SOUTH DAKOTA DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT

WILLIAM MOLITOR, **HF No. 143, 2000/01**

Claimant, **DECISION**

vs.

QUINN CONSTRUCTION,

Employer,

and

UNITED FIRE & CASUALTY COMPANY,

Insurer.

This is a workers' compensation proceeding brought before the South Dakota Department of Labor pursuant to SDCL 62-7-12 and Chapter 47:03:01 of the Administrative Rules of South Dakota. A hearing was held before the Division of Labor and Management on June 13, 2002, in Sturgis, South Dakota. Claimant appeared personally and through his attorney of record, Bruce A. Hubbard. Daniel E. Ashmore represented Employer/Insurer. The only issue addressed at the hearing was whether Claimant's work was a major contributing cause of the illness for which he sought treatment on August 17, 2000.

FACTS

1. At the time of the hearing, Claimant was 60 years old and lived in Sturgis.
2. Claimant was in the Army for two years from 1960 to 1961. After that, Claimant mainly worked in the construction industry. Claimant has over twenty years of experience as an equipment operator.
3. Claimant started smoking cigarettes when he was fifteen years old. Claimant quit smoking in 1983, but resumed smoking in 1989. Claimant currently smokes at least a half a pack of cigarettes per day.
4. Claimant was diagnosed with non-Hodgkin's lymphoma in 1992. Claimant received cancer treatment in 1992 and 1993 and is in remission.
5. Claimant also has had difficulty with his lungs and breathing problems. In 1992, Claimant had a pulmonary embolism and was treated at the Fort Meade Department of Veterans Affairs Hospital (VA) for acute breathing problems. In 1993, Claimant was hospitalized with pneumonia. In December 1994, Claimant had a cold with sputum production. In December 1995, Claimant had chest congestion and shortness of breath. In November 1996, Claimant had an ongoing chronic cough. In September 1998, Claimant was diagnosed with bronchitis. In December 1996, Claimant was diagnosed with chronic obstructive pulmonary disease (COPD).

6. Smoking is the predominant, etiologic factor in COPD. When COPD sufferers continue to smoke, the COPD continues to get worse.
7. Claimant started working for Employer in August 1999 as an equipment operator.
8. On July 17, 2000, Claimant saw Dr. Robert Vosler, his primary treating physician at the VA, for a regularly scheduled check-up. Dr. Vosler noted that Claimant continued to smoke, but that his condition was stable and there were no significant findings.
9. On July 31, 2000, Employer began a project in Phillip, which consisted of excavating a streambed and inserting cement box culverts at two separate locations. The soil in the streambed was wet and mucky and the area surrounding the job site was grassy. It was also hot and humid.
10. Employer had a crew of six or seven workers on the Phillip project. Art Askland was the supervisor and Dale Graham was the lead man, or foreman.
11. Employer used two track hoes for this project. One track hoe had a thirty foot reach and that other had a sixty foot reach. The track hoes were used to excavate the streambed, lay rock and sand and then backfill once the culverts were installed.
12. Claimant was the primary equipment operator for Employer and ran one of the track hoes. Claimant operated the track hoe with the cab windows open due to the heat.
13. Employer had either the supervisor or the foreman complete a daily report detailing such things as weather conditions, workers and equipment used, problems, accidents and activities completed during the day.
14. On August 7th, two loads of oversized rock were delivered to the work site. On August 8th, one load of gravel and two loads of bedding sand were delivered to the work site.
15. On the Phillip project, Employer used "clean rock," meaning that it has been either washed or screened. Clean rock has been inspected by a state inspector to make sure that is does not contain very much dirt. This rock is approximately six to nine inches in diameter.
16. It takes approximately ten to fifteen seconds for a dump truck to dump a load of rock. Some dust is generated when the rock hits the ground, but it is quickly dissipated.
17. The excavation area was approximately thirty feet wide, ninety feet long and at least fifteen to twenty feet deep.
18. Claimant testified that the work site in Phillip had excessively dusty conditions, especially on August 7 and 8, 2000. Claimant explained that he was exposed to dust when the dump truck dropped the load of clean rock. In addition, Claimant stated that he was "sitting right directly over the hole" so when he dropped the rock into the excavation hole he was exposed to more dust.
19. Claimant's testimony conflicts with credible testimony that the conditions on the Phillip project were not unusually dusty and that Claimant was not exposed to more dust than other workers, especially those workers in the excavation hole.
20. John Page, the surveyor on the Phillip project, testified there was some dust, but that it was not overwhelming. Page was down in the excavation hole checking grade. Page stated, "[i]t wasn't anything out of the ordinary. Certain amount of dust. What dust does linger tends to linger in the excavation."

