U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MATTHEW A. EASTERBROOK and DEPARTMENT OF JUSTICE, U.S. PENITENTIARY, Lompoc, CA

Docket No. 99-828; Submitted on the Record;
Issued June 13, 2000

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has established that he sustained a respiratory condition causally related to factors of his federal employment.

On August 29, 1997 appellant, then a 31-year-old correctional counselor, filed an occupational disease claim alleging that he sustained lung problems and occupational asthma, which he attributed to factors of his federal employment. Appellant stopped work on September 3, 1997. In a statement accompanying his claim, appellant attributed his condition to exposure to second-hand smoke at work and an infestation of pigeons and pigeon feces in his office.

By decision dated May 29, 1998, the Office of Workers' Compensation Programs denied appellant's claim on the grounds that appellant did not establish an injury in the performance of duty.

Appellant, in a letter dated June 25, 1998, requested a review of the written record by an Office hearing representative. In a decision dated November 2, 1998, the hearing representative affirmed the Office's May 29, 1998 decision.

The Board has duly reviewed the case record on appeal and finds that the case is not in posture for decision due to a conflict in medical opinion evidence.

An employee seeking benefits under the Federal Employees' Compensation Act[1] has the burden of establishing the essential elements of his or her claim, including that fact that an injury

[1] 5 U.S.C. §§ 8101-8193.

was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury.[2]

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 the 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.[3] The medical evidence required to establish a causal relationship, generally, is rationalized medical opinion evidence.[4] 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,[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 specific employment factors identified by the claimant.[7] The mere fact that a condition manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two. Neither the fact that the condition became apparent during a period of employment, nor the belief of appellant that the condition was caused by or aggravated by employment conditions is sufficient to establish causal relation.[8]

In the present case, appellant has alleged and the evidence supports, that he was exposed to second-hand cigarette smoke, pigeons and pigeon feces during the course of his federal employment. In support of his claim, appellant submitted a clinic note dated August 28, 1997 from Dr. Sterling Pollock, an employing establishment physician, who diagnosed acute and chronic bronchitis likely due to allergies and checked "yes" that the condition was work related. In a work status report dated August 29, 1997, Dr. Warren H. Frankel, appellant's attending physician who is Board-certified in family practice, diagnosed alveolitis and occupational asthma. He found that appellant could return to work but recommended that he avoid pigeon

[2] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[3] *Jerry D. Osterman*, 46 ECAB 500 (1995); *see also Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[4] The Board has held that in certain cases, where the causal connection is so obvious, expert medical testimony may be dispensed with to establish a claim; *see Naomi A. Lilly*, 10 ECAB 560, 572-73 (1959). The instant case, however, is not a case of obvious causal connection.

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

[6] *See Morris Scanlon*, 11 ECAB 384-85 (1960).

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

[8] *Manuel Garcia*, 37 ECAB 767, 773 (1986); *Juanita C. Rogers*, 34 ECAB 544, 546 (1983).

feces. On September 15, 1997 Dr. Frankel opined that appellant was unable to work and noted that he was referring him to a pulmonary specialist.

On September 18, 1997 Dr. Laura Lubarsky, a Board-certified internist, admitted appellant to the hospital with complaints of cough and dyspnea. Dr. Lubarsky noted:

> "Where he works there are multiple pigeons that fly into the room and pigeon droppings are very abundant there and he and the other officers clean the area and recently there has been a bit of increased exposure. Also, there has been construction where he has been working and he does get exposed to second-hand smoke."

On physical examination Dr. Lubarsky noted findings of "drenching sweats" and relentless coughing. She further noted that an x-ray on that date showed "questionable patchy infiltrate and bronchitis changes." Dr. Lubarsky diagnosed "[s]tatus asthmaticus with possible etiologies including occupational asthma due to dust exposure or pigeon droppings."

In a form report dated October 10, 1997, Dr. Frankel diagnosed occupational asthma and checked "yes" that the condition was caused or aggravated by employment. He found appellant totally disabled from August 28, 1997 to the present.

In a report dated December 11, 1997, Dr. Frankel related that appellant had "confirmed occupational asthma that arose out of employment [and] during the course of employment."

In a report dated February 2, 1998, Dr. Lubarsky noted that she had treated appellant since September 1997. She stated:

> "He required immediate hospitalization and was treated with IV steroid therapy, antibiotics and inhaler therapy. All cultures were negative and it has been assumed that his reaction was due to exposure at his workplace.
>
> "He returned to work December 8, 1997 and although he was no longer working in a heavily pigeon populated area as he was previously, he continued to be exposed to smoke periodically and cleaning fumes, which he notes caused him to cough quite a bit."

Dr. Lubarsky noted that Dr. Frankel had found that appellant should not return to work and indicated that it appeared that appellant could not "continue working in these conditions due to his severe symptomatology."

