United States Department of Labor
Employees' Compensation Appeals Board

T.S., Appellant	)	
and	)	**Docket No. 09-1245**
	)	**Issued: May 24, 2010**
ENVIRONMENTAL PROTECTION AGENCY, HEADQUARTERS, Washington, DC, Employer	)	

Appearances:
Appellant, pro se
No Appearance, for the Director

Oral Argument February 2, 2010

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 14, 2009 appellant filed a timely appeal from the April 18, 2008 merit decision of the Office of Workers' Compensation Programs, which denied his injury claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of the case.

ISSUE

The issue is whether appellant sustained an injury causally related to his exposure to environmental factors in his employment from December 1991 to July 1995.

FACTUAL HISTORY

On April 25, 1997 appellant, then a 54-year-old retired program analyst, filed a claim alleging that his neurological and respiratory symptoms were a result of his federal employment, primarily a result of his work environment in the Waterside Mall office complex. He began working in the Waterside Mall in December 1991. Appellant first became aware of his disease or illness in November 1993. He first became aware of a causal relationship to his employment in April 1994, after his supervisor told him the Waterside Mall had a history of sick building

syndrome. Initially, appellant's symptoms were apparent only when working in his immediate office space in the West Tower annex but gradually seemed to appear and worsen in adjoining work spaces. Following an exposure to smoke and fumes from an electrical fire on May 17, 1994, symptoms seemed to emerge upon entering the building from any site. From August 1994 to March 1995, appellant was allowed to work primarily from home, after which he began working at an alternative work site but occasionally visited the Waterside Mall. He stopped work in July 1995 and retired on disability. Appellant identified the nature of his diagnosed disease or illness as occupational asthma/reactive airways disease, migraine headaches, chronic fatigue syndrome and allergic rhinitis.[1]

The Office received results of a screening study to evaluate the Waterside Mall indoor air quality after a May 17, 1994 fire, which started and was contained in an electrical switching unit in the truck loading area of the West Tower garage. Employees reported odors of smoke and fumes on the lower and upper West Tower floors and in the stairwells.

On May 31, 1994 Dr. Christopher S. Holland, a specialist in occupational medicine and a health unit consultant, related appellant's complaints, history of present illness and past medical history. He noted that appellant provided a history of childhood asthma, seasonal allergies to mold and pollen, chronic bronchitis, prostatitis, reflux esophagitis and an episode of spontaneous pneumothorax. Dr. Holland reported that appellant had experienced headaches for five years but an increase in the intensity and frequency of his pain caused him to see a neurologist for the first time in November 1993. In addition to being followed on a long-standing basis for his migraine headaches and esophagitis, appellant was treated episodically with antibiotics for upper respiratory infections and bronchitis.

Dr. Holland described normal findings on physical examination, though a pulmonary function test was aborted when coughing interrupted the procedure. He discussed a May 25, 1994 indoor air quality investigation of appellant's office space, conducted to discover any environmental factor that might be exacerbating appellant's upper respiratory condition. Dr. Holland concluded that appellant's complaints were consistent with "tight building syndrome." He noted that the Waterside Mall was a tight building and that appellant's history of allergies and allergic bronchitis might place him in a higher risk group, as it seemed to be generally accepted that atopic persons were more prone to develop symptoms associated with tight building. Based on the walk-through survey, Dr. Holland could find no factor or air contaminant that could be considered causative.

On November 30, 1994 Dr. Lawrence M. Stein, a pulmonologist, diagnosed allergic rhinitis and airway hyperresponsiveness. He reviewed appellant's self-reported respiratory peak flow measurements and found them strongly suggestive of airway hyperresponsiveness related to occupational exposure. Dr. Stein reviewed an allergist's report documenting that appellant was an atopic individual suffering from both allergic rhinitis and airway hyperresponsiveness. He found that appellant's symptoms of cough, chest tightness, lightheadedness and weakness were associated with exposure to his workplace.

[1] Appellant would amend the supplemental statement in support of his formal claim to include neurocognitive impairment.

On December 1, 1994 Dr. Rosemary K. Sokas, a specialist in occupational medicine, diagnosed reactive airways disease. She noted that allergy testing revealed a wide variety of positive allergens, including Aspergillus niger and Rhizopus. Dr. Sokas noted an indoor air quality assessment from 1989, which revealed that microorganisms collected from condensation pans in the Waterside Mall's West Tower annex grew Aspergillus niger and Rhizopus, among several yeasts, molds and bacteria. She also noted respiratory peak flow measurements indicating that continued exposure to the compounds that triggered appellant's initial bout of respiratory problems would be expected to cause a progressive decline of pulmonary function. Dr. Sokas concluded that the precise identification of exposures and the elimination of those exposures was an admirable goal.