21. Robert Pagan, one of Claimant's co-workers on the Phillip project, agreed that there was nothing unusual about the amount of dust on this project.
22. Graham testified there were no unusually dusty conditions on this project. Graham agreed there was some dust, but nothing "out of the ordinary." He explained, "you're going to get some dust moving dirt or rocks or anything. But if it was anything that's overwhelming, you would have to get a respirator or something, I mean, if it's overwhelming, but I've never been in them conditions."
23. Graham stated the workers in the excavation hole were getting the bulk of the dust. Graham estimated that Claimant was at least thirty to sixty feet away from any dust that was created on the work site.
24. Graham also testified that no one ever complained about the dust or about any breathing problems. In addition, Employer's daily reports show that no one complained of any breathing problems or an extreme amount of dust.
25. Page explained that Claimant was exposed to "considerably less" dust while operating the track hoe as opposed to someone on the ground or in the excavation hole.
26. Claimant testified he was smoking about one pack of cigarettes per day while working on the Phillip project.
27. Page testified that Claimant smoked all the time. Graham agreed that Claimant was constantly smoking. Several of Claimant's co-workers estimated that Claimant was smoking at least two packs of cigarettes per day.
28. On either Saturday, August 12, 2000, or Sunday, August 13, 2000, Claimant developed a sore throat and runny nose. On Sunday evening, Claimant began coughing and was coughing up a greenish sputum.
29. Claimant's cough worsened throughout the week. By Thursday, August 17, 2000, Claimant had a constant cough and could not breathe. Claimant thought he was getting pneumonia.
30. Claimant left the work site on August 17th to seek medical treatment at the VA.
31. Dr. Nancy Phipps initially treated Claimant on August 17, 2000. The medical note from August 17th stated, "58 yr. old vet. presents with a cough which began with a cold and runny nose and sore throat on Sunday 8/13. He reports sputum as greenish and has pain behind left shoulder."
32. The VA medical note also reads, "[h]e states he was working heavy construction driving in a cab that was well over a 100 degrees for several days with a lot of dust and did start out with a bit of a sore throat and progressed to coughing. He does smoke a pack a day."
33. Dr. Phipps diagnosed "acute bronchitis" and admitted Claimant into the hospital for tightness in his chest and wheezing.
34. Dr. Vosler followed Claimant's care while he was in the hospital.
35. Claimant was treated with antibiotics, bronchodilator medications, nebulizer treatments and oxygen.
36. On August 23, 2000, Dr. Ashok Kumar, an internal medicine specialist, examined Claimant at Dr. Vosler's request. Dr. Kumar diagnosed Claimant with "acute bronchitis, most likely viral."
37. X-rays were taken of Claimant's lungs while he was in the hospital. The x-rays did not show changes from his previous x-rays. Dr. Vosler explained the significance because "a bacterial infection causes abnormality on an x-ray."

Therefore, a bacterial infection was ruled out as a possible cause of Claimant's breathing problems.

