ARKANSAS COURT OF APPEALS
NOT DESIGNATED FOR PUBLICATION
WENDELL L. GRIFFEN, JUDGE

DIVISION II

CA07-1196

June 4, 2008

LARRY MCGINLEY
APPELLANT

AN APPEAL FROM THE WORKERS' COMPENSATION COMMISSION
[F604075]

V.

LITTLE ROCK SHEET METAL and SOUTHERN GUARANTY INSURANCE CO.
APPELLEES

AFFIRMED

On September 27, 2007, the Workers' Compensation Commission affirmed and adopted the opinion of the administrative law judge (ALJ), who found that appellant Larry McGinley failed to prove that his chronic obstructive pulmonary disorder (COPD) was a compensable occupational disease. Appellant challenges the sufficiency of the evidence to support the finding. We affirm, holding that the Commission's opinion is supported by substantial evidence.[1]

Appellant worked for Little Rock Sheet Metal from January 1973 until April 2006. He started as an apprentice, during which time he trained and went to school. He then worked as a journeyman and continued in that capacity until 1991, when he became a shop foreman. His duties as foreman included overseeing the fabrication work, taking phone calls, assisting customers, and overseeing production. While appellant acknowledged that he was

[1]Appellant argues separately that he was entitled to additional medical treatment and temporary-total disability. However, compensability is a threshold question. Because appellant's COPD is not compensable, he is not entitled to additional medical treatment or temporary-total disability.

not constantly welding the entire time, he stated that he was constantly in a welding environment. Appellant testified that when he was a foreman, his time on the floor varied, but that he would spend a major part of his day in the shop and doing work himself. He stated that the shop was 120 feet long and 90 feet wide. His office, which he received in 1995, was next to the shop and was 10 feet by 12 feet. He stated that the air quality in his office was no better than the air quality in the shop. On an average day, employees would be working on five or six different projects, and the welding would emit a visible cloud of smoke.

Appellant started having cold-like symptoms in 2001, including coughing, runny nose, and shortness of breath. His symptoms never improved. He testified that he would visit his doctor, who would give him medication. He would get better and return to work, but his symptoms would later worsen. He continued to work for Little Rock Sheet Metal until his doctors told him that he could not work without a mask. Both he and his supervisor opined that he could not do his type of work while wearing a mask; therefore, he quit his job and filed a workers' compensation claim. Appellant testified that his COPD has improved since leaving his job to the point where he does not have as many episodes; however, he said that his episodes were as intense as they were before when he does have them.

The medical records show that appellant first presented to Dr. Charles Barg on November 21, 2000, where he was diagnosed with an upper respiratory infection. He was prescribed medication. Appellant returned on May 2, 2001, and underwent a physical. Dr. Barg diagnosed appellant with chest pain and opined that the pain was musculoskeletal. He returned to Dr. Barg, and later to Dr. Joseph Rose, periodically for treatment for his chest pain. Drs. Barg and Rose later diagnosed him with asthma and prescribed Singular, Prednisone, Albuterol, Doxycycline, and Flovent at various times.

Appellant presented to Dr. Rose with chest pain on September 9, 2003. Dr. Rose

commented that the chest pain was not related to any food, but he mentioned appellant's history of gastroesophageal reflux disease (GERD). Appellant returned to Dr. Rose on May 27, 2004, with complaints about his GERD and requested a refill for his Prevacid. After this time, the medical records show that Dr. Rose continually saw appellant for appellant's cough.

Appellant presented to Baptist Health Medical Center on December 5, 2005, with complaints of abdominal pain, cramping, and diarrhea. He was admitted to the hospital for abdominal pain and possible bowel obstruction, but Dr. Gail McCracken also noted an impression of COPD and multiple occupational chemical exposures. A CT scan showed small-bowel loops with air-fluid levels of different heights. Appellant was discharged from the hospital on December 12, 2005, after receiving treatment for bowel obstruction.

Appellant returned to Dr. McCracken on December 29, 2005, where he was assessed with probable bronchial infection and venous engorgement. After another CT scan, Dr. McCracken diagnosed appellant with COPD. In a progress note dated March 7, 2006, Dr. McCracken opined that appellant could have "occupational induced arc-welding asthma versus chronic bronchitis from his fume exposure at work." She recommended a respirator to avoid further damage to his lungs. Because he was not allowed to wear a respirator at work, she considered appellant 100% disabled. Dr. Rose concurred in a letter dated July 7, 2006.

