U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MARTY ROBERTSON, claiming as widow of HARVEY T. ROBERTSON, and DEPARTMENT OF THE NAVY, MARE ISLAND NAVAL SHIPYARD, Vallejo, CA

Docket No. 00-2763; Submitted on the Record;
Issued July 12, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
MICHAEL E. GROOM

The issue is whether the employee's death was causally related to his federal employment.

On May 21, 1999 appellant filed a Form CA-5, claim for compensation by widow, stating that her husband, a former pipefitter, died on September 20, 1998 from heart disease and asbestosis. Dr. Stephen Kolpacoff, who treated the employee for chronic obstructive pulmonary disease (COPD), reported on October 5, 1998 that the employee had known asbestos exposure and pulmonary fibrosis related to this. It was his opinion that the primary cause for the employee's demise was predominantly associated with smoking as an etiology for his arteriosclerosis and myocardial infarction. Dr. Kolpacoff added, however: "There appears to be some contributing factor from his asbestosis and pulmonary fibrosis, as this was, in addition to his smoking, causing ongoing respiratory failure."[1]

The employee's death certificate indicated that the immediate cause of death was a myocardial infarction to arteriosclerosis. Asbestosis was listed as a significant condition contributing to death but not related to the immediate cause. An autopsy was performed on September 21, 1998 and used in determining the cause of death.

Dr. O.G. Rosolia prepared the autopsy report for the county coroner's office. He reported the clinical data and noted that the family had asked the coroner's office to determine whether the employee suffered asbestos inhalation that could have caused or contributed to his respiratory difficulties. Dr. Rosolia described his review of the lungs as follows:

> "The weight of the right lung is 750 gm and left weighs 700 gm. In the upper lobe of the right lung and near to the hilus is an area of induration measuring

[1] Dr. Kolpacoff had earlier indicated on appellant's claim form that the employee's death was not due to his occupational exposure to asbestos: "Atherosclerosis and myocardial infarction are not directly related to asbestos exposure -- in addition the patient continued smoking throughout his lifetime."

4.5 centimeter (cm) in greatest dimension, surrounding one of the medium size bronchi a [sic] consistent with a malignancy with chronic, focal inflammatory reaction. Both lungs show severe emphysema, edema, hyperemia and increased consistency of the parenchyma suggestive of severe interstitial fibrosis. There [are] also scattered foci of bronchial pneumonia."

Microscopic examination included the following:

"Sections from both lungs show severe emphysema with interstitial fibrosis and scattered foci of bronchial pneumonia.

"Sections from the hilus of the right lung show an infiltrating, well[-]differentiated squamous cells carcinoma, surrounded by innumerable inflammatory cells. There [is] no evidence of metastasis.

"The iron stain of the lungs sections, show moderate pneumoconiosis made of multiple groups of inorganic amorphous dusts particles, in some areas surrounded by moderate fibrosis. No silica or asbestos bodies are identified."

Dr. Rosolia's diagnoses included arteriosclerosis, generalized, severe; carcinoma of the right lung, squamous cell type; and emphysema of the lungs, severe. Under emphysema, Dr. Rosolia noted (a) fibrosis of the lungs, interstitial type, severe; (b) pneumonia, bronchial, focal, moderate; and (c) edema and hyperemia, lungs and liver, passive, severe. He commented:

"This 72[-]year[-]old man suffered a series of health difficulties and died of a terminal episode of acute myocardial infarction. The most severe condition consisted of COPD with interstitial fibrosis and pneumoconiosis by inorganic dust particles. He showed also an infiltrating squamous cells carcinoma of the right lung apparently originated from a medium size bronchus near to the hilus. This condition did not show evidence of metastasis.

"The special iron stain of the lungs did not show evidence of asbestos, and the inorganic particles are of indetermined type. However, sections from the lungs and formalin fixed lung tissue, will be sent to another pathologist in the San Francisco Bay area, who specializes in pneumoconiosis, for consultation and additional special testing. An addendum report with his findings, will be issued as soon as it will become available."