38. Claimant's condition gradually improved and he was released from the hospital on August 25, 2000. Claimant remained on a number of medications, including three different inhaled medications, medication for his COPD, antibiotics and oxygen at night.
39. Dr. Vosler next saw Claimant on September 6, 2000. Dr. Vosler noted that Claimant was "quite a bit improved." Claimant's lungs were clear and he was not having any significant trouble breathing.
40. Dr. Kumar examined Claimant for a second time on September 26, 2000, at Dr. Vosler's request. Dr. Kumar noted that Claimant was feeling better, but continued to have shortness of breath.
41. Dr. Kumar reviewed Claimant's pulmonary function test that was performed on September 20, 2000. Dr. Kumar noted the test showed "severe airway obstruction." Dr. Kumar diagnosed Claimant with "chronic bronchitis and reactive airway disease."
42. Claimant continued to treat with Dr. Vosler and Claimant's condition improved.
43. In October 2000, Dr. Vosler stated that Claimant could return to work, but recommended that Claimant should not be exposed to dust or smoke.
44. Claimant returned to work for Employer for only nine days in October 2000 driving a water truck.
45. Dr. Wayne Anderson, board certified in occupational medicine, performed a review of Claimant's medical records and issued a report on October 11, 2000. Dr. Anderson opined that Claimant's work for Employer was not a major contributing cause of his illness and need for hospitalization.
46. Claimant remained unemployed through March 2001.
47. Claimant currently works for a recycling company as a truck driver.
48. Dr. Lee M. Kamman, board certified in internal medicine, pulmonary medicine and critical care medicine, performed a review of Claimant's medical records and issued a report on August 16, 2001.
49. In addition to Claimant's medical records dating back to 1992, Dr. Kamman reviewed depositions from Claimant, Dr. Kumar and Dr. Vosler, the report generated by Dr. Anderson and spoke with two of Claimant's co-workers.
50. Based on review of Claimant's medical history and records, Dr. Kamman diagnosed Claimant with "obstructive lung disease, moderately/severe obstructive lung disease."
51. Dr. Kamman opined that Claimant's ongoing smoking was a major contributing cause of his exacerbation that required hospitalization.
52. Other facts will be developed as necessary.

ISSUE

WHETHER CLAIMANT'S WORK WAS A MAJOR CONTRIBUTING CAUSE OF THE ILLNESS FOR WHICH HE SOUGHT TREATMENT ON AUGUST 17, 2000?

Claimant has the burden of proving all facts essential to sustain an award of compensation. King v. Johnson Bros. Constr. Co., 155 N.W.2d 183, 185 (S.D. 1967).

Claimant must prove the essential facts by a preponderance of the evidence. Caldwell v. John Morrell & Co., 489 N.W.2d 353, 358 (S.D. 1992). Claimant "must establish a causal connection between [his] injury and [his] employment." Johnson v. Albertson's, 2000 SD 47, ¶ 22. "The medical evidence must indicate more than a possibility that the incident caused the disability." Maroney v. Aman, 565 N.W.2d 70, 74 (S.D. 1997). Claimant's burden is not met when the probabilities are equal. Hanten v. Palace Builders, Inc., 558 N.W.2d 76 (S.D. 1997). SDCL 62-1-1 states, in part:

> (7) "Injury" or "personal injury," only injury arising out of and in the course of the employment, and does not include a disease in any form except as it results from the injury. An injury is compensable only if it is established by medical evidence, subject to the following conditions:
>
> (a) No injury is compensable unless the employment or employment related activities are a major contributing cause of the condition complained of [.]

"The testimony of professionals is crucial in establishing this causal relationship because the field is one in which laymen ordinarily are unqualified to express an opinion." Day v. John Morrell & Co., 490 N.W.2d 720, 724 (S.D. 1992). When medical evidence is not conclusive, Claimant has not met the burden of showing causation by a preponderance of the evidence. Enger v. FMC, 565 N.W.2d 79, 85 (S.D. 1997).

Claimant alleged that he was exposed to an excessive amount of dust while working on the Phillip project, especially on August 7 and 8, 2000, and this dust exposure caused his breathing problems for which he sought treatment and was hospitalized. According to Claimant, he was exposed to dust when the clean rock was dumped from the dump trucks, when he scooped the rock with the track hoe and when he dropped the rock into the excavation hole. It is true that the workers were exposed to some dust while working on this project. However, Claimant was exposed to a minimal amount of dust. Claimant was not exposed to more dust than any other worker on the Phillip project. The conditions on this project were not unusually dusty. Clean rock was used, which generates less dust and any dust that is created dissipates quickly. Claimant was farther away from what dust was generated on the project.

