U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 January 2018

CASE NO.: 2016-LHC-00252

OWCP NO.: 14-152919

In the Matter of:

ARCHIE MILLER,
Claimant,

vs.

CHM2 HILL ALASKA, INC.,
f/k/a VECO, INC.,
Employer,

and

AIGA, as successor in interest to AMERICAN MOTORISTS INSURANCE COMPANY, and NORTHERN ADJUSTERS, INC., its Workers' Compensation Insurance Adjuster,
Carrier.

NOTICE OF CORRECTION TO CASE CAPTION

On January 5, 2018, I issued a Decision and Order Denying Benefits in this Longshore matter. My Decision and Order identified the carrier in this case as "AIG, as successor in interest to American Motorists Insurance Company." On January 26, 2018, Respondents' counsel filed a "Notice of Corrected Caption Reflecting Substitution of AIGA for Insolvent Carrier" and asked that the caption and OALJ and OWCP records be corrected to accurately reflect the current parties. Her suggestion is the caption reflected above.

It is hereby ORDERED that caption in the Decision and Order issued January 5,2018, be corrected to be the same as that indicated above, specifically, that "AIG" be corrected to "AIGA" and that the words "and Northern Adjusters, Inc., its Workers' Compensation Insurance Adjuster" be added.

Digitally signed by Jennifer Gee
DN: CN=Jennifer Gee,
OU=Administrative Law Judge, O=US
DOL Office of Administrative Law
Judges, L=San Francisco, S=CA, C=US
Location: San Francisco CA

JENNIFER GEE
Administrative Law Judge

U.S. Department of Labor

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AIG, as successor in interest to
AMERICAN MOTORISTS INSURANCE COMPANY,
Carrier.

Appearances: Samuel S. Frankel, Jr., Esquire
For the Claimant

Nina M. Mitchell, Esquire
For the Employer/Carrier

Before: Jennifer Gee
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

INTRODUCTION

This is an action for benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901 *et seq.*, ("Longshore Act") filed by the Claimant, for respiratory issues suffered while working for the Employer. It was initiated with the Office of Administrative Law Judges ("OALJ") on November, 16, 2015, when it was referred to the OALJ for formal hearing by the District Director of the Office of Workers' Compensation Programs.

For the reasons set forth below, Claimant's claims for compensation and medical benefits are DENIED.

PROCEDURAL BACKGROUND

The Claimant Archie Miller filed a claim for medical benefits under the Longshore Act on December 23, 2009. On November 2, 2012, Administrative Law Judge William Dorsey granted summary judgment for Respondent, finding that the Claimant's employment was not covered under the Act. *Miller v. CH2M Hill Alaska, Inc.*, USDOL/OALJ Reporter (PDF), ALJ No. 2012-LHC-00419 (ALJ November 2, 2012). The Benefits Review Board vacated this finding and remanded for further consideration.[1] *Miller v. CH2M Hill Alaska, Inc.*, USDOL/OALJ Reporter (HTML), BRB No. 13-0069, ALJ No. 2012-LHC-00419 (BRB September 25, 2013). On remand, Judge Dorsey found that Mr. Miller's employment was covered under the Act, and that he was entitled to see a physician of his choice to determine the relationship between his respiratory complaints and his work for Respondent. *Miller v. CH2M Hill Alaska, Inc.*, USDOL/OALJ Reporter (PDF), BRB No. 13-0069, ALJ No. 2012-LHC-00419 (ALJ May 15, 2015).

On July 16, 2015, Respondent authorized a medical evaluation for the Claimant, which Dr. Mary DeMers conducted on July 23, 2015. (RX 1, pp. 7-8.) Dr. DeMers recommended ongoing treatment for the Claimant's respiratory issues. Respondent refused to authorize any further treatment, which is the basis for this case.

On October 30, 2015, Dr. DeMers found that the Claimant's respiratory issues limit his ability to work. The Claimant consequently amended his claim on January 29, 2016, seeking compensation benefits beginning October 2015 and ongoing. This matter was heard in Anchorage, Alaska on June 29, 2016. Counsel for both parties appeared and participated in the trial, as did the Claimant. I received the parties' post-trial briefs on October 3, 2017.

a. Exhibit Issues

At trial, I admitted ALJ Exhibit 1 and Claimant's Exhibits (CX) 1-11. Claimant's counsel advised that he would submit Claimant's Exhibit 13 after the hearing, described as Dr. DeMers' August 23, 2016, deposition transcript. At trial I also admitted Respondent's Exhibits (RX) 1-16 and 19-21. Respondent's Exhibits 17 and 18 were unavailable. Respondent described these exhibits as Claimant's SSA Earnings/Disability Records and Dr. Barker's Deposition Transcript, respectively. Claimant's counsel had no objection, so I said that I would admit these exhibits into evidence when I received them from Respondent.

Respondent's counsel's Exhibit List filed with his pre-hearing submissions listed the following exhibits:

EX 17: SSA Earnings and Disability Records **(pending)**
EX 18: Deposition of Dr. Barker **(pending)**

[1] The Benefits Review Board affirmed in part and vacated in part. It affirmed Judge Dorsey's finding that the Claimant's work on land was not covered by the Act, but vacated his finding that the Claimant's work on navigable waters was not covered. Other aspects of the Board's decision are not relevant at this stage.

EX 19: Claimant's April 29, 2016 Deposition Transcript
EX 20: Claimant's July 10, 2012 Deposition Transcript
EX 21: Dr. DeMers' June 7, 2016 Transcript

Respondent submitted Claimant's SSA Earnings/Disability Records and Dr. Barker's Deposition Transcript on October 3, 2016, but labeled them as EX 19 and 20. In an amended exhibit list submitted in the same filing, Respondent described EX 17 and 18 as two completely new exhibits (in bold below), having apparently wedged these new exhibits into the middle of the list and moved everything down two spots. Respondent's October 3, 2016, amended exhibit list described EX 17 through 23 as follows:

EX 17: **Claimant's Repeat Pulmonary Function Testing June 17, 2016**
EX 18: **Dr. Barker IME Addendum, June 22, 2016**
EX 19: SSA Earnings and Disability Records
EX 20: Deposition of Dr. Barker
EX 21: Claimant's April 29, 2016 Deposition Transcript
EX 22: Claimant's July 10, 2012 Deposition Transcript
EX 23: Dr. DeMers' June 7, 2016 Transcript

On October 17, 2016, Respondent submitted Claimant's Repeat Pulmonary Function Testing and Dr. Barker's IME Addendum, as EX 17 and 18, respectively. I assumed that these exhibits were the same EX 17 and 18 that Respondent reserved as pending at trial, so I admitted EX 17 and 18 on November, 7, 2016. In the course of working on this decision, however, I realized the confusion. This presented two issues: first, I had never admitted Respondent's *original* EX 17 and 18, which Claimant had agreed to at trial and which Respondent submitted as EX 19 and 20 on October 3, 2016. Second, Claimant had not had an opportunity to object to Respondent's *new* EX 17 and 18 before I admitted them.

