**U.S. Department of Labor**

Office of Administrative Law Judges
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**Issue Date: 07 November 2019**

Case No.: 2017-LDA-00829

OWCP No.: 06-313398

In the Matter of:

WILLIAM COHEN, III,
Claimant,

v.

LEIDOS,
Employer,

INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA
c/o AIG CLAIMS, INCORPORATED,
Carrier,

and

DIRECTOR, OFFICE OF
WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: Gary Pitts, Esq.
Attorney for the Claimant

John Karpousis, Esq.
Attorney for the Employer

BEFORE: DANA ROSEN
Administrative Law Judge

## DECISION AND ORDER

This claim is filed under the Defense Base Act, as amended (DBA), U.S. Code, Title 42, Chapter 11, and is governed by the implementing Regulations found at Code of Federal Regulations, Title 20, Chapter VI, Subchapter A, Part 704 and Part 702.

A formal hearing was held on December 13, 2018 in Atlanta, Georgia, at which time the Parties were given a full and fair opportunity to present evidence and argument. Joint Exhibit 1, the joint

stipulations of fact, was admitted into the record. (TR at 5-6) Administrative Law Judge (ALJ) exhibits 1 through 3 were admitted into the record. (TR at 7) Employer's counsel objected to Claimant's exhibit 6 and 7. The undersigned admitted Claimant's exhibits 6 and 7, noting that they would be given the weight to which they were entitled. (TR at 16, 22) Claimant's exhibit 9, Director's Memorandum of Informal Conference, was admitted solely for its use in a potential attorney's fee petition.[1] (TR at 7) Claimant's counsel noted that the LS-18 originally included a high blood pressure claim, but it had since been withdrawn. *Id.* Claimant's[2] exhibits 1 through 14 were admitted into the record. (TR at 22) Employer's exhibits A through O were admitted into the record. (TR at 24) The record was left open for Employer's exhibit P for the pulmonary independent medical evaluation *de bene esse* deposition of Dr. DeMarini, which was to be taken the following day. (TR at 25) The record was left open for Employer's exhibit Q for the *de bene esse* deposition of Dr. Upshaw, which was to be taken in January 2019. (TR at 25) A sentence from CX 13, page 9, from Dr. Bhar's April 11, 2017 report was stricken from the record because the note made reference to a patient's work in Dubai, and the Parties agreed that Claimant was not in Dubai in 2017. (TR at 127) Dr. Spector's *curriculum vitae* was admitted into the record as part of Employer's exhibit F. (TR at 139)

Claimant alleges a psychological injury and a respiratory injury that arose out of and in the course of his employment in Afghanistan. The findings and conclusions which follow are based upon a complete review of the entire record in light of the arguments of the Parties, applicable statutory provisions, Regulations and pertinent precedent.

The ultimate finding of the court is based on weighing the evidence and testimony in the record, and is no reflection on Claimant's service supporting the military in Afghanistan.

## STIPULATIONS

In a joint exhibit filed December 5, 2018, the Parties stipulated and this Administrative Law Judge finds the following as fact: (JX 1)

1. The LHWCA applies to this claim.
2. An employer/employee relationship existed at the time of the injury.
3. An informal conference was held December 8, 2016 and July 13, 2017.
4. The claimant is now working.

[1] The following exhibit notation applies: JX – joint exhibit; ALJX – Administrative Law Judge exhibit; CX - Claimant's exhibit; EX – Employer's exhibit; TR – transcript of hearing.

[2] "Claimant" is used in this decision for the proper name of the individual who is the subject of this decision. "Employer" or "Respondent" is used for the name of the Respondent Employer.

## ISSUES

1. Whether Claimant sustained respiratory and psychological injuries arising out of employment?
2. Whether the claim was timely noticed?
3. Whether the claim was timely filed?
4. Whether Claimant is entitled to temporary partial disability from August 26, 201 6 to the present and continuing?
5. Whether Claimant is entitled to medical treatment under Section 7?

## SUMMARY OF THE EVIDENCE

The issue is whether Claimant's alleged post-traumatic stress disorder (PTSD) and alleged respiratory problems were caused by his employment with Leidos from 2009 – 2013.

Claimant worked as a military contractor with Leidos in Afghanistan from 2009 to 2013, when his contract ended due to a drawdown of forces in Afghanistan. Claimant found employment approximately five to seven months after returning to the United States, and worked at that same job continuously for the four years leading up to the hearing. Claimant received treatment for psychological complaints and respiratory complaints. Claimant argued his psychological conditions and respiratory arose out of his employment in Afghanistan. Claimant argued he has post-traumatic stress disorder. Claimant argued the PTSD was caused by rocket attacks that occurred while he was in the warzone. Claimant argued that exposure to burn pits and dust storms caused his respiratory condition. Employer argued that Claimant does not have post-traumatic stress disorder because he did not meet the medical elements of PTSD. Employer also argued that Claimant's respiratory condition and any psychological condition did not arise out of his employment in Afghanistan. Based on the persuasive medical evidence in the record, Claimant has not shown that his mental health condition arose out of or was contributed to by his employment in Afghanistan. Based on the persuasive medical evidence in the record, Claimant has not shown that his respiratory condition arose out of or was contributed to by his employment in Afghanistan. While he suffers from personal health conditions, the evidence as a whole does not support they arose out of employment.

## FINDINGS OF FACT

### CLAIM FILINGS

**LS-203, dated July 15, 2015 (CX 2; EX D at 2)**

On July 15, 2016, Claimant described the nature of his injury as: "high blood pressure, flashbacks, nightmares, asthma, difficulty sleeping at night, negative and detached emotions." (CX 2 at 1) Claimant described how the injury occurred as "war zone violence, [illegible], smoke, stressful environment, loss of employee, traumatic events." *Id.* On the 2015 LS-203, Claimant stated that the date the Employer first knew of the injury was January 9, 2009, when he first began working for Leidos in Afghanistan. *Id.*

**LS-202, dated August 24, 2016 (EX C)**

Employer's first report of injury stated that Claimant's injuries were "high blood pressure, flash backs, nightmares, asthma, difficulty sleeping at night, negative and detached emotions." (EX C)

**Amended LS-203, dated October 28, 2016 (CX 2 at 2; EX D at 3)**

Claimant described the nature of his injury as follows: "high blood pressure, flashbacks, nightmares, asthma, difficulty sleeping at night, negative and detached emotions...or aggravation." (CX 2 at 2) He stated that the date of last exposure was July 15, 2015.

**Second Amended LS-203, dated December 8, 2016 (CX 2 at 3; EX D at 5)**

Claimant described the nature of his injury as follows: "high blood pressure, flashbacks, nightmares, asthma, difficulty sleeping at night, negative and detached emotions...or aggravation, skin disorder." (CX 2 at 3) Claimant stated that his date of last exposure was August 15, 2013. (CX 2 at 3) He added "skin disorder" to the nature of his injury. *Id.*

**Claimant's LS-18, dated July 19, 2017 (CX 10)**

Claimant's July 19, 2017 LS-18 stated that Claimant worked in Afghanistan for Employer for several years. It stated that Claimant's treating mental professionals "attributed the cumulative prolonged exposure to war-zone violence and stressful work environment to a worsened psychological condition." (CX 10) The LS-18 also stated that, "His exposures overseas are also causally linked to a pulmonary condition." *Id.*

**Claimant's LS-18, dated January 11, 2018 (CX 12)**

Claimant's January 11, 2018 LS-18 stated that Claimant's high blood pressure, dermatological problems, and pulmonary problems were related to his work as a government contractor in Afghanistan.

