BEFORE THE WORKERS' COMPENSATION BOARD

STATE OF OREGON

| | | |
|---|---|---|
| In the Matter of the Compensation | ) | WCB Case No. 06-03726 |
| | ) | Claim No. 7988923G |
| | ) | DOI: 12/09/2005 |
| of | ) | WCD File No. HAS4901 |
| | ) | |
| DAVID B. YOUNG, Claimant | ) | ORDER ON REVIEW |

Reviewing Panel: Members Lowell and Weddell.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Smith's order that set aside its denial of claimant's occupational disease claim for a lung condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplementation.[1]

Claimant began working at an asphalt plant in December 2004. Although manufacturing asphalt was his primary duty, his job also involved rebuilding large metal bins, which required grinding and welding metal, and maintenance of the plant machinery. In October 2005, he sought treatment for shortness of breath. In January 2006, he underwent a lung biopsy. Dr. Treger, a pathologist, interpreted the biopsy as showing a pattern consistent with desquamative interstitial pneumonia (DIP), which, he stated, could be associated with heavy smoking. (Ex. 41-1). However, he also noted the frequent presence of multinucleated giant cells not usually found in DIP, thus requiring consideration of other conditions.[2] (*Id.*) SAIF denied claimant's occupational disease claim for his lung condition, and claimant requested a hearing.

[1] We do not adopt the last sentence on page 41 or footnote 11 of the ALJ's order.

[2] A "giant cell" is a large cell formed when several individual cells, such as macrophages, join together. (Ex. 176-28).

In finding claimant's lung condition compensable, the ALJ determined that the opinion of Dr. Abraham, a pathologist, was most persuasive. On review, SAIF contends that the most persuasive medical evidence is not Dr. Abraham's *opinion,* but the opinions of Drs. Barker and Burton, who examined claimant on *its behalf.* For the following reasons, we disagree with SAIF's contentions.

To establish compensability, claimant must show that employment conditions were the major contributing cause of his lung condition. ORS 656.266(1); ORS 656.802(2)(a). The major contributing cause is the cause, or combination of causes, that contributed more than all other conditions combined. *Smothers v. Gresham Transfer, Inc.*, 332 Or 83, 133 (2001).

Determination of the major contributing cause is a complex medical question that must be resolved by expert medical evidence. *Uris v. State Comp. Dep't*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). When presented with disagreement among experts, we give more weight to those expert opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

SAIF contends that Dr. Abraham's opinion is unpersuasive because the record does not support his diagnosis of claimant's lung condition, which was interstitial fibrosis, involving scarring in the lungs and accumulation of dust. (Ex. 176-19). SAIF also asserts that Dr. Abraham's reasoning is unpersuasive and does not consider the contribution of smoking to claimant's lung condition.

In disputing Dr. Abraham's diagnosis of interstitial fibrosis, SAIF notes that Dr. Treger reported that one section of claimant's lung tissue had "no marked increase in interstitial fibrosis." (Ex. 41-2). However, Dr. Treger also noted that another area showed "prominent fibrosis and some honeycomb formation," albeit "limited in extent."[3] (*Id.*) Further, Dr. Abraham explained that the fibrosis diagnosis was supported by findings by Dr. Ordal, claimant's treating pulmonologist, of severe restrictive defect/disease. (Ex. 176-57).

[3] Although Dr. Treger did not discuss the interstitial fibrosis diagnosis, Dr. Keppel, a worker-requested medical examiner, explained that Dr. Treger's findings were consistent with "late-stage pulmonary fibrosis." (Ex. 205-1).

We also note that Dr. Burton, whose opinion is discussed further below, disagreed with the interstitial fibrosis diagnosis. (Ex. 220-46). However, he based that disagreement on his belief that Dr. Abraham did not describe claimant as suffering from lung fibrosis. (*Id.*) Because Dr. Abraham described claimant's condition as interstitial fibrosis, Dr. Burton's rejection of that diagnosis is unpersuasive. Under such circumstances, Dr. Abraham's explanation of his diagnosis is persuasive.[4]

SAIF asserts that Dr. Abraham did not explain the mechanism of injury or weigh claimant's history of smoking or genetics against his employment exposure. Again, we disagree with SAIF's assertion.