Appellees deposed Dr. McCracken on November 8, 2006. She reiterated that appellant had occupationally induced arc-welding asthma. She noted that appellant did not smoke, did not have childhood asthma, and was exposed to conditions that led to conditions consistent with pulmonary disease. Dr. McCracken did not know that appellant had a history of raising cattle; however, she ruled out those activities as the cause of appellant's condition. While she could not say without relying on speculation that appellant's COPD resulted from his employment as opposed to any of his other personal activities, Dr. McCracken stated:

> Common sense would tell you that the volume of exposure a person would have Monday through Friday at a work place, as opposed to a weekend, you know, whatever, an hour, I don't know how it works . . . , then common sense would tell you, and I think based on a reasonable scientific thought process, that the exposure he would have in the work place would be far more consistent and therefore more at risk for causing the lung problem. It wouldn't make sense to me that the occupational exposure would not bother him, and when he's at home it would make him have chronic bronchitis.

Dr. McCracken continued:

> Considering the facts, I feel confident that the welding exposure and fumes are the cause of his lung condition. Pulmonary functions have established that as the lung problem. And really, when you look at occupational lung disease literature, it rules out other things, basically, which I think we've done. We've ruled out endobroncial lesion; we've ruled out other reasons why he would have COPD asthmatic condition. And it's my opinion that he has it related to these exposures. There aren't any tests that can prove the causation of this condition. It's history, pulmonary functions, and examination. There is no test. You can't do open lung biopsies and figure it out. There isn't a test that can be done that I am aware of. I have to rely on pulmonary history and if he had told me that the cattle and the vegetable gardening were a part of his life, I would have told him I didn't think it was important.

Appellees hired toxicologist Henry Simmons to review the case. In a December 31, 2006 letter, he concluded that appellant's pulmonary problems could not be attributed to workplace chemical exposures. After reviewing appellant's medical history, Dr. Simmons wrote:

> Although, there is no doubt that Mr. McGinley has "COPD with asthmatic bronchitis" Dr. McCracken has not justified either the diagnosis of "arc welding asthma" or convincingly connected it to chemical exposure at Little Rock Sheet Metal. To diagnose asthma of occupational origin as opposed to that from another cause without speculation, one is obligated to prove that the asthma was actually caused by one or more workplace chemicals. The reappearance of characteristic signs and symptoms should display an impressive connection to the workplace environment relative to other areas. One must further demonstrate that the bulk of the technical literature supports the conclusion that the putative, work-place toxicants are widely accepted as causes of occupational asthma. In addition, one should be able to demonstrate that the implicated chemicals were present in concentrations that are known to give rise to occupational asthma. Finally one must convincingly demonstrate that alternative causes of asthma have been eliminated. Thus, as a general proposition, there is also no doubt that it is much easier to diagnose asthma clinically than it is to prove its cause.

Relying on literature, Dr. Simmons defined occupational asthma as "variable airflow

limitation caused by a specific agent in the workplace." He then noted that Dr. McCracken failed to identify a specific agent present at Little Rock Sheet Metal responsible for appellant's condition. He also disputed with Dr. McCracken for disregarding the fact that appellant's condition developed years after appellant became a supervisor, thus likely reducing his direct exposure to irritants, and the fact that appellant's most prominent symptoms occurred when he was away from work and doing other activities unrelated to work.

Next, Dr. Simmons said, "significant doubt exists in the medical and scientific community that the welding environment causes chronic lung disease although data do suggest that it is associated with acute symptoms and reversible pulmonary function changes." He then cited several studies that show a lack of causal link between the welding environment and COPD.