## CLAIMANT'S EVIDENCE

**Claimant's Summary of Events in Afghanistan (CX 8)**

On September 8, 2017, Claimant addressed to Dr. Spector a summary of events that Claimant alleged occurred while he was in Afghanistan. (CX 8) The subject of the document was "Memorandum for Record" and stated that the letter was "To: Dr. Jack Spector." *Id.* at 1. He wrote, "Dr. Spector, please see below for sequence of events that accrued while I was in Afghanistan." *Id.* Dr. Spector is a neuropsychologist who examined Claimant on September 8, 2017 at the request of Employer. Claimant testified at the hearing that his lawyers were not with him when he wrote this memorandum, nor were they on the phone with him. (TR at 88) Claimant testified at the hearing that he typed the memorandum himself. *Id.* at 88-89. He did not testify as to why he wrote this letter. *Id.*

Claimant wrote to Dr. Spector that he worked in Kandahar in 2010. He inspected damaged vehicles which he found disturbing. Claimant wrote that he worked in Kandahar, Camp Wolverine, Camp Spin Boldack, Camp Shindand/Thomas, Kandahar, Bagram, Camp Nathan Smith, and Kandahar until his contract ended in August 2013. Claimant wrote Dr. Spector that he experienced rocket-propelled or ground attacks in these locations, and stayed in the bunker.

**Hearing Testimony of Claimant (TR at 44-134)**

Claimant testified at the hearing on December 13, 2018. He testified that he was forty-three years old. (TR at 46) He worked overseas for six or seven years. *Id.* His last date working in Afghanistan was August 15, 2013. *Id.* at 47. Claimant worked for SAIC or Leidos[3] continuously from 2009 until August 15, 2013 in Afghanistan. *Id.* Claimant worked as a "quality assurance, quality control coordinator." *Id.* He coordinated repair efforts for the (Mine Resistant Ambush Protected) MRAP vehicle program. *Id.* at 48. Claimant also inspected military vehicles. *Id.* at 70. These vehicles were "used to carry the war fighters out in the field, protect them from harm, danger, [improvised explosive devices] IEDs, bombs, things of that nature." *Id.* Claimant supervised fifteen to sixteen people. *Id.* at 48. He testified that he was in Kandahar about 40 percent of the time he was overseas. *Id.* at 48. The rest of the time, he was at forward operating bases (FOBs) throughout the country. *Id.*

Claimant testified about his overseas work history before Leidos. From May 2008 to November 2008, he worked in Kandahar with General Dynamics. *Id.* at 70. Prior to that, he worked in Kuwait with ITT. *Id.*

Claimant testified regarding his pulmonary condition. Prior to joining Leidos, Claimant underwent a physical. Claimant testified he received treatment for shortness of breath approximately four or five times while in Afghanistan between 2009 and 2013. (TR at 63, 71) He testified that he did not bring this up during his deposition because "there were no documents to prove that." *Id.* at 74. He testified that he could not get records from the Army clinics he went to in Afghanistan. *Id.* He testified that the providers he treated with in Afghanistan "told [him] it must have been something [he] picked up while [he] was over there." *Id.* at 75. He testified that in his mind, this meant it "could have been" caused by dust storms or burn pits. *Id.* He also had R&R for fifteen to twenty-five days every five or six months. *Id.* at 71. He testified that he did not follow up with any doctor stateside while he was on R&R between the years 2009 and 2013 for treatment regarding health concerns. *Id.*

Claimant testified that prior to working overseas, he had no pulmonary problems or shortness of breath. *Id.* at 49. He testified that he did not smoke. *Id.* at 49. He testified that, prior to working in Afghanistan, he had no psychological problems, had not treated with a psychologist or psychiatrist, and had not taken a "psychologically active medication." *Id.*

Claimant testified that Claimant's exhibit 6 was a Joint Program Office Memorandum dated April 4, 2013 that showed the results from the Air Force sampling team. *Id.* at 49-50. Claimant testified that the welding and grinding described in this exhibit was going on during the time that

[3] The name "Leidos" will be used throughout this opinion for consistency.

he was in Kandahar. *Id.* at 50. Claimant described the burn pit and testified that his living quarters were approximately a ten minute walk away. *Id.* at 51-52. Claimant testified there were burn pits in Kandahar and Bagram. (TR at 75, 133) The forward operating bases he went to did not have burn pits. *Id.* at 134. He surmised that "local nations came and picked them up." *Id.* at 134. Claimant testified that there were dust storms while he was in Afghanistan. *Id.* at 67. He testified that he could not remember the specifics of the events leading to his treatments overseas for shortness of breath. *Id.* at 79. He did not miss any time from work. *Id.* at 80.

Claimant returned to the United States at the end of his contract in August 2013. He testified he went to the hospital for a respiratory incident two to three weeks after returning from Afghanistan. He testified the tests, including a chest x-ray, were normal. *Id.* at 99. Claimant testified he had two pulmonary function tests that were abnormal. *Id.* at 100. Claimant testified no one told Claimant why these were abnormal. *Id.* Claimant was asked by counsel, "In fact, Dr. Bhar, B-H-A-R, hasn't even diagnosed you with anything concrete?" Claimant responded, "That's correct." *Id.* at 100. Claimant testified that Dr. DeMarini suggested Claimant "do an upper GI." *Id.* at 101. Claimant had not had that test done. *Id.* Claimant was told by Employer's doctors that he had acid reflux. *Id.* at 101-102.

Claimant testified that he had an active lifestyle. *Id.* at 95. Claimant testified that since he returned to the United States, he experienced shortness of breath while running, working out, or otherwise over-exerting himself. He had not experienced this prior to going overseas. *Id.* at 58. Claimant testified that he cut his own grass using a "zero turn lawn mower." *Id.* at 102. Claimant was asked whether he recalled telling Dr. Upshaw, an internist who treated Claimant for ten years as his primary physician[4], in May 2016 that he was exercising regularly and without difficulty. *Id.* at 110. He testified, "[e]xercising could be walking...You mean exercising? You mean walking? I mean, exercising could be yoga, could be -- ...it could be anything." *Id.* at 110. [The court notes that Claimant told Dr. Upshaw on May 6, 2016 that that he "exercises regularly with no problem." (CX 1 at 16). The court notes that Claimant told Dr. DeMarini that he ran 15 miles before his evaluation on May 17, 2016. (EX P at 14) The court notes that Claimant told Dr. Bhar on April 11, 2017 that he ran a seven minute mile, CX 13 at 9, and on November 9, 2017 did Crossfit, CX 12.] Claimant testified at the hearing he last did Crossfit in 2013 or 2014. *Id.* at 95. Claimant testified at the hearing that he did Crossfit while he was in Kandahar. *Id.* at 102. He experienced symptoms including shortness of breath while in Kandahar. *Id.* He noticed these symptoms anytime he was over-exerted. *Id.* at 103.

Claimant was asked, "Did Dr. Upshaw in your mind say that there was a connection between what you had been exposed to overseas and this problem with your breathing?" *Id.* at 64. Claimant testified, "Yes." *Id.* Claimant testified that Dr. Upshaw was not the first doctor to make that connection, as "[t]here were different doctors overseas that I went to..." that made that connection. *Id.* at 64. Claimant was asked, "And [Dr. Upshaw] also said that he didn't think you should go back overseas to your old job where there are those exposures existing. Is that right?" *Id.* at 65. Claimant testified, "That's correct." *Id.* at 65.

