United States Department of Labor
Employees' Compensation Appeals Board

L.W., Appellant	)	
and	)	**Docket No. 13-1238**
	)	**Issued: September 24, 2013**
DEPARTMENT OF THE NAVY, MILITARY SEALIFT COMMAND-PACIFIC, Norfolk, VA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On April 19, 2013 appellant filed a timely appeal from an April 11, 2013 decision of the Office of Workers' Compensation Programs (OWCP) that denied his claim. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he has asbestosis that was caused or aggravated by factors of his federal employment.

On appeal, appellant generally asserts that he is entitled to benefits.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On February 23, 2012 appellant, then a 61-year-old retired able seaman, filed an occupational disease claim alleging that employment factors caused asbestosis. He indicated that he was first aware of the illness on December 9, 1999 and its relationship to employment on January 7, 2008. The employing establishment indicated that appellant was last exposed to employment factors on February 7, 2008, when he retired. In attached statements,appellant indicated that he had other medical conditions. He reported that he worked 12 to 13 hours a day on ships and had shortness of breath.[2]

A December 9, 1999 chest x-ray demonstrated pleural thickening and a pleural plaque that raised the possibility of asbestos-related pleural disease. No pleural calcification was seen. Pulmonary function studies on August 13, 2009 demonstrated reduced vital capacity, suggestive of a restrictive defect and a mildly reduced diffusing capacity. The study noted that, when compared to a previous study, airway mechanics had improved. An August 24, 2009 chest x-ray revealed stable bilateral pleural thickening without evidence of acute cardiopulmonary disease.[3]

By letter dated March 20, 2012, OWCP informed appellant of the type of evidence needed to support his claim. This was to include a comprehensive medical report from his physician which described his symptoms, results of examinations including chest x-rays, diagnoses, the treatment provided and the physician's opinion, with medical reasons, regarding the cause of his condition, to include an explanation of whether and how exposure in federal employment contributed to the condition. The record was held open for 30 days. OWCP also asked the employing establishment to comment on appellant's claim and include information regarding his employment and exposure.

Evidence received included an April 10, 2012 chest x-ray which revealed mild congestive heart failure, fluid overload pattern, with small bilateral pleural effusions and minor basilar atelectasis. In an April 17, 2012 report, Dr. Sarah K. Toner, a Board-certified internist, indicated that appellant was seen due to difficulty breathing. She provided a history that he started smoking at age 13 and stopped three months previously, that he could not walk a full block without shortness of breath and that he had been diagnosed with obstructive sleep apnea. Dr. Toner reviewed January 5 and April 10, 2012 chest x-rays and noted multiple medical problems including chronic obstructive pulmonary disease (COPD). Pulmonary examination demonstrated no wheezes, rhonchi or rales.

In an April 24, 2012 report, Dr. Anthony J. Gerbino, Board-certified in internal medicine and pulmonary disease, reported that appellant had a history of obstructive sleep apnea, hypertension, tobacco use, dyspnea, some wheezing and a persistent cough and that he was morbidly obese with a height of 5 feet 7 inches and a weight of 340 pounds.He noted appellant's history of asbestos exposure. Diffuse expiratory wheezes were heard through lung examination. Dr. Gerbino reviewed August 2009 and April 10, 2012 chest x-rays, advising that no pleural plaques were evident on either film. He indicated that the April 13, 2012 pulmonary function

[2] Portions of his statements are illegible.

[3] Appellant submitted additional medical evidence regarding additional medical conditions.

test was indicative of severe obstruction with some improvement through bronchodilation, perhaps some restriction due to appellant's morbid obesity and advised that he had a high risk for congestive heart failure. Dr. Gerbino stated that, although appellant had a history of asbestos exposure, there were no apparent signs of asbestosis on his recent chest x-ray and an August 2009 abdominal computerized tomography (CT) scan which showed the lower 1/3 of his lungs, with no calcified plaques, fibrosis or other findings that would be indicative of asbestosis. He indicated that, given appellant's prior history of asbestos exposure, this did not rule out that he could develop asbestosis in the future. Dr. Gerbino concluded that appellant's acute presentation at that time was likely due to a combination of congestive heart failure, obstructive sleep apnea and COPD and advised that, once these conditions had improved, he should consider getting a CT scan of his lungs to look for further evidence of asbestosis. In an April 24, 2012 report, Dr. Toner noted Dr. Gerbino's findings and diagnosed multifactorial dyspnea caused by heart failure, COPD and obstructive sleep apnea.