Finally, Dr. Simmons related appellant's condition to GERD. After referring to the literature, he explained:

> Given its description, it is relatively easy to relate the claimant's symptoms to GERD. According to Goyal (2005) reflux from the stomach can cause chronic cough, bronchoconstriction, bronchitis, pneumonia, and chronic asthma which have all been experienced by the claimant. As discussed previously, Mr. McGinley first developed these problems in 2002 which was 11 years after he became a supervisor and 7 years after becoming a part time office worker. By that time he was well past the period of maximum exposure to workplace chemical irritants during which maximal symptoms would most likely have occurred if they were secondary to work place irritants. However, he was demonstrably not beyond the point of progressive GERD with its associated symptoms. Accordingly, it is not surprising that his earliest, most prominent and persistent complaint has been coughing particularly at home at night. This history not only strongly suggests a cause outside the workplace but also is entirely consistent with GERD as the explanation since reflux often worsens with one lies down and loses the assistance of gravity to keep stomach content in place. Cough represents the body's reflex attempt to expel the irritating gastric content from the lungs.
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> As the reflux progresses other pulmonary problems appear. Sinusitis such as that diagnosed in Mr. McGinley in February of 2005 can result from reflux into the upper airways. As the bronchi or airways become increasingly irritated chronic, productive cough often worsens and physicians diagnose bronchitis on clinical grounds as in this case. The irritated bronchial tubes eventually reach the point that they react in a non specific fashion by constricting on contact with previously tolerable concentrations of airborne irritants inside and outside workplace. Such bronchoconstriction manifests

> as shortness of breath, gives rise to audible wheezes, and produces abnormal pulmonary function testing, again as seen in the McGinley case. Thus it is not surprising that by 2005 when Dr. McCracken first saw him that he had developed symptoms at work. However, he also had them when tending his cattle and in particular, even more so at home at night in bed. GERD also provides a satisfying explanation for why Mr. McGinley has experienced pneumonia from time and why his physicians have not documented infectious causes. Pneumonitis is an inflammation of lung tissue. If sufficient gastric content enters one or more portions of the lungs, then pneumonitis can develop in those areas that can appears [sic] clinically as pneumonia in the absence of a proven infection.
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> Finally, a particularly strong argument for GERD as the best explanation for Mr. McGinley's pulmonary problems is his ongoing if not worsening course despite complete removal from the workplace. Ordinary, if his asthma were related to irritants or allergens in his work environment, one would expect removal from that location plus treatment with multiple bronchodilators and steroids (not to mention the powerful immunosuppressant, Imuran, that he takes for his Crohn's disease) to lead to dramatic improvement. However, sustained positive changes has [sic] not been seen in Mr. McGinley. In point of fact, he complained of having pneumonia when deposed three months after leaving Little Rock Sheet Metal. Unfortunately, his asthma medications are not designed to combat persistent aspiration of stomach contents and the acid-suppressing medication was not completely controlling his reflux problem based upon endoscopic findings of reflux-related esophageal erosion in April of 2006.

The ALJ issued an opinion finding that appellant's COPD was non-compensable, as appellant failed to show that his condition was caused by exposure to fumes at work. In his decision, the ALJ credited the opinion of Dr. Simmons over that of Dr. McCracken. The ALJ acknowledged that Dr. Simmons never examined appellant; nevertheless, he found that Dr. McCracken had no advantage over Dr. Simmons with respect to reviewing the literature on the issue of causation. The ALJ further found that appellant's work history and other medical conditions were more consistent with Dr. Simmons's conclusions. The Commission affirmed and adopted the ALJ's opinion.

The sole issue here is whether appellant's COPD is a compensable occupational disease under the workers' compensation statutes. When reviewing decisions from the Workers' Compensation Commission, we view the evidence and all reasonable inferences deducible therefrom in the light most favorable to the Commission's decision and affirm if that decision is supported by substantial evidence. *Smith v. City of Ft. Smith*, 84 Ark. App. 430, 143 S.W.3d

593 (2004). Substantial evidence is evidence that a reasonable mind might accept as adequate to support a conclusion. *Williams v. Prostaff Temps.*, 336 Ark. 510, 988 S.W.2d 1 (1999). The issue is not whether we might have reached a different result from the Commission; if reasonable minds could reach the result found by the Commission, we must affirm the decision. *Minnesota Mining & Mfg. v. Baker*, 337 Ark. 94, 989 S.W.2d 151 (1999). Normally, we only review the findings of the Commission and not those of the ALJ. *Logan County v. McDonald*, 90 Ark. App. 409, 206 S.W.3d 258 (2005). However, when the Commission adopts the conclusions of the ALJ, as it is authorized to do, we consider both the decision of the Commission and the decision of the ALJ. *Death & Permanent Total Disability Trust Fund v. Branum*, 82 Ark. App. 338, 107 S.W.3d 876 (2003).