At the hearing, Claimant testified Pulmonologist Dr. Bhar was treating him for his breathing problems. *Id.* at 68.

[4] (EX R at 7)

Q: Did Dr. Bhar ever tell you that your shortness of breath may be due to asthma?
A: Maybe. Yes, sir.
...
Q: Okay and did he go so far as to say that it was exercise induced asthma?
A: I don't remember that, sir.

*Id.* at 121.

Claimant was prescribed antibiotics, inhalers with steroids, and regular or rescue inhalers. *Id.* at 68. Claimant testified that he "may have" discussed having asthma with Dr. Upshaw. *Id.* at 111.

He testified that he told Dr. Upshaw to write him a note along with his medical records on August 26, 2016. *Id.* at 111. Claimant testified that he presented Dr. Upshaw with some literature regarding burn pits, and asked him to write a note to Employer. *Id.* at 112-113.

Claimant testified regarding his mental health condition. Claimant testified that one aspect of his job was repairing vehicles. *Id.* at 48. He testified that the vehicles would need repair because they had been hit by bombs or IEDs. *Id.* at 52. Claimant testified that he wrote his Summary of Events for Dr. Spector. *Id.* at 53. Claimant testified that his statement in CX 8 that looking at damaged vehicles was "very disturbing" (CX 8 at 1) because soldiers had been killed in those vehicles. *Id.* at 54.

Claimant testified that when rocket attacks occurred, he sought shelter. *Id.* at 55. Rocket attacks occurred throughout the four years Claimant was in Afghanistan. He was asked if he "feared for his life and safety," and Claimant testified, "Yes." *Id.* at 55.

Claimant testified regarding the inconsistencies between his hearing testimony December 2018 and his deposition testimony April 2018[5]. Claimant testified that at his April 17, 2018 deposition, he recounted a rocket attack in which he had to seek shelter in a bunker. *Id.* at 85. At his deposition, he testified that he did not see any injured people. *Id.* at 86. At the hearing, he testified conversely that he saw two men injured from shrapnel. *Id.* at 86.

Claimant testified that he prepared CX 8, his September 8, 2017 Summary of Events for Dr. Spector, on his own. None of his attorneys were involved and he saw his attorney for the first time at the hearing. *Id.* at 88.

Claimant testified that his lawyer retainer with Pitts & Mills showed that he retained the firm on October 27, 2016. *Id.* at 118. Claimant testified that he was able to recall more about those events in September 2017 than at the deposition in April 2018[6] because he had time to sit and think about it, and it was "hard to rattle off times and dates" when Employer's counsel was in front of him. *Id.* at 89.

[5] The transcript here states "April 2017," but the deposition of Claimant occurred April 17, 2018. (EX K)
[6] The transcript here states "April 2017," but the deposition of Claimant occurred April 17, 2018. (EX K)

Claimant testified regarding rocket attacks. Claimant testified that he was eating inside a dining facility in July 2010 in Kandahar when the kitchen was hit by a rocket propelled grenade, which unfortunately killed and injured several personnel. *Id.* at 55-56.

Claimant testified that in September 2010, he was at FOB Camp Wolverine when there was a ground attack and he stayed in a bunker. *Id.* at 56. Claimant testified that he feared for his life. *Id.* at 56. In July 2011, Claimant was inside a military treatment facility at FOB Camp Shindad when it was hit by a rocket propelled grenade and unfortunately killed and injured several personnel. *Id.* at 56-57. Claimant was eating at a restaurant and a grenade went off nearby. *Id.* Claimant was asked if he "feared for his life and safety," and he testified, "Yes." *Id.* at 57.

Claimant testified at the hearing regarding his job search after he returned to the United States. During his deposition testimony, he testified he applied for work overseas and in the United States to satisfy the unemployment benefits requirement. (See fn. 6.) Claimant testified that he left Employer in August 2013 because of a staff reduction. *Id.* at 80. He did not look for other employment overseas. *Id.* When he returned to the United States, he did not start working because he felt that he needed some time off. *Id.* at 80. Claimant testified he received unemployment while applying for jobs. (TR at 82)

Claimant was asked at the hearing whether he would accept employment overseas, though he applied for work overseas as part of his job search while receiving unemployment. Employer's counsel asked:

> Q: Now, when I asked you at your deposition, do you recall what your answer was if you were granted a job, would you have accepted one overseas?
> A: I don't remember what I said to you.
> ...
> Q: Your deposition, sir, at page 39 and I'll start with the actual question. "If you were offered a job to work overseas after SAIC, would you have gone?" Your answer was, "Just my choice."[7] Do you remember giving those answers?
> A: I probably did, sir.

[7] The transcript of the deposition reads as follows:

> Q: If you were offered a job to work overseas after SAIC, would you have gone?
> A: No, sir.
> Q: Why not?
> A: Just my choice.
> Q: Okay. I'm not trying to be flippant, but if you didn't want to go back to work overseas, why did you apply?
> A: Start off, part of the unemployment, you had to apply for jobs weekly.
> Q: Okay.
> A: In a nutshell, could have been one out of every six months, but I did what they told me to do. I applied and called in and told them I had applied for jobs.
> Q: Okay. Is there a reason you can articulate for me today as to why you wouldn't go back overseas to work?
> A: No, sir.

(EX K at 39)

*Id.* at 84.

Claimant was hired by Hill Phoenix as a supervisor. He testified he has continued to work there for the last three to four years. *Id.*

He testified that two or three months after returning to the United States, his wife noticed that he was having psychological symptoms. *Id.* at 58. He testified, "was in withdrawal because I didn't want to seek any kind of medical attention, but it just became a family problem." *Id.* at 58. Claimant eventually treated with Dr. Samuel[8]. *Id.* at 59. Dr. Samuel prescribed medication to treat major depressive disorder, recurrent episode, and post-traumatic stress disorder. *Id.* at 59. Claimant testified that the medication helped. When he did not take his medication, he felt "more antsy, jittery." *Id.* at 60. Claimant found a job in the United States in August 2014. *Id.* at 61. He was still working that job at the time of the hearing. *Id.* He testified that the medication helped him maintain his job. *Id.* at 60.

Claimant testified that his nightmares "have improved" since treating with Dr. Samuel. *Id.* at 90. Claimant testified his sleeplessness improved with medication.

> Q: It's fair to say since February 9, 2018, you really don't have any complaints of a psychological nature?
> A: If I'm taking medication, I'm fine.

*Id.* at 90.

Claimant testified that he had nightmares overseas but did not state when. *Id.* at 93. He did not seek treatment for that while overseas. *Id.* He did not seek treatment while home in the United States on R&R. *Id.* Claimant testified that he saw a gastroenterologist in October 2017. *Id.* at 115.

Claimant testified that his psychological symptoms had not resolved by October 2, 2017, when he completed a psychiatric checklist on which he checked that he had no personal problems or depression. *Id.* at 116-117. He testified that he had assumed the questions were about how he felt on the date he completed the checklist, and that day, he happened to not be suffering from those symptoms. *Id.* at 117.

