

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of REBECCA J. LONGLEY and U.S. POSTAL SERVICE,
POST OFFICE, Burlington, VT

*Docket No. 02-2167; Submitted on the Record;
Issued February 13, 2003*

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant has met her burden of proof in establishing that she sustained an injury in the performance of duty causally related to factors of her federal employment or a recurrence of disability causally related to an employment-related respiratory condition.

On August 26, 1999 appellant, then a 50-year-old distribution clerk, filed a notice of recurrence of disability (Form CA-2a), alleging that on August 20, 1999 she suffered a recurrence of disability causally related to her February 9, 1999 employment injury.¹

By letter dated September 22, 1999, the employing establishment controverted the claim.

In a letter dated November 9, 1999, the Office requested that appellant submit additional information. The Office also requested medical documentation explaining how the reported work incident caused or aggravated the claimed injury. Appellant was allotted 21 days to submit the requested evidence.

¹ The record reflects that on December 7, 1992 appellant filed a notice of traumatic injury for "loss of voice" on August 19, 1992, which was denied. On October 7, 1995 she filed a second notice of traumatic injury indicating that she suffered respiratory problems due to exposure to chemicals at work. The claim was initially denied on December 4, 1995; however, following a hearing on February 26, 1997 the case was remanded and on November 21, 1997 the Office of Workers' Compensation Programs issued a decision accepting the October 7, 1995 injury claim for temporary aggravation of preexisting upper airway sensitivity, which resolved no later than February 4, 1996. On September 27, 1998 appellant filed a third notice of traumatic injury indicating that on September 25, 1998 she developed respiratory problems due to exposure to paint fumes in a trailer which the Office accepted for chemical exposure. On February 16, 1999 she filed a notice of occupational disease indicating that on February 9, 1999 she developed respiratory problems due to strong odors in the workplace which was accepted by the Office for toxic effects of chemical exposure.

In an emergency room report dated August 20, 1999, a physician whose name is illegible, wrote an illegible diagnosis with the exception of "PANIC ATTACK."

In a statement dated November 28, 1999, appellant stated that she believed that her current condition was related to her original injury on February 9, 1999. She described the incident that occurred on August 20, 1999 and indicated that there was a strong odor present among the flats that she was working on that day while sorting packages. Appellant noted that all of her symptoms were the same as those that she had on the earlier February 2, 1999 incident. She stated that she immediately began to have difficulty breathing and began to feel lightheaded and faint within minutes of exposure to the strong chemical odor that was present among the flats she was working on. Appellant indicated that she immediately began to feel lightheaded and switched the tray with a coworker around 2:30 p.m. She stated that it became necessary that she be immediately removed from her workstation where the strong odors were present and the assistance of coworkers was necessary to assist her along with immediate emergency medical attention at the nearest hospital.

By decision dated December 13, 1999, the Office denied the August 20, 1999 recurrence claim as the evidence of record failed to establish a causal relationship between the claimed recurrence and the accepted employment injury.

By letter dated January 6, 2000, appellant and her attorney disagreed with the decision and requested a hearing, which was held on August 29, 2000.²

In a March 20, 2000 report, Dr. Robert K. McClellan³ opined that appellant's condition was related to her August 1992 workplace incident that first created respiratory and irritant membrane symptoms. Dr. McClellan explained that, since that time, appellant had recurrent exposures and reactions culminating most recently in the exposure on August 20, 1999. He noted that appellant was experiencing recurrent symptoms because of her underlying hyperactive airways and dating back to the original exposure in 1992. Dr. McClellan indicated that, as a result of her hyperactive airway, exposure to respiratory irritants or strong odors such as perfumes would reliably provoke an asthmatic attack. He opined that he believed that the August 20, 1999 episode was related to the preexisting condition that first occurred and has recurred in the workplace. Dr. McClellan explained further that the condition documented by the methacholine challenge test was asthma or hyperactive airways and the events of August 20,

² During the hearing, appellant indicated that on August 20, 1999 she was working on a flat box with magazines when her eyes started hurting and she became light headed. She indicated that these were the same symptoms she experienced at the time of her prior exposures. Appellant stated that she took a break in her supervisor's office and returned to the CFS unit, but she still did not feel well, so a coworker took her outside for some fresh air. She indicated that her condition worsened and an ambulance took her to the emergency room. Appellant discussed the magazines she was working with and when questioned regarding whether they had perfume inserts, the appellant responded, "I believe so, yes, because there was -- I did n[o]t paw through the box to find out what it was, but I know it was there because I could smell it." Appellant stated that she could smell an odor while working on the magazines and on her hands. Asked whether she specifically saw a perfume insert, the appellant stated, "I do n[o]t look for perfume inserts."