On June 2, 1995 Dr. Sokas informed Dr. Holland that she had reviewed the industrial hygiene form he provided, describing the industrial hygienist's evaluation of appellant's office space. She advised that September 28, 1994 scratch testing showed appellant to be allergic to several specific fungi identified in his work space. Dr. Sokas noted that appellant's allergies were fairly well documented and that the history of his workplace included a number of incidents of water damage leading to occasional episodes of fairly high fungal overgrowth.

On January 20, 1995 Dr. Lewis B. Eberly, a neurologist, saw appellant as a consultant to Dr. Stein. Appellant told Dr. Eberly that he was diagnosed with migraines in 1994 and had no prior history of headaches. Thereafter he developed respiratory problems, including allergic rhinitis and upper airways responsiveness. Dr. Eberly reviewed a list appellant provided of occupational chemical exposures. He described his findings and stated that appellant had toxic headaches induced by environmental toxins.

On May 18, 1995 Dr. Eberly noted that appellant's symptoms seemed to be generalizing to some degree to other environmental situations, such as when he visited shopping malls, particularly sporting goods or hardware stores or at times with exposure to exhaust fumes. He stated that he could not rule out the possibility of an intracranial mass with associated headaches occurring more frequently.

On May 22, 1996 Dr. Kenneth B. Singleton, a consulting Board-certified internist supported appellant's application for a disability retirement. He reported that appellant's three major diagnoses were reactive airways disease, migraine headache and chronic fatigue syndrome. Other well-documented diagnoses included undifferentiated somatoform disorder, irritable bowel syndrome, hiatal hernia, reflux esophagitis and vasomotor rhinitis.

On August 1, 1997 the Office asked the employer to provide the results of any other air samples or investigative reports on the problems at the Waterside Mall. The employer replied on September 29, 1997 that they would supply the results shortly.

In a decision dated January 21, 1998, the Office denied appellant's injury claim. It found that the medical evidence was insufficient to establish that his claimed conditions were caused by his exposure at the Waterside Mall.[2] The Office noted that none of the medical reports discussed

[2] The Office identified the claimed conditions as occupational asthma, occupational reactive airways disease, migraine headaches due to toxic exposures, chronic fatigue syndrome, allergic rhinitis and neurocognitive impairment.

how or why any specific substance, chemical or irritant (or combination) in what specific level or concentration in appellant's work location caused or contributed to the claimed conditions since November 1993. It stated that it was unclear from the medical evidence how the claimed conditions were due to exposure at work when the environmental studies showed no apparent problems with the work location. The physicians did not support their opinion with any specific exposure evidence, environmental studies or convincing medical rationale.

Appellant submitted a substantial number of documents related to the indoor air quality at the Waterside Mall, including memoranda, surveys, findings, safety and occupational health inspection reports, microbiological samplings, indoor air quality measurement studies, evaluations of organic emissions and analysis of the heating, ventilating and air conditioning systems. The Office received a July 21, 1995 indoor air quality evaluation of his office space, which found that measured values for carbon dioxide, carbon monoxide, temperature, relative humidity and airborne fungi and bacteria were within the acceptable range, except for a relatively low air exchange rate of 0.2 air changes an hour. Fungi, bacteria and yeast contaminated the wallboard and probably carpet surrounding the interior air conditioning unit located in the north hallway of the Washington Information Center, where appellant spent a significant amount of time. Perimeter induction units in appellant's office space were significantly blocked by objects placed on or in front of the units by the occupants.

Dr. Mark E. Bradley, a specialist in occupational medicine, worked at the health unit as a consultant from November 1988 through May 1989. On June 25, 1989 he reported that he had interviewed and examined about 60 employees and expressed very serious concerns about their health and well being. At least 80 percent had bona fide medical problems that Dr. Bradley believed were caused by working in the Waterside Mall; 50 to 60 percent had symptoms and physical findings consistent with tight building syndrome, including eye and throat irritation and headaches; 30 to 40 percent having symptoms and findings of airway hyperreactivity, a form of occupational asthma; 10 percent had evidence of allergic alveolitis.