Claimant last worked for Leidos in August 2013. At the time of the hearing, Claimant was working as a production supervisor at a refrigeration production company, Hill Phoenix. *Id.* at 62. Claimant earned $70,000 per year. When he worked overseas, he earned $220,000 to $230,000 per year. *Id.*

## PSYCHOLOGICAL INJURY EVIDENCE

[8] Dr. Samuel is a psychiatrist who practices tele-psychiatry. (CX 14 at 3) He evaluated and treated Claimant, meeting with him four times. *Id.*

**Dr. Samuel Samuel,[9] February 10, 2017 Intake Evaluation; June 5, 2017 Medical Opinion Letter; Treatment Notes dated February 9, 2018, April 10, 2018, and October 17, 2018 (CX 1 at 22-25; CX 14 at 26-47)**

On February 10, 2017, Claimant underwent an outpatient psychiatric evaluation by Dr. Samuel Samuel, a psychiatrist in Charlotte, North Carolina. Dr. Samuel stated that the evaluation took 20 to 30 minutes. (CX 1 at 24) In the history, Claimant stated he returned home after working overseas as a contractor for several years. *Id.* at 22. He returned from Afghanistan "about two or three years ago." *Id.* Claimant reported that he had "been having difficulties with his mood and having mood swings and that his wife suggested he should talk to someone." *Id.* Dr. Samuel opined that "[a]s far as can be determined [Claimant's] psychiatric history is entirely negative." *Id.*

Upon examination, Dr. Samuel stated that Claimant denied suicidal ideation, self-injurious impulses, assaultive or homicidal intentions, hallucinations, and delusions. *Id.* at 2. Dr. Samuel opined that there were "[s]igns of moderate depression" present, and that Claimant's demeanor was "sad" and "glum." *Id.* at 23. Dr. Samuel opined that Claimant appeared "listless," "anergic," and "downcast." *Id.* Following examination, Dr. Samuel opined that Claimant had post-traumatic stress disorder and "major depressive disorder, recurrent episode, mild." *Id.*

On June 5, 2017, Dr. Samuel opined in a "To whom it may concern" letter that Claimant had diagnoses of major depressive disorder, recurrent episode, and post-traumatic stress disorder. *Id.* at 25. Dr. Samuel did not discuss the elements of PTSD and if they applied to Claimant. Dr. Samuel did not state what caused Claimant's PTSD, what triggered Claimant's PTSD, where it began, or when it started. He opined:

> The short-term expectation from the two diagnoses above is fairly satisfactory as long as he continues to take his medications and stays in treatment. The long-term prognosis of his conditions will depend on what kind of new trauma or stressors he comes across in future.

*Id.* at 25.

Dr. Samuel opined that Claimant should stay within the country and close to his treatment clinic in case he went into any mental health crisis. *Id.*

On February 9, 2018, Claimant was treated by Dr. Samuel and reported that his behavior had been stable and uneventful. He denied any psychiatric problems or symptoms. He reported no side effects and Dr. Samuel opined that no side effects were evident. Dr. Samuel stated, "Psychotic, depressive, and anxiety symptoms are denied." (CX 14 at 29) Upon examination of Claimant, Dr. Samuel opined that there were no signs of depression or elevation, no indications of hallucinations or delusions, no signs of thought disorder, and no signs of anxiety. Dr. Samuel diagnosed PTSD and "major depressive disorder, recurrent episode, mild." *Id.* at 29. Dr. Samuel instructed that Claimant continue taking his prescribed medications.

[9] Dr. Samuel's Evaluation Report dated February 10, 2017 stated that he was Board-certified in general adult psychiatry and child and adolescent psychiatry. (CX 1 at 24).

On April 10, 2018, Dr. Samuel treated Claimant for follow-up. Dr. Samuel stated that Claimant denied all psychiatric problems. Claimant reported no side effects. Claimant reported no psychotic, depressive, or anxiety symptoms. (CX 14 at 31) Upon examination, Dr. Samuel opined that Claimant "convincingly denies suicidal ideas or assaultive or homicidal thoughts or intentions." *Id.* Dr. Samuel opined that "there are no indications that hallucinations or delusions are present." *Id.* Dr. Samuel opined that there were no signs of a thought disorder or anxiety. *Id.* Dr. Samuel diagnosed PTSD and "major depressive disorder, recurrent episode, mild." *Id.* Dr. Samuel instructed that Claimant continue psychotherapy and medication management. *Id.* at 32.

On October 17, 2018, Nurse Practitioner Samuel stated, "Patient is seen with Dr. Samuel who decided the treatment." *Id.* at 34. Claimant reported that he missed several appointments because he was in Arizona for work. Claimant reported that he was "doing well and stable on his medications." *Id.* at 34. Claimant denied side effects from medications or psychiatric problems. Claimant reported no psychotic, depressive, or anxiety symptoms. Nurse Practitioner Samuel stated that Claimant had no signs of depression or manic process. Claimant denied suicidal or self-injurious ideas or impulses, and assaultive or homicidal ideations or intentions. Nurse Practitioner Samuel stated that Claimant was counseled on "how to deal with his or her mood." *Id.*

**Deposition of Dr. Samuel Samuel, November 5, 2018 (CX 14)**

Dr. Samuel was deposed on November 5, 2018. He testified that he is Board-certified in psychiatry, child and adult psychiatry, and addiction medicine. (CX 14 at 2). He testified regarding his educational background. He testified that he is licensed in North Carolina and Georgia. Dr. Samuel testified that he practices tele-psychiatry. *Id.* at 3. He testified that this is similar to Skype. *Id.*

Dr. Samuel testified that he treated Claimant four times: February 10, 2017; February 9, 2018; April 10, 2018; and October 17, 2018. He testified that Claimant was "a Skype referral" [10] and Claimant paid with private health insurance. He testified that he did not review any records other than his own reports in connection with Claimant. *Id.* Dr. Samuel testified that he was aware that Claimant was working as a military contractor in Kandahar, Afghanistan. *Id.* at 4. He did not know Claimant's job title. He did not know that in May 2008, Claimant had become a supervisor to over 100 employees. Dr. Samuel opined that if someone had a "severe psychological disability," it would likely interfere with his ability to supervise over 100 people. *Id.* He opined that if "someone" worked for the same employer for four years uninterrupted, that would be counterintuitive to a finding of a "severe" psychological disability. *Id.*

Dr. Samuel testified that in his first report, dated February 10, 2017, he noted that Claimant was exposed to a hostile work environment in Kandahar, Afghanistan, but Claimant did not indicate a specific hostility. *Id.* at 4.

Q: Doctor, when assessing a causal relationship –

[10] The undersigned notes that Claimant testified that his wife found Dr. Samuel "on a website." (TR at 59)

A: Yes.
Q: -- would you agree with me that the nature of his exposures overseas would be a pretty significant thing?
A: Yes.

*Id.* at 4.

Dr. Samuel stated that Claimant relayed combat nightmares. Dr. Samuel did not know whether Claimant ever saw combat. *Id.* Dr. Samuel based his reports on Claimant's self-reports of his experiences. Dr. Samuel testified regarding what he knew of Claimant's experiences:

> Yes, apart from [the hostile work environment], but he was a contractor, and he had some hostile work environments, and that is pretty much. And then I added that off to his symptoms that he presented with, which were – which were to suggestive of illness, and so he had some symptoms that was suggestive of PTSD: the nightmares, the anxiety.

*Id.* at 4.

In the initial February 10, 2017 evaluation, Dr. Samuel testified that his examination was based primarily on an intake interview. *Id.* at 6. He testified that he had 32 years of experience with "these kind of problems, and I can easily perceive whether, you know, he is telling me the truth or not." *Id.* at 5. He testified that tests are done by psychologists, not by psychiatrists. *Id.* at 5. He testified that Claimant "did have problems, no doubt about that. I mean, the wife would not send him out there unless there was trouble." *Id.* at 6. He testified that, per Claimant, Claimant's problems started when he came back from Afghanistan. *Id.*

Dr. Samuel testified that Claimant's problems at the time of the February 10, 2017 meeting included a sad or glum demeanor and listlessness. He testified that, "when somebody is listless, you know, they are more or less restless...They are not comfortable in themselves, so they, you know, they are shaky. It could be anxiety; it could be depression." *Id.* at 6. Dr. Samuel testified that his observations were all subjective, but they were "very professional and very clinical." *Id.* at 6. He testified that this is "why we do second opinions. If one psychiatrist gets it wrong, someone else – and we very often see it differently because of their subjective input." *Id.* at 7.

