U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JANET ORLA and DEPARTMENT OF THE TREASURY, U.S. CUSTOMS SERVICE, Jamaica, NY

Docket No. 03-327; Submitted on the Record;
Issued March 18, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON, A. PETER KANJORSKI

The issue is whether appellant sustained an injury in the performance of duty, causally related to factors of her federal employment.

On July 15, 1999 appellant, then a 41-year-old customs inspector, filed a claim alleging that on that date she developed dizziness and numbness in her arms due to breathing exhaust fumes from a mobile x-ray van and jet engines all day. She also alleged that she hit her left hand, which became numb and her right hand and right thigh and she added that she had not eaten all day. Two witness coworkers noted that appellant complained of dizziness and tingling in her fingers, which increased towards the end of her shift and that she was driven to the John F. Kennedy (JFK) medical facility and from there was transported to a hospital by ambulance. A July 16, 1999 Form CA-16 report from the JFK medical facility noted as history that appellant experienced sudden weakness with bilateral upper extremity tingling, that her blood glucose was 40 mg/dl[1] and that her condition was caused by inhaled exhaust fumes combined with hypoglycemia. Appellant stopped work on July 16 and returned to work on July 19, 1999.

In support of her claim, appellant submitted a July 19, 1999 report from Dr. Mario Torrents, a Board-certified physiatrist, which noted as history that on July 15, 1999 appellant got carbon monoxide intoxication. He indicated that, at the hospital emergency room when a technician attempted to draw arterial blood gases, appellant experienced acute onset of pain at the ventral elbow and left hand and thumb and then at the right wrist. A right femoral artery stick was also noted to be unsuccessful. Dr. Torrents noted that appellant had right elbow tenderness on palpation of the ventral aspect with a subcutaneous hematoma at the medial aspect, and tenderness at carpal tunnel palpation. The left elbow range of motion was noted to elicit pain, with marked tenderness at the medial epicondyle and tenderness at the ventral aspect of the left wrist with pain upon extension. Dr. Torrents diagnosed "[p]ost-traumatic left median and

[1] Normal 48-hour fasting glucose is 65 mg/dl. *See Principles of Internal Medicine,* (9th ed.), p. 454.

ulnar nerve neuritis, left elbow contracture, left carpal tunnel syndrome [and] post-traumatic right median [nerve] neuritis."

A July 19, 1999 form report from the JFK medical office noted appellant's diagnosis as left arm/wrist neuropathy and indicated that she was put on light duty with minimal use of her left hand.

Dr. Torrents saw appellant again on July 23, 1999 complaining of left arm pain and hand numbness. He noted that appellant had tenderness at palpation of the radial artery over the right ventral wrist with a subcutaneous hematoma and a positive Tinel's with median nerve percussion and on the left she had tenderness with palpation at the medial aspect over the radial artery and a positive Tinel's sign with median nerve percussion. Dr. Torrents diagnosed "post-traumatic arteritis and neuritis of both upper extremities" and indicated that appellant should not work for the next nine days.

A July 23, 1999 report from appellant's supervisor noted that appellant was assigned to x-ray cargo being exported at several airline cargo facilities, that by the end of her shift she was not feeling well, that after examination at the JFK medical facility she was transported to a hospital where she complained about the method used to obtain arterial blood gases, alleging that she was injured in the process. The supervisor noted that the treating physician opined that appellant appeared to be suffering from low blood sugar and an elevated carbon monoxide level.

In an August 5, 1999 report, Dr. Torrents noted that electromyographic (EMG) testing of the left upper extremity revealed normal motor and sensory nerve conduction. He noted that appellant's right wrist had full range of motion without tenderness and with a negative Tinel's sign and that her left elbow had slight tenderness at deep palpation of the ventral aspect and a positive Tinel's at the ulnar groove and over the carpal tunnel. Dr. Torrents diagnosed "[status post]-traumatic median nerve neuritis at the elbow and wrist" without evidence of severe nerve damage. On August 17, 1999 he noted that appellant was improving.

By letter dated October 14, 1999, the Office of Workers' Compensation Programs advised appellant that further information was needed to establish her claim, including a rationalized medical opinion diagnosing an injury-related condition and discussing the causal relationship with her employment exposures.

In response appellant submitted an October 29, 1999 report from Dr. Torrents which noted his findings upon physical examination and diagnosed "[p]ost-traumatic median nerve neuritis at the elbow and wrist bilaterally from several arterial blood test withdrawals [in an] attempt to measure arterial monoxide levels after being intoxicated at work on July 15, 1999. Residual neuritis is job related and as a direct consequence of the incident she had on July 15, 1999."

On November 1, 1999 appellant submitted paperwork regarding her brief hospitalization. The paperwork indicated a diagnosis of "altered mental status/ hypoglycemia" and noted that she was treated with dextrose administration. A July 15, 1999 assessment from JFK medical office noted appellant's history of working in a closed garage with a running truck and experiencing "altered mental status, rule out TIA [transient ischemic attack], rule out hypoglycemic reaction."

It indicated that she was treated with intravenous (IV) fluids containing dextrose. On July 19, 1999 the paperwork indicated that appellant was seen complaining of left hand and wrist numbness, tingling of the first three digits and pain in her left forearm and wrist "status post multiple needle sticks from the emergency room of the hospital. The diagnosis was noted as "left hand neuropathy."

In a December 6, 1999 letter, the Office requested further clarification of how appellant's extremity symptomatology was related to the work incident.

By report dated December 13, 1999, Dr. Torrents noted as follows:

> "[Appellant] became intoxicated with carbon monoxide accidentally while at work on July 15, 1999. Because of the dangerous exposure to the poisonous gas, she was taken to Mary Immaculate Hospital Emergency Room on the same day and arterial blood samples were taken to measure the arterial levels of carbon monoxide on her circulatory system.
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> "An unexperienced [sic] technician-medical doctor attempted several times to punctuate [sic] the arteries of [appellant] at the wrist, elbow and groin areas finally succeeding in withdrawing blood.
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> "As a direct result of the multiple attempts to perforate the arteries, [appellant] suffered direct trauma to the right median nerve at the wrist and left ulnar and median nerves at the elbow and wrist with post-traumatic neuritis of the same nerves."
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> "In brief, the July 15, 1999 accident at work with carbon monoxide intoxication led [appellant] to seek medical attention at Mary Immaculate Hospital where arterial blood gases withdrawn traumatized the ulnar and median nerves of [appellant] with residual post-traumatic neuritis, almost completely recovered by now."

On July 16, 2001 an Office medical adviser reviewed the medical evidence of record and opined that there was no documentation of a diagnosis of carbon monoxide poisoning and he indicated that the EMG and nerve conduction studies were normal. The Office medical adviser noted that the only diagnosis that was documented was hypoglycemia and he opined that, although nerve injuries can occur with arterial puncture to measure blood gases, he found no documentation of that in this case.

By decision dated July 18, 2001, the Office rejected appellant's claim finding that appellant failed to establish fact of injury. The Office found that no diagnosis of carbon monoxide had been made and no objective evidence of nerve damage had been submitted.

Appellant disagreed with the July 18, 2001 decision and requested reconsideration. In support she submitted an August 14, 2001 report from Dr. Torrents which noted as diagnoses "post-traumatic bilateral median nerve neuritis and left arteritis at brachial and radial arteries

secondary to and as a consequence of the intoxication accident at work on July 15, 1999 which required arterial blood gases drawal [sic]."

In support of her reconsideration request, appellant submitted a June 6, 2002 statement from a coworker, Martin Black, who indicated that he observed appellant in the late morning not feeling well and wobbling when she tried to walk to her car.

Appellant also submitted a June 11, 2002 statement from her fiancé, James Bienkowski, who claimed that a physician admitted to hurting appellant while trying to draw her arterial blood gases and he claimed that the blood tests were positive for carbon monoxide. Mr. Bienkowski also claimed that he witnessed the blood drawing procedure and noted that the doctor had the drawing needle bent in appellant's wrist, causing severe pain.

Appellant further submitted a June 21, 2002 statement from a coworker, Kathleen Blandeburgo, who saw appellant slumped over her desk feeling light-headed and dizzy. She stated that when appellant was seen at the JFK medical facility she was incoherent and feeling weak and could barely respond to staff questions. Ms. Blandeburgo stated that the emergency room physician, Dr. Snicer, made five or six attempts to draw arterial blood gases, and that each time he stuck appellant, she screamed for him to stop and complained that her fingers felt numb.

A July 17, 2002 statement from Gary Boire, a coworker, claimed that he witnessed the doctor attempting to obtain arterial blood gases and appellant screaming in pain.

Appellant additionally provided two statements recounting her exposure and her condition, including the physician's aborted attempts to draw blood which she felt injured her upper extremity nerves.

On August 14, 2002 the Office medical adviser reviewed the entire case record and opined that appellant's carbon monoxide levels were not elevated, that the arterial blood gas results were within normal limits, that the carboxyhemoglobin levels were normal for a nonsmoker and that, therefore, there was no documentation of carbon monoxide poisoning. The Office medical adviser also noted that EMG and nerve conduction testing by Dr. Torrents showed normal nerve conduction in both right and left median and ulnar nerves, and that EMG studies showed no evidence of nerve injury. However, the Office medical adviser noted that hypoglycemia was documented by a finger stick blood test at the JFK medical office.

By decision dated August 16, 2002, the Office denied appellant's request for modification finding that the evidence submitted in support was insufficient to warrant modification. The Office found that Dr. Torrents' opinions were not supported by objective evidence of carbon monoxide intoxication or nerve injury or trauma and that the objective evidence of record supported only hypogylcemia as an incident-related diagnosed condition. The Office found that any injury due to hospital treatment for hypoglycemia would not be compensable under the Federal Employees' Compensation Act.

The Board finds that appellant has failed to establish that she sustained an injury in the performance of duty, causally related to factors of her federal employment.

An employee seeking benefits under the 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 essential elements of each compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[4]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it must first be determined whether a "fact of injury" has been established. Fact of injury consists of two components which must be considered in conjunction with one another. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place and in the manner alleged.[5] This component can be established by an employee's uncontroverted statement on the Form CA-1.[6] A consistent history of the injury as reported on medical records, to the claimant's supervisor and on the notice of injury can also be evidence of the occurrence of the incident. In this case appellant has provided a consistent history of breathing truck and aircraft exhaust fumes and experiencing dizziness, weakness and tingling in her arms during her work shift on July 15, 1999.

The second component is whether the employment incident caused a personal injury and can generally be established only by medical evidence. To establish a causal relationship between the condition and any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, must be one of reasonable certainty and must be supported by medical rationale explaining the relationship between the diagnosed condition and the specific employment event or factors identified by the employee.[7]

In this case the Office accepted that appellant experienced the employment incident at the time, place and in the manner alleged. However, appellant has submitted insufficient medical evidence to establish that the employment incident caused a personal injury.

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[2] 5 U.S.C. §§ 8101-8193.

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

[4] *Victor J. Woodhams*, 41 ECAB 345 (1989); *Delores C. Ellyett*, 41 ECAB 992 (1990). In accordance with 20 C.F.R. § 10.5(ee) traumatic injury means a condition of the body caused by a specific event or incident or series of events or incidents, within a single workday or shift. *Compare* § 10.5(q) which defines occupational disease or illness as a condition produced by the work environment over a period longer than a single workday or shift.

[5] *John J. Carlone*, 41 ECAB 354 (1989). For a detailed discussion of the components of an appellant's burden of proof in establishing fact of injury, see *Elaine Pendleton*, 40 ECAB 1143 (1989).

[6] *John J. Carlone*, *supra* note 5.

[7] *See Dennis M. Mascarenas*, 49 ECAB 215 (1997); *Jean Culliton*, 47 ECAB 728 (1996); *Rebel L. Cantrell*, 44 ECAB 660 (1993).

Appellant's treating physician, Dr. Torrents, opined that appellant had sustained carbon monoxide intoxication after working her shift on July 15, 1999 and then sustained post-traumatic left median and ulnar nerve neuritis, left elbow contracture, left carpal tunnel syndrome and post-traumatic right median nerve neuritis from the hospital's attempts to draw arterial blood gases to document the carbon monoxide intoxication. He did not explain, however, how he arrived at these conclusions and diagnoses, particularly when the blood tests did not establish the diagnosis of carbon monoxide intoxication and the EMG and nerve conduction study results were within normal limits. The Board has explained that the weight of medical opinion evidence is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the opinion.[8] As Dr. Torrents' reports were not based upon the objective evidence of record, but rather were based on the subjective beliefs of appellant and lacked any explanation or rationale regarding how he reached the diagnostic conclusions he did, they are of diminished probative value and are insufficient to establish appellant's claim.[9]

The Office medical adviser, however, noted that the objective medical evidence of record, which consisted of appellant's blood testing results and the EMG and nerve conduction studies, failed to support the alleged diagnoses of carbon monoxide intoxication or bilateral upper extremity nerve damage. He noted that appellant's carbon monoxide levels were not elevated, her arterial blood gas results were within normal limits and her carboxyhemoglobin levels were normal for a nonsmoker and he concluded that, therefore, the medical evidence supported that there was no carbon monoxide poisoning. The Office medical adviser further reviewed appellant's EMG and nerve conduction studies and determined that the results were completely normal and did not support any upper extremity nerve damage or any of the diagnoses given by Dr. Torrents. The Office medical adviser did, however, note that the only condition diagnosed by blood testing was hypogylcemia, which had been contributed to by appellant's failure to eat that day. As the Office medical adviser's opinions were based upon the objective evidence of record and explained how he reached his conclusions, they are of great probative value and, therefore, constitute the weight of the medical evidence of record in establishing that appellant did not sustained an employment-related injury but instead sustained hypoglycemia on July 15, 1999 which caused her to be dizzy and weak and that she sustained no objective upper extremity neurologic injury during follow-up diagnostic intervention at the hospital.

As appellant has not submitted any further objective and rationalized medical evidence to support her allegations of carbon monoxide exposure and neurologic injury due to arterial needle sticks, she has failed to meet her burden of proof to establish her claim.

[8] *Anna C. Leanza*, 48 ECAB 115 (1996).

[9] A physician's report is of little probative value where it is based on the claimant's beliefs concerning causal relationship rather than the physician's independent opinion. *Earl David Seal*, 49 ECAB 152 (1997). The statement of a lay person, such as the claimant, is not competent evidence on the issue of causal relationship. *See James A. Long*, 40 ECAB 538 (1989); *Susan M. Biles*, 40 ECAB 420 (1988).

Accordingly the decision of the Office of Workers' Compensation Programs dated August 16, 2002 is hereby affirmed.

Dated, Washington, DC
March 18, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member