On October 20, 1989 Dr. Bradley reviewed a health survey and found that some employees, particularly those with respiratory illnesses, were at immediate health risk with long-term health effects. He noted that the prevalence of symptoms from the survey was astonishingly high, by an order of magnitude than he expected.

Appellant submitted an April 15, 2004 report from Dr. Singleton, who was now serving as the lead physician supporting his claim for workers' compensation. Dr. Singleton reviewed appellant's examinations and treatment from December 1993 to 2004. He related the history of disease given by appellant. Dr. Singleton described his findings on physical examination and the results for diagnostic testing from December 1993 to April 2004. He diagnosed occupational asthma and reactive airways disease; migraine headaches; sensitization and hyperreactivity; neurocognitive impairment; chronic fatigue and immune dysregulation syndrome; neurally mediated hypotension and dysautonomia; chronic dizziness; ataxia/loss of balance; and upper airways disease consisting of vasomotor rhinitis.

Dr. Singleton concluded with reasonable medical certainty that each diagnosed medical condition was directly caused by appellant's 2.5 years of occupational exposures to seriously deficient ventilation and high-dose exposures to particulates and multiple specific chemical and

microbiological contaminants in the workplace. He explained that it was not medically reasonable to conclude that any of the diagnoses were due to preexisting medical conditions, preexisting allergic diseases or nonwork concurrent causes, such as his home. Dr. Singleton stated that appellant's only preexisting illnesses were hiatal hernia, reflux esophagitis and a self-reported past history of allergic rhinitis. He stated that there was no valid, credible evidence to support that appellant's respiratory illness and headaches were preexisting and nonoccupational. Dr. Singleton noted his agreement with other treating physicians from 1994 to 1996 that all of appellant's illnesses were occupationally caused. Health unit records clearly indicated that appellant's headaches, increased frequency of upper respiratory infections and all his other symptoms were strongly associated with working in the Waterside Mall. Appellant's physicians could find no nonoccupational medical reasons for his illness. Appellant had recovered from allergic bronchitis more than 20 years before working at the employing establishment, his preexisting allergic rhinitis was not the cause of new respiratory problems, he had none of the new respiratory symptoms or illnesses when he began work at the employing establishment and 30 days of respiratory peak flow measurements (May to June 1994) produced objective medical proof of occupational causation of appellant's asthma and reactive airways diseases. Dr. Singleton addressed causation for all of the diagnosed conditions.

Dr. Singleton relied on the December 25, 2003 report of Dr. Richard Cothern, a physicist with experience as a toxicologist, chemist and environmental risk assessor, for information on appellant's exposure data. Dr. Cothern was appellant's colleague in the Waterside Mall and filed his own claim for workers' compensation.[3]

Following a telephonic hearing on May 5, 2005, an Office hearing representative asked the employer to provide all reports and studies concerning the air quality where appellant worked in the 1990s.

In a decision dated August 2, 2005, the Office hearing representative found that further development of the evidence was warranted. Factual evidence demonstrated problems with the ceiling in 1992 and problems with the carpet in 1994. The medical evidence related a worsening of appellant's condition to his workplace. The hearing representative instructed the Office to prepare a statement of accepted facts and refer appellant to an appropriate Board-certified specialist for a second opinion.

The Office prepared an October 30, 2006 statement of accepted facts, which accepted that appellant's workplace posed a degree of environmental hazards due to defective ceiling tiles and carpet from December 1992 to August 1994. The statement also accepted that the following occurred during this period:

"-1992 Recommendation made to replace ceiling tiles;

"-April 6, 1994 OHSA report indicated need for changing carpet in the workplace;

[3] Dr. Cothern is not a "physician" under 5 U.S.C. § 8101(2).

"July 21, 1995 report showed evidence of contamination in the carpet consisting of fungi, bacteria and yeast.

"In addition the claimant was exposed to normal workplace odors and smells during this period. Evidence of excessive levels of workplace bacteria, hazardous chemicals, odors or improper ventilation, during this period, has not been definitively established.

"-March 21, 1996 report showed evidence of bird droppings in the workplace."

The Office referred appellant, together with the medical evidence and the statement of accepted facts, to Dr. Robert L. Bloom, Board-certified in pulmonary disease, for a second opinion on appellant's respiratory condition. Dr. Bloom evaluated appellant on November 28, 2006. He related appellant's history of illness and his findings on physical examination. Dr. Bloom interpreted the spirometry performed that day as entirely normal. He reviewed complete pulmonary function tests performed on July 2, 2003 and found them to be entirely normal, including diffusing capacity. Dr. Bloom also reviewed a February 22, 2005 computerized tomography (CT) scan, which he read to be entirely normal.