In July 2012, OWCP referred appellant to Dr. Robert E. Cox, Board-certified in internal medicine and pulmonary disease. In an August 13, 2012 report, Dr. Cox noted his review of the statement of accepted facts and medical record and indicated that appellant was being seen for an asbestos evaluation, noting that he had a work history as a seaman with exposure to asbestos anda smoking history, although he had recently quit. Hereported appellant's complaint of shortness of breath with minimal activity, sleep apnea, COPD, degenerative joint disease of the back and a heart arrhythmia. Dr. Cox recorded a height of 67 inches and a weight of 361 pounds. He advised that pulmonary examination demonstrated normal inspection, palpation and percussion and that lung fields revealed trace end expiratory wheezes with no crackles or rales. Dr. Cox reviewed the April 10, 2012 x-ray, noting that it showed no pleural plaques. He diagnosed COPD, smoking related, with no objective evidence of asbestos-related pleural or parenchymal pulmonary disease. Dr. Cox stated that he agreed with Dr. Gerbino's assessment that appellant's radiographic studies and pulmonary function findings showed no evidence of pleural or pulmonary asbestos-related lung disease but were consistent with COPD. He further diagnosed sleep apnea, hypertension, history of hepatitis C, spinal stenosis, possible congestive heart failure and prostatic hypertrophy, which were not related to this claim. Dr. Cox concluded that appellant's pulmonary conditions, particularly COPD and any congestive heart failure, were not related to his exposure history. On an attached work capacity evaluation, he indicated that appellant could not work because he was severely impaired from nonoccupational diseases including back pain, congestive heart failure, COPD and morbid obesity and that he had no occupational pulmonary disease.

By decision dated August 22, 2012, OWCP denied the claim. It found that the claimed exposure was established but that the record did not establish any medical condition caused by the accepted exposure.

On September 11, 2012 appellant requested a hearing. He submitted employing establishment health records including an undated record of asbestos monitoring indicating that asbestos exposure had occurred and that appellant had a 30-year smoking history. A June 11, 1980 chest x-ray was read as normal. A February 26, 1981 chest x-ray demonstrated mild pleural thickening along the chest wall and a single mid-lung fibrotic scar. A second surveillance record dated December 18, 1989 noted that appellant was exposed to asbestos and

had smoked one pack of cigarettes daily for 13 years. An employing establishment medical report dated November 6, 1986 indicated that appellant had asbestos exposure.

In January 28, 2013 correspondence, Shirley Flippin, doctor of pharmacology, indicated that she was writing on behalf of appellant who was trying to receive medical and financial assistance. She described his work duties and opined that he had sustained multiple injuries and that his condition had progressively worsened, stating that he had difficulty performing activities of daily living due to debilitating back and upper extremity pain and breathing problems that could be attributed to asbestos and chemical exposure.

At the hearing, held February 13, 2013, OWCP's hearing representative noted that asbestos exposure had been accepted and explained that supportive medical evidence was needed to establish causal relationship. Appellant described his work history beginning in 1977, stating that many ships were contaminated with asbestos and indicated that he had two additional claims, one for carpal tunnel syndrome and one for COPD. He maintained that OWCP's referral physician did not do a thorough examination. The record was to be held open for 30 days.

A July 31, 2006 interpretation of a June 17, 1997 chest x-ray revealed small opacities and pleural plaques and no large opacities or calcification. The diaphragm border and heart border were ill-defined.

On April 11, 2013 OWCP's hearing representative found that there was no medical evidence to support that appellant had work-related asbestosis or a work-related pulmonary condition and affirmed the August 22, 2012 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA 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 FECA, that the claim was timely filed within the applicable time limitation period of FECA, 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 is causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[4]

OWCP regulations define the term "occupational disease or illness" as a condition produced by the work environment over a period longer than a single workday or shift."[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 diagnosed

[4] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[5] 20 C.F.R. § 10.5(ee).

condition is causally related to the employment factors identified by the claimant. The medical opinion must be one of reasonable medical certainty, 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.[6]

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[7] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, 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 employee.[8] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[9]

ANALYSIS

The Board finds that appellant did not meet his burden of proof to establish that he sustained asbestosis caused by the accepted asbestos exposure during federal employment, because the medical evidence is insufficient to establish causal relationship.