In order to determine if Claimant's work was a major contributing cause of his breathing problems, it is necessary to examine the medical evidence. Claimant and Employer offered medical opinions from Drs. Vosler, Kumar, Kamman and Anderson.

Dr. Vosler is board certified in internal medicine and testified in-person at the hearing. Dr. Vosler opined that smoking, in and of itself, would not cause an acute insult to Claimant's lungs. Dr. Vosler stated, "I don't think I've ever identified somebody who's been a chronic smoker have an exacerbation of their underlying lung condition simply by continuing to smoke or perhaps smoking a little bit more." Dr. Vosler recognized that "[r]ecurrent lung trouble is more common with someone with lung disease," like Claimant who has COPD, and he is more susceptible to developing problems associated with a virus.

Dr. Vosler explained that Claimant's blood work, chest x-ray and sputum culture did not show evidence of a bacterial infection. This meant that Claimant's illness was caused by either an environmental exposure or a virus. Dr. Vosler opined, based upon Claimant's history, that Claimant's breathing problems were caused by an

environmental exposure. Dr. Vosler stated, "[m]y impression is that his acute lung trouble occurred from an exposure, and that is related to a conversation with Mr. Molitor." Dr. Vosler relied upon Claimant's history that he was exposed to "quite a bit of dust" on the Phillip project. Dr. Vosler testified:

> Q: Doctor, based upon the history that Mr. Molitor gave you and your training and experience, do you have an opinion with reasonable medical certainty what that acute insult was that brought Mr. Molitor to the hospital?
> A: Well, he had an exposure to - - he had an insult that tipped him off to come in with the respiratory distress that he had. And that's the timing of that exposure is consistent with and his story is consistent with the exposure occurring while he was working on that particular job [in Phillip].

Dr. Vosler described Claimant's condition as "reactive airway disease or asthmatic bronchitis associated with his underlying lung disease." Dr. Vosler testified:

> Q: So at some point did your diagnosis ever change?
> A: I don't think the specific diagnosis was ever clearly established other than sort of this generic term of asthmatic bronchitis.
> Q: Now, as I understand it, correct me if I'm wrong, if I read Dr. Kumar's deposition and your opinions, are you under the general impression that he had a reactive airway disorder due to dust?
> A: I'd say it's not possible to identify the specific agent that caused the reactive airway disease. There may have been a particle in the dust; there may have been organic material. You know, as I heard earlier, I guess I was never aware of the fact that he was digging in mud and sludge. Those would also be potential areas where an antigen or an insult could have occurred from [what] was inhaled. So he had an inhalation of some agent that seemed to be associated with that exposure.

Dr. Vosler also testified:

> Q: And you've treated patients over the years at the VA, I assume, who have COPD?
> A: Yep.
> Q: And occasionally they will present with symptoms similar to what Mr. Molitor presented with in August 2000?
> A: That's true.
> Q: And you're not always able to pinpoint why they are having this particular episode, are you?
> A: Not always.
> Q: There are certain things that you suspect, but oftentimes you just have to attribute it to the fact that they have a weakened lung condition?
> A: Well, your goal is to try and pin it down as closely as possible so that you can treat it most appropriately. But if they do have an underlying lung condition, a lot of times those - - the initial presentation when someone

comes in, it's not - - you're not clearly able to, you know, define a specific etiological agent to that problem.

Dr. Vosler admitted that he does not know what specific agent may have been involved in the acute insult and that there is no way to find out. However, Dr. Vosler opined, "I feel that I can give within reasonable knowledge that there was an exposure that caused the insult. There was an inhaled exposure that caused the insult. Whether it was organic or inorganic would be, again, difficult to surmise." Dr. Vosler could not rule out a viral infection as the cause of Claimant's symptoms in August 2000 and agreed that a virus could explain Claimant's symptoms.