Dr. Bloom found that appellant had an entirely normal pulmonary function with no evidence of any type of disability or chronic pulmonary dysfunction. He stated that appellant did not require oxygen. Dr. Bloom cautioned that the current evaluation did not absolutely exclude a diagnosis of mild intermittent asthma, "but there is certainly no evidence to support that diagnosis." Though he did not think it warranted, he noted that a methacholine challenge test would give definitive information on whether mild intermittent asthma was present. Dr. Bloom noted that he was not an expert in toxicology or an expert in neurology or chronic fatigue syndrome and was unable to state any opinion regarding appellant's other multiple complaints.

Dr. Samuel V. Spagnolo, Board-certified in pulmonary disease, a professor of medicine and an Office medical consultant, reviewed appellant's medical record and found that lung function values from 1994, 2003 and 2006 were completely normal, with no evidence of obstructive or restrictive lung impairment. Methacholine challenges in 1994 and 1995 were negative. It was Dr. Spagnolo's opinion that the evidence did not support any lung condition caused by, precipitated by, aggravated by or as a consequence of any occupationally related exposure. "[Appellant's] lungs are normal and have been normal since initially tested in 1994." He noted that the result of self-reported peak flow measurements could not be validated and should not be used in determining a diagnosis of asthma or an asthma-like condition. Dr. Bloom found that appellant did not meet the criteria for the diagnosis of chronic asthma, reactive airways dysfunction syndrome or hyperreactive airways disease. He could not offer an expert opinion on the conditions referred to as chronic fatigue syndrome or multiple chemical sensitivities.

The Office prepared a June 22, 2007 statement of accepted facts amended to include as accepted a May 17, 1994 fire at the Waterside Mall and a subsequent screening study showing elevated levels of tetrachloroethylene and dichloromethane. It attached the study to the statement of accepted facts.

The Office referred appellant, together with the medical record and the statement of accepted facts, to Dr. Harvey A. Schwartz, Board-certified in rheumatology and allergy/ immunology, for a second opinion on chronic fatigue syndrome. On July 23, 2007 Dr. Schwartz related appellant's history and current symptoms and complaints. He described findings on examination and reviewed the statement of accepted facts. Dr. Schwartz diagnosed chronic fatigue syndrome, history of reactive lung disease, possible heart murmur and other symptoms as noted. It was his opinion that, based on current objective findings, the medical evidence did not support that appellant developed chronic fatigue syndrome as a result of his workplace exposure. Dr. Schwartz explained that chronic fatigue syndrome had no known causative agent or agents. Infections, environmental factors, allergies, psychological stress and other agents had been posed to cause or contribute, but to date there was no objective data showing a causal relationship. Dr. Schwartz saw no medical data to support that appellant developed shortness of breath and coughing or permanent respiratory symptoms as a result of exposure to toxic chemicals at work. He stated that the likelihood of causal relationship was greater at the time of work exposure, but he saw no evidence that exposures more than 10 years ago had resulted in any permanent respiratory condition. Dr. Schwartz specifically found that chronic fatigue syndrome, dizziness, alleged orthostatic hypotension, heart murmur and respiratory symptoms (with the exception of possible increased respiratory symptoms during the time of exposure) and other symptoms were unrelated to appellant's workplace exposure. He noted that the primary diagnosis he was asked to review was chronic fatigue syndrome.

The Office prepared an August 10, 2007 statement of accepted facts amended to include a copy of the July 21, 1995 indoor air quality survey. It attached the survey to the statement of accepted facts.

The Office found a conflict in medical opinion on the issue of pulmonary or respiratory injury (asthma, occupational reactive airways disease and allergic rhinitis). It found a separate conflict on the issue of chronic fatigue injury. The Office referred appellant, together with the medical record and the statement of accepted facts, to Dr. Jeff B. Hales, Board-certified in pulmonary disease, and to Dr. Madalene K. Greene, Board-certified in rheumatology, to resolve these conflicts. When it was discovered that Dr. Hales had previously seen appellant, the Office informed appellant that it would reschedule him with another pulmonologist.