Dr. Samuel testified that Claimant exercised and worked out. Dr. Samuel testified this was not consistent with severe depression.

Q: And if he continued to work out, that would be something that would be inconsistent with –
A: With severe depression. At the time that he claimed to be very severely depressed, most of them don't work out. The work out is a very – no, many of them don't work out.
Q: Okay. But if he was working out in 2017 at or around the time you saw him –
A: Yes, sir.

Q: -- it would be somewhat inconsistent with the presentation that he presented to you?
A: It could be, yes.
Q: Okay.
A: It could be persistent, depending. And, you know, the – exercise treats depression. Exercise is clinical, prevents depression, helps keep away depression.
Q: It releases endorphins, doesn't it?
A: Correct. So anyone who is able to get out there, and the thing is they do not feel like it, you are right. But anyone who could do it, probably could be doing it because they want to deal with that depression as opposed to, you know, I cannot do it at all. I'm too tired, or maybe they are forcing themselves out there. But I don't remember. I don't remember him telling me –
Q: Whether he did or didn't?
A: Uh-huh (affirmative).

*Id.* at 23.

Dr. Samuel testified that the DSM IV Appendix E criteria was used to diagnose post-traumatic stress disorder (PTSD). *Id.* at 7.[11] He testified that one of the criteria is that a person has been exposed to a traumatic event that involved actual threatened death or serious injury, and the person must have an intense reaction of fear, horror, or helplessness. *Id.* at 7. Dr. Samuel testified that there was no note in his records that Claimant experienced an intense reaction of fear, helplessness, or horror. *Id.* Dr. Samuel testified that the most important part of PTSD treatment was the specific exposure. *Id.* at 8. He testified that Claimant did not give any specifics beyond "hostile work environment" which could range in severity and could be many things. *Id.* He also testified that trauma did not have to be physical, and could be a "threatened psychological situation." *Id.* at 8. He testified, "that DSM thing is good, but it's not everything." *Id.* at 8.

Dr. Samuel testified that another requirement in the DSM is the "persistent of ordinance [sic[12]] of stimuli." *Id.* He testified that applying for additional jobs in Afghanistan after leaving Employer would be unusual for persistent avoidance. *Id.* at 8. He testified that Claimant's participation in exercise activities is also not consistent with a diminished interest in participating in activities, another aspect of avoidance. *Id.* at 9.

Dr. Samuel testified that Claimant angered quickly, and had a "low tolerance for things he was once able to tolerate." *Id.* at 9.

Dr. Samuel testified that Claimant tested 65 and 70 in two administrations of the global assessment of functioning (GAF) test. *Id.* at 9. He agreed that 65 to 70 showed "mild symptoms" and "some difficulty in social or occupational functioning." *Id.* at 9.

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[11] Dr. Samuel did not address the DSM and how it applied to Claimant in his initial evaluation, treatment notes, or interim report.

[12] The undersigned takes judicial notice that this criteria is correctly termed "persistent avoidance of stimuli," and is a deposition transcript error. "Avoidance" is how it is termed throughout the remainder of this exhibit, and this is the criteria in the DSM IV. (CX 14 at 8, 9; Appendix E: DSM-IV-TR Criteria for Posttraumatic Stress Disorder)

Dr. Samuel testified that Claimant had some social disturbance which caused his wife to urge him to seek treatment. *Id.* at 10.

> Q: Appendix E of the DSM IV, right, one of the criteria, right, is that the disturbance causes clinically significant distress or impairment and social occupational or other areas of function?
> A: Correct.
> Q: And in February 2017, you didn't really see that with [Claimant] did you?
> A: Well you said – you said social occupational. So socially, he was having trouble with his wife. So we have the wife telling him, I can't take it anymore. You have to do something. Get help. So that is a big social impact in his life.

*Id.* at 10.

Dr. Samuel testified that he prescribed Effexor and Ambien. Dr. Samuel testified the Effexor was effective and Claimant's anxiety and depression resolved. *Id.* at 10. He did not know how many times, if ever, Claimant refilled those prescriptions. *Id.* at 10.

Dr. Samuel testified that he did not ask Claimant about his occupational functioning. He testified, "I wish I asked him. It's very important. But I think I was really interested in PTSD and anti-depression." *Id.* at 10. Dr. Samuel testified that he did not know why Claimant stopped working for his contracting company in Afghanistan. *Id.* at 5.

Dr. Samuel was asked whether Claimant looked for work overseas after his contract ended, and if so, how that would affect the diagnosis of a psychological disability. *Id.* at 5.

> Q: Do you now if after his work ended with SAIC, he continued to seek employment overseas with other employers in a war zone?
> A: I didn't know that.
> Q: Okay. Would that conduct be inconsistent with someone who had a continuing psychological disability?
> A: Especially a severe type of disability, yes.

*Id.* at 5.

Dr. Samuel testified that between February 10, 2017 and February 9, 2018, there was a significant improvement in Claimant's mental health to the point that there were no signs of anxiety. *Id.* at 10-11. When Dr. Samuel treated Claimant on April 10, 2018, there were no signs of anxiety or depression. *Id.* at 11. Dr. Samuel testified that Claimant denied psychological problems on February 9, 2018 and on April 10, 2018. *Id.* at 11. Dr. Samuel testified that many people show rapid improvement with Effexor. He testified that with the help of medication, Claimant's issue was more or less resolved, but if he stopped medication, the problem would return. *Id.*

Dr. Samuel testified that the last time he treated Claimant was October 17, 2018. *Id.* at 11. Dr. Samuel testified Claimant "is doing very well," denied all psychiatric problems, and had successfully recovered with the help of medication.

Q: But you report on October 17th, 2018, that he is doing well. He is stable on his medications, correct?
A: Yes, sir.
Q: And in fact, [Claimant] was in Arizona working, and he missed several appointments for that reason?
A: Yes, sir, he is taking medication now, so I expect him to do well.
Q: Okay. And he is sleeping well?
A: He should. He is sleeping well. He is taking his medication.
Q: And he denies all psychiatric problems?
A: Correct.
Q: Again, is he euthymic?
A: Yes, sir.
Q: No sign of depression?
A: Yes. Sir.
Q: His functioning is appropriate. Essentially, we've got a resolved condition with the help of medication there, right?
A: As long as he is doing medication, he is going to be doing well. But if he goes off that medication, we have a problem. That is why he has to be on it. We cannot confirm that he is in remission, unless we wean him off medication and see that he's fine without medication.
...
Q: Right now, would you consider [Claimant] to have successfully recovered thus far, with the help of medication?
A: He is doing very well. He is – the answer would be yes. But I cannot prove remission yet, because he is still on.
Q: He is still on the medication?
A: Yes, sir.
Q: But if he continues with the medications, there is, essentially, there is no psychiatric problem with this individual?
A: Correct.

*Id.* at 11.

Dr. Samuel testified that people could and did function on the medications he prescribed Claimant. *Id.* at 14.

Dr. Samuel testified that Claimant had been a cooperative and straightforward patient. He testified that Claimant's employment as a military contractor in Afghanistan went to Criteria A for PTSD in the DSM, the stressor for PTSD.