Dr. Kumar, board certified in internal medicine and "board-eligible"[1] in pulmonary medicine and critical care medicine, testified through his deposition. Dr. Kumar saw Claimant on two occasions. Dr. Kumar initially diagnosed Claimant with acute bronchitis, "most likely viral." After Claimant had a pulmonary function test in September 2000, Dr. Kumar diagnosed Claimant with "chronic bronchitis and reactive airway disease." Dr. Kumar described reactive airway disease as "an inflammation in the airways which is a result of an insult to the airway, which makes that airway twitchy." Dr. Kumar agreed with Dr. Vosler that Claimant did not have a bacterial infection based upon the sputum test and blood tests.

Claimant informed Dr. Kumar that he was exposed to dust and pollen on the work site. Claimant told Dr. Kumar it was dusty and "it was all grass and weed where he was working at." Dr. Kumar opined that Claimant suffered an acute episode of reactive airway disease caused by his work exposure. Dr. Kumar based his opinion that the reactive airway disease was most likely caused by an acute insult on the history given him by Claimant that there had been a severe dust exposure and pollen exposure. Dr. Kumar stated he relied solely on Claimant's history because any diagnostic testing is non-specific.

Dr. Kumar opined:

Q: What I'd like to know is, first of all, do you have an opinion as to whether the work that he was doing as he described it to you was a major contributing cause of his condition that he presented with in August?

A: I do. The dust exposure did contribute to that acute exacerbation setting him up for the reactive airway disease which caused him long hospitalization and a prolonged course of symptoms.

. . . .

Q: So are you able to say to what percentage the work caused this condition that he presented with versus other causes that - - the smoking, things like that?

A: That hospitalization and that symptomatology and that prolonged course is completely contributed by that exposure to the dust.

Q: Or pollen?

A: Or pollen. The underlying lung condition has been there and it's still there and that is not contributed to by the work, obviously. That's what you're

[1] Dr. Anderson testified, "[Dr. Kumar] said he's Board-Certified in internal medicine. He used the term Board-Eligible in pulmonary medicine. If you contact the board, they don't recognize that term."

> trying to say. So there's no percentage. But that acute exacerbation and that deterioration, that part is completely caused by the dust exposure.

Dr. Kumar stated it did not "make much of a difference" whether the exposure was from dust or pollen. He explained, "[b]ecause both dust and pollen can produce a reactive airway disease. It can make a chronic obstructive airway disease person or anybody produce that reactive airway disease in the lung in the airway." Dr. Kumar stated there is no way to know whether the exposure was specifically caused by dust or pollen.

Dr. Kumar recognized that Claimant had COPD pre-dating August 2000. Furthermore, Dr. Kumar agreed that people who smoke "do get more infections." Dr. Kumar testified people who smoke "are more prone for infections. And any time you have an infection, that will make the COPD worse." Despite Claimant's history of COPD and smoking, Dr. Kumar opined, "[b]ut he developed a reactive airway disease from either a dust or pollen, an acute insult to the lung, to the airways, which brought him into the hospital and caused him to have a prolonged course of wheeze."

Dr. Vosler and Dr. Kumar relied solely on Claimant's representation to them that it was unusually dusty on the Phillip job and that he had been working on the Phillip job at the time he became ill and required medical treatment. Both Dr. Vosler and Dr. Kumar assumed a correlation between the timing of the alleged work exposure and the onset of Claimant's symptoms. However, both Dr. Vosler and Dr. Kumar ignored the fact that Claimant presented with common viral symptoms of a sore throat, runny nose, cough and greenish sputum several days before he became ill enough to require hospitalization. Dr. Anderson found these symptoms very significant in determining what caused Claimant's breathing problems.