Dr. Greene reviewed appellant's extensive medical record and on October 18, 2007 she interviewed and examined him. She found that he clearly had disabling chronic fatigue syndrome. Dr. Greene noted that appellant's symptoms of extreme fatigue, weakness, myalgia, arthralgia, headache, dizziness, disruptive sleep and neurocognitive impairment started out with a flu-like syndrome in 1993 and then persisted and progressively worsened over the ensuing three to four years. She stated that the onset of appellant's chronic fatigue syndrome was temporally related to his "occupational exposure" from December 1991 to July 1995. Dr. Greene noted that the exposures in the statement of accepted facts -- elevated levels of tetrachloroethylene and dichloromethane in 1994 and contamination in the carpet with fungi, bacteria and yeast and in 1996 bird droppings -- were all documented one to three years after the onset of appellant's symptoms. Further, Dr. Greene stated that she was unaware of any data showing these substances to be directly causative, precipitating, aggravating or a consequence of chronic fatigue syndrome. She explained that studies had looked for an "infectious agent" etiology of chronic fatigue syndrome, but none was found. Dr. Greene an "immune dysfunction" theory of

chronic fatigue syndrome that at best showed only nonspecific findings with no significance yet determined in the pathogenesis of the disorder. She indicated that it was possible that the workplace environment contributed to appellant's chronic fatigue syndrome but explained "the current state of standard medical knowledge" could not draw a causal connection.

In a January 8, 2008 supplemental report, Dr. Greene stated, "In my opinion, based on a reasonable degree of medical certainty and based upon my ongoing practice of [r]heumatology and ongoing medical updates of current and past literature, I do not think that [appellant's] occupational exposure during the period December 1991 [to] July 1995 contributed to his [c]hronic [f]atigue [s]yndrome."[4]

In a decision dated April 18, 2008, the Office denied appellant's claim, finding that the medical evidence failed to establish a causal relationship between a diagnosed condition and exposures in his workplace. It found that the weight of the evidence rested with the impartial medical specialist, Dr. Greene.

On appeal, appellant contends that the Office's decision is not supported by substantial, rationalized evidence, that it contains errors of law and an improper legal standard of causation, that the Office incorrectly adjudicated factors of employment, selectively chose evidence, ignored uncontested evidence favorable to appellant, gave the weight of the evidence to the impartial medical specialist despite little or no rationalization and failed to weigh properly the well-reasoned medical opinions of seven attending physicians whose opinions were supported by uncontested, heavily documented evidence.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.[5] An employee seeking benefits under the Act 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. He must also establish that such event, incident or exposure caused an injury.[6]

Causal relationship is a medical issue[7] and must be shown by a medical opinion that is based upon a specific and accurate history of employment incidents or conditions,[8] that is of

[4] Prior to allowing Dr. Greene an opportunity to submit her supplement report, the Office referred appellant to Dr. Neil I. Stahl, Board-certified in rheumatology, who reported on January 22, 2008 that chronic fatigue syndrome is a syndrome of unknown cause with triggers that cannot often be identified.

[5] 5 U.S.C. § 8102(a).

[6] *John J. Carlone*, 41 ECAB 354 (1989).

[7] *Mary J. Briggs*, 37 ECAB 578 (1986).

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

reasonable medical certainty[9] and that is supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[10]

If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[11] When there exist opposing medical reports of virtually equal weight and rationale and the case is 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, must be given special weight.[12]

In assessing the medical evidence, the number of physicians supporting one position or another is not controlling. The weight of such evidence is determined by its reliability, its probative value and its convincing quality. 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 physician's opinion are factors which enter into such evaluation.[13]

ANALYSIS

Appellant filed a claim alleging that his various neurological and respiratory symptoms were causally related to his work environment, primarily at the Waterside Mall, from December 1991 to July 1995. He has the burden of proof to establish that he experienced a specific exposure occurring at the time, place and in the manner alleged. Appellant must also establish that such exposure caused an injury.

The Office accepted that appellant established certain workplace exposures. It found that his workplace posed "a degree of environmental hazards" due to defective ceiling tiles and carpet from December 1992 to August 1994. The Office's statement of accepted facts referred to a recommendation in 1992 to replace ceiling tiles, an April 6, 1994 OSHA report indicated the need to change carpet, a July 21, 1995 report showing evidence of contamination in the carpet consisting of fungi, bacterial and yeast and a March 21, 1996 report showing evidence of bird droppings in the workplace.[14] It would amend the statement of accepted facts to include a copy of the July 21, 1995 indoor air quality survey and a screening study following the May 17, 1994 fire at work.