Criteria B was memories and flashbacks. He testified that Criteria B in the DSM was intrusive symptoms such as persistently experienced nightmares, unwanted upsetting memories,

flashbacks, and emotional distress. He testified that Claimant met Criteria B. *Id.* However, Dr. Samuel testified that he did not use the word "flashback" in any of his reports. *Id.* at 13. He testified that Claimant's history of exposure would be a significant finding, but there was no history of exposure in his reports. *Id.*

Q: And we have established, I think on my questioning, that his history of exposure would be a significant finding, and yet, there was no history of exposure in any of your reports, right?
A: No. But my understanding when he told me this, this is 2017 February, it must have been within the context of military exposure, combat exposure, even though I did not write it. I don't – I wish I could write everything that I feel my patients tell me, but...

*Id.* at 14.

Criteria C was avoidance. Dr. Samuel testified that he did not know of any particulars of avoidance for Claimant. *Id.*

Criteria D was negative alterations of mood. Dr. Samuel testified that these symptoms were included in his report. Dr. Samuel testified Claimant angered quickly. *Id.*

Criteria E included irritability, aggression, and difficulty sleeping. Dr. Samuel testified that he prescribed Ambien to treat Claimant's difficulty sleeping. *Id.*

Criteria F was duration of symptoms lasting more than one month. Dr. Samuel testified Claimant had the symptoms "for a while." *Id.* at 12. Dr. Samuel agreed the "symptoms have abated with the medication" so he should remain on medication and avoid stress. *Id.* at 12-13.

Dr. Samuel testified that Claimant should avoid being in a "combat" situation. *Id.* at 13. Dr. Samuel was asked why he wrote a letter for Claimant, opining that Claimant should avoid "combat."

Q: Do you know – do you know why you wrote it?
A: He requested it.
Q: He who?
A: The patient.
Q: The patient requested it?
A: Yes.
Q: Did he tell you why he requested it?
A: Yes, sir.
Q: What did he tell you?
A: He asked me if he could go back to combat. I told him it might not be a good idea for him. He asked me if I could put that in writing, and I said yes, of course.
Q: Okay. Well, he asked you if he could go back to combat. Did he use those words specifically?
A: No, of course not.

*Id.* at 13.

Dr. Samuel testified:

> I'm just saying that even though he is doing well on medication, if he was to go back – if he was go [sic] into combat, that would be a risk. I think we have to note that very importantly. And we have had to take people out of stressor situations, like give him a different job completely. So that is something to remember. The fact that he shouldn't go back to combat doesn't necessarily mean that he cannot do anything else.

*Id.* at 15.

**Dr. Jack Spector, Neuropsychology Evaluation September 8, 2017 and November 15, 2017 Report (EX F)**

Dr. Spector is a clinical neuropsychologist. He evaluated Claimant on September 8, 2017 upon referral by Employer. He prepared a report of the evaluation dated November 15, 2017. Dr. Spector stated that Claimant claimed "persistent symptoms of emotional distress secondary to perceived threats to life and limb experienced in the course of his contract employment." *Id.* at 1. Dr. Spector summarized Claimant's description of his employment in Afghanistan between January 2009 and August 2013. He summarized Claimant's report of rocket attacks resulting on two occasions in the deaths of personnel, as well as the death of a coworker (unrelated to a rocket attack). Dr. Spector stated, "[a]t no time did [Claimant] encounter dead or wounded personnel" while in Afghanistan. *Id.* He stated that Claimant left Afghanistan when his contract was terminated in August 2013. He stated that Claimant did not complain of stress-related symptoms while in Afghanistan. *Id.* at 2. He stated that according to Claimant, "it was not until 9-10 months later that he first experienced shortness of breath, chest pain, sleep problems, and other physical complaints that he has since attributed to the effects of accumulated stress." *Id.* at 2. Dr. Spector stated that Claimant reported it was not until February or March 2017 that he first experienced nightmares and intrusive daytime experiences related to his time in Afghanistan. *Id.* at 2.

Dr. Spector stated that Claimant had been treated by psychiatrist, Dr. Samuel, and psychotherapist, Ms. Brown. Dr. Spector stated that since returning to the United States, Claimant had been employed continuously for three and a half years as a production supervisor. He stated that Claimant reported he performed well there, and denied that his physical or emotional symptoms interfered with this job performance. *Id.*

Objective testing was conducted by Kirk Szczepkowski, "a Master's level psychological associate working under [Dr. Spector's] license and supervision." *Id.* at 3. Dr. Spector performed all data analysis, and conducted a clinical interview, behavioral observations, and review of records.

Dr. Spector opined that Claimant was pleasant, polite, reserved, friendly, and cooperative. He opined that Claimant's "affective range was only modestly constricted in range and overall his mood appeared at worst a little tense." *Id.* He stated that Claimant "acknowledged persistent (albeit rare) symptoms of unhappiness and worry in recent months, as well as occasional Neurovegetative changes in sleep, appetite, interest, and drive were reported, although improved in the years since he returned from Afghanistan." *Id.* at 3. Dr. Spector stated that Claimant had no hallucinations, delusions, paranoid ideation, or ideas of reference. He stated, "[u]pon direct questioning, suicidal and homicidal ideation were denied." *Id.* at 3.

Dr. Spector evaluated Claimant's IQ test, vocational functioning test, visual and verbal learning tests, recall, memory, recognition, and vigilance task tests. *Id.* at 4.

Psychological function testing included the Minnesota Multiphasic Personality Inventory (MMPI) -2 and Trauma Symptom Inventory (TSI) -2. *Id.* at 4. Claimant's results "revealed elevated levels of emotional distress." *Id.* at 4. Dr. Spector opined:

> He appears to have exaggerated his psychiatric symptoms, presenting his condition in an improbably poor light. Within this context, [Claimant] presents as depressed, anxious, and emotionally distraught. High levels of demoralization, dysphoria, and low positive affect were reported, as was excessive physical symptom sensitivity, anxiety, and ruminative worries.

*Id.* at 4.

Dr. Spector opined,

> [Claimant's] responses on the MMPI-2-RF FBS and RBS scales...was suggestive of modestly exaggerated complaints of cognitive and functional impairment. Clinical scale elevations on the MMPI-2 and TSI-2 suggest that [Claimant] is experiencing minimal levels of emotional distress.

*Id.* at 4.

He opined:

> On the MMPI-2 and TSI-2 [Claimant] reported surprisingly few symptoms of a post-traumatic stress disorder. There was scant evidence of anxious arousal, defensive avoidance, or social withdrawal. There was modest evidence of intrusive ideation....

*Id.* at 4.

In summary, Dr. Spector opined that:

> Psychological testing revealed moderately exaggerated reports of emotional distress, marked by depression, anxiety, and somatization in roughly equal

> measure. There was scant objective evidence of a post-traumatic stress disorder at the time of the present evaluation.

*Id.* at 5.

Dr. Spector opined that Claimant may have:

> warranted the diagnosis of a non-disabling stress reaction at various times in the course of his 4 year contract employment in Afghanistan. However, he never complained of PTSD symptoms nor sought treatment for them until well after his contract had ended and he had returned to the United States. His experiences in Afghanistan may well have been distressing, but are believed to have fallen well short of those imminent threats to life and limb typically associated with post-traumatic stress disorders. Performance on a standardized measure of post-traumatic stress revealed surprisingly few PTSD-related complaints.
>
> [Claimant] manifests symptoms of a mild affective disorder, most likely a persistent depressive disorder with anxious arousal. I do not believe that his current, mild psychiatric symptoms were caused by his contract work in Afghanistan, which ended more than four years ago.