Therefore on November 8, 2017, I issued an order to correct these problems. I explained that going forward I would rely on Respondent's amended exhibit list numbers. This decision uses Respondent's amended exhibit list numbering.[2] I admitted Claimant's SSA Earnings/Disability Records and Dr. Barker's Deposition as Respondent's EX 19 and 20, since at trial Claimant had no objections to either of these exhibits. I vacated my order admitting Respondent's Exhibits 17 and 18, in order to give Claimant an opportunity to raise any objections to the new exhibits. Following Claimant's timely notice of no objections, I issued an order on November 24, 2017, readmitting Respondent's EX 17 and 18. Respondent's final exhibit list describes EX 17 through 23 as follows:

EX 17: Claimant's Repeat Pulmonary Function Testing June 17, 2016
EX 18: Dr. Barker IME Addendum, June 22, 2016
EX 19: SSA Earnings and Disability Records
EX 20: Deposition of Dr. Barker
EX 21: Claimant's April 29, 2016 Deposition Transcript
EX 22: Claimant's July 10, 2012 Deposition Transcript

[2] Even though Claimant relied on Respondent's original exhibit list in his closing brief, it was unnecessary for Claimant to amend his brief with new numbering since I could just refer back to the earlier exhibit list.

EX 23: Dr. DeMers' June 7, 2016 Transcript

On October 3, 2016, Respondent submitted Dr. DeMers' August 23, 2016, Deposition Transcript as EX 24. Claimant had already submitted Dr. DeMers' August 23, 2016, Deposition Transcript as Claimant's Exhibit 13 on September 29, 2016, and I admitted it on October 4, 2016.[3] Since there is no need to have two copies of the same deposition, and I had not yet admitted Respondent's copy, I simply excluded Respondent's EX 24 in my November 7, 2017, order.

I. STIPULATIONS

At trial, the parties stipulated to the following:

1. The Longshore and Harbor Workers Compensation Act applies to this claim for the period from June 10, 1989, to July 5, 1989.
2. The Claimant worked for VECO Corporation from May 1989 through June 29, 1989.
3. The Claimant's employment with the Employer ended on July 5, 1989.
4. The Employer, formerly VECO Corporation, is now known as CH2M Hill Alaska, Inc.
5. If the Employer is found liable, the Alaska Insurance Guaranty Association will pay the claim
6. The average weekly wage should be calculated under Section 10(c)

(Hearing Transcript ("HT"), pp. 12 – 14).

II. ISSUES

The parties agreed at the hearing that the issues to be decided in this case include the following:

1. Was this claim timely noticed?
2. Was this claim timely filed?
3. Did the Claimant suffer an injury or disease?
4. Was the injury or disease work related?
5. What was the Claimant's average weekly wage at the time of his alleged injury?
6. Has the Claimant's condition reached maximum medical improvement?

(HT, pp. 5 – 7).

III. FACTUAL BACKGROUND

Mr. Miller was born in 1962 and has lived in Alaska for nearly all of his life. (RX 21, pp. 16 and 21; RX 9.) He grew up in Alaska's Upper Yukon Flats, about 170 miles north of Fairbanks and currently lives in Fairbanks. (HT, pp. 28 and 50.)

[3] There is no Claimant's Exhibit 12.

The claim in this case arises from Mr. Miller's 1989 work for VECO Corporation. (RX 21, p. 29.) After the March 1989 Exxon Valdez oil spill in Alaska's Prince William Sound, Exxon Corporation subcontracted with VECO to manage the cleanup. (Claimant's Post-Trial Brief, p. 6.) VECO hired the Claimant in early May 1989, and transported him by helicopter from Valdez to Prince William Sound. (HT, p. 2; RX 21, pp. 32.–34.) Mr. Miller stayed with other cleanup workers on-site in a converted tourist vessel. (HT, p. 40.) He "just did what [he] was told." (RX 22, p. 27.) At first, he sprayed chemical dispersants on the shore. (*Id.* at 8.) After about a month, he was stationed on barges to perform mechanical repairs. (RX 21, p. 39.) He also operated a small boat called a skiff, as well as other water vessels, to ferry personnel and equipment to and from the beaches. (RX 22, p. 26; RX 21, p. 40.) He recalls working 8 to 10 hours a day, 7 days a week. (RX 21, p. 37.)

The oil, according to Mr. Miller, was "everywhere." (RX 21, p. 49.) He describes a "black sheen" that coated "everything, from the bottom of the boat to the sides of the boat, on everything." (*Id.* at 46.) VECO provided protective gear – rubber pants, jacket, gloves, boots and a helmet – but Mr. Miller says the gear did not protect his face and hands from being covered in oil. (*Id.* at 33-34 and 49.) "You could go out in the skiff and with a clean face and at the end of the day, your face was black. You would take a white rag and it would come off your face and it was really nasty stuff that would float in the air." (HT, pp. 34-35.) The Claimant says that the combination of hot temperatures with fumes from the oil, chemical dispersants and equipment's diesel fuel made him feel nauseous and generally "unhealthy."[4] (RX 21, p. 49.) On May 8, 1989, he complained of cough and sore throat, and was diagnosed with bronchitis. (CX 11, p. 624.) On May 11th, he complained of flu-like symptoms, cough, weakness, and chest tightness, and was referred to town to see a doctor. (RX 3, pp. 54.) A prescription note from the same day says that he was seen at Valdez hospital for bronchitis and advised to wait until May 13th to return to work. (*Id.* at 56.)

A month later on June 10th, Mr. Miller told medical providers his "lungs are bad," and attributed his symptoms to exposure to the heat and cold. (RX 3, p. 63.) On June 18th, he was seen by VECO medical staff, where he complained of a sore throat and the provider noted enlarged lymph nodes and bronchitis. (*Id.* at 60.) The provider also wrote "Hx pneumonia," perhaps noting a reported history of pneumonia. (*Id..*) He returned the next day, and again on June 23rd, complaining both times of sore throat and congestion. (*Id.* at 61.) On June 23rd, the provider noted an ear infection and that Mr. Miller would "use amoxicillin for ears till seen by physician at Fairbanks." (*Id.* at 64.) On June 24, 1989,, he was seen at Humana Hospital. (CX 6, p. 45.) A Humana Hospital form referred him to a doctor in Fairbanks, and contained information on bronchitis symptoms and treatment. (*Id.* at 65.) On June 29, 1989, the Claimant was seen by VECO medical providers for a check-up, and was noted to have a "resolved URI/bronchitis." (*Id.* at 68.) The Claimant says he was diagnosed with pneumonia during this time, but this is unsupported by any medical records or other documentation.[5] (RX 21, p. 63.) He

[4] The Claimant had multiple injuries during his VECO employment, including bruised fingers, a sprained ankle, and oily water splashing into his eye. (CX 2, pp. 19-20 and 32-34; CX 3, p. 59.) He has not indicated any relationship between these non-respiratory injuries and his claim, which is for respiratory problems. (RX 21, p. 52.) Therefore I only discuss his respiratory issues during his work for VECO.