The record indicates that appellant arranged for the body to be cremated.

In a report dated November 10, 1998, Dr. William R. Salyer, the consulting pathologist, advised Dr. Rosolia that he had reviewed the seven pathology slides:

"In the three, Fe-stained sections of lung tissue, with an approximate section area of 6.7 square cm, I identified 11 asbestos bodies. I marked 'dots' on the slides adjacent to some of these. In addition, there were occasional, other Fe-positive structures suspicious for asbestos bodies. I found these slides difficult to screen for asbestos bodies because of abundant hemosiderin and anthracotic pigment. I

would conclude that the patient had prior, occupational-level exposure to asbestos fibers.[2]

"I agree with your diagnosis of emphysema, fibrosis, and squamous cell carcinoma. Most of the sections of lung, which show fibrosis also contain variable amounts of carcinoma and organizing pneumonia. Thus, from these slides alone, I cannot be certain that the pulmonary fibrosis is diffuse and, presumably, secondary to the asbestos, *i.e.*, asbestosis or if the fibrosis is localized and secondary to the neoplasm and organizing pneumonia. I would suggest that additional sections of the lungs be prepared, with emphasis on the left lung. That will help to resolve the diffuse versus localized issue."

Dr. Rosolia prepared an addendum autopsy report for the county coroner's office. He noted only that Dr. Salyer had identified asbestos fibers in sections from the lungs, indicating occupational-level exposure to asbestos, and that this information should be part of the death certificate and the family informed.

In a decision dated March 2, 2000, the Office denied appellant's claim on the grounds that the factual and medical evidence was insufficient to establish the necessary causal relationship between the employee's death and his asbestos exposure in federal employment.

Appellant disagreed with the Office's decision and requested reconsideration. The Office thereafter referred the medical record and a statement of accepted facts to Dr. Charles C. McDonald, a specialist in pulmonary disease, for consultation and an opinion on whether the employee's occupational exposure to asbestos in any way contributed to his death.

In a report dated June 5, 2000, Dr. McDonald reviewed the history and medical record, including Dr. Salyer's suggestion that additional sections of the lungs be prepared, with emphasis on the left lung, to help resolve the diffuse versus localized issue. He reported:

"Subsequent analysis of the [employee's] lung tissue has not been provided for review.

"In summary, the autopsy confirms the [employee's] sudden death to be due to an acute myocardial infarction. This was secondary to significant coronary atherosclerosis. The relationship of a pulmonary condition to the myocardial infarction will be difficult to establish. He appears to have a significant comorbid condition of severe emphysema as well as a carcinoma of the lung. It is possible that the carcinoma led to a hypercoaguable state, predisposing the claimant to a myocardial infarction. It is also possible that he had pulmonary hypertension from his lung disease that placed a stress upon his heart.

"In order to determine a relationship between the [employee's] occupational exposure to asbestos and either the interstitial fibrosis or carcinoma of the lung, it

[2] The Office accepts that the employee was exposed to asbestos in the course of his federal employment as a pipefitter.

would be necessary to demonstrate that he has diffuse interstitial fibrosis consistent with asbestosis. As detailed in Dr. Salyer's report, only the right lung was submitted to him for evaluation. Given the organizing pneumonia as well as desmoplastic reaction near the lung cancer, it could not be determined whether diffuse interstitial fibrosis were present.

"I agree with Dr. Salyer that the left lung should be examined. The specific question as to whether asbestosis is present should be addressed. It would also be useful to have information concerning whether the hypoxemia due to lung disease had been documented, and whether the claimant had evidence of pulmonary hypertension.

"I would be pleased to review the file once again when this data has been received."

On June 28, 2000 the Office notified appellant that additional medical information was required, according to its consultant and requested that she submit such information no later than July 21, 2000. Appellant replied that she lived on a fixed income and was unable to obtain another report from Dr. Salyer due to the costly expense. She submitted general information on asbestosis and noted that the reports of Drs. Rosolia and Salyer showed that both lungs were examined. She also submitted an October 22, 1986 treatment note from a Dr. M. Roberts, a specialist in internal medicine. The note makes reference to asbestosis and, apparently, Mare Island, but the handwriting is largely indecipherable.