*Id.* at 5.

**Hearing Testimony of Dr. Jack Spector (TR at 135-176)**

Dr. Spector testified at the hearing on December 13, 2018. He testified that he was a clinical neuropsychologist. (TR at 136) He testified, "[i]t means I have a doctorate in psychology specializing in brain behavior." *Id.* He is Board-certified in clinical neuropsychology by the American Board of Professional Psychology. *Id.* He received his doctorate in clinical psychology specializing in clinical neuropsychology at the University of Louisville. *Id.* At the time of the hearing, he was in private practice. *Id.* He testified regarding his educational experience with post-traumatic stress disorder (PTSD) and head and brain injuries, including investigating traumatic brain injuries for the U.S. Army during the first and second Gulf Wars. *Id.* at 137. He testified that he had been working with PTSD patients continuously since 1983. *Id.*

Dr. Spector testified that he performed an evaluation of Claimant at the request of Employer. (TR at 139) On November 15, 2017 he prepared a report of his evaluation. (TR at 139)

> Q: You indicate that [Claimant] was seen for an evaluation more than four years after he stopped work in Southwest Asia. Why did you feel the need to highlight that fact?
>
> A: In my reports where there's a period of time or even a discrete event that is in some way believed to be responsible for the person's difficulties, I'll indicate roughly how long a time has passed between the time of the discrete event or groups of experiences and the time of my evaluation.

*Id.* at 140-141.

He testified that this could be clinically significant, because, "[t]he findings that one might see in someone who's had a brain injury or a physical injury or an emotionally traumatic event takes a different form if you see them a few months after the injury versus a few years after the injury." *Id.* at 140. He testified that in this case, the four year period between the alleged event and his examination meant that he could not know whether the suspected post-traumatic stress disorder was present throughout that time, or whether it appeared later and closer to his evaluation. *Id.* at 141.

Dr. Spector testified that per Claimant's history, Claimant encountered dead or wounded personnel during his time in Afghanistan. *Id.* at 141. Dr. Spector testified that his understanding was that Claimant left Afghanistan when his position was terminated due to a draw-down. *Id.* at 141. He testified, "[t]he implication is that [Claimant] left when the job was done rather than precipitously due to injury or illness." *Id.* at 142. Dr. Spector was asked:

> Q: Do you know if he complained of any stress related symptoms when he was in Afghanistan?
> A: To the best of my knowledge, he did not. He had episodes of shortness of breath, but beyond that, I don't believe he came to medical or to mental health attention.

*Id.* at 142.

Dr. Spector testified that "the majority of [Claimant's] symptoms and complaints, I believe, did not manifest until about 2017." *Id.* at 141. This was four years after Claimant left Afghanistan. He testified regarding the significance of that timing:

> In general when bad things happen to you, you have your worst reactions to them close to the time that they occurred. What we know about treatment for PTSD or what we knew about treatment for PTSD, assumed that the symptoms would present relatively early on after exposure to the traumatizing event and the principles by which we treated them in the military was proximity, close to when they occurred, immediately right after or soon after you could after they occurred and expectancy which would be expectation to presume to be returned to duty. About 3 percent of cases of post-traumatic stress present as cases as delayed post-traumatic stress which is when there is a period of six months or longer between the time of the exposure to the stressful stimulus and the time of the more significant complaints, stress-related complaints. Those are exceedingly rare then. The factors that tend to predispose someone to delayed PTSD are not particularly present in this case as far as I know.

*Id.* at 143.

He testified that the factors predisposing delayed PTSD are as follows:

> They tend to be older veterans so that you have individuals who are aging or even dementing so there's a disinhibition of those resources that might protect them or have protected them from the effects of horrific stress. In addition, there tends to be another severe stressor that serves as a trigger that leads to a return of those or at least a presentation of symptoms that are now attributable or linked to the earlier stressor. Finally, there is the individuals [sic] who present with delayed PTSD typically have subclinical or partial stress disorders or PTSD in the intervening years and it's the aging process and additional stressors or deaths of spouse or family so that there's social isolation or there's other factors that then contribute to strip the person of the resources that were previously protected.

*Id.* at 144.

Dr. Spector testified, "I wouldn't expect to see it [delayed onset of PTSD] in anyone because it's really rare." *Id.* at 144. If he saw it in a 43-year old man, he "would expect it would occur with other significant environmental stressors and that individual with manifested symptoms that might not quite meet criteria continuously until that time." *Id.* at 144.

Dr. Spector testified that he reviewed the records of Dr. Samuel. *Id.* at 144. He testified that "there are reports that [Claimant's] symptoms improved with the combination of psychiatric treatment as well as what seemed to be relative and frequent psychotherapy." *Id.* at 146. Dr. Spector testified that "whatever the severity of [Claimant's] symptoms, he's remained functional." *Id.* at 147.

Dr. Spector testified that he examined Claimant and found Claimant to be friendly, likeable, cooperative, and "effortful." *Id.* at 147. He testified, "I did not believe that he was exaggerating his experiences as he described them. I believed what he told me about the experience there....I didn't find him to be particularly numb or underreporting the effect of associating with them nor did I think that he was embellishing them." *Id.* at 147.

Dr. Spector testified that he administered tests measuring a variety of cognitive, motivational, and emotional functions. *Id.* He testified that if these tests were not administered, treatment could be "flying a little blind." *Id.* at 148. He testified that some psychological treatments were "fairly straightforward." *Id.*

He testified that in a case such as this one, there were "so many other things that could be at play" that it would be "a little naïve to immediately assume you've got a case of PTSD when it's delayed by a significant period of time and those other obvious acute stressors especially if advanced aging are present." *Id.* at 148. He testified that the "other things that could be at play" referred to "life circumstance, changes, family relationship changes." *Id.* at 149. He testified that this could also refer to a dramatic income loss from $225,000 a year to $70,000 a year. *Id.* at 149.

Dr. Spector testified regarding the tests he administered:

> The battery of tests was designed both to assess the possibility of a cognitive disorder secondary to either blast or brain injury or for that matter given the part

> of the world we're dealing with, heat injury as well as tests that are designed to look at psychological adjustment as in general, somatization tendencies and the tendencies to express physical symptoms under stress as well as tests that are designed specifically to look for symptoms of PTSD.

*Id.* at 149.

The tests Dr. Spector used "are sensitive to exaggeration or inadequate test taking effort." *Id.* at 150. He testified, "[s]o besides our impression...that he was trying hard, there was objective data to suggest that we were getting his best efforts." *Id.* at 150. He testified, "the area where [Claimant] did best was in psychomotor speed and on tests that are more sensitive to brain injury than some of the other tests composing the I.Q." *Id.* Dr. Spector testified that the psychological testing showed that Claimant "somewhat exaggerated emotional distress. Not enough to invalidate the procedures that were administered, but enough to say that he was – when in doubt, he was reporting symptoms rather than remaining stoic with respect to reporting symptoms." *Id.* at 152. Dr. Spector also testified that Claimant "presented as somewhat depressed, anxious and emotionally distraught" and that this was "consistent with I think Dr. Samuel's identification of symptoms of depression and anxiety and treatment for same." *Id.* at 152. There were "[h]igh levels of demoralization of unhappiness or dysphoria, and low positive affect. There was somewhat of an exaggeration of cognitive and functional impairment, but again, not enough to invalidate the process." *Id.* at 152-153.