³ A physician of unknown specialty, whose title is Medical Director of the Center for Occupational and Environmental Health.

1999 corroborated this condition. He opined that appellant had a full-duty work capacity with a sole restriction to avoid perfume and other strong odors such as solvents and dusty irritating environments and enclosed several reports dating from January 17 to May 1, 2000.

In a July 10, 2000 report, Dr. C. Scott Griffin,⁴ indicated that it was 10 weeks since his last contact with appellant. He noted that, during that time, she was taking her Intal with no problems and was gradually reintroducing herself to stores that previously caused her to have reactions, noting that she has had none and with the exception of the menopausal symptoms, she was feeling well.

In an August 11, 2000 report, Dr. Lee Monroe, a psychologist, stated that he first saw appellant in 1995, when he first saw her for help dealing with the difficulties of trying to work in an increasingly medically threatening situation. She was anxious, depressed and frustrated at her medical condition (chemical sensitivity), the response of her employer, and the effect of all this on her family. Dr. Monroe noted that, throughout the next three years, he met with her intermittently and periods of well being were disrupted by increasing distress following repeated health crises at work. He stated that at no time throughout the years did he consider her to have a diagnosis of panic disorder and opined that he believed that her anxiety was directly related to her fear of having a disabling medical condition as well as her fear of not being able to earn an adequate living.

In a September 11, 2000 treatment note, with a physician whose signature was illegible, it was noted that appellant had a reaction to a floor cleaner.

Along with her claim, appellant submitted numerous witness statements attesting to her sensitivity to odors, her exemplary attendance record and her diligent work efforts.

By letter dated October 2, 2000, the employing establishment provided comments on appellant's hearing testimony.

In an October 12, 2000 report, Dr. McClellan indicated that on February 4, 1997 he diagnosed appellant as having preexisting upper airway sensitivity to irritants and odorants aggravated by workplace exposures resulting in a sick building syndrome. He concluded that her condition was more probably than not work related and that at the time he did not feel any medical intervention was needed other than maintaining reasonable optimal indoor air quality in both her workplace and home. Dr. McClellan indicated that the most likely diagnosis for appellant's symptoms on August 20, 1999 was asthma. He stated that he did not believe that it is likely that she has developed asthma at some point subsequent to that August 20, 1999 incident. Further, Dr. McClellan opined that he believed more likely than not, that appellant's attack on August 20, 1999 was not a panic attack. He explained that his opinion included the fact that she had symptoms consistent with a history of repeated similar symptoms on exposure to known tests which documents the respiratory irritants in the workplace that appellant was exposed to on August 20, 1999. Further, Dr. McClellan again indicated that the medical history, in combination with the methacholine challenge test, supported his conclusion that the August 20,

⁴ A physician of unknown specialty.

1999, episode was a recurrence of the February 9, 1999, episode and that both injuries were caused by exposures to respiratory irritants in the workplace.

By letter dated October 24, 2000, appellant's representative responded to the employing establishment's comments and provided additional medical reports.

In a decision dated March 21, 2001, the Office hearing representative denied appellant's claim for compensation as she did not establish the fact of injury.

By letter dated February 25, 2002, appellant and her representative requested reconsideration and submitted additional evidence including: medical reports; a duplicate Form CA-2a; an accident report; a copy of the August 20, 1999 ambulance report; and an article on odor sensitivity.

In an October 18, 2001 witness statement, Katherine Balch responded to information that was previously provided and indicated that she never checked the tub that she switched with appellant to determine if there was "something smelly" inside. Ms. Balch noted that she suffered from a severe sinus condition with chronic sinus infections and it was much worse between the months of July and October and stated that it prevented her from smelling most odors and fragrances in the air. She indicated that it would have been impossible for her to have smelled anything in the tub that afternoon, and, in light of her sinus condition, she did not attempt to determine whether an odor was present in that tub. Ms. Balch stated that on the afternoon of August 20, 1999 she was working at a tie-out case near appellant in the CFS unit in the afternoon returning no-record mail. She stated that typically the tubs had magazines commingled with other envelopes and packages in the tubs. Ms. Balch stated that the tub in question did contain magazines and when appellant asked if she would switch tubs with her, she did not ask any questions and switched tubs with her. She stated that she was never asked by appellant, nor anyone else at the time, to determine if something smelly was in the tub as she could not make such a determination. Appellant stated that she could not smell anything due to her sinus condition, which was particularly aggravated during that month of August 1999. Further, she indicated that she witnessed the severity of appellant's injury on that date.

In a September 7, 2001 reports, Dr. McClellan opined that appellant suffered an asthma attack as a result of exposure to fragrances present in the mail that she was handling at the time. He explained that his opinion was based on the clinical history in which appellant reported the exposure to fragrances, the symptoms of respiratory distress that she reported both to him and to the emergency personnel who responded to the scene, her positive methacholine challenge test, her subsequent response to asthma medications and the scientific literature which supports fragrances as an environmental trigger of asthma. Dr. McClellan noted that he was aware of the emergency room physician's diagnosis of a panic attack on this date and explained that this was unlikely due to the lack of a physical examination and spirometry indicating these were two key pieces of clinical data that could be obtained at that time to rule out asthma. He explained that the absence of this information, especially in the context of the other clinical data available, made the diagnosis of panic attack unsupportable. Dr. McClellan disagreed with the characterization of appellant's condition as a panic attack for a number of reasons. He explained that appellant met the clinical criteria for asthma and second, the August 20, 1999 emergency room diagnosis of panic attack appears to have been made without a full examination, including

listening to her chest or performing spirometry. Dr. McClellan stated that the ambulance which responded to the scene, where appellant was in respiratory distress, treated her with 10 liters per minute of oxygen prior to transport to the emergency room and in the emergency room, arterial blood gases revealed normal oxygen saturation after treatment with oxygen and revealed signs of hyperventilation. He stated hyperventilation was a common physiologic response to an asthma attack, noting it was common for asthmatics who do not fully understand their condition to be anxious when they cannot breathe and to hyperventilate more than is physiologically necessary. Dr. McClellan advised that an anxiety disorder or panic syndrome was present with recurrent episodes and ongoing problems with anxiety. Further, he noted that, on another review of her symptoms during an August 13, 2001 office visit, appellant indicated that she has had only isolated problems of shortness of breath, specific to situations in which she is exposed to strong odors. By controlling her environment and exposures, appellant has not had episodes of anxiety or panic. Dr. McClellan opined that he believed that the emergency room doctor's diagnosis of panic attack was flawed because there was no documented physical examination by the physician, no pulmonary function test and there was no evidence that her past history of respiratory distress precipitated by specific environmental exposures was considered. Further, he noted that appellant had an abnormal methacholine challenge test, a symptom complex consistent with asthma and a clinical history of recurrent precipitation of characteristic symptoms on exposure to environmental triggers scientifically known to have the capability of precipitating an asthma attack. Dr. McClellan indicated that he was not present to evaluate her during the August 20, 1999 episode; however, the entirety of the clinical data that he had collected led him to diagnose this episode as a typical asthmatic episode. He added further that the methacholine challenge test by itself could not diagnose asthma, the presence of other characteristics of asthma, along with the methacholine challenge test, support the diagnosis of asthma. These other characteristics include a typical respiratory syndrome, precipitation by classic asthma triggers and her response to asthma medications. In the absence of odor triggers, appellant has not had any syndrome that could be construed as a panic attack. Dr. McClellan opined that the recurrent episodes of respiratory distress at work subsequent to exposure to environmental triggers supported a progression of severity of her respiratory condition from upper airway symptoms to asthma. He indicated that the environmental agents produced irritation of the mucous membranes that could ultimately promote an inflammatory response in the lungs, resulting in asthma and a permanent susceptibility to environmental triggers. Dr. McClellan added further that it should also be clear that appellant had a permanent condition which was controlled with chronic medication and that she was susceptible to asthma attacks which themselves are typically transient but which reflect an underlying chronic condition.

In office notes dated August 13, 2001, Dr. McClellan diagnosed mild intermittent asthma, well controlled with Intal and rare rescue medication. He noted upper airway sensitivity with hoarseness and cough and a sense of dyspnea with exposure. Further, Dr. McClellan noted no recurrence of any episode that could be conceived of as a panic attack. He advised that appellant maintain Intal at the current dosage, as well as availability of Ventolin as a rescue inhaler. Dr. McClellan advised maintaining the current work setting, which seems to be working well for her and continued avoidance of fragrances, strong odors and respiratory irritants.

By decision dated May 20, 2001, the Office denied modification of the Office's March 21, 2001 decision. The Office found that the evidence submitted in support of appellant's request for reconsideration was insufficient to warrant modification of its prior decision.

The Board finds that appellant has met her burden of proof to establish that she sustained an injury in the performance of her duties.

An employee seeking benefits under the Federal Employees' Compensation Act⁵ has the burden of proof to establish the essential 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. She must also establish that such event, incident or exposure caused an injury.⁶

The Board finds that the factual evidence of record is sufficient to establish that appellant experienced a reaction to some type of odor at work occurring at the time, place and in the manner alleged.