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

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

[11] 5 U.S.C. § 8123(a).

[12] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[13] *Naomi A. Lilly*, 10 ECAB 560 (1959).

[14] The report actually found that fungi, bacteria and yeast contaminated the wallboard and "probably" carpet surrounding the interior air conditioning unit located in the north hallway of the Washington Information Center.

The Board finds that the Office's statement of accepted facts is limited in scope. While it is not practicable to include within the written statement of accepted facts every survey, finding, sampling, measurement, analysis, inspection report or memoranda appearing in the case record, it is unreasonable to present only a small fraction of that evidence as factually established. A physician giving an opinion on causal relation should have available for review, if needed, any environmental data or finding relevant to appellant's workplace from December 1991 to July 1995.[15] The Office should sift through the evidence, particularly the substantial number of documents it received in April 2005 and copy all relevant reports of environmental data and findings to a CD-ROM, which may then accompany a properly revised statement of accepted facts.

The statement of accepted facts should make no reference to "normal" workplace odors and smells and should make no finding that "excessive" levels of bacteria, chemicals, odors or improper ventilation are not established.[16] Any survey that finds levels of contaminants to be normal or within acceptable standards should be included in the accepted environmental data and findings, but the judgment of whether the actual levels were nonetheless sufficient to injure appellant must be left to the physician addressing causal relationship. The statement of accepted facts should also avoid describing environmental factors as "hazards." Whether such factors posed a danger or risk to appellant should also be left to the physician.

Further development is warranted based on a revised statement of accepted facts. It may be broadly accepted as factual that appellant was exposed to environmental factors in his federal employment from December 1991 to July 1995. The question then becomes whether appellant's occupational exposure caused an injury.

Appellant submitted medical opinion evidence to support the element of causal relationship. Dr. Stein, a pulmonologist, associated allergic rhinitis and airways hyper-responsiveness to workplace exposure. Dr. Sokas, a specialist in occupational medicine, found that appellant was allergic to specific allergens found in his workplace in 1989 and in an industrial hygienist's evaluation of appellant's office. Dr. Eberly, a neurologist, found that appellant had toxic headaches induced by environmental toxins, but he could not rule out the possibility of an intracranial mass with associated headaches occurring more frequently.

Dr. Singleton, a Board-certified internist who served as the lead physician in support of appellant's claim, included in his April 15, 2004 report a diagnosis of a number of medical conditions and concluded that each was directly caused by appellant's 2.5 years of occupational exposures to seriously deficient ventilation and high-dose exposures to particulates and multiple specific chemical and microbiological contaminants in the workplace. He saw in the health unit records a strong association between working in the Waterside Mall and appellant's headaches, increased frequency of upper respiratory infections and all his other symptoms. Dr. Singleton

[15] Environmental data prior to December 1991 or after July 1995, such as a March 21, 1996 report showing evidence of bird droppings in the workplace, may be of limited relevance to appellant's actual exposure.

[16] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.0809.4.a(4) (September 2009) (vague or generic terms such as light, heavy, undue, severe, irregular and abnormal are to be avoided, since they are subject to great differences of interpretation).

considered appellant's self-reported record of respiratory peak flow measurements for 30 days in 1994 to be objective medical proof of occupational causation of appellant's asthma and reactive airways diseases.

A conflict in medical opinion arose, however, with respect to appellant's pulmonary or respiratory complaints. Dr. Bloom, Board-certified in pulmonary disease and a second-opinion physician, interpreted appellant's November 28, 2006 spirometry as entirely normal, as he did the complete pulmonary function tests on July 2, 2003 and a CT scan on February 22, 2005. It was his impression that appellant had entirely normal pulmonary function with no evidence of any type of disability or chronic pulmonary dysfunction. Dr. Bloom concluded that appellant did not require oxygen.

Dr. Spagnolo, Board-certified in pulmonary disease, a professor of medicine and an Office medical consultant, supported Dr. Bloom's impression. He noted that lung function values from 1994, 2003 and 2006 were completely normal, with no evidence of obstructive or restrictive lung impairment and negative methacholine challenges in 1994 and 1995. It was Dr. Spagnolo's opinion that the evidence did not support any lung condition caused by, precipitated by, aggravated by or as a consequence of any occupationally-related exposure. He declared that appellant's lungs were normal "and have been normal since initially tested in 1994." Dr. Spagnolo took issue with Dr. Singleton's reliance on self-reported peak flow measurements, stating they could not be validated and should not be used to determine a diagnosis of asthma or asthma-like condition. Dr. Bloom further found that appellant did not meet the criteria for the diagnosis of chronic asthma, reactive airways dysfunction syndrome or hyperreactive airways disease.