In a report dated February 20, 1998, Dr. Frankel discussed his initial treatment of appellant on August 29, 1997. He related that "[p]hysical examination showed that [appellant] coughed on deep breathing and had inspiratory and expiratory wheezes. Chest x-ray was done which was within normal limits. Spirometry was within normal limits. Diagnosis at that time was occupational asthma (extrinsic alveolitis secondary to pigeon droppings)." He related that he again treated appellant on September 9 and 15, 1997 for continued problems and that a repeat pulmonary function study yielded findings "typical of asthma." He noted that appellant had no

history of smoking or pulmonary problems, including asthma, in the past. Dr. Frankel stated that he had referred appellant to Dr. Lubarsky who admitted him to the hospital. He discussed appellant's attempts to return to work and continued symptoms and recommended that he find a different job setting. Dr. Frankel concluded:

> "[Appellant] has occupational asthma, which has been proven with pulmonary function tests and both objective and subjective signs. He has had a trial of work three times, all of which caused him to have shortness of breath. [Appellant] has no predisposing factors of smoking or past history of asthma. [His] pulmonary function test shows a definite asthmatic pattern with small airways disease, improved by bronchodilation. This has been verified by myself and by the pulmonologists, both Dr. Soll and Dr. Lubarsky. [Appellant's] occupational asthma [a]rose out of work and during the course of employment and, therefore, is work related…."

In a report dated April 9, 1998, Dr. Robert S. Wright, a Board-certified internist to whom the Office referred appellant for a second opinion evaluation, discussed appellant's medical and employment history, listed findings on physical examination and reviewed the results of objective tests. Dr. Wright diagnosed cough and dyspnea of uncertain etiology and occupational asthma by history. He stated:

> "The diagnosis of occupational asthma is made by his history alone. With exposure to the work situation, he has become short of breath. However, the database provided to me is not entirely consistent with the diagnosis of asthma. Pulmonary function testing by Dr. Lubarsky did not show obstruction, instead suggested restriction. There was some decrease in small airways function but the forced vital capacity was reduced more than the FEV^1 [forced expiratory volume] and this is not consistent with asthma. In fact, I cannot find any objective evidence at the time of this examination to substantiate a diagnosis of asthma."

Dr. Wright noted that appellant showed poor effort on pulmonary function testing performed in his office. He opined:

> "The diagnosis of occupational asthma is made on the basis of his history. I cannot further substantiate it nor refute this diagnosis on the basis of the information given to me. To fully establish the diagnosis, one should see aggravation upon exposure to the workplace and the best way to document such worsening is with peak flow measurements both on and off the work site. To validate the diagnosis of occupational asthma, I would want to see peak flow measurements done both at work and at home. Worsening of peak flow rate measurements should be seen at the workplace."
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> "Pigeon droppings have been implicated in his situation. I see no proof that this is the case although he certainly could have hypersensitivity to these droppings. This can be tested and I have actually ordered by Ig [immunoglobulin]E and IgG specific precipitants to pigeon droppings from Johns Hopkins Laboratory. I asked [appellant] for his consent for this blood testing and he agreed. An erythrocyte

> sedimentation rate and total IgE level and CBC [complete blood cell count] were also sent. Complete blood count was normal as was the erythrocyte sedimentation rate. An IgE level is slightly elevated, but this findings is nonspecific. I am still awaiting the results of the hypersensitivity precipitants measurements. However, a normal erythrocyte sedimentation rate makes hypersensitivity pneumonitis highly unlikely at this point in time."

Dr. Wright stated that he disagreed that appellant had occupational asthma. He noted that appellant seemed anxious and recommended psychological testing.

In an addendum to his report, Dr. Wright stated that he had reviewed appellant's August 29 and September 18, 1997 pulmonary function tests and that "[a]lthough there is a bronchodilator response, both pulmonary function tests show evidence of restriction rather than obstruction. In other words, there is not proof that he has asthma." He again recommended psychological evaluation.

In a report dated April 24, 1998, Dr. Wright related that serum precipitins obtained from blood tests were negative for pigeon serum and droppings. He stated:

> "In view of these negative findings and the lack of evidence of obstructive airways, I find no evidence to support a diagnosis of pigeon allergies. It is still possible that he could have some allergy and reactive airways for pigeons. To conclusively rule out any allergy whatsoever, [he] could have skin testing performed for feathers and pigeon antigens. Put in another way, he still needs testing to be certain that he does not have IgE mediated reaction to pigeons. At this point in time, that seems unlikely."

The Board finds that there is a conflict in the medical evidence between Dr. Frankel, appellant's attending physician and Dr. Wright, an Office referral physician, regarding whether appellant has occupational asthma or any other respiratory condition causally related to factors of his federal employment. Section 8123(a) of the Act,[9] provides in pertinent part: "If there is a 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 the examination."[10]

Consequently, the case must be remanded so that the Office may refer appellant, together with the case record and a statement of accepted facts, to an appropriate Board-certified specialist for a rationalized medical opinion regarding whether appellant had any respiratory condition causally related to factors of his federal employment and, if so, whether appellant sustained any resulting periods of disability. After such development as it deems necessary, the Office shall issue a *de novo* decision.[11]

[9] 5 U.S.C. §§ 8101-8193.

[10] 5 U.S.C. § 8123(a).

[11] Appellant submitted evidence subsequent to the Office's November 2, 1998 decision; however, the Board has

The decisions of the Office of Workers' Compensation Programs dated November 2 and May 29, 1998 are set aside and the case is remanded for further action consistent with this decision of the Board.

Dated, Washington, D.C.
June 13, 2000

George E. Rivers
Member

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

no jurisdiction to review this evidence for the first time on appeal; *see* 20 C.F.R. § 501.2(c).