To establish that an injury occurred as alleged, the injury need not be confirmed by eyewitnesses, but the employee's statements must be consistent with the surrounding facts and circumstances and his subsequent course of action. In determining whether a *prima facie* case has been established, such circumstances as late notification of injury, lack of confirmation of injury and failure to obtain medical treatment may, if otherwise unexplained, cast sufficient doubt on a claimant's statements. The employee has not met this burden when there are such inconsistencies in the evidence as to cast serious doubt on the validity of the claim.⁷

In the present case, appellant's account of the events of August 20, 1999 is largely confirmed by her statement and other witness statements, including Ms. Balch. All parties agree that appellant was exposed to something in the workplace on August 20, 1999 that caused her to have an attack. Although, the specifics of the cause of the attack are not 100 percent certain, for example, the exact fragrance that caused appellant to experience an attack, it is clear that some

⁵ 5 U.S.C. §§ 8101-8193.

⁶ See generally, *John J. Carlone*, 41 ECAB 354 (1989); *Abe E. Scott*, 45 ECAB 164 (1993); see also 5 U.S.C. § 8101(5) ("injury" defined); 20 C.F.R. §§ 10.5(a)(q),(ee) ("occupational disease or illness" and "traumatic injury" defined.)

⁷ *Carmen Dickerson*, 36 ECAB 409 (1985); *Joseph A. Fournier*, 35 ECAB 1175 (1984).

type of fragrance in the workplace caused appellant to sustain the attack and these inconsistencies are not sufficient to impugn the validity of appellant's claim.⁸

Causal relationship is a medical issue⁹ 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,¹⁰ must be one of reasonable medical certainty¹¹ 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.¹²

In the present case, appellant submitted numerous reports from Dr. McClellan. In his March 20, 2000 report, Dr. McClellan opined that appellant's condition went back to her August 1992 incident.¹³ He elaborated by explaining that, because of her underlying hyperactive airways, exposure to respiratory irritants or strong odors would provoke an asthmatic attack. Dr. McClellan opined that the August 20, 1999 episode was related to appellant's preexisting condition that first occurred in the workplace. Additionally, in his October 12, 2000 report, Dr. McClellan reported that, in 1997, he had diagnosed appellant with preexisting upper airway sensitivity to irritants and odorants aggravated by workplace exposure and the most likely diagnosis for appellant's symptoms was asthma. Further, he explained that he believed this event was caused by exposure to respiratory irritants in the workplace and opined that this incident was a recurrence of the February 9, 1999 episode¹⁴ and opined that both injuries were caused by respiratory irritants in the workplace. In his September 7, 2001 reports, Dr. McClellan opined that appellant's asthma attack was the result of exposure to fragrances in the mail that she was handling at the time. He based his opinion on the clinical history and the record noting that fragrances could be an environmental trigger for asthma. Further, Dr. McClellan explained why the emergency room physician's diagnosis of panic attack was in error based upon the lack of physical examination and conduction of spirometry, noting the absence of this information made a panic attack diagnosis improbable. Further, he indicated that, if such diagnosis were correct, recurrent episodes would have been likely and such was not the case. Finally, Dr. McClellan explained the progression of severity of appellant's condition due to recurrent episodes of

⁸ There is no dispute that appellant was in the course of employment at the time of her injury. The only question is what specifically caused the injury. Because the risk appears to have been neither distinctly associated with the employment nor personal to the appellant, the risk was neutral and having arisen in the course of appellant's employment, the injury caused thereby is compensable. *See Edward P. Prior*, 45 ECAB 288 (1994).

⁹ *Mary J. Briggs*, 37 ECAB 578 (1986).

¹⁰ *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

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

¹² *See William E. Enright*, 31 ECAB 426, 430 (1980).

¹³ The record reflects that this incident was not accepted as work related.

¹⁴ The record reflects that this was an accepted condition.

respiratory distress in the employing establishment. In the instant case, appellant's physician, clearly explained the nature of the relationship between the diagnosed condition and the specific employment factors identified by the appellant.¹⁵ Given Dr. McClellan's reasoned explanations of how appellant's condition was causally related to the August 20, 1999 injury, and the fact that the record is devoid of evidence contradicting such a conclusion, the Board finds that appellant has established that her attack on August 20, 1999 was causally related to her employment.

As appellant has submitted the requisite medical evidence needed to establish her claim, she has met her burden of proof.

The case will be remanded to the Office to determine the nature and extent of disability, for medical expenses incurred and a determination of any periods of wage loss for which compensation is claimed. After such further development of the record as is necessary, a *de novo* decision shall be issued.

The May 20, 2002 decision of the Office of Workers' Compensation Programs is reversed and the case is remanded for further development consistent with this decision.

Dated, Washington, DC
February 13, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

¹⁵ *Id.*