The diagnostic studies, including x-rays and pulmonary function tests, do not provide a cause of any diagnosed condition and medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[10] While Dr. Flippin generally supported appellant's claim, she is a doctor of pharmacology. Section 8101(2) of FECA defines the term "physician" to include surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by state law.[11] Medical opinion, in general, can only be given by a qualified physician.[12] Doctors of pharmacology are not included among the healthcare professionals recognized as a physician under FECA.[13] Dr. Flippin's report therefore does not constitute probative medical evidence.

Dr. Toner, an attending internist, indicated that appellant was seen due to difficulty breathing. She diagnosed multifactorial dyspnea caused by heart failure, obstructive sleep apnea and COPD.

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[6] *Supra* note 4.

[7] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[8] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[9] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[10] *Willie M. Miller*, 53 ECAB 697 (2002).

[11] 5 U.S.C. § 8101(2); *see George H. Clark*, 56 ECAB 162 (2004).

[12] *E.K.*, Docket No. 09-1827 (issued April 21, 2010).

[13] *Supra* note 11.

Dr. Gerbinonoted appellant's medical history and advised that, although appellant had a history of asbestos exposure, there were no apparent signs of asbestosis on his recent chest x-ray, an August 2009 CT scan and an April 13, 2012 pulmonary function study. He indicated that, given appellant's prior history of asbestos exposure, this did not rule out that he could develop asbestosis in the future, but concluded that his acute presentation at the present was likely due to a combination of congestive heart failure, obstructive sleep apnea and COPD and advised that, once these conditions had improved, he should consider getting a CT scan of his lungs to look for further evidence of asbestosis. The record does not contain an additional CT scan study and the possibility of future injury does not form a basis for compensation.[14] Dr. Gerbino's opinion is therefore insufficient to establish causal relationship.

Dr. Cox, an OWCP referral physician, provided an August 13, 2012 report. He indicated that he had reviewed the medical record and noted appellant's work history with asbestos exposure and smoking history, and his complaints of shortness of breath, sleep apnea, COPD, degenerative joint disease of the back and heart arrhythmia. Dr. Coxreviewed the April 10, 2012 x-ray and April 13, 2012 pulmonary function tests and advised that he agreed with Dr. Gerbino's assessment that the diagnostic studies showed no evidence of asbestos-related lung disease and were consistent with a diagnosis of COPD. He additionally diagnosed sleep apnea, hypertension, history of hepatitis C, spinal stenosis, possible congestive heart failure and prostatic hypertrophy, which were not related to this claim. Dr. Cox advised that none of appellant's pulmonary conditions, particularly COPD and any congestive heart failure, were related to his exposure history. He indicated that appellant could not work because he was severely impaired from nonoccupational diseases including back pain, congestive heart failure, COPD and morbid obesity and that he had no occupational pulmonary disease.

The medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty. Such opinion, however, cannot be speculative or equivocal.[15] It must be one of reasonable medical certainty that the condition for which compensation is claimed is causally related to his federal employment and such relationship must be supported with affirmative evidence, explained by medical rationale and be based upon a complete and accurate medical and factual background of the claimant.[16] It is appellant's burden to establish that claimed asbestosis is causally related to factors of his federal employment. In this case, the medical evidence does not support that he has asbestosis.

The record also does not support that any of appellant's diagnosed pulmonary conditions are employment related. Dr. Toner, Dr. Gerbino, nor Dr. Cox related appellant's COPD or sleep apnea to his federal employment. Moreover, appellant testified at the hearing that he had a separate claim for COPD.

[14] *C.S.*, Docket No. 09-1597 (issued February 4, 2010).

[15] *Patricia J. Glenn*, 53 ECAB 159 (2001).

[16] *A.D.*, 58 ECAB 149 (2006).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant did not establish that he sustained asbestosis causally related to factors of his federal employment in this occupational disease claim.

ORDER

IT IS HEREBY ORDERED THAT the April 11, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 24, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board