United States Department of Labor
Employees' Compensation Appeals Board

S.T., Appellant	)	
and	)	**Docket No. 08-1675**
	)	**Issued: May 4, 2009**
TENNESSEE VALLEY AUTHORITY, PARADISE STEAM 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:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 27, 2008 appellant, through his representative, filed a timely appeal from the November 5, 2007 and April 1, 2008 merit decisions of the Office of Workers' Compensation Programs, which denied his claim for compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant sustained a pulmonary injury in the performance of duty.

FACTUAL HISTORY

On November 7, 2006 appellant, then a 58-year-old retired gas and diesel mechanic and machinist, filed an occupational disease claim alleging that his pneumoconiosis, chronic obstructive airway disease and chronic bronchitis were a result of exposure to coal dust and asbestos in his federal employment from 1976 to 1996.

On February 8, 2007 the Office accepted, based on appellant's account, that he was exposed to coal dust and asbestos on a daily basis for eight-plus hours with no protective mask. However, on February 26, 2007 the employer advised that it had no record of appellant being exposed to coal dust or asbestos:

> "Data for some other machinists at TVA indicates only trace exposure to respirable coal dust at 0.1 to 0.3 milligrams per cubic meter of air (mg/m3) calculated as an [eight]-hour time weighted average. The OSHA [Occupational Safety and Health Administration] permissible limit (PEL) for respirable coal with less than [five percent] silica is 2.4 mg/m3 calculated as an [eight]-hour time weighted average. Exposure data for other machinists also indicates a possible exposure to asbestos of 0.01 to 0.05 fibers per cubic centimeter of air (fiber/cc) calculated as a time-weighted average. This exposure may have occurred 2 to 3 times per year (7 hours a day)."

Appellant submitted an October 3, 2006 report from Dr. Glen R. Baker, Jr., Board-certified in pulmonary disease and a certified B-reader, who reported that appellant had occupational pneumoconiosis caused by the total history of coal dust exposure and probable asbestos exposure. He stated that appellant's chronic obstructive airway disease and chronic bronchitis were caused by a combination of coal dust exposure and smoking, with smoking being a more substantial factor in the latter condition.

On April 19, 2007 Dr. H. Dale Haller, Jr., Board-certified in pulmonary disease and an Office second opinion physician, reported that appellant did have some pulmonary pathology with a degree of chronic obstructive pulmonary disease and maybe some early emphysema, but the predominant process was chronic bronchitis.[1] He had his partner, Dr. Kenneth C. Anderson, a certified B-reader, interpret the chest x-ray. As to the extent of occupational exposure, Dr. Haller noted that he carefully reviewed the record but did not have the reported exposure report form. He stated that he was not at all convinced that appellant had evidence of pneumoconiosis or asbestos-related disease. In an addendum, Dr. Haller reviewed computerized tomography (CT) scans obtained on May 14, 2007. He found it unlikely that appellant had evidence of coal workers' pneumoconiosis or asbestos: "As with all medical problems it is difficult to say anything with certainty but the preponderance of evidence is against either of these entities."

On June 4, 2007 the Office denied appellant's claim on the grounds that he failed to establish that his pulmonary condition was causally related to his federal employment. On August 14, 2007 an Office hearing representative set aside the denial. The hearing representative found a conflict in medical opinion and remanded the case for referral to an impartial medical specialist for an opinion on the issue of causal relationship between exposure in federal employment and any diagnosed pulmonary condition.

[1] The statement of accepted facts noted only that appellant "was exposed to coal dust and asbestosis [sic] on a daily basis, eight-plus hours, with no protective mask." It also made reference to an enclosed exposure report, not of record.

The Office referred appellant, together with the case record and a statement of accepted facts to Dr. Manoj H. Majmudar, Board-certified in pulmonary disease, for an impartial medical evaluation. On September 27, 2007 Dr. Majmudar related appellant's complaints and occupational history:

> "[Appellant] worked as an auto[mobile] mechanic from [19]68 [to] [19]74. He was exposed to a lot of gasoline fumes. [Appellant] worked with brake-liner. From 1974 [to] 1996, [he] worked at TVA where he worked in a room full of coal dust. [Appellant] worked with a belt where there was a heavy coal dust exposure. [He] also worked as a heavy equipment machinist. [Appellant] also worked [at] a [coal preparation] plant. Throughout his 23 years, he did have significant exposure to coal dust. [Appellant] states that he did not directly work with asbestos, but there was asbestos around where he worked. Occasionally, he did work where he had to remove the asbestos from the pipes."

Dr. Majmudar described his findings on examination. There was no wheezing, rhonchus or rales, but there was an expiratory wheeze on forced expiration. A chest x-ray showed some increased markings but no definite signs of asbestos plaque or significant interstitial lung disease. Pulmonary function testing showed moderate obstructive airway impairment with good response to bronchodilator therapy. Total lung capacity was normal. Residual volume was markedly elevated, suggestive of some significant air trapping. Diffusion capacity was normal. Dr. Majmudar offered his assessment:

> "Middle-aged [appellant] presented with shortness of breath, cough and whitish sputum production. [He] has a significant history of smoking. [Appellant] smokes 1½ pack per day for 45 years. [He] also worked with a lot of fumes when he worked as an auto[mobile] mechanic and as a heavy equipment mechanic. [Appellant] worked with coal dust at TVA for 23 years. In my opinion, [his] symptoms are mainly shortness of breath, cough and sputum production probably related to chronic obstructive airway impairment, mostly secondary to cigarette smoking and exposure to gasoline fumes. There is no clinical evidence suggestive of pneumoconiosis or asbestosis."

In a decision dated November 5, 2007, the Office denied appellant's claim for compensation. It found that Dr. Majmudar resolved the conflict on causal relationship. In a decision dated April 1, 2008, an Office hearing representative affirmed the November 5, 2007 decision, finding that the weight of the medical evidence, as represented by Dr. Majmudar's opinion failed, to substantiate that appellant had a pulmonary condition as a result of his exposure to coal dust and asbestos at work.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[2] An employee seeking benefits under the Act has the burden of proof to establish the essential

[2] 5 U.S.C. § 8102(a).

elements of his claim. When an employee claims that he sustained an injury in the performance of duty, he must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. The claimant must also establish that such event, incident or exposure caused an injury.[3]

Causal relationship is a medical issue[4] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion of the physician must be based on a complete factual and medical background of the claimant,[5] must be one of reasonable medical certainty[6] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[7]

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.[8] 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.[9]

ANALYSIS

Given the disagreement between appellant's pulmonary specialist, Dr. Baker, and the Office pulmonary specialist, Dr. Haller, the Office properly referred appellant to an impartial medical specialist to resolve whether he had any pulmonary condition causally related to his federal employment. It provided Dr. Majmudar, who is Board-certified in pulmonary disease, with appellant's record and a statement of accepted facts so he could base his opinion on a proper history.

However, the statement of accepted facts does not adequately address the level of appellant's exposure to coal dust or asbestos in the course of his federal employment. The Office accepted appellant's account of exposure, but the employing establishment advised that it had no such record. The employing establishment provided specific data for other machinists showing only trace exposure to respirable coal dust, far below OSHA permissible limits. The

[3] *See generally John J. Carlone*, 41 ECAB 354 (1989).

[4] *Mary J. Briggs*, 37 ECAB 578 (1986).

[5] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[6] *See Morris Scanlon*, 11 ECAB 384, 385 (1960).

[7] *See William E. Enright*, 31 ECAB 426, 430 (1980).

[8] 5 U.S.C. § 8123(a).

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

employing establishment also provided specific data for other machinists showing a possible exposure to asbestos -- 0.01 to 0.05 fiber/cc -- only two to three times a year. The Office never followed up on this crucial issue.

To be given special weight, the opinion of an impartial medical specialist must be based on a proper factual background. Given the importance of appellant's occupational exposure to any medical opinion on causal relationship, the Board finds that further development of the evidence is warranted. The Board will set aside the Office's November 5, 2007 and April 1, 2008 decisions and will remand the case to it for review of the statement of accepted facts and all relevant evidence concerning appellant's level of exposure. After such further development as may be necessary, it shall make findings of fact for Dr. Majmudar's review. After obtaining a supplemental report from Dr. Majmudar, the Office shall issue an appropriate final decision on appellant's claim for compensation.

The Board also notes that appellant worked as a gas and diesel mechanic during a portion of his federal employment and that Dr. Majmudar attributed appellant's chronic obstructive airway impairment mostly to cigarette smoking and exposure to gasoline fumes. The Office should make findings of fact on whether and to what extent appellant was exposed to gasoline fumes in the course of his federal employment and amend the statement of accepted facts accordingly.

The Office should advise Dr. Majmudar to use more definite language. After examining appellant, Dr. Majmudar found no clinical evidence suggestive of pneumoconiosis or asbestosis, but concluded that appellant's symptoms were probably related to chronic obstructive airway impairment, mostly secondary to cigarette smoking and exposure to gasoline fumes.

Terms such as "probably" or "most likely" need not constitute a speculative opinion, depending upon the context of usage. Such words may mean that the physician is expressing reasonable certainty, as opposed to absolute certainty.[10] Dr. Majmudar's use of the phrase "mostly secondary," however, warrants an explanation. Causal relationship does not require a significant contribution from employment factors. So Dr. Majmudar's conclusion that appellant's chronic obstructive airway impairment was "mostly secondary" to cigarette smoking and exposure to gasoline fumes does not rule out exposure to coal dust and asbestos as contributing factors. In his supplemental report, he should be asked to use clearer, less equivocal language.

Appellant's attorney objects to the fact that the impartial medical specialist is not a B-reader. Dr. Baker was a certified B-reader and Dr. Anderson, consultant to Dr. Haller, was also a certified B-reader. The Office should therefore consider whether it would be helpful to authorize Dr. Majmudar to consult a certified B-reader.

CONCLUSION

The Board finds that this case is not in posture for decision. Further development of the factual evidence and clarification from the impartial medical specialist are warranted.

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.4.(a)(5) (September 1993).

ORDER

IT IS HEREBY ORDERED THAT the April 1, 2008 decision of the Office of Workers' Compensation Programs hearing representative and the November 5, 2007 decision are set aside. The case is remanded for further action consistent with this opinion.

Issued: May 4, 2009
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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