairment. Dr. Cosmo indicated that appellant had a nonindustrial significant lung condition which was severe COPD with severe obstructive airflow limitation.

By decision dated April 30, 2007, the Office denied appellant's claim finding that the medical evidence was insufficient to establish that he sustained an injury as alleged.

By letter dated May 7, 2007, appellant's representative requested a review of the written record.

In a July 21, 2006 report, Dr. Jock M. Sneddon, Board-certified in occupational medicine, noted appellant's history of injury and treatment, including his exposure to asbestos. He examined appellant and diagnosed COPD or emphysema, asbestos-related disease, pleural plaques and pleural effusion. Dr. Sneddon opined that his asbestosis was work related by direct cause. He explained that appellant's pulmonary disability was primarily related to his chronic smoking and lung surgery secondary to the smoking. However, Dr. Sneddon determined that asbestos-related factors were also present based on pleural plaques, which were found on chest x-ray and computerized tomography (CT) scan. Appellant's pulmonary complaints were primarily related to his history of smoking and Dr. Sneddon could not determine what proportion should be attributed to appellant's asbestos exposure. He added that appellant's emphysema and chronic obstructive lung disease was caused by smoking and was nonindustrial. Dr. Sneddon further advised that appellant would continue to have residuals from his asbestos exposure.

On September 27, 2007 the Office hearing representative set aside the April 30, 2007 decision and remanded the case. The hearing representative determined that there was a conflict in medical opinion between Dr. Sneddon, appellant's treating physician, and Dr. Cosmo, the second opinion physician, as to whether his asbestos exposure contributed to his current disability and pulmonary condition.

On October 19, 2007 the Office referred appellant, together with a statement of accepted facts and the medical record, to Dr. Daniel Haim, Board-certified in internal medicine with a specialty in pulmonary disease, for an impartial medical evaluation.

In a November 9, 2007 report, Dr. Haim reviewed appellant's history of injury and treatment, which included smoking one pack a day for at least 35 years with shortness of breath on physical activity. He determined that appellant was exposed to asbestos as a machinist in the shipyard for many years and confirmed the presence of calcified pleural plaques consistent with prior asbestos exposure. Dr. Haim also noted that pulmonary function tests were obtained by his office and revealed a total lung capacity is 7.1 or 113 percent of predicted. He noted that appellant had endured many years of smoking and a right lower lobe resection from a large bulla. Dr. Haim advised that he had some chronic changes in the lungs due to asbestos exposure with chronic pleural plaques and calcifications, which was based on the CT scan that was taken in 2006. He explained that appellant's "symptoms were most likely due to underlying chronic obstructive pulmonary disease/emphysema and due to the fact that he had surgery with resection of part of the right lower lobe." Dr. Haim noted that the pulmonary function tests showed "significant obstructive ventilatory defect; however, his diffusion capacity and lung volumes are pretty decent." He opined that the "asbestos exposure may be contributing to some degree to his shortness of breath but I think it is the predominant factor here."

By letter dated December 31, 2007, the Office requested that Dr. Haim clarify his opinion with regard to the cause of appellant's condition.

In an April 10, 2008 report, Dr. Haim explained that there was a mistake in his earlier report, as it should have read: "The asbestos exposure may be contributing to some degree to his shortness of breath but I think it is not the predominant factor here. This is a correction to my original note." He explained that appellant's diagnosis was COPD. Dr. Haim determined that appellant did not have asbestosis because he had a long history of smoking and his pulmonary function tests predominantly showed an obstructive pattern with very little restriction and very little decrease in diffusion capacity. He added that this was "important in the diagnosis of asbestosis, which usually causes a lot of restriction and decrease in diffusion capacity." Dr. Haim advised that there were very little findings on x-ray to support the diagnosis of asbestosis and the cause of appellant's pulmonary condition was smoking. He explained that the findings of pulmonary function tests supported the diagnosis of COPD, which was predominantly an obstructive pattern. The pulmonary function tests did not show any significant restriction or decrease in diffusion capacity which was usually seen with symptomatic asbestosis patients. Dr. Haim added that appellant's work duties "may have contributed to his condition; however, his condition is predominantly due to many years of smoking." He opined that appellant's symptoms were "predominantly due to COPD which is caused from many years of smoking. I do not think his symptoms are due to exposure at work."

By decision dated April 24, 2008, the Office denied appellant's claim on the grounds that the weight of the evidence, as represented by Dr. Haim established that his pulmonary condition was the result of smoking and not due to his asbestos exposure at work.

On April 30, 2008 appellant's representative requested a review of the written record, contending that the Office did not utilize the correct standard of causation. On June 2, 2008 he requested that the Office issue a subpoena for Dr. Haim.

In an August 18, 2008 decision, an Office hearing representative affirmed the April 24, 2008 decision. The hearing representative found that the report of Dr. Haim was entitled to

special weight. The Office hearing representative also denied appellant's subpoena request, noting that it did not fully address the criteria for issuing a subpoena.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[2] 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 timely filed within the applicable time limitation period of the Act, that an injury was sustained 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.[3] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[4]

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) a 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, 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, 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 claimant.[5]

Section 8123(a) of the Act[6] 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.[7] In situations were there are 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

[2] 5 U.S.C. §§ 8101-8193.

[3] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[4] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[5] *Id.*

[6] *See supra* note 2.

[7] 5 U.S.C. § 8123(a).

specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[8]

ANALYSIS

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

The Office determined that a conflict in medical opinion was created between appellant's physician, Dr. Sneddon, who advised that appellant's federal asbestos exposure contributed to his current condition and disability and Dr. Cosmo, the second opinion physician, who opined that his current condition was related to his long history of cigarette smoking. It properly referred appellant to Dr. Haim, a Board-certified orthopedic surgeon, to resolve the medical conflict.[9]

However, Dr. Haim did not clearly resolve the conflict. His first report noted that appellant's "asbestos exposure may be contributing to some degree to his shortness of breath." By letter dated December 31, 2007, the Office requested clarification with regard to the cause of appellant's condition. The Board has held that, when the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[10] The Office properly requested clarification from Dr. Haim.

In a supplemental report, Dr. Haim advised that appellant's federal work duties "may have contributed to his condition; however, his condition is predominantly due to many years of smoking." He opined that appellant's symptoms were "predominantly due to COPD, which is caused from many years of smoking. I do not think his symptoms are due to exposure at work." The Board finds that Dr. Haim did not provide sufficient medical rationale addressing the issue of causal relation. The Board notes that an employee is not required to prove that occupational factors are the sole cause of his claimed condition. If work-related exposures caused, aggravated or accelerated appellant's pulmonary condition, he is entitled to compensation.[11] Dr. Haim's opinion appears speculative and does not resolve the issue of whether appellant's federal work duties contributed to his pulmonary condition. The conflict remains unresolved. When an impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record to

[8] *Barbara J. Warren*, 51 ECAB 413 (2000).

[9] *See supra* note 7.

[10] *Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979); *see also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810(11)(c)(1)-(2) (April 1993).

[11] *Beth P. Chaput*, 37 ECAB 158 (1985).

another impartial specialist for the purpose of obtaining a rationalized medical opinion on the issue.[12]

Upon return of the case record, the Office should refer appellant to another impartial specialist. It should also ensure that the record contains all available pulmonary function studies and other relevant diagnostic studies. The impartial specialist should provide an opinion addressing the causes of appellant's lung condition and whether his workplace asbestos exposure caused or contributed to a diagnosed condition and disability. Following this and any other development deemed necessary, the Office shall issue an appropriate merit decision.[13]

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs' hearing representative dated August 18, 2008 is set aside and the case is remanded for further proceedings consistent with the above decision.

Issued: June 5, 2008
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

[12] *See supra* note 10.

[13] In light of the Board's disposition on the first issue, it is not necessary to address the subpoena issue.