Dr. Spector testified that regarding symptoms of PTSD, Claimant seemed to give an "honest and accurate appraisal of his symptoms on the Trauma Symptoms Inventory (TSI). So, what we got on TSI is how he seemed to be doing." *Id.* at 153.

Dr. Spector testified regarding the factors needed to meet the criteria for PTSD. *Id.* at 154-155. Dr. Spector testified that of the twelve clinical scales that could have been elevated on the TSI, two were elevated for Claimant. One was not relevant to this claim; the other was intrusive ideation, such as flashbacks and nightmares. *Id.* at 154. He testified that "intrusive ideation is associated with PTSD. It's not the only – you need to have a lot more than that to meet criteria for PTSD." *Id.* at 154. He testified that other criteria needed for a PTSD diagnosis include anxious arousal and defensive avoidance, or avoidance of "the sorts of situations that would – to which the PTSD is attributed in the first place." (TR at 154) He testified that another criteria would be dissociation, and "[t]here was no report that he made either in interview or of course on this instrument to suggest that he was." *Id.* at 155. Dr. Spector testified that it would be difficult to hold down a job with dissociation, as there are often physical symptoms such as seizures, sleepwalking, and periods of absence. *Id.* at 155. Dr. Spector was asked whether Claimant's workout regimen factored into his medical opinion that Claimant did not meet the criteria. Dr. Spector testified that participation in fitness activities did not affect his medical opinion at all, opining, "You can have a mental illness and as part of your therapeutic regimen, throw yourself into fitness activities...[Claimant] appears to be into fitness activities and that's admiral [sic] and affects my opinion neither one way nor the other." *Id.* at 156-157.

> Q: All right, what does affect your opinion one way or the other?

A: Well, he's got PTSD.[13] I think particularly since what we're supposedly presenting with here is a delayed onset of PTSD, (1) I don't think we meet the diagnostic criteria anyway, but (2) –

Q: Why don't we meet the diagnostic criteria?

A: I – well, hold on.

Q: I mean, in three sentences or less, what do you think?

A: We don't have persistent avoidance beginning after the traumatic event. We don't have negative alterations in mood associated with the traumatic event rather than free-floating. We don't seem to have marked alterations in arousal or reactivity associated with the event in question. ... And we don't seem to have clinically significant levels of distress or impairment in social, occupational, or other important areas of functioning.

Q: Okay. Now, you started with one – I cut you off. You said, "One, I don't think we meet the diagnostic criteria," and you were about to say two before I cut you off.

A: Two is where this is a case of delayed PTSD, we ought to be seeing much – I mean, obvious triggers for the appearance of PTSD years after the return from the stressful environment.

Q: Okay. I want to –

A: Excuse me, or those developmental factors like aging or dementia that seem predisposed or his delayed PTSD.

Q: Right. Given his age at 43 and there's no evidence of it, right, of any of those things?

A: Not on this examination.

*Id.* at 157-158.

Dr. Spector testified that Claimant met the criteria for dysthymic disorder, a mild depressive disorder, or persistent depressive disorder. *Id.* at 158, 159. He testified that Claimant did not meet the criteria for major depressive disorder. *Id.* He testified that persistent depressive disorder "tends to be continuous low mood rather than periods of severe debilitating unhappiness, melancholy, usually in cases of major depression associated with suicidality or suicidal thoughts." *Id.* at 159. Dr. Spector testified, "The things that get you a major depressive disorder diagnosis generally are inabilities to get out of bed much less get out of bed and go to work...." *Id.* at 159. He testified that a person could work with mild depressive disorder. *Id.* He testified that a person could work while in remission. *Id.* at 160. He testified that whether a person could work overseas in a combat zone while in remission would depend on whether a person was allowed to take psychoactive medications while doing that work. *Id.* He testified that he found Claimant to be functional, and "[w]ithin the limits of whether you're allowed to be taking medication while you're [overseas]," able to work overseas. *Id.* at 162.

Dr. Spector testified that Claimant's psychological condition "was not caused by his exposures in Afghanistan, or it would have appeared contemporaneous with his service in Afghanistan or really, really soon after and that's not consistent with the history that I was given in this

[13] The court notes this is the hearing transcript but finds it not accurate based on Dr. Spector's testimony, opinions, and reports. The hearing was recorded by a hearing monitor on a cassette recorder, and typed at a later date by a different person. No weight is given to this statement.

case....Beyond that, I don't know what it is. When someone returns from overseas, you look for family stressors or difficulties reintroducing oneself to a stateside routine after years away or you look for recurrence, whatever factors it was to let him go overseas in the first place." *Id.* at 162.

Dr. Spector testified that "if you're prepared to be [in a war zone], you are somewhat protected from the effects. The things that are occurring become somewhat routinized." *Id.* at 164. He testified that remaining in Afghanistan for four years with the same employer shows that the job was a good fit, and that "whatever it is about those things to make a war zone, frankly pretty frightening, for whatever reason, don't frighten you." *Id.* at 164.

Dr. Spector was asked:

> Q: Within a reasonable degree of medical certainty do you believe that whatever we characterize [Claimant's] psychological difficulties, do you believe that they were not caused by his work in Afghanistan?
>
> A: Well, first, for me, it will be within a reasonable degree of professional certainty, not being a physician. ... That said, if they were due to his service in Afghanistan, you would have seen them sooner, you would have seen them more severe and you would have seen them much more quickly and in their final form upon his arrival in the states and not years later barring other stressors that I'm not aware of.

*Id.* at 164-165.

Asked whether periodically coming under rocket attacks and indirect fire over four years would cause imminent threat to life and limb, Dr. Spector testified as follows:

> This is going to sound more cavalier than I intend it to, but after the first couple months, you become sort of immune to the background noise of rockets overhead. There are certain things associated with it particularly the warnings of 'incoming, incoming.' They can produce a visceral response years, maybe even decades after the fact, but when you're there and it's really part of the ambient stress of the environment, if you're going to respond to it, you respond to it relatively early and you get the heck out. If not, it tends to fade into the background. The exception, of course, are those who present with symptoms proximate to the time of those things occurring which doesn't seem to have happened here.

*Id.* at 171.

Dr. Spector testified that other contributing factors of the war zone environment are "long work hours, hot environments, loss of privacy, changes in routine, sometimes arbitrary changes [in] conditions of employment." *Id.* at 172. He testified that "the hallmark of knowing if they produce stress is whether you're symptomatic at the time." *Id.* at 172.

Dr. Spector testified that his understanding was that when Claimant worked with vehicles hit by IEDs, there would only be "blood, not guts and I know that sounds like a fairly arbitrary

distinction...but it's a meaningful distinction." *Id.* at 172-173. He testified that the distinction is "the degree to which what you're looking at resembles the person that it once was." *Id.* at 175.

Dr. Spector testified:

> Civilians are lousy at PTSD particularly in war zone situations. They don't get that simply being in a war zone isn't enough because any sane civilian would appreciate that when there's explosions and people dying, that's a horrible situation, but there's degrees of horror and you become somewhat immune to them if you're working in that environment with admission [sic] versus if you've been dropped into it unexpectedly. The – you've got to ask about the nature of the exposure. You have to ask in detail, not just did you hear of anyone hurt, did you see anyone hurt, exactly what did you see. When you think about it later and how much detail did you see it [sic], do you also experience a bio-rising when you think about it. Do you – were you touched by any of the fluids that the person who you saw die gave up as they died and so on. It's tough work to ask those questions, but it's the essential core of post-traumatic stress.

*Id.* at 176.

He testified that it was possