United States Department of Labor
Employees' Compensation Appeals Board

BILLY D. CAMPLIN, Appellant	)	
and	)	**Docket No. 04-921**
	)	**Issued: July 14, 2004**
TENNESSEE VALLEY AUTHORITY, Chattanooga, TN, Employer	)	

Appearances:
Ronald K. Bruce, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
COLLEEN DUFFY KIKO, Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On February 24, 2004 appellant filed a timely appeal from a merit decision of the Office of Workers' Compensation Programs dated November 26, 2003, which affirmed a February 13, 2003 decision finding that appellant had not sustained a pulmonary condition causally related to factors of his federal employment. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue on appeal is whether appellant met his burden of proof in establishing that he has a pulmonary condition causally related to factors of his federal employment.

FACTUAL HISTORY

On February 25, 2002 appellant, then a retired 66-year-old maintenance electrician, filed an occupational disease claim alleging that he developed a lung disease in the performance of

duty.[1] Appellant indicated that he first became aware of the injury and its relation to his work on November 14, 2001.[2] The employing establishment indicated that appellant was last exposed to employment factors on October 12, 1993. Appellant submitted his employment history and chest x-ray films dated January 23, 2002 which showed parenchymal abnormalities consistent with pneumoconiosis. He also submitted a January 23, 2002 report from Dr. Glen Baker, Board-certified in pulmonary disease, who noted appellant's history of injury and treatment which included possible dust-induced lung disease secondary to occupational dust exposure. The physician noted appellant's previous employment which included work as a laborer, office clerk, electrician and chuck tender. He provided findings on examination and diagnosed bronchitis and occupational pneumoconiosis based on an abnormal x-ray and history of coal dust exposure and asbestos exposure. Additionally, Dr. Baker opined that appellant was totally disabled.

In an undated response received by the Office on July 12, 2002, the employing establishment controverted the claim on the basis that appellant's exposure to coal dust was minimal. The employing establishment indicated that appellant smoked a pack of cigarettes per day for 45 years and that he never complained of pulmonary problems while working.

By letters dated July 18 and 26, 2002, the Office requested additional factual and medical evidence from appellant and the employing establishment.

In a July 18, 2002 report, the Office medical adviser questioned Dr. Baker's diagnosis of an occupational condition and recommended a diffusion capacity study.

In response to the Office's July 26, 2002 request, the employing establishment listed magnetite, frother and fuel oil emissions and coal dust as substances which existed at the plant.

By letter dated August 29, 2002, appellant indicated that he began work in 1959 and had worked approximately 24 years for the employing establishment in various capacities. He stated that he was exposed to coal dust on a daily basis and was also exposed to flue gas, transformer oil and asbestos for eight hours a day, five to six days a week. He stated that, for the last six years of his employment, he worked in the coal wash plant. Additionally, he indicated that a paper breathing mask was provided, however, it caused his glasses to fog and caused difficulty breathing. Appellant confirmed that he had smoked cigarettes, one-half to three-quarters of a pack, on a daily basis, for forty-five years.

By letter dated October 3, 2002, appellant's representative submitted the results of the diffusion capacity evaluation which had been performed on September 19, 2002.

In a December 19, 2002 report, the Office medical adviser reviewed the results of the diffusion capacity evaluation and opined that, based on the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A. *Guides)* at 107, Table 5-12, appellant had zero percent impairment.

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[1] Appellant retired on October 13, 1993.

[2] On June 3, 2002 appellant filed a claim for a schedule award.

By letter dated December 17, 2002, the Office determined that a conflict existed between the Office medical adviser and appellant's physician, Dr. Baker, regarding whether appellant had an employment-related pulmonary condition. The Office referred appellant, together with the case record and a statement of accepted facts, to Dr. Robert A. Greenberg, a Board-certified internist in pulmonary disease.

In a January 24, 2003 chest x-ray taken for Dr. Greenberg, Dr. D.E. Ware, a Board-certified internist, indicated that appellant had normal long volumes, with no focal infiltrate or effusion, the heart and mediastinum were within normal limits and opined that there was no acute cardiopulmonary disease.

In a report dated January 27, 2003, Dr. Greenberg noted appellant's history and reported examination findings. He stated that appellant had clear lung fields and an unremarkable examination. He reviewed chest x-rays and pulmonary function studies performed on January 24, 2003 and noted that they demonstrated an increased residual volume, consistent with early small airways disease, the remainder of the examination was normal. Dr. Greenberg indicated that it was impossible to determine how much of appellant's lung impairment was due to smoking versus occupational exposures and advised that appellant had "no significant pulmonary disease, despite his exposures and cigarette smoking." Dr. Greenberg added that appellant's exertional dyspnea was related to his cigarette smoking as opposed to his employment and stated there was "no evidence of pneumoconiosis."

By decision dated February 13, 2003, the Office denied the claim, finding that Dr. Greenberg's opinion represented the weight of the medical evidence and established that appellant did not have any employment-related pulmonary condition.

By letter dated February 25, 2003, appellant's representative requested a hearing, which was held on October 2, 2003.[3] Appellant submitted new reports from Dr. Baker and Dr. Judah Skolnick, a Board-certified internist. In a September 12, 2003 report, Dr. Baker noted mild restricted ventilatory defect on a pulmonary function test performed on January 24, 2003. He opined that appellant would have a "Class II impairment, with FEV_1 and/or vital capacity between 60 and 79 percent predicted." The physician provided an impairment rating of "10 to 25 percent impairment of the whole person" and opined that this was related to pneumoconiosis. In a report dated September 11, 2003, Dr. Skolnick reviewed appellant's chest x-ray of January 23, 2003 and reported similar findings. She answered "yes" regarding whether appellant had findings consistent with pneumoconiosis, however, she did not provide any opinion on causal relationship.

[3] Appellant testified that, over a 24-year period for the employing establishment, he was exposed to silica, asbestos and coal dust and described the conditions he worked under. He also claimed exposure to a flue gas in the switch yard. He stated that he first sought treatment in November 2001 and upon seeing the report of Dr. Baker, became aware of his condition.

By decision dated November 26, 2003, an Office hearing representative affirmed the February 13, 2003 decision finding that appellant had not established that he sustained a pulmonary condition causally related to the factors of his federal employment.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act 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 filed within the applicable time limitations 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."[4] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

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 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. The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. 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 identified by the claimant.[6] 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 or aggravated by employment conditions is sufficient to establish causal relation.[7]

Section 8123 of the Federal Employees' Compensation Act[8] provides that where there is disagreement between the physician making the examination for the United States and the physician of the employee, the Office shall appoint a third physician who shall make an examination.[9] In situations where there exists a conflict in medical opinion and the case is

[4] *Gary J. Watling*, 52 ECAB 278 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1154 (1989).

[5] *Michael E. Smith*, 50 ECAB 313 (1999).

[6] *Solomon Polen*, 51 ECAB 341 (2000).

[7] *Ernest St. Pierre*, 51 ECAB 623 (2000).

[8] 5 U.S.C. § 8123.

[9] *Richard L. Rhodes*, 50 ECAB 259 (1999).

referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.[10]

ANALYSIS

In the instant case, appellant's physician, Dr. Baker, diagnosed bronchitis and occupational pneumoconiosis based on an abnormal x-ray and a history of coal dust and asbestos exposure and opined that appellant had an employment-related pulmonary condition disabled. The Office medical adviser questioned Dr. Baker's diagnosis and conclusion. Based on this, the Office referred appellant to Dr. Robert Greenberg, a Board-certified internist and pulmonologist, to resolve the medical conflict.

In his report, Dr. Greenberg conducted a physical examination and testing which resulted in findings which included clear lung fields and an unremarkable examination. He also noted that the chest x-rays and pulmonary function studies showed early small airways disease, however, he determined that appellant had no signs of any significant pulmonary disease at the time of his examination and indicated the remainder of the examination was normal. He explained that it was impossible to separate the cause of appellant's lung impairment as he was a smoker, however, despite his smoking, there was no significant pulmonary disease and no evidence of pneumoconiosis. Regarding appellant's exertional dyspnea, Dr. Greenberg indicated that it was related to his 45-year continued history of cigarette smoking. The doctor reviewed appellant's history, had pulmonary testing and x-rays performed, examined appellant and found no basis on which to attribute any pulmonary condition to his employment that ended nine years before he filed his claim.

The Board has carefully reviewed the opinion of Dr. Greenberg and finds that it has reliable, probative value and convincing quality with respect to his finding that appellant has not sustained a pulmonary condition causally related to his exposure to coal dust in the course of his federal employment. Dr. Greenberg provided a thorough factual and medical history and accurately summarized the relevant medical evidence. He further supported his conclusions with medical rationale by noting that appellant did not have radiographic evidence of pneumoconiosis or any lung disease. Consequently, Dr. Greenberg's opinion is sufficiently rationalized and entitled to the special weight accorded an impartial medical specialist.[11]

Subsequently, appellant submitted an additional report from Dr. Baker dated September 12, 2003, which included his findings for an impairment related to pneumoconiosis. In this report, instead of indicating appellant was 100 percent occupationally disabled, he stated that appellant had a 10 to 25 percent impairment of the whole person. While the report is new in that Dr. Baker provided an impairment rating, he did not provide any new findings or rationale. Further, as this doctor was on one side of the conflict that had been resolved, the additional

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[10] *Guiseppe Aversa*, 55 ECAB ___ (Docket No. 03-2042, issued December 12, 2003); *Jaja K. Asaramo*, 55 ECAB ___ (Docket No. 03-1327, issued January 5, 2004); *LaDonna M. Andrews*, 55 ECAB ___ (Docket No. 03-1573, issued January 30, 2004).

[11] *See supra* note 9.

report, in the absence of any new findings or rationale, from appellant's doctor was insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[12]

A September 11, 2003 report was also received from Dr. Skolnick. In this report, Dr. Skolnick reviewed the findings in appellant's chest x-ray of January 24, 2003. However, she did not address causal relationship or provide any relevant new evidence. This report was similar therefore insufficient to overcome the weight of the impartial medical examiner.

The Board also notes that appellant's assertions regarding the degree of lung impairment are of minimal value where the weight of the medical evidence establishes that there is no employment-related condition.

An award of compensation may not be based on surmise, conjecture or speculation, or a claimant's belief of causal relationship. The mere fact that a disease or condition manifests itself or worsens during a period of employment or that work activities produce symptoms revelatory of an underlying condition does not raise an inference of causal relationship between the condition and the employment factors. Neither the fact that a claimant's condition became apparent during a period of employment nor the belief that the condition was caused, precipitated or aggravated by the employment is sufficient to establish causal relationship.[13]

CONCLUSION

The Board finds that appellant failed to establish that he sustained respiratory disease or a pulmonary impairment causally related to factors of his federal employment.

[12] *Jaja K. Asaramo*, *supra* note 10.

[13] *Michael E. Smith*, *supra* note 5; *Samuel Senkow*, 50 ECAB 370 (1999); *Thomas A. Faber*, 50 ECAB 566 (1999).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 26, 2003 is hereby affirmed.

Issued: July 14, 2004
Washington, DC

Alec J. Koromilas
Chairman

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member