In a decision dated August 10, 2000, the Office reviewed the merits of appellant's claim and denied modification of its prior decision, as appellant did not submit the additional evidence requested.

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

It is clear from Dr. Rosolia's autopsy report that he examined both of the employee's lungs. He weighed both and reported that both showed findings suggestive of severe interstitial fibrosis. It is also clear that Dr. Rosolia conducted a microscopic examination of both lungs. He reported that sections from both lungs showed severe emphysema with interstitial fibrosis. When he reported that the iron stain of the lung sections showed moderate pneumoconiosis made of multiple groups of inorganic amorphous dust particles, in some areas surrounded by moderate fibrosis, he did not limit his finding to one lung or the other. And when he reported that he would seek consultation from another pathologist, Dr. Rosolia stated that he would send sections "from the lungs" and "formalin-fixed lung tissue" for additional testing.

In his consultation report, Dr. Salyer indicated that he reviewed seven pathology slides. Whether Dr. Rosolia had prepared only seven slides or whether he had prepared more slides and sent only seven, or whether he sent more slides and Dr. Salyer reviewed only seven, the record does not make clear. According to Dr. McDonald's reading, however, Dr. Rosolia sent sections from only the right lung for evaluation. This is significant because both Drs. Salyer and McDonald have explained that findings from left lung tissue would be useful to determine whether the employee had a diffuse interstitial fibrosis consistent with asbestosis.

Because this information appears critical to appellant's claim for benefits, and because it appears that Dr. Rosolia may have obtained left lung sections or tissue that could be examined to settle the issue of diffuse versus local interstitial fibrosis, the Board will set aside the Office's denial of appellant's claim and remand the case for further development of the evidence. Appellant bears the ultimate burden of proof to demonstrate entitlement to benefits,[3] but the Office shares responsibility in developing the evidence. The Board has held that the function of the Office is a peculiar one in that proceedings before it are not adversary. The Office is not a disinterested arbiter, for it performs many roles: investigator, protector of the compensation fund, adjudicator. Therefore the burden of proof is difficult to place and once the Office starts to procure medical opinion it must do a complete job.[4]

The Office undertook development of the medical opinion evidence when it referred the case to Dr. McDonald, the consulting specialist in pulmonary disease. The Office asked Dr. McDonald whether the employee's occupational exposure to asbestos in any way contributed to his death. Dr. McDonald advised the Office that specific additional medical information was needed, or would be useful, to answer this question and that he would be pleased to review the file once again when this data was received. Under these circumstances, particularly when the requested medical evidence must come not from one of the employee's attending physicians but from a county coroner's office, it is incumbent upon the Office to pursue the evidence as far as is reasonably possible. The Office should determine what specimens Dr. Rosolia obtained from the employee's lungs, whether he obtained specimens from the left lung in particular, whether he sent specimens of the left lung to Dr. Salyer for examination, and if not, whether such specimens are still available for examination. If specimens of the left lung exist, the Office should have them examined to help answer the questions raised by Drs. Salyer and McDonald on the issue of diffuse interstitial fibrosis. If specimens of the left lung do not exist, the Office should nonetheless ask its consultant, Dr. McDonald, whether a reasonable medical conclusion on diffuseness can be drawn from a careful reading of the autopsy report, which found interstitial fibrosis or conditions suggestive of severe interstitial fibrosis in both lungs. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to benefits.

[3] *See Leonora A. Bucco (Guido Bucco)*, 36 ECAB 588 (1985); *Lorraine E. Lambert (Arthur R. Lambert)*, 33 ECAB 1111 (1982).

[4] *William N. Saathoff*, 8 ECAB 769 (1956) (the Office was then known as the Bureau).

The August 10 and March 2, 2000 decisions of the Office of Workers' Compensation Programs are set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, DC
July 12, 2001

Michael J. Walsh
Chairman

David S. Gerson
Member

Michael E. Groom
Alternate Member