U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BENJAMIN F. BODIFORD and DEPARTMENT OF THE NAVY, NAVAL SUBMARINE BASE NEW LONDON, Groton, CT

Docket No. 03-1302; Submitted on the Record;
Issued October 15, 2003

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether appellant developed a pulmonary condition causally related to exposure to asbestos in the performance of duty.

On October 1, 2001 appellant, then a retired 62-year-old industrial equipment mechanic, filed an occupational disease claim alleging that he contracted asbestosis and asbestos-related pleural disease due to factors of his federal employment.[1] Medical evidence submitted by appellant included a July 25, 1997 x-ray, which was noted as being normal, and an August 24, 1998 x-ray in which some evidence of benign pleural thickening was noted. Lawrence Memorial Hospital records dated January 2, 2001, as written by Dr. John Bigos, a Board-certified internist specializing in pulmonary medicine, noted that appellant's extensive occupational history was remarkable for extensive asbestos exposure. Also noted was a smoking history of one pack of cigarettes per day with a 50-plus pack year smoking history. Appellant was admitted to the hospital for respiratory insufficiency, chronic obstructive pulmonary disease. No opinion was rendered on the cause of appellant's condition. Out of work notes dated January 18, 2001 were also received from Dr. Bigos or his office along with a February 8, 2001 report denoting appellant's work restrictions.

As the evidence failed to establish that appellant's medical condition was caused by employment activities, by letter dated March 4, 2002, the Office of Workers' Compensation Programs requested additional factual and medical information. The employing establishment noted that appellant had worked steam valve repair on domestic and heating systems throughout the base and indicated that appellant had been exposed to asbestos from a few minutes to over eight hours a day until 1990, when a contractor started removing the asbestos. Copies of "B" reader results of x-rays dated July 25, 1997, August 24, 1998, April 23, 1999, February 28 and April 20, 2002 were noted as being negative for pneumoniosis.

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[1] Appellant retired effective October 1, 2001.

The Office referred appellant to Dr. Joseph Harrison, a Board-certified internist specializing in pulmonary medicine, for a second opinion evaluation. In the accompanying statement of accepted facts, the Office accepted appellant's asbestos exposure as factual along with a history of chlorine exposure and a smoking history of one pack of cigarettes per day ending in January 2001.

In a report dated August 29, 2002, Dr. Harrison noted a history of injury and reviewed appellant's work history and medical chart. An examination was performed along with a pulmonary function test and an arterial blood gas study. Chest x-rays from August 23, 2002 showed mild chronic fibroemphysematous changes without acute active lung disease processes. Minimal peribronchial cutting was suggestive of bronchitis. Prior x-ray reports and x-rays reviewed failed to indicate pleural thickening, calcification of the diaphragm or pleura or bibasilar interstitial abnormalities. Dr. Harrison diagnosed moderate to severe chronic obstructive pulmonary disease with a reversible component consistent with emphysema with asthmatic reactivity. There was no evidence of asbestosis- or asbestos-related lung disease. Dr. Harrison stated that pulmonary testing did not support a diagnosis of asbestosis as there was no evidence of restrictive ventilatory defect, only obstructive defect. X-ray evidence also failed to show fibrosis consistent with asbestosis or calcification. Dr. Harrison opined that appellant's symptoms, x-ray and pulmonary function tests were more likely related to emphysema and asthma which were more likely related to his prior cigarette smoking. Copies of the objective testing were submitted.

By decision dated October 2, 2002, the Office denied appellant's claim on the grounds that the evidence was insufficient to establish that he sustained an employment-related condition due to his asbestos exposure.

By letter dated November 1, 2002, appellant's attorney requested reconsideration. She alleged that appellant had been exposed to asbestos, welding fumes, grinding dusts and chemicals, including large quantities of chlorine, as a result of his federal employment and wished to amend the CA-2 form. A copy of an October 17, 2002 amended CA-2 form listing occupational exposure to asbestos and/or other harmful lung irritants including but not limited to welding fumes, grinding dust and chemical/solvent fumes was submitted along with an April 30, 2002 pulmonary function study and a July 26, 2002 medical report from Dr. Bigos which advised that appellant's occupation most definitely contributed to his underlying respiratory state. He further stated that appellant would be considered a Class IV impairment and totally disabled. In another report also dated July 26, 2002, Dr. Bigos opined that appellant's exposures to asbestos, welding fumes and chemical/solvent fumes most definitely contributed to his underlying respiratory impairment and his pleural and parenchymal abnormalities. Previously submitted evidence which the Office had previously considered was also received.

By decision dated January 27, 2003, the Office denied modification of its prior decision. It specifically noted that appellant's attorney's request to amend the CA-2 did not fall under the review for reconsideration and advised that a new claim may be filed for the new factors alleged.

The Board finds that appellant has not established that he sustained a pulmonary condition causally related to exposure to asbestos in the performance of duty.

An employee seeking benefits under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of his or her claim, including the fact 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]

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.[4] The medical evidence required to establish a causal relationship, generally, is rationalized medical opinion evidence.[5] 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,[6] must be one of reasonable medical certainty,[7] 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.[8] 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.[9]

The Board finds that appellant has not submitted sufficient evidence to establish that he sustained a pulmonary condition due to his employment-related asbestos exposure. In a hospital report of January 2, 2001, Dr. Bigos, a Board-certified internist specializing in pulmonary medicine and appellant's attending physician, noted that appellant's occupational history was remarkable for extensive asbestos exposure. Smoking history was also noted. The admitting diagnosis was respiratory insufficiency, chronic obstructive pulmonary disease. However, no

[2] 5 U.S.C. §§ 8101-8193.

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

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

[5] 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.

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

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

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

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

opinion was offered as to the cause of appellant's condition. In two reports dated July 26, 2002, Dr. Bigos first generally opined that appellant's occupation "most definitely contributed to his respiratory state" and opined in the other July 26, 2002 report, that appellant's "exposures to asbestosis, welding fumes and chemical/solvent fumes most definitely contributed to his underlying respiratory impairment and his pleural and parenchymal abnormalities." These reports, however, are of limited probative value as they fail to provide a reasoned medical opinion based on a complete and accurate history relating the diagnosed obstructive pulmonary disease condition to appellant's exposure to asbestos in her federal employment.[10] Dr. Bigos did not explain the medical process through which the accepted employment factor of asbestos exposure could be related to appellant's current condition, or how his exposures caused or contributed to his findings or examination. Dr. Bigos did not fully address the absence of restricted lung disease as opposed to the chronic obstructive lung disease diagnosed symptomatic of smoking and exposure to other irritants, not the specific subject of this claim.

In an August 29, 2002 report, Dr. Harrison, a Board-certified internist specializing in pulmonary medicine and Office referral physician, found that appellant did not have any condition related to his exposure to asbestos. He opined that appellant had moderate to severe chronic obstructive pulmonary disease with a reversible component consistent with emphysema asthmatic reactivity which was more likely related to appellant's history of cigarette smoking. Dr. Harrison interpreted the x-rays of record as negative for pleural thickening, calcification of the diaphragm or pleura or bibasilar interstitial abnormalities. The recent x-ray of August 23, 2002 showed mild chronic fibroemphysematous changes without any other acute lung disease processes superimposed. He further noted that pulmonary testing failed to support a diagnosis of asbestosis as there was no evidence of restrictive ventilatory defect. Dr. Harrison based his opinion on a thorough review of the factual and medical evidence of record, an accurate history of injury and the results of objective testing. He further provided rationale for his opinion by citing the results of studies and distinguishing the diagnostic criteria for asbestos versus what was found on examination and diagnostic testing of appellant. Dr. Harrison's well-rationalized opinion constitutes the weight of the medical evidence and establishes that appellant did not sustain an asbestos-related pulmonary condition causally related to exposure to asbestos in the performance of duty.

The Board notes, however, that to the extent that appellant's amended CA-2 claim filing was to allege exposure to additional industrial irritants, the Office has yet to issue a decision on that matter.[11] The medical evidence submitted with appellant's request for reconsideration constitutes a claim for exposure to additional industrial irritants.[12] After return of the case

[10] *See Leon Harris Ford*, 31 ECAB 514, 518 (1980) (finding that a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

[11] It is well established that a claim for compensation need not be filed on any particular form. A claim may be made by filing any paper containing words, which reasonably may be construed or accepted as a claim. *Barbara A. Weber*, 47 ECAB 163 (1995); *William F. Dotson*, 47 ECAB 253 (1995). Letters and statements in amplification and expansion of a claim are as much a part of a claim as the claim form itself.

[12] *Id.*

record, the Office should further develop the medical evidence pertaining to a claim for exposure to additional industrial irritants.

The January 27, 2003 and October 2, 2002 decisions of the Office of Workers' Compensation Programs are hereby affirmed.

Dated, Washington, DC
October 15, 2003

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member