Dr. Abraham had performed a quantitative analysis for the concentration of inorganic particulates in claimant's lung biopsy samples and found high levels of particulates, including high levels of metals. (Ex. 163-1). Dr. Abraham explained that claimant had been exposed to a variety of materials, including metallic and nonmetallic particulates, as verified by the biopsy, and gasses involved in welding, which were capable of causing such injury. (Ex. 176-39, -65, -71). Dr. Abraham explained that claimant's particulate levels were significantly higher than normal, and that the metals found in the lung biopsy could only be explained by employment exposure described by claimant, or by a hobby or bystander proximity to metal use, the latter two of which the record does not support. (Ex. 176-46). He noted that some of the particulates were consistent with stainless steel, and other particulates were consistent with other metal or solder, and that such particulates were consistent with grinding and welding activities.[5] (Ex. 176-48-49). He also stated that cigarette smoking is not a source of the metals

---

[4] Claimant need not prove a specific diagnosis, but must prove that employment conditions were the major contributing cause of his condition. *See Tripp v. Ridge Runner Timber Servs.*, 89 Or App 355, 358 (1988); *Aracely Zavala*, 65 Van Natta 1395 (2013); *Jen Bradley*, 65 Van Natta 1137, 1138 (2013). Therefore, we consider the persuasiveness of the experts' diagnoses insofar as they are relevant to the persuasiveness of their causation analysis.

[5] SAIF asserts that claimant's work activities involved less grinding and welding of large metal bins than he described, and that his work on such bins, which were rusty, would not explain his exposure to stainless steel. However, in addition to working on the bins, claimant's work also involved metal working when he repaired machinery. (Ex. 89). Further, regardless of the exact amount of time spent working on the bins, the record supports claimant's assertion that his work involved significant grinding and welding, and no expert has persuasively opined that such work would not explain the metal particulates found in claimant's lungs or that another cause was more likely.

found in claimant's lungs. (Ex. 176-49). Thus, in the absence of an alternative source of inhaled metal particulates, Dr. Abraham concluded that the metal in claimant's lungs came from his employment conditions. (Ex. 176-50).

Dr. Abraham acknowledged that his opinion was based on "a very limited history" and he could not quantify claimant's exposure, but opined that it was sufficient to know that claimant was exposed to dust and fumes from grinding and welding metals. (Ex. 176-39, -65). Based on that history, and the biopsy findings, he opined that there was sufficient exposure to cause injury. (Ex. 176-45, -65).

Dr. Abraham also explained that whereas smoking can cause various diseases, such as emphysema and DIP, it generally does not cause fibrosis. (Ex. 176-40). He noted medical literature showing that fibrosis and scarring in the lungs of smokers is more correlated with dust detected in analysis of their lungs than with their smoking history. (*Id.*)

Finally, Dr. Abraham discussed the contribution of genetics to claimant's lung condition. SAIF notes that Dr. Abraham stated that he "d[id]n't know how to weigh" the genetic contribution to causation, but that statement was a general statement made regarding the "usual approach in occupation medical circles * * * not to blame the worker for whatever genetics they bring to their situation, but to protect them from exposures that are capable of harming them." (Ex. 176-34). Regarding this specific case, Dr. Abraham explained that the available information did not indicate that claimant is genetically susceptible to his lung disease. (Ex. 176-32, -51). Further, he explained that even if there were a genetic susceptibility, it would have been the work exposure, not the genetic susceptibility, that caused inflammation and fibrosis in the lungs. (Ex. 176-34).

Dr. Abraham opined that employment conditions were the major contributing cause of claimant's lung condition. (Ex. 176-55). His opinion is persuasive. Further, as explained below, we find the contrary opinions of Drs. Barker and Burton unpersuasive.