[5] Mr. Miller claims that Respondent "was aware of diagnoses of bronchitis and pneumonia" in 1989, citing a section of his request for Employer's admissions. (Claimant's Post-Trial Brief, p. 25, citing CX 6, pp. 45-47.) Pneumonia is

was released to go back to work on June 29, 1989. (*Id.* at 69.) Upon returning to Prince William Sound, however, he recalls feeling too sick to resume work. (RX 21, pp. 62-3.) His employment with VECO formally ended on July 5, 1989. (HT, p. 13.)

On July 30, 1989, the Claimant sought treatment at Fairbanks Memorial Hospital ("FMH") for bronchitis symptoms and non-respiratory complaints, but an x-ray ruled out bronchitis. (RX 4, pp. 119-121.) On August 9, 1989, he returned to FMH, expressing concerns about the "toxic effects of working with crude oil." (RX 3, p. 71.) An outpatient emergency record concluded that the Claimant was suffering from "possible hydrocarbon inhalation, chronic," and a viral syndrome. (RX 4, p. 122.) The health insurance claim lists "hydrocarbon inhalation" as the primary diagnosis. (CX 11, p. 675.) It appears he was discharged on the same day. (RX 4, p. 122.)

Though the Claimant was diagnosed with pneumonia in 1982, he says that he was generally healthy before his work for VECO. (HT p. 31; RX 4. P. 75.) He feels that his health has deteriorated since 1989, and that his symptoms are chronic at times. (HT, p. 49). "My lungs after I left Prince William Sound steadily went down." (RX 21, p. 52.) He complains of chest tightness, cough, wheezing, shortness of breath, and migraine headaches. (CX 7, pp. 57, 62, and 65.) Some days, he says, he has difficulty breathing. (RX 21, pp. 48 and 80.) "I stopped being around people because...I'd end up sick, bronchitis pneumonia, just really worn out because of my immune system being damaged."[6] Mr. Miller reports that he does not have an accessible primary care doctor, so when he is very sick he visits the FMH Emergency Department. (HT, p. 48.) He sought hospital treatment for chest pain or shortness of breath on 18 occasions between 1999 and May 2016. (RX 13, p. 255.)[7]

Between 1989 and 2005, the Claimant continued work in various fields, including automotive and mechanical repair, environmental research, security, and taxi driving. (RX 9.) He usually spends November to April in the Upper Yukon, performing his primary lifelong occupation as a seasonal fur trapper. (RX 21, pp. 78 and 82; HT, p. 23.) During fur trapping season temperatures can get as low as 60 degrees Fahrenheit below zero; he stays in wood-fired cabins. (RX 21, pp. 15-16, 23, and 72-3.) In 2005, Mr. Miller stopped working, aside from fur trapping. He attributes this change to his declining health. (HT, p. 46.) Mr. Miller's current sources of income are disability benefits from the State of Alaska, Social Security, and fur trapping. (Claimant's Post-Trial Brief, p. 10.)

IV. MEDICAL EVIDENCE

I. *Examination and Treatment by Dr. Mary DeMers, D.O.*

Dr. DeMers is a board-certified osteopathic doctor specializing in Internal Medicine and Occupational and Preventative Medicine, and has a Master's in Public Health, with a focus on Environmental and Occupational Health. (CX 13, p. 6.) She works primarily as an internist in

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not mentioned once in this section. In fact, in the same document, the Employer explicitly denied that the Claimant developed pneumonia. (CX 6, p. 32.)

[6] I consider Mr. Miller's immune system complaints only to the extent that they implicate his respiratory health.

[7] The parties did not submit these records as exhibits. (HT, pp. 21-22.)

private practice. (RX 23, p. 5.) She estimates that she has treated over 1,000 patients with breathing difficulties over the past 20 years. (*Id.* at 9.)

The Claimant first saw Dr. DeMers for an examination on July 23, 2015, to determine the relationship between Mr. Miller's respiratory problems and his work for VECO. (CX 7, p 54.) She has treated him four times since then. (CX 13, showing visits on 7/29/15, 8/26/15, 12/15/15, 6/24/16.) The Claimant told her about his work and exposures at the oil spill in 1989, and discussed his current health issues, including "spells where he couldn't breathe and became very ill." (CX 13, p. 11.) He described his 1989 symptoms as "head congestion, chest congestion, [and] shortness of breath." (RX 23, p. 35.) Dr. DeMers never received any of Mr. Miller's medical records, despite requesting them. (CX 13, pp. 12-13.) Her opinions of his 1989 illnesses and current issues are thus based on her examinations and the history that he self-reported. (RX 23, pp. 15-16.) Based on his recollection, she believed that his June 23, 1989, visit to Humana Hospital involved pneumonia or another upper respiratory condition. (*Id.* at 22.)

After his first visit, Dr. DeMers diagnosed the Claimant with asthma or reactive airways disease ("RAD") (CX 7, p. 55.)[8] Dr. DeMers based her asthma/RAD diagnosis on the Claimant's history of breathing issues, coughing, mucus, reported irritation from cold and smoke, and frequent hospital visits. (RX 23, p. 43.) She noted that the Claimant showed "prolonged excursion" when she saw him in December 2015, which is "mild asthma." (*Id.* at 41.) Prolonged excursion means it takes him longer to exhale because his airways are "tight." (*Id.*) She also observed a type of rash on the Claimant's abdomen that can be linked to asthma. (*Id.* at 31.) Based on this diagnosis she gave him steroid inhalers and Singulair. (CX 13, p. 23.) He reports that both medications have helped his symptoms, but the inhalers sometimes make him feel worse or "funny." (CX 10, p. 430; HT, p. 53; CX 7, p. 68; CX 13, p. 23.) Dr. DeMers says she would not rely on the Claimant's first pulmonary function test because he was on a steroid inhaler when he took the test. (RX 23, p. 30.)

Dr. DeMers describes asthma/RAD as "a disease of irritability." (RX 23, p. 10.) Irritants such as chemicals, cold temperatures, smoke and respiratory infections can "exacerbate" the disease. (RX 23, pp. 20-21; CX 13, pp. 34-5.) She believes that the Claimant's chemical exposure at the Exxon Valdez oil spill exacerbated his underlying asthma/RAD, which caused his chest congestion and breathing issues at the time. (RX 23, p. 10.) Yet she doubts that this was the first time his asthma/RAD was exacerbated. "Whether he remembered [pre-1989 exacerbations] or not when he talked to me," she says, "he does have asthma, and they were probably all asthma, and they were all overtreated as an infection because no one diagnosed the asthma." (RX 23, p. 23.)[9] She says the 1982 pneumonia diagnosis is "kind of a big deal," and suggests an earlier onset date of his asthma/RAD. (CX 13, pp. 12 and 30.)

Dr. DeMers emphasizes that asthma/RAD requires proactive maintenance in order to be controlled, and she believes the Claimant's past exacerbations were misdiagnosed and poorly treated. (*Id.* at 24; RX 23, p. 18.) This mistreatment, she says, combined with the Claimant's

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[8] Dr. DeMers uses the terms "asthma" and "reactive airways disease" interchangeably. She describes his condition as "kind of a low level asthma that is caused more by aggravating circumstances." (RX 23, p. 31.) Reactive airways disease more likely involves "intermediate insults" rather than ongoing symptoms. (*Id.* at 21; CX 13, p. 15.)