Claimant led Dr. Vosler and Dr. Kumar to believe that he had an extraordinary exposure to dust. Dr. Vosler and Dr. Kumar, again relying solely on Claimant's history, concluded that this extraordinary exposure caused his breathing problems, which required hospitalization. But, it was established that Claimant was not exposed to a significant amount of dust. Claimant was exposed to a minimal amount of dust on the Phillip project. Expert testimony is entitled to no more weight than the facts upon which it is predicated. Podio v. American Colloid Co., 162 N.W.2d 385, 387 (S.D. 1968). "The trier of fact is free to accept all of, part of, or none of, an expert's opinion." Hanson v. Penrod Constr. Co., 425 N.W.2d 396, 398 (S.D. 1988). Both Dr. Vosler's and Dr. Kumar's opinions are rejected as lacking in foundation.

Dr. Vosler's and Dr. Kumar's opinions are also rejected because they are speculative. Neither physician could identify any particular agent that could have caused Claimant's breathing problems. Dr. Vosler could opine only that there was an exposure that caused the insult. Dr. Kumar stated there is no way to know whether the exposure was caused by dust or pollen. Again, this opinion was based on the presumption that there was an extraordinary amount of dust. "Proof need not arise to a degree of absolute certainty, but an award may not be based upon mere possibility or speculative evidence." Hanten, 558 N.W.2d at 80. These opinions are insufficient for Claimant to meet his burden.

Dr. Kamman performed a review of Claimant's medical records and issued a report on August 16, 2001. In addition, Dr. Kamman testified through his deposition. Dr. Kamman recognized that Claimant had moderate to severe COPD. Dr. Kamman explained COPD as:

> It is an entity in which the airways, the bronchial tubes, have been narrowed by insult. They can be of different varieties. The most common by far is chronic tobacco use, but what happens is the airways are narrowed and so you have obstruction to air flow, and people become short of breath because they have narrowed airways, they tend to cough because the airways are irritated, and that's the usual symptoms for that disease.

Based on his review of Claimant's medical records, depositions of Claimant, Dr. Kumar and Dr. Vosler, Dr. Anderson's report, and conversations with Claimant's co-workers, Dr. Kamman opined that Claimant's continued smoking was a major contributing cause "to his having an exacerbation requiring the hospitalization, with probably minor contributing factor of some exposure at the workplace."

Dr. Kamman opined that the major contributing cause of Claimant's hospitalization was his cigarette use. He gave the following explanation for his opinion:

> Well, cigarettes are a much more defined exacerbator for lung problems, something that you can have a better sense of quantifying the effects, and when someone is smoking up to two packs a day they are likely to be exposing their airways to a significant insult.
>
> The other factors, the exposures in the workplace, dust, certainly could cause some problems, but with his coworkers describing the situation which put him a number of feet away from the major amount of dust, it would seem to me that that would be a smaller contributing factor, and that cigarettes are a well-known factor, and smoking two packs a day is something I have a sense that I can quantify, where being a number of feet away from where dust is generated seems to me to be a smaller factor in this.

Dr. Kamman opined that cigarette smoking alone could have caused Claimant's symptoms.

Dr. Kamman disagreed with Dr. Kumar's opinion that Claimant's problems were caused by an exposure to either dust or pollen. Dr. Kamman disagreed with Dr. Kumar on two points:

> One has to do with my discussion with the two coworkers that gave me a little more sense of what the conditions were like, which resulted in my feeling that the dust exposure was not enough to cause the problems that required his hospitalization.
>
> And the other part is their observation of the ongoing smoking use in somebody who has underlying obstructive lung disease, and, again, two packs a day is something that I can have a better sense of its effects than I can dust exposure for someone who is [60 to] 80 feet away from a hole where dust is being generated.
>
> So I think it was those two factors that led me to believe that the cigarettes were much more of the exacerbating factor than the dust.

Dr. Kamman opined, assuming that Claimant did have some kind of a reaction to dust in some quantity, that the effect of that exposure would be a short-term problem, causing some symptoms returning to "baseline" with some treatment. Dr. Kamman admitted that because of Claimant's history of smoking and his underlying lung disease, he was more susceptible to dust exposure than a person who did not have that history. Dr. Kamman opined that "[e]nough dust exposure could cause [Claimant's] symptoms," depending on the quantity of the dust and the length of exposure. Even so, it has been established that Claimant's exposure to dust was minimal.