Dr. Barker noted that claimant had a history of smoking cigarettes, as well as grinding and welding metal for his job. (Ex. 65-2, -6). He stated that claimant had severe restrictive impairment and noted that the lung biopsy report, authored by Dr. Treger, a pathologist, identified a DIP pattern, but also noted the presence of giant cells suggestive of other diagnoses. (Exs. 41-1, 65-2, -6). He initially identified both smoking and occupational exposure as significant causes of

claimant's lung condition, and was unable to determine which was the major contributing cause. (Exs. 65-8, 88-4). He recommended "review by an expert such as Dr. Abraham" to evaluate the contribution from hard metals. (Ex. 88-2-3).

In August 2006, Dr. Barker noted that claimant had left work approximately nine months earlier and reported quitting smoking approximately seven months earlier, after his lung biopsy, although he continued to be exposed to second-hand smoke from his wife. (Ex. 88-1, -3). Opining that DIP would be expected to improve after the end of causal exposure, Dr. Barker expressed confusion that claimant had not experienced such improvement over those periods. (Ex. 88-3).

Dr. Barker later viewed surveillance video of claimant smoking cigarettes in August 2006.[6] (Ex. 107-1-2). Based on such footage, he opined that claimant suffered from DIP caused, in major part, by smoking. (Ex. 107-2).

Dr. Barker stated that the proportion of DIP cases involving nonsmokers was "very, very small." (Ex. 136-31). Nevertheless, he acknowledged that DIP could be caused by exposure to particulates and that giant cells were generally not associated with smoking. (Ex. 136-19, -44). He explained that in reaching his ultimate opinion, he reasoned that because claimant continued to smoke, but not to work, claimant's worsening indicated that the smoking, not employment exposure, was causal. (Ex. 136-43-44).

However, even after concluding that claimant's lung condition was not caused, in major part, by employment conditions, Dr. Barker acknowledged that giant cells were not caused by smoking, and continued to opine that claimant's giant cells were not caused by his history of smoking. (Ex. 136-44, -54). Thus, his opinion does not account for the giant cells, which was the finding that first led him to believe that work could have been the major contributing cause of the condition. Additionally, as discussed further below, we find Dr. Ordal's discussion of the progression of claimant's condition more persuasive. Therefore, we do not find Dr. Barker's opinion persuasive.

We turn to Dr. Burton's opinion. He stated that claimant's condition had been confirmed to be DIP by all other expert opinion. (Ex. 193-15, -17). He noted that DIP was strongly associated with smoking, and not regarded as

[6] Claimant testified that he "tried to quit" after the lung biopsy, but "would sneak cigarettes on and off on occasion." (Tr. 82).

an occupational disease. (Ex. 193-17). Citing an industrial hygiene survey and his understanding of grinder operation, he also opined that claimant had not been exposed to significant amounts of airborne particulates. (Exs. 193-15, 194-8). Based on the DIP diagnosis, claimant's history of smoking, and the lack of documented exposure to airborne particulates, he concluded that claimant's lung condition was caused by smoking, not by employment conditions. (Exs. 193-16, 194-8, -10, 220-20, -68).

As noted above, Dr. Abraham did not diagnose DIP, and Drs. Barker and Treger noted that claimant's giant cell pattern was not consistent with smoking-related DIP. Additionally, Dr. Ordal and Dr. Keppel, a worker-requested medical examiner, opined, based on the presence of giant cells, that claimant did not have a typical smoking-related DIP condition.[7] (Ex. 137-1, 209-1, 221-3). Insofar as Dr. Burton's diagnosis was based on the unanimity of the DIP diagnosis among other medical experts, it is unpersuasive. *See Miller v. Granite Constr. Co.*, 28 Or App 473, 478 (1977) (medical evidence based on inaccurate information found unpersuasive).