[9] Mr. Miller forgot about the 1982 pneumonia diagnosis, and Dr. DeMers learned about it during her deposition.

ongoing exposure to the Upper Yukon's irritating cold temperatures and smoke in his wood-fired cabins, is why he feels constantly ill. (RX 23, p. 25.)

When asked if his 1989 exposure contributed even one percent to his current breathing issues, she says, "Honestly, I don't know." (CX 13, p. 24.) His current symptoms are "from an underlying condition; I don't think that was specifically caused by Exxon Valdez." (RX 23, pp. 28, 37-38.) Any of the Exxon Valdez chemicals that entered Claimant's lungs in 1989 are long gone. "There is such a fast turnover of lung tissue," according to Dr. Demers, "that unless it's a solid [like asbestos or silicon], it's not going to stay there...a chemical is not going to be there." (CX 13, p. 17.) Yet the 1989 illness "possibly" caused a "small amount of lung damage" that could still affect Mr. Miller. (RX 23, pp. 28, 40.) This is because lung tissue is "likely" damaged during "severe" asthma reactions. (*Id.* at 33.) Damaged lung tissue remodels into "less elastic" scar tissue, which "might" permanently worsen lung function. (*Id.* at 32-34; CX 13, pp. 26 and 29.)

Dr. DeMers is unsure of the degree to which scar tissue worsens overall respiratory status, and says the impact is "so variable that it would be hard to quantitate without actually measuring before and after" the reaction. (RX 23, p. 33.) The earliest measurement in evidence of Mr. Miller's respiratory function is from 2016. (RX 15.) Dr. DeMers did not see any scar tissue on the Claimant's x-ray, but he could have scar tissue that is not visible on a regular chest x-ray. (CX 13, p. 20; RX 23, pp. 34-35 and 39.) She noted that his consistent failure to take a deep breath during medical exams could be due to scar tissue. (CX 13, p. 20.) If the Claimant had a severe reaction in 1989, he "probably" developed scar tissue. (CX 13, p. 35.) A hospitalization plus chest and head congestion and shortness of breath – all of which the Claimant told Dr. DeMers he experienced in 1989 – are consistent with a severe reaction. (RX 23, p. 35.) Scar tissue from his 1989 episode is the only basis Dr. DeMers offers for a potential causal link to his current issues.[10]

II. Medical Records Review by Dr. Alan Barker, M.D.

Dr. Barker is Professor of Pulmonary and Critical Care Medicine at Oregon Health and Science University. (RX 8, p. 217.) He is board-certified in pulmonary medicine, critical care medicine, and internal medicine. (*Id.* at 218.) He was scheduled to conduct an initial medical examination of the Claimant, but it was canceled.[11] (RX 13, p. 253.) Instead he completed a records review of Claimant's medical records, mostly from between 1999 and 2015, recent chest imaging studies, and pulmonary function tests. (*Id.* at 254-256, RX 18.)

a. Dr. Barker's Opinion of the Claimant's Health While Working for VECO

Dr. Barker found no evidence that the Claimant had any respiratory reaction, "severe or not," from his work on the oil spill in 1989. (RX 20, p. 24.) He says none of the Claimant's 1989 medical encounters contain any "objective findings that indicate anything that might have been

[10] Q: If that work on the Exxon Valdez oil spill did not cause lung damage, then the future care that you're recommending is not related to the work on the Exxon Valdez oil spill? A: Correct. (*Id.* at 40.)

[11] According to the Employer, Mr. Miller objected to traveling from Fairbanks to Portland, Oregon. The parties therefore agreed that in lieu of an IME, Mr. Miller would participate in pulmonary function testing in Fairbanks, the results of which were provided to Dr. Barker.

damaged" from the exposures. (*Id.* at 16.) Dr. Barker reviewed records of seven total Claimant medical visits in the summer of 1989. According to Dr. Barker, these records show evidence of a bronchitis diagnosis, an ear infection, and a viral syndrome. A July 30, 1989, chest x-ray was normal. (RX 13, p. 254.) He saw no evidence that Mr. Miller was hospitalized during this time (which Dr. Barker defines as an overnight stay in a non-emergency medical ward), nor did he find evidence of a pneumonia diagnosis. (RX 20, pp. 10-11.)

While it is "plausible" that the Claimant was exposed to "irritating" hydrocarbon fumes, Dr. Barker is skeptical about any consequent reaction. (RX 13, p. 257; RX 20, p. 14.) Most exposure-related medical concerns arise "within hours and a few days," but a month passed between the Claimant's last day of work on July 5, 1989, and his August 9, 1989, diagnosis of possible hydrocarbon exposure. (RX 20, p. 14.) Dr. Baker stated this hospital visit "was getting longer away [from the job], and I think that the people at the time felt the same way. They were not at all concerned about exposure, and that's why they made the diagnosis of probable virus and sent him on his way." (*Id.*.) The Claimant's work on the oil spill, he concluded, does "not play any role" in his current respiratory complaints. (*Id.* at 46; RX 13, p. 258.)

b. Dr. Barker's Opinion of the Claimant's Current Respiratory Status

Dr. Barker does not believe that the Claimant has any diagnosable respiratory condition. (*Id.* at 254-257; RX 20, p. 9.) He says that none of the Claimant's 18 respiratory-related hospital visits suggested asthma or resulted in hospitalizations. (RX 13, p. 254; RX 20, pp. 10-11 and 18.) Chest exams were "virtually" always normal. (RX 13, p. 255)

Dr. Barker found "minimal to no" objective evidence of asthma in the Claimant's records. (RX 13, p. 257; RX 20, p. 9.) The lack of objective evidence is significant, he says, in light of national guidelines which require objective data for an asthma diagnosis. (RX 20, pp. 19-20; RX 13, p. 256.) Dr. Barker refers to the American Medical Association ("AMA") Guide to the Evaluation of Permanent Impairment, which requires a pulmonary function test for an asthma diagnosis.[12] The AMA Guide also advises providers to rely on the National Institutes of Health ("NIH") Guidelines for the Diagnosis and Management of Asthma; these guidelines likewise require a pulmonary function test for an asthma diagnosis.[13] The NIH Guidelines say that objective tests "are necessary for the diagnosis of asthma because medical history and physical examination are not reliable means of excluding other diagnoses or of characterizing the status of lung impairment." (NIH Report, p. 66.)

The NIH guidelines specifically recommend a pulmonary function test called "spirometry," which measures the "maximal volume of air forcibly exhaled" after a very deep breath. (RX 20, pp. 20-21; NIH Report, p. 42-43.) For a reliable spirometry test, the patient must provide his "maximal effort" during the test, and there must be at least two consistent spirometry results for an asthma diagnosis. (RX 20, p. 21.) Mr. Miller completed two spirometry tests, in

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[12] *Guides to the Evaluation of Permanent Impairment* 87 (Robert D. Rondinelli et al. eds., Am. Med. Ass'n 6th ed. 2009.)

[13] Nat'l Insit.of Health Nat'l Heart, Lung and Blood Inst., *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma* 11 (2007.) "The presence of multiple key indicators increases the probability of asthma, but spirometry is needed to establish a diagnosis...Spirometry is an essential objective measure to establish the diagnosis of asthma." Note: the AMA Guide cites the 2002 Expert Panel Report, which was revised in 2007.

March 2016 and June 2016. (*Id.* at 20; RX 15, p. 263; RX 17, p. 235.) According to Dr. Barker, on both occasions the technicians commented that the Claimant had failed to give his maximal effort. (RX 20, p. 21.) Dr. Barker concluded that the test results are unacceptable for analysis. (*Id.*.)

Dr. Barker also reviewed approximately seven chest imaging studies of the Claimant from 2012 to 2015. He found that all of these studies were "normal." (RX 13, p. 257.) He was not concerned that several studies showed a partially collapsed airway ("atelectasis".) (RX 20, pp. 22-23.) He explained that lack of deep breath causes atelectasis, and if the person is healthy, the atelectasis will go away in subsequent x-rays. (*Id.*.) Dr. Barker believes that this is "pretty much what we are seeing" with the Claimant: providers frequently noting the Claimant's "decreased inspiratory effort" during x-rays, and his x-ray in 2014 showing that previous atelectasis had cleared. (*Id.* at 22-23; RX 13, pp. 256- 257.)

Finally, Dr. Barker reviewed the Claimant's hospital visits. In April 1982, he was hospitalized for one week with pneumonia which was resolved during the same stay. (RX 13, p. 254.) In May 1987, he visited the emergency department complaining of chest and neck discomfort and was diagnosed with acute bronchitis; his chest x-ray was normal. (*Id.*.) He found that between 1999 and May 2016, the Claimant visited the emergency department 140 times. On 18 of these occasions, the Claimant reported respiratory symptoms such as chest pain or breathing issues. (*Id.* at 254-255.; RX 18, p. 327.) Dr. Barker says that none of these 18 visits suggested asthma. (RX 20, p. 18.) He notes that the Claimant only "rarely" complained of wheezing, and medical providers recorded abnormal breathing sounds "only a couple of times." (RX 13, p. 2.55.) Wheezing is an abnormal finding because it indicates an obstruction of the breathing passage. (*Id.* at 257; RX 20, p. 18.) Dr. Barker does not elaborate on the apparent occasional evidence of abnormal breathing and abnormal chest x-rays. (RX 13, p. 255.) He did not find any evidence of scar tissue or other permanent lung damage from the Claimant's recent x-rays (nor, he notes, did the radiologist who examined them.) (RX 20, pp. 10 and 24.)

The Claimant visited the emergency department most recently on May 11, 2016. He complained of cough and back pain. (*Id.* at 328.) His chest exams showed reduced inspiratory effort and atelectasis, but were normal. (*Id.*)

V. LEGAL ANALYSIS AND FINDINGS

a. Timely Notice and Timely Filing

Before considering the merits of this case, I must consider two timeliness requirements. First, Respondent must have received timely notice of Mr. Miller's respiratory issues, and second, Mr. Miller must have timely filed his claim. In other words, Mr. Miller's claim must satisfy two deadlines. Both of these deadlines turn on the date of Mr. Miller's reasonable awareness: as soon as Mr. Miller was aware – or should have been aware – of the relationship between his work for VECO, his respiratory problems, and his alleged disability, he had one year to give Respondent notice of his recurring respiratory problems, and he had two years to file his claim. 33 U.S.C. §§ 912(a) and 913(a).[14] Failure to satisfy either of these requirements only

[14] The one-year limitation for timely notice and two-year limitation for timely filing apply to occupational disease claims. The limitations for traumatic injury claims are 30 days and one year, respectively. 33 U.S.C. §§ 912(a) and

renders a claimant ineligible for disability benefits; the claimant's eligibility for medical benefits can never be time-barred. *Wendler v. American National Red Cross*, 23 BRBS 408 (1990).

I find that Mr. Miller should have been aware of this alleged relationship by the end of 2005. He says that he stopped working in 2005 because of his declining health, which he attributed to his work for Respondent. (HT, p. 46.) The end of 2005 is a generous determination, since Mr. Miller seems to have believed there was such a relationship years earlier: Mr. Miller describes years-long respiratory issues that impacted his ability to work. As he said in his deposition, "My lungs after I left Prince William Sound steadily went down." (RX 21, p. 52.) At the hearing, he said that his symptoms have gotten worse since 1989, and have become chronic at times. (HT, p. 49). In addition, though he frames these issues as having lasted for decades, he does not explain what prompted him to file this claim after 20 years. Dr. DeMers was the first doctor to suggest – in 2015 – that his work for Respondent related to his current respiratory issues; his filing preceded her evaluation by 6 years. Since 2005 is the first time that Mr. Miller recalls identifying a relationship between his breathing problems and an inability to support himself, I find that this absolutely foreclosed any reasonable ignorance regarding a potential relationship. Therefore by December 31, 2005, Mr. Miller should have known about the alleged relationship between his 1989 work and his ongoing health problems.

Timely Notice

In order for notice to be timely, Respondent must have received noticed within one year of December 31, 2005. Mr. Miller suggests that Respondent received notice in 1989, when Respondent knew about his bronchitis and "possible hydrocarbon inhalation." (Claimant's Post-Trial Brief, p. 25; RX 4, p. 122.) I disagree. Mr. Miller seeks benefits for respiratory issues that arose after his work for Respondent ended. Respondent could not know in August 1989 about issues that did not exist yet. The next time that Respondent received any information about Mr. Miller was when Mr. Miller filed his claim in 2009. I find that this date of filing – December 23, 2009 –was when Respondent received notice of Mr. Miller's respiratory issues.

Since December 23, 2009, is more than one year after December 31, 2005, Mr. Miller failed to provide Respondent with timely notice. However, this failure does not bar his claim unless Respondent proved by substantial evidence that it was prejudiced by this late notice. 33 U.S.C. §§ 912(d). *See Kashuba v. Legion Ins. Co.*, 139 F.3d 1273, 1275 (9th Cir. 1998), *Jones Stevedoring Co. v. Dir., Office of Workers' Comp. Programs*, 133 F.3d 683, 689 (9th Cir. 1997) Respondent failed to do so. Respondent argues that the delay "severely limited the employer's ability to successfully litigate the claim." (Respondent's Post-Trial Brief, p. 11.) Respondent argues that there is scant medical documentation still available to sufficiently investigate the Claimant's treatment in 1989, and that relevant witnesses are no longer available. If proven, these challenges might have amounted to prejudice. Yet Respondent must produce evidence of the difficulties that resulted in prejudice. *Capuano v. Navy Exchange Service Command*, USDOL/OALJ Reporter (HTML), BRB No. 14-0362, (BRB July 23, 2015.) Respondent offers no evidence of efforts to locate witnesses who turned out to be unavailable, or evidence that critical records were lost. Respondent's assertions alone are insufficient. Since Respondent failed

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913(a). It is unnecessary to classify the Claimant's breathing problems as an injury or occupational disease: even applying the longer timelines, the Claimant did not give Respondent timely notice or timely file his claim.

to prove that it was prejudiced by Mr. Miller's late notice, the late notice does not bar Mr. Miller's claim.

Timely Filing

Mr. Miller must have filed his claim within two years after December 31, 2005. This means the last day that Mr. Miller could have filed his claim was December 31, 2007. Mr. Miller filed his claim on December 23, 2009. Therefore Mr. Miller's claim is untimely filed. In contrast to timely notice, the issue of Respondent's prejudice is irrelevant to timely filing. However, as discussed, untimely filing only bars a claim for disability compensation, not medical benefits. *Wendler, supra*; 33 U.S.C. § 913(a). Therefore I will proceed with the merits of his claim for medical benefits.

b. Credibility Determinations and Weight Accorded to Medical Opinions

The fact finder is entitled to determine the credibility of witnesses, to weigh the evidence, to draw her own inferences from such evidence. *Bank v. Chicago Grain Trimmers Assoc., Inc.*, 390 U.S. 459, 467 (1968), *reh'g denied*, 391 U.S. 929 (1968); *Duhagon v. Metro. Stevedore Co.*, 31 BRBS 98, 101 (1997), *aff'd*, 169 F.3d 615 (9th Cir. 1999). In evaluating expert testimony, the judge may rely on her own common sense. *Avondale Indus., Inc. v. Dir., OWCP*, 977 F.2d 186, 189 (5th Cir. 1992).

In cases under the Longshore Act, the judge determines the credibility and weight to be attached to the testimony of a medical expert. *Perini Corp. v. Hyde*, 306 F. Supp. 1321, 1327 (D.R.I. 1969.) The Claimant's treating physician's opinion generally deserves greater weight, since the treating physician "is employed to cure and has a greater opportunity to know and observe the patient as an individual." *Amos v. Dir., OWCP*, 153 F.3d 1051, 1054 (9th Cir. 1998), *amended by* 164 F.3d 480 (9th Cir. 1999), *cert. denied*, 528 U.S. 809 (1999); *Duhagon*, 31 BRBS at 101; *see also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830 n.3 (2003). A treating physician's opinions are "not, however, necessarily conclusive as to either a physical condition or the ultimate issue of disability." *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989) (Health and Human Services administrative law decision).

i. The Claimant's Credibility

I find that the Claimant's subjective complaints of shortness of breath, coughing, and chest tightness are credible. He has sought medical treatment for respiratory complaints many times, including at least 18 visits to the hospital since 1999, and to Dr. DeMers 5 times. (RX 13, p. 255; RX 18, p. 328; CX 13.) He accepted and used inhalers and related breathing medication, and appears to have switched blood pressure medicine because of respiratory side effects. (CX 13, p. 23; RX 23, pp. 42-43.) Dr. DeMers, his treating physician, found his complaints credible. (RX 23, p. 15 ("I do believe he's been really sick")).

Yet regarding the Claimant's recollection of 1989 events, I am realistic about memory's limitations. While I believe the Claimant offers his honest recollection, I lack confidence in someone's ability to recall, with sufficient specificity, discrete symptoms and medical encounters from nearly 30 years ago. I will therefore assign more weight to the objective evidence than his testimony regarding 1989-related factual questions.

ii. Dr. DeMers' Opinions

Dr. DeMers is a board-certified osteopathic doctor specializing in occupational medicine. She treated the Claimant over five visits, and demonstrates familiarity with his various medical issues, lifestyle, and work. (CX 7, p. 66; CX 13, pp. 9 and 11-12.) Her assessment sometimes departs from the Claimant's explanations or recollection of his medical history, which demonstrates impartiality and lends weight to her opinion. (RX 23, pp. 14-15 ("I didn't expect him to get better...He presented as a victim"); *id.* at 17 ("He could have just had an upper respiratory infection that he described as pneumonia because he got so sick"), *id.* at 23 ("whether he remembered [prior exacerbations] or not when he talked to me...they were probably all asthma")..

However I have two concerns about Dr. DeMers' opinions: first, she based the Claimant's asthma diagnosis on subjective evidence alone, which conflicts with national guidelines that require objective evidence for an asthma diagnosis. Dr. DeMers did not address her departure from these guidelines, and only discussed the Claimant's spirometry to express concern about its reliability. (RX 23, p. 30.)

Second, Dr. DeMers never reviewed the Claimant's medical records. (RX 23, pp. 15-16; CX 13, p. 12.) It is unclear how the Claimant's records were made available to Dr. Barker but not the Claimant's own doctor, who asked for them. In any case, she was forced to form her opinion based only on her examination of the Claimant and what he told her. This diminishes the weight of her medical opinion, particularly regarding certain conclusions about his 1989 health issues. For instance, the Claimant told her that 1989 was the first time he had breathing issues, which led her to conclude that the episode was his first asthma exacerbation. She learned during a deposition that he had pneumonia in 1982, which she believed strongly suggests pre-1989 asthma exacerbations. She never received the medical records documenting this 1982 pneumonia diagnosis. In sum, Dr. DeMers' very limited objective knowledge of the Claimant's medical history weakens her reliability. Otherwise, I give Dr. DeMers' opinion considerable weight because she demonstrates impartiality and is the Claimant's treating physician. *See Amos, supra.*

iii. Dr. Barker's Opinions

Dr. Barker is board-certified in pulmonary medicine, critical care medicine, and internal medicine. Whereas Dr. DeMers examined the Claimant several times but did not review his medical records, Dr. Barker reviewed the Claimant's medical records but never examined him. Inasmuch as Dr. Barker's opinion diverges from Dr. DeMers on questions of treatment and subjective conclusions about the Claimant, I will give greater weight to Dr. DeMers. However I give more weight to Dr. Barker regarding analysis of medical records that Dr. DeMers did not see, and both doctors equal weight on objective findings unrelated to the Claimant's examination.

c. The 20(a) Presumption and *Prima Facie* Case

The Claimant seeks medical coverage and compensation for an alleged injury under the Longshore Act. The Longshore Act defines an "injury" as any accidental injury or death "arising out of and in the course of employment, and such occupational disease or infection as arises

naturally out of such employment or as naturally or unavoidably results from such accidental injury." 33 U.S.C. § 902(2.) The phrase, "naturally or unavoidably results" includes aggravations that arise naturally or unavoidably from a primary injury. *Cyr v. Crescent Wharf & Warehouse Co.*, 211 F.2d 454, 456 (9th Cir. 1954.) If an employment-related injury contributes to, combines with, or aggravates an underlying condition, the entire resultant disability is compensable. *Indep. Stevedore Co. v. O'Leary*, 357 F.2d 812 (9th Cir. 1966); *Kooley v. Marine Indus. N.W.*, 22 BRBS 142 (1989)

In establishing that an injury arises "out of and in the course of employment," claimants are aided by the presumption in Section 20(a) of the Longshore Act: if they can establish a *prima facie* case, then they are entitled to the presumption that the claim comes within the provisions of the Act. 33 U.S.C. § 920 This includes the issue of whether the injury or disability is work-related. *Kubin v. Pro-Football, Inc.*, 29 BRBS 117 (1995.) To establish a *prima facie* claim for compensation, a claimant only has the burden of establishing that (1) the claimant sustained a harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which *could* have caused that harm or pain. *Kelaita v. Triple A Mach. Shop*, 13 BRBS 326, 330-31 (1981), *decision and order after remand*, 17 BRBS 10 (1984), *aff'd sub nom. Kelaita v. Dir., OWCP*, 799 F.2d 1308 (9th Cir. 1986.)

A claimant can establish the harm prong of a *prima facie* case with his own credible complaints of symptoms and pain; he need not establish any particular diagnoses, just that "something has gone wrong with the human frame." *Wheatley v. Adler*, 407 F.2d 307 (D.C. Cir. 1968) (*en banc*); *Golden v. Eller & Co.*, 8 BRBS 846 (1978), *aff'd*, 620 F.2d 71 (5th Cir. 1980.) The "working conditions" prong of a *prima facie* case requires that the ALJ determine whether the employment events that the claimant asserts caused the harm in fact occurred, and that the claimant's theory as to how the injury occurred is more than "mere fancy." *Champion v. S&M Traylor Bros.*, 690 F.2d 285, 295 (D.C. Cir. 1982); *Sewell v. Noncommissioned Officers' Open Mess*, 32 BRBS 127 (1997)

If the claimant shows these two elements, then under Section 20(a) there is a presumption of a compensable injury related to the claimant's employment. 33 U.S.C. § 920(a). The burden then shifts to the employer to rebut that presumption with "substantial evidence to the contrary." 33 U.S.C. § 920. Substantial evidence "means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938.) A physician's unequivocal testimony that no relationship exists between a claimant's employment and injury, rendered to a reasonable degree of medical certainty, is sufficient to rebut the presumption. *O'Kelley v. Dept. of the Army/NAF*, 34 BRBS 39, 41 (BRB May 2, 2000); *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129 (BRB Feb. 27, 1984.) Proof of another agency of causation is not necessary. *See Stevens v. Todd Pac. Shipyards*, 14 BRBS 626, 627-28 (BRB Jan. 18, 1982), *aff'd mem.*, 722 F.2d 747 (9th Cir. 1983), *cert. denied*, 467 U.S. 1243 (1984.)

Mr. Miller contends that his VECO work exposed him to chemical irritants which caused his current respiratory issues. He makes two alternative arguments that his current issues are related to his VECO work: first, he argues that his 1989 illness remains as an unresolved respiratory condition, and that he has "been suffering from bronchitis since 1989." (Claimant's Post-Trial Brief, p. 29.) Alternatively, he argues that his 1989 illness aggravated an underlying condition, resulting in scar tissue that worsened his current problems. (*Id.* at 29-30.)

I find that Mr. Miller has established the existence of some form of respiratory issue, sufficient to satisfy the first prong of a *prima facie* case. As discussed, I find that his subjective complaints are credible, and show that something is "wrong" with his respiratory function. As to the second prong, it is undisputed that Mr. Miller was exposed to crude oil while working for VECO, and that chemical dispersants were used to remove oil from the water. (CX 6, p. 48.) He was diagnosed with "possible hydrocarbon exposure, chronic" soon after his work at the oil spill site. (RX 4, p. 122.) It is more than "mere fancy" that under either of his theories of work-relatedness, this exposure affected the Claimant's respiratory health resulting in ongoing breathing issues. *Champion, supra*. Therefore, I find that Mr. Miller has established both prongs of a *prima facie* case.

However, I find that Respondents have rebutted Mr. Miller's *prima facie* case. They produced Dr. Barker's unequivocal testimony that Mr. Miller's respiratory condition is unrelated to his work for VECO. I reject Mr. Miller's characterization of Dr. Barker's testimony as "equivocal at best." (Claimant's Post-Trial Brief, p. 27.) First of all, Mr. Miller fails to highlight anything "equivocal" about Dr. Barker's statements. Yet even if he had, my task at the *prima facie* stage is not to weigh the medical evidence, but to decide if Respondent has produced evidence that *could* persuade a reasonable fact-finder that there is no causal relationship. *Hawaii Stevedores, Inc. v. Ogawa*, 608 F.3d 642, 651 (9th Cir. 2010). Dr. Barker offered an unequivocal opinion on two occasions. First, in his review of Mr. Miller's medical records, Dr. Barker wrote, "Mr. Miller's work in 1989 doing the Exxon Valdez cleanup did not play any role in his medical conditions." (RX 13, p. 258.) Second, in Dr. Barker's deposition, counsel for the Employer asked, "So nothing he was exposed to in 1989 in any way, whatsoever, within a reasonable degree of medical certainty in your opinion contributed at all to his ongoing breathing disorder from 1989 through today?" Dr. Barker responded, "That is correct." (RX 20, P. 46.) This opinion is at odds with either a generalized respiratory condition or a 1989 aggravation. Either of Dr. Barker's unambiguous statements could persuade a reasonable fact-finder that there is no causal relationship between Claimant's work for Respondent and his respiratory issues. Therefore Dr. Barker's unequivocal opinion is sufficient to rebut the Claimant's *prima facie* case, under either of Claimant's theories of work-relatedness.

c. Weight of the Evidence Based on the Record as a Whole

If the employer rebuts the Section 20(a) presumption, the presumption falls from the case, and the administrative law judge must then weigh all the competing evidence on the record as a whole. *See Hughes v. Bethlehem Steel Corp.*, 17 BRBS 153, 155 (BRB Jul. 22, 1985.) The claimant bears the ultimate burden of persuasion, and must establish that his conditions are work-related by a preponderance of the evidence. 5 U.S.C. § 556(d); *Dir., OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). The preponderance of the evidence standard requires that the claimant provide more convincing evidence than the employer. *D.D. v. Electric Boat Corporation*, BRB No. 08-0103, slip op. at 9 (BRB Aug. 14, 2008); *Santoro v. Maher Terminals Inc.*, 30 BRBS 171, 173-75 (BRB Oct. 11, 1996).

Since the 20(a) presumption has fallen from this case, I must weigh all the evidence on the record as a whole. In order to succeed on his claim, Mr. Miller's evidence that his respiratory symptoms are work-related must be more convincing than the Employer's contrary evidence. As discussed, the Claimant offers two alternative theories linking his respiratory harm to his VECO

work. First, he argues that his respiratory issues in 1989 progressed into his current condition. Alternatively, he argues that his work for VECO exacerbated an underlying respiratory condition, and that his existing breathing problems are worse as a result.

i. 1989 Issues as an Ongoing Respiratory Condition

An employer is liable for future health issues that are the "natural or unavoidable result" of a work injury. *Colburn v. General Dynamics Corp.*, 21 BRBS 219 (1988). According to Mr. Miller, he "has been suffering from bronchitis since 1989," and his current symptoms are the latest iteration of an undertreated, 28-year-long general respiratory illness that began during his work on the oil spill. (Claimant's Post-Trial Brief, p. 29). Since Dr. Barker unequivocally denied any relationship between the Claimant's 1989 issues and his current health, the Claimant must show by a preponderance of the evidence that his current symptoms are a continuation of his 1989 issues. He has failed to do so.

The Claimant provided medical records for the following respiratory issues during the covered period, from June 10 – July 5, 1989: on June 18-19, 1989, he reported a sore throat, and on June 23, 1989, he reported chest tightness resulting in treatment for an ear infection.[15] About one month after his job ended, he was diagnosed with a viral syndrome and "possible hydrocarbon inhalation, chronic." (RX, p. 122.) Notwithstanding conclusory statements in his depositions and brief, Mr. Miller failed to offer any evidence framing these issues as the beginning of an ongoing generalized respiratory condition. There is a 10-year gap in medical evidence (Dr. Barker only received medical records from 1999 and later), and the Claimant does not offer any other form of objective evidence from this decade to indicate an ongoing respiratory condition.[16] From 1999 through 2016, the Claimant visited the hospital 18 times for respiratory complaints, yet he was never hospitalized and nearly always had a normal chest examination. (RX 13, pp. 254-255.)[17] Even the Claimant's own doctor, Dr. DeMers, believes his current issues relate to a pre-1989 underlying condition, rather than a condition that began in 1989.

In light of the scant evidence the Claimant offered to support this argument, I find that he failed to prove by a preponderance of the evidence that his current problems are the latest iteration of a 28-year-old respiratory condition. The Claimant cannot recover under this theory.

ii. 1989 Issues as an Exacerbation of Underlying Asthma

In contrast to his first theory of causation, Mr. Miller finds some support in Dr. DeMers' testimony for his alternative argument: aggravation. A work-related aggravation of a pre-existing condition is a compensable injury under the Act. *Gardner v. Bath Iron Works Corp.*, 11 BRBS 556 (1979), *aff'd sub nom., Gardner v. Dir., OWCP*, 640 F.2d 1385 (1st Cir. 1981). Relying on Dr. DeMers' explanation of lung tissue scarring, Mr. Miller argues that his 1989 illness exacerbated his pre-existing asthma; that the exacerbation caused a "severe" respiratory reaction; that such a severe reaction caused scar tissue to form in his lungs; and that this scar tissue

[15] He was diagnosed with bronchitis and/or cough before the covered period, on May 11, 1989.
[16] It is unfortunate that the Claimant apparently lost several years of medical records in a flood, and that older hospital records are unavailable, but this does not relieve him of his evidentiary burden. (HT, p. 21.)
[17] This is based on Dr. Barker's report, since the Claimant did not submit these chest exams into the record.

worsened his respiratory function. (Claimant's Post-Trial Brief, pp. 29-30.) According to Dr. DeMers, scar tissue "could" cause breathing issues, and a severe respiratory reaction "probably" leads or "can" lead to scar tissue, but not certainly. (CX 13, pp. 26 and 35; RX 23, p. 39.) Under this theory the Claimant must prove that his respiratory health has declined since 1989, and that this decline is at least partially due to scar tissue that he developed after lung damage in 1989.

The Claimant did not prove that his respiratory health has declined. Aggravation is a comparative question – it requires at least two reference points. While I accept that he has a history of respiratory health symptoms, Mr. Miller has not established that his respiratory function is *worse* than it was before the stipulated period or that it has worsened since 1989. The main tool for measuring changes in respiratory function is a pulmonary function test. Mr. Miller's pulmonary function tests are inconclusive or unreliable, and they are also too recent: lung damage's impact on respiratory capacity is "so variable," Dr. DeMers says, "that it would be hard to quantitate without actually measuring before and after." (RX 23, p. 33.) The Claimant did not offer any objective medical evidence of declining respiratory capacity during any period. Specifically, he did not submit any pulmonary function measurements before his work on the oil spill, or for 27 years thereafter.[18]

Indeed, the Claimant's only evidence of this decline is his own testimony that his lungs were never the same after working on the oil spill. While I believe that Mr. Miller honestly believes his respiratory health got worse after 1989, I will not rely on someone's memory alone for a decades-long comparison that typically involves technical, objective testing administered by a medical provider. In light of a reaction's unpredictable and "variable" impact on respiratory function, as well as the considerable passage of time since the alleged aggravation, his subjective testimony by itself is insufficient to prove decline. His justifiable memory lapse regarding a 1982 pneumonia episode reinforces my concerns. Without any supporting objective evidence, it is only *possible* that Mr. Miller's respiratory function has gotten worse; not probable. Possibility does not satisfy his evidentiary burden.

Even if I accepted that the Claimant's respiratory function has declined, he nonetheless failed to link this to his work for VECO. Here again, the absence of objective evidence is key: without medical data, it is a muddled endeavor to identify any 1989-related influence on his current health. Assuming without deciding that Mr. Miller has an underlying respiratory condition, he has had decades of irritant exposure and associated "reactions," any of which might have harmed his respiratory capacity. In addition to his 1982 pneumonia, which could have caused lung damage, Mr. Miller has spent half of each year for most of his life in the Upper Yukon. (RX 21, pp. 10 and 16-17.) The Upper Yukon's extreme cold is an irritant, as is smoke from his wood-fired cabins. (RX 23, p. 25.) Dr. DeMers believes that prolonged exposure to these irritants, as well as consistent mistreatment, explains why his respiratory health has gotten so bad. (RX 23, p. 25.) She could not, on the other hand, confidently attribute "even one percent" of causation to the Claimant's health issues in 1989. Dr. Barker, who reviewed all of his available medical records and including those from 1989, found absolutely no relationship between his VECO work and his current complaints.

[18] Dr. DeMers' opinion that one of the Claimant's pulmonary function test results shows a restrictive lung disease does not suggest any *change* in respiratory capacity after the oil spill.

It is unnecessary to decide whether the Claimant in fact has an underlying respiratory condition, or whether his 1989 symptoms suggest a "severe" exacerbation of the condition. If the Claimant had proven both of these issues, he would still come up short. He did not prove that his respiratory function declined since 1989, and even if he had, he failed to link this alleged decline to his work for VECO. The Claimant therefore cannot recover under an aggravation theory of work-relatedness.

In conclusion, the Claimant failed to prove that his respiratory issues are work-related. He is not entitled to medical benefits under the Act. Therefore Mr. Miller's claim for disability compensation, even if timely filed, would also fail. Since his claim for disability compensation fails as to both timeliness and on the merits, it is unnecessary to determine his average weekly wage at the time of the alleged injury, or his maximum medical improvement.

VI. ORDER

Based on the foregoing, Claimant's claims for medical benefits and compensation are DENIED.

Digitally signed by Jennifer Gee
DN: CN=Jennifer Gee, OU=Administrative Law Judge, O=US DOL Office of Administrative Law Judges, L=San Francisco, S=CA, C=US
Location: San Francisco CA

JENNIFER GEE
Administrative Law Judge