Employer also offered opinions from Dr. Anderson, who generated a written report dated October 11, 2000, and testified in-person at the hearing. Prior to testifying, Dr. Anderson reviewed Claimant's medical records and the depositions of Dr. Vosler, Dr. Kumar, Dr. Kamman and several of Claimant's co-workers. Based on this review, Dr. Anderson opined that Claimant's work for Employer was not a major contributing cause of his illness and need for hospitalization. Dr. Anderson explained:

> If you go back and look at the initial hospitalization records, Dr. Phipps states that Mr. Molitor's problems began August 13. He had a cold, runny nose, sore throat, was coughing up a greenish sputum. She diagnosed acute bronchitis, started him on I.V. antibiotics. Dr. Vosler saw him also. Dr. Vosler states that earlier in the week he had a greenish sputum, turned kind of yellowish and grayish. Dr. Kumar consulted. Dr. Kumar initially had two diagnoses, and I quote from Dr. Kumar's report, number one, acute bronchitis most likely viral. Number two, very likely to have underlying chronic airway obstruction due to smoking. The x-ray that was done on initial presentation showed three conditions. These three conditions did not occur due to the dust exposure over the previous few weeks. The three found on the x-ray were COPD, mild interstitial fibrosis in the mid and lower lung fields, and peribronchial thickening, basal segments, suggestive of bronchiecstasis. Those are three things that are visible to the radiologist that have occurred over time, not within the previous month. And so he's admitted, given I.V. antibiotics, and in fact sent home on I.V. antibiotics. And I understand both Dr. Vosler and Dr. Kumar believe it was not bacterial, even though they treated him for a ten-day time period on antibiotics, I.V. and oral, but a virus will produce the same type of symptoms as does bacterial. <u>And the reason I believe this to be viral is the symptoms of a cold, runny nose, sore throat is what happened with a virus. And the typical scenario is that someone who has lung damage due to years of smoking, gets an upper respiratory infection, goes on to develop a viral or bacterial bronchitis, causes what's called an acute exacerbation of COPD, very common reason for admission to the hospital, treated in exactly the way Mr. Molitor was</u>, and that's what I believe happened in this case.

(emphasis added).

Dr. Anderson disagreed with Dr. Kumar's opinion that Claimant had a reactive airway disease due to a dust exposure. To the contrary, Dr. Anderson specifically opined that Claimant did not have a reactive airway disease due to a dust exposure. He explained:

> Mr. Molitor had two pulmonary function tests performed. One, the date was January 23 of 2001. There was also one done in the fall of 2000. And on both of those testing they performed pre and post bronchodilator spirometer, meaning you blow into the testing machine, test your lung capacity. You then use nebulizer, which it delivers bronchodilator and then do the same test over again afterwards. In both of those tests there was no improvement pre and post bronchodilator. . . . And, in fact, in both of those his pulmonary functions were a little worse after the bronchodilator than they were before, which would be consistent with smoking damage which causes non-reversible damage to the lungs.

Dr. Anderson further testified:

> Q: It's your opinion that he doesn't have the reactive airway disorder related to dust because an essential part of that diagnosis is that when the bronchodilator test is given, there should be a reaction or some reversibility?
> A: Correct.
> Q: And there were a couple of those tests given in September and January, and those are the results that you reviewed?
> A: Yes.
> Q: And instead, because there wasn't any improvement with those bronchodilators, it was your belief that the results were consistent with somebody who just has underlying chronic lung disease from smoking?
> A: Yes.
> Q: The reason you also ruled out the hypersensitive pneumonitis, which would come from the organic materials, is because that would show up on x-ray, and the symptoms would present differently than what Mr. Molitor had?
> A: Yes.