Further, Dr. Burton acknowledged that although DIP is generally considered a smoking-related disease, and not an occupational disease, some cases of DIP occur in the absence of smoking. (Ex. 220-53). Therefore, even if Dr. Burton's DIP diagnosis were correct, persuasive assignment of causation to smoking, rather than employment conditions, would require consideration of the circumstances of this particular case. *See Sherman v. Western Employers Ins.*, 87 Or App 602, 606 (1987) (medical evidence not persuasive here it was general in nature and not addressed to the claimant's situation in particular).

In reaching his causation conclusion, Dr. Burton relied on an industrial hygiene survey that did not measure significant amounts of airborne particulates. However, that survey offered incomplete information regarding claimant's work

---

[7] Dr. Burton opined that the presence of giant cells did not cast doubt on the DIP diagnosis. He explained that because macrophages are cells that "eat" debris, and macrophages are present in DIP, it is unsurprising that DIP would involve macrophages that "eat each other and result in an occasional giant cell." (Ex. 220-9-11). Nevertheless, he did not persuasively refute the observation by Drs. Treger, Ordal, Keppel, and Barker that claimant's pattern of giant cells was not consistent with smoking-related DIP.

SAIF also notes that Dr. Abraham did not find "enough of the giant cells or the really peculiar giant cells that [he had] seen in hard metal disease or giant cell interstitial pneumonia" to support a diagnosis of that condition. (Ex. 176-44-45). Nevertheless, while he did not find a giant cell pattern indicative of hard metal disease, he did not opine that the giant cell pattern was consistent with smoking-related DIP.

environment. The survey did not address the grinding and welding to which Dr. Abraham attributed claimant's exposure to metal particulates. (Ex. 64-3). The survey also measured claimant's exposure to dust inside the sheltered cab of a loader, with the windows open "to simulate 'worst case' conditions to outdoor dust levels," whereas claimant worked both outside, where he was exposed to greater dust levels, and in machinery and bins that were open on top or on two sides. (Exs. 64-3, 80-1; Tr. 51, 65, 119, 121). Claimant's wife verified that claimant's work resulted in "tiny little burn marks" in his clothing, and she and Dr. Ordal verified that claimant's work left him covered in particulates. (Ex. 137-1; Tr. 36-37). Under such circumstances, we conclude that Dr. Burton's understanding of claimant's work exposure was inaccurate.

Dr. Burton's causation opinion is based, in large part, on the DIP diagnosis and claimant's work exposure. Because we find Dr. Burton's diagnosis unpersuasive and his understanding of claimant's work exposure inaccurate, we find his reasoning unpersuasive.

Finally, even if we found Dr. Abraham's opinion unpersuasive, we would nevertheless find Dr. Ordal's opinion more persuasive than those of Drs. Barker and Burton.

Dr. Ordal considered the possible DIP diagnosis, but explained that claimant's pattern of giant cells and the metal particulates found in claimant's lungs were not consistent with smoking-related DIP. (Ex. 221-3). He noted claimant's exposure to particulates, and explained that such exposure was more consistent with claimant's lung condition. (Ex. 137-1). He also opined that although claimant had a history of smoking, that history did not involve the "heavy" smoking that would generally cause DIP. (Ex. 137-2).

Dr. Ordal responded to Dr. Barker's opinion that the progression of claimant's lung condition in 2006, after claimant ceased working but continued to be exposed to cigarette smoke, established that smoking was the primary cause. In addition to noting claimant's giant cells and metal particulates, Dr. Ordal opined that the initial lung damage probably began an inflammatory process that could continue long after exposure had ended. (Ex. 137-1). Further, Dr. Ordal explained that claimant experienced periods of improvement in 2006, thus undermining Dr. Barker's premise. (*Id.*) As claimant's treating pulmonologist, Dr. Ordal was in a better position to make such an observation. *See Weiland v. SAIF*, 64 Or App 810, 814 (1983) (greater weight generally given to opinion of

the treating physician based on greater opportunity to evaluate the claimant's condition); *but see Hammons v. Perini Corp.*, 43 Or App 299, 301 (1979) (no special credit given to the treating physician's opinion where the case involved expert analysis rather than expert observation). We conclude that his discussion of the progression of claimant's lung condition is more persuasive than Dr. Barker's.