An occupational disease is characteristic of occupation, process, or employment, for purposes of determining whether disease is compensable by workers' compensation, where there is a recognizable link between the nature of the job performed and increased risk in contracting occupational disease in question. *Crossett School Dist. v. Gourley*, 50 Ark. App. 1, 899 S.W.2d 482 (1995); *see also* Ark. Code Ann. § 11-9-601(e)(1)(A) (Repl. 2002). Where an employee suffers from an occupational disease and is disabled as a result of the disease and where the disease was due to the nature of the occupation or process in which he was employed within the period previous to his disablement, the employee shall be entitled to compensation as if the disablement were caused by injury. Ark. Code Ann. § 11-9-601(a). A causal connection between the employment and the disease must be proven by a preponderance of the evidence. Ark. Code Ann. § 11-9-601(e)(1)(B). The fact that the general public may contract the disease is not controlling on the issue of workers' compensation for the disease; the test of compensability is whether the nature of employment exposes the worker to greater risk of that disease than risk experienced by the general public or workers in other employments. *Heptinstall v. Asplundh Tree Expert Co.*, 84 Ark. App. 215,

137 S.W.3d 421 (2003); *Osmose Wood Preserving v. Jones*, 40 Ark. App. 190, 843 S.W.2d 875 (1992).

The Commission has the duty of weighing medical evidence, and the resolution of conflicting evidence is a question of fact for the Commission. *Stone v. Dollar General Stores*, 91 Ark. App. 260, 209 S.W.3d 445 (2005). The interpretation of medical opinion is also for the Commission, and its interpretation has the weight and force of a jury verdict. *Oak Grove Lumber Co. v. Highfill*, 62 Ark. App. 42, 968 S.W.2d 637 (1998). Further, the Commission is entitled to review the basis for medical opinion in deciding the weight and credibility of the opinion and medical evidence. *Maverick Transp. v. Buzzard*, 69 Ark. App. 128, 10 S.W.3d 467 (2000). However, the Commission may not arbitrarily disregard medical evidence or the testimony of any witness. *Hill v. Baptist Med. Ctr.*, 74 Ark. App. 250, 48 S.W.3d 544 (2001).

In arguing that the Commission's decision is not supported by substantial evidence, appellant argues that the Commission put too much weight on the fact that he could not produce an objective test to determine causation. This is incorrect. The Commission did mention the lack of available tests to conclusively prove the issue; however, that did not conclude the Commission's analysis. It commented that the question of causation turned on a review of the applicable literature, compared the analyses of Drs. Simmons and McCracken, and gave Dr. Simmons's analysis more weight. The Commission then found that Dr. Simmons's analysis was more consistent with appellant's work history and symptom presentation. This is reasonable, as the fact that appellant was symptomatic even when removed from the environment is evidence that appellant's COPD was not related to his workplace. The Commission was also within its authority to credit Dr. Simmons's opinion that appellant's condition was related to GERD. Nothing in the record shows that Dr. McCracken did anything to rule out GERD as a factor causing appellant's COPD.

Appellant also accuses the Commission of arbitrarily disregarding Dr. Rose's opinion

that appellant suffered from occupational induced arc-welding asthma. However, this opinion simply mirrored Dr. McCracken's findings, and there is no evidence to show that Dr. Rose's opinion was independent of Dr. McCracken's. Therefore, by crediting Dr. Simmons over Dr. McCracken, the Commission implicitly credited Dr. Simmons over Dr. Rose as well.

Dr. Simmons reviewed the evidence and opined that appellant's condition was attributable to GERD, not the workplace. Though this opinion contradicts that of Dr. McCracken, it was within the Commission's province to credit that opinion. Dr. Simmons's opinion is substantial evidence that appellant's COPD was not related to his employment at Little Rock Sheet Metals. Accordingly, we affirm.

GLOVER and HEFFLEY, JJ., agree.