A conflict in medical opinion arose between the Office physicians and appellant's physicians on whether appellant sustained a pulmonary or respiratory injury in the performance of duty. This conflict remains unresolved. The Office referred appellant to Dr. Hales, Board-certified in pulmonary disease, for an impartial medical evaluation; however, Dr. Hales had previously seen appellant. It never referred appellant to another pulmonologist. On remand, the Office shall refer appellant to an impartial medical specialist Board-certified in pulmonary disease to resolve the conflict pursuant to section 8123(a) of the Act.

A second conflict arose on the issue of chronic fatigue syndrome. Dr. Schwartz, Board-certified in rheumatology and allergy/immunology and a second-opinion physician, diagnosed chronic fatigue syndrome but stated that, based on current objective findings, the medical evidence did not support that appellant developed chronic fatigue syndrome as a result of his workplace exposure. He explained that chronic fatigue syndrome had no known causative agent or agents. Dr. Schwartz specifically found that chronic fatigue syndrome, dizziness, alleged orthostatic hypotension, heart murmur, respiratory symptoms (with the exception of possible increased respiratory symptoms during the time of exposure) and other symptoms were unrelated to appellant's workplace exposure.

To resolve the conflict on whether appellant sustained a chronic fatigue injury in the performance of duty, the Office properly referred appellant to Dr. Greene, Board-certified in rheumatology. Dr. Greene sided with Dr. Schwartz. She diagnosed disabling chronic fatigue syndrome and noted that the onset of appellant's symptoms -- extreme fatigue, weakness,

myalgia, arthralgia, headache, dizziness, disruptive sleep, neurocognitive impairment -- coincided with appellant's federal employment. Dr. Greene indicated that it was possible that the workplace environment contributed to appellant's chronic fatigue syndrome, but she explained "the current state of standard medical knowledge" could not causally connect the two. Studies had looked for an "infectious agent" etiology of chronic fatigue syndrome but found none. In Dr. Greene's supplemental report, she made clear that based on a reasonable degree of medical certainty and based upon her ongoing practice of rheumatology and ongoing medical updates of current and past literature, she did not think that appellant's occupational exposure during the period December 1991 to July 1995 contributed to his chronic fatigue syndrome.

On the issue of whether appellant sustained a chronic fatigue injury in the performance of duty, the Board finds that the weight of the medical opinion evidence rests with Dr. Greene, the impartial medical specialist, whose opinion was clear and unequivocal and her rationale was straightforward. Echoing Dr. Schwartz' observation that chronic fatigue syndrome has no known causative agent, she stated that the current state of standard medical knowledge did not permit a causal link between appellant's chronic fatigue syndrome and his federal workplace. Dr. Greene's opinion stands as the weight of the medical evidence notwithstanding the imperfections in the Office's statement of accepted facts. They have no bearing on her rationale and must be considered harmless error in the context of the opinion she provided.

The Office's April 18, 2008 decision correctly denied one aspect of appellant's claim -- that relating to chronic fatigue syndrome -- but improperly denied the whole of the claim. There remains, as discussed earlier, a conflict on the issue of pulmonary or respiratory injury, a matter Dr. Greene, as rheumatologist, is unqualified to resolve. The Board will therefore affirm the April 18, 2008 decision on the issue of chronic fatigue injury.

One of the arguments appellant makes on appeal deals with the breadth of his claim. He argues the Office must adjudicate each of his 11 claimed medical conditions: occupational asthma, reactive airways disease, chronic fatigue syndrome, migraines, sensitization, neurocognitive impairment, hypotension, dysautonomia, chronic dizziness, ataxia and rhinitis. As explained above, an impartial medical specialist will address the claimed pulmonary or respiratory conditions. The Office has adjudicated appellant's claim for chronic fatigue syndrome. Dr. Greene seemed to indicate that extreme fatigue, weakness, myalgia, arthralgia, headache, dizziness, disruptive sleep and neurocognitive impairment were symptoms of appellant's chronic fatigue syndrome. The Office should follow up with Dr. Greene to determine whether her opinion on chronic fatigue syndrome effectively addressed more than one of the 11 claimed conditions, such as dysautonomia, hypotension, dizziness, ataxia/loss of balance, headache/migraine and cognitive impairment. To the extent that her opinion effectively addressed these claimed conditions or symptoms, no further development of the medical evidence is warranted. To the extent that it did not and to the extent that any remaining nonrespiratory condition constitutes a separate medical diagnosis, the Office shall further develop the evidence by obtaining a second opinion on causal relationship.