Further, Dr. Ordal's opinion not only considers claimant's smoking and employment exposure, but persuasively explains the presence of giant cells and metal particulates.

SAIF contends that Dr. Ordal had an incorrect history regarding claimant's smoking history. Dr. Ordal believed that claimant's smoking history consisted of approximately eight pack-years of cigarette smoking. (Ex. 114-2). Claimant testified that he smoked approximately a half-pack to a pack of cigarettes per day from the age of 20 through the time he got sick. (Tr. 82). He was born in 1975 and first sought treatment 2005. (Ex. 2-1). Thus, his testimony is consistent with Dr. Ordal's history.

Citing testimony by Mr. Meyer, claimant's employer, that claimant smoked "all the time" at work, claimant's failure to disclose to various doctors that he continued to smoke after his biopsy in 2006, and evidence that SAIF alleges is inconsistent with claimant's description of his alcohol consumption, SAIF contends that claimant's testimony is not credible.

Although Mr. Meyer stated that claimant smoked "all the time" and was a "heavy smoker" he did not estimate how many cigarettes claimant smoked in a work day.[8] (Tr. 26). Thus, the record does not contradict claimant's testimony regarding his smoking. Further, the other alleged inconsistencies in the record regard collateral issues that do not impeach his general credibility. *See Daniel E. Baxter*, 61 Van Natta 866, 869 (2009) (no particular significance attached to inconsistencies regarding collateral matters); *but see George V. Jolley*, 56 Van Natta 2345, 2348 (2004) (inconsistencies in the record may raise such doubt that a witness's material testimony may be deemed unreliable).

[8] Mr. Meyer explained that claimant was "a heavy smoker compared to what [Mr. Meyer] was smoking. [Mr. Meyer] smoked small cigars." (Tr. 26).

Accordingly, we conclude that Dr. Ordal's opinion is based on accurate information. Further, we find it more persuasive than the opinions of Drs. Barker and Burton. Under such circumstances, we find claimant's lung condition compensable. Accordingly, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $10,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, his counsel's fee submission, and SAIF's objection), the complexity of the issue, and the value of the interest involved.

Finally, claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by SAIF. *See* ORS 656.386(2); OAR 438-015-0019; *Gary E. Gettman*, 60 Van Natta 2862 (2008). The procedure for recovering this award, if any, is prescribed in OAR 438-015-0019(3).

## ORDER

The ALJ's order dated October 4, 2012 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $10,500, payable by SAIF. Claimant is awarded reasonable expenses and costs for records, expert opinions, and witness fees, if any, incurred in finally prevailing over the denial, to be paid by SAIF.

**Notice to all Parties:** This order is final unless, within 30 days after the date of this order, one of the parties files a petition for judicial review with the Court of Appeals under ORS 656.298. The petition for judicial review must either be mailed or delivered to the State Court Administrator, Records Section, Supreme Court Building, 1163 State St., Salem, OR 97301-2563, along with proof that copies of the petition have been mailed or delivered to the Board and all other parties who appeared in this review proceeding. If the petition for judicial review is filed by mail, the date of filing will be the date of mailing, provided the petition is mailed by registered or certified mail and the party filing the petition has proof from the post office of such mailing date. If the petition for judicial review is received by the State Court Administrator on or before the expiration of the 30-day time period, proof of mailing is not required.

Entered at Salem, Oregon and copies mailed to:

David B Young, 805 Pine St, Silverton OR 97381
Black Chapman et al, 221 Stewart Ave # 209, Medford OR 97501
Mountain View Paving, 2560 E Main St, Ashland OR 97520
SAIF Corporation, 400 High St SE, Salem OR 97312
Julie Masters, SAIF Legal Salem
Info copy electronically transmitted to: DCBS WCD Operations

on

AUG 13 2013

**Workers' Compensation Board**

Greig Lowell, Board Member

Margaret F. Weddell, Board Member