Dr. Anderson opined that it is "extremely uncommon" for dust to cause an acute exacerbation of COPD, which would require hospitalization. Dr. Anderson stated:

> Lungs can be overwhelmed just by pure quantity of dust. If the dust is so thick that you can't see through it, it can overwhelm your lungs' ability to clean that dust out and clear it. That doesn't seem to be what we're talking about in this case. There wasn't that much dust. There was dust like there is in any construction site. But from my review of things, it doesn't appear that there was a quantity of dust that would just simply overwhelm lungs to cause this kind of problem. So you'd have to assume it's something about the dust that caused some kind of a reaction that would make the airways overreact and spasm and then therefore cause wheezing and therefore result in the hospital admission. And that's what I'm saying, if that had been the case, that's essentially asthma or reactive airways disease, and it wasn't found in this case. There's not the objective documentation in the file to substantiate that diagnosis.

Dr. Anderson further explained his opinions:

Q: What is it about the medical records and the symptoms or Mr. Molitor's - - the history that he gave that would lead you to believe and give your opinion that it would have a viral cause rather that an environmental cause?
A: The fact that he has cold, runny nose, sore throat, cough, greenish sputum and which the - - and one place said yellowish. And green and yellow sputum are hallmarks of a diagnosis of some type of infection of your bronchi.
Q: I see. Could those symptoms be consistent with an environmental cause also?
A: They really shouldn't. I mean, if you assume that someone has reactive airways disease and so this was induced by dust and if someone breathes a lot of dust, and I've cared for Homestake miners for 18 years, you cough up black stuff; they leave the mine and cough black stuff. But you don't cough up green and yellow stuff. Also if you just purely have a reaction to dust, you don't cough up sputum. If you do, it's a small amount of clear or white sputum and not green and yellow.

Dr. Anderson opined that Claimant's need for additional medication was caused by his smoking. Dr. Anderson explained the medications prescribed to Claimant were the "same medications used to treat people with chronic obstructive pulmonary disease due to years of smoking."

Dr. Anderson agreed that Claimant had an acute episode in August 2000, which required additional medication. However, Dr. Anderson opined Claimant had a "virally-induced episode being an acute exacerbation of chronic obstructive pulmonary disease, COPD." Dr. Anderson explained that it is common for someone with COPD to have an acute exacerbation from time to time due to lung damage caused by years and years of smoking.

The opinions expressed by Dr. Anderson are more persuasive. Dr. Anderson's opinions were well-reasoned and consistent with the medical history and hearing testimony. Claimant has longstanding COPD. Claimant continued to smoke against doctors' advice and his lungs have continued to deteriorate. As Dr. Anderson opined, any medication that Claimant takes is related to his COPD. The evidence established that smokers with COPD can be expected to have more and more breathing problems. More importantly, Dr. Anderson's opinions take into account that Claimant suffered from common viral symptoms the week before he sought medical treatment and that Claimant was not exposed to an unusual amount of dust on the Phillip project. Dr. Anderson's opinions are accepted and establish that Claimant's work was not a major contributing cause of his illness and need for hospitalization.

Claimant failed to bring forth specific medical evidence to support his burden of proving there was a causal connection between his employment and his illness. Claimant failed to prove by conclusive medical evidence that his work activities were a major contributing cause of his illness, which required hospitalization. When medical evidence is not conclusive, Claimant has not met the burden of showing causation by a preponderance of the evidence. Enger, 565 N.W.2d at 85. Claimant failed to establish

by a preponderance of the evidence that his work was a major contributing cause of his illness for which he sought treatment on August 17, 2000. Claimant's request for benefits is denied and his Petition for Hearing must be dismissed, with prejudice.

Employer shall submit Findings of Fact and Conclusions of Law, and an Order consistent with this Decision, and if necessary, proposed Findings and Conclusions within ten days from the date of receipt of this Decision. Claimant shall have ten days from the date of receipt of Employer's proposed Findings and Conclusions to submit objections or to submit proposed Findings and Conclusions. The parties may stipulate to a waiver of Findings of Fact and Conclusions of Law and if they do so, Employer shall submit such Stipulation along with an Order in accordance with this Decision.

Dated this 8th day of April, 2003.

SOUTH DAKOTA DEPARTMENT OF LABOR

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Elizabeth J. Fullenkamp
Administrative Law Judge