Appellant places significance on the number of physicians he counts on his side of the ledger and on the length of and number of footnotes in, Dr. Singleton's April 15, 2004 report, compared to the length of the reports obtained from Office referral physicians. But that is not controlling. The report of an Office referral physician need not be as lengthy as the attending

physician's or as copiously footnoted to establish an actual disagreement under section 8123(a) of the Act. The report of an impartial medical specialist need not be as involved to satisfactorily resolve that disagreement. Appellant argues the probative value of the medical opinion evidence, but ultimately that determination falls within the adjudicator's judgment.

Appellant argues that the employer never responded to the Office's request for relevant environmental data. He obtained a remarkable amount of such data on his own (1,500 or 2,000 pages, he told the Board) and submitted that evidence to the record. Therefore, there appears to be no compelling reason to ask the employer to duplicate appellant's effort and further burden an already ponderous case record.[17]

Appellant argues that the employer did not "validly contest" his claim and that in the absence of a valid contest, the Office must accept his evidence of occupational causation for his entire claim as uncontested fact. The authority he cites does not support this contention. The Office may accept a claimant's account of an incident at work. Causal relationship is a medical issue that depends on the medical opinion evidence.[18]

Appellant argues that the doctrine of "relative circumstances" should apply to half a dozen of his claimed conditions, including chronic fatigue syndrome. Under the doctrine, circumstances may allow, in rare cases, an inference of causal relationship not generally permitted from the coincidence of employment and injury.[19] Application of the doctrine is not mandatory but a matter of judgment and adjudicatory discretion.[20] Appellant has not persuaded the Board that the doctrine should apply in his case. He cites two cases, but the medical record does not establish a recognized precipitating factor or efficient producer of chronic fatigue syndrome, without which -- not to mention the opinion of the impartial medical specialist -- there is no strong suggestion of causal relationship.[21]

Appellant further argues that the Office accepted the claims of other employees exposed to the same environmental factors in the Waterside Mall. His individual claim must stand on its own merits based on the medical evidence submitted. In deciding the merits of this appeal, the Board may not review the outcomes of other claims or evidence in other case records.

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[17] *See* Federal (FECA) Procedure Manual, supra note 16, *Development of Claims*, Chapter 2.0800.5.b(3) (January 2004) (the Office should avoid requesting evidence which already appears in the file or for which no need is anticipated, as such requests place an unwarranted burden on the party asked to submit the information and unnecessary material creates a bulky file which then requires additional time to review).

[18] *Ausberto Guzman*, 25 ECAB 362 (1974).

[19] *Elsbeth Severin (Nicholas Severin)*, 9 ECAB 91 (1956); *Alice E. Nielsen*, 8 ECAB 413 (1955); *Robert Symonds*, 4 ECAB 541 (1952); *Anna Strehl (William Strehl)*, 2 ECAB 74 (1948).

[20] *Bernard P. Godbold*, 8 ECAB 407 (1955) (the relative circumstances of the claim "may" be relied upon in conjunction with the medical evidence to support a compensation award if they strongly suggest a relationship of cause and effect) (Alternate Chairman Lawyer dissenting).

[21] *Cf. id*. (where a medical treatise supported and the Office medical advisers accepted, that Parkinson's disease may be attributed to a sufficiently severe head trauma); *Laura H. Hoexter*, 44 ECAB 987 (1993) (where the Office medical adviser confirmed a specific causal agent by explaining that a virus was the precipitating factor in adult Reye's syndrome).

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that his chronic fatigue syndrome is causally related to his exposure to environmental factors of employment from December 1991 to July 1995. The Board further finds that this case is otherwise not in posture for decision. Further development of the evidence is warranted.

ORDER

IT IS HEREBY ORDERED THAT the April 18, 2008 decision of the Office of Workers' Compensation Programs is affirmed on the issue of chronic fatigue syndrome and is otherwise set aside. The case is remanded for further action consistent with this opinion.

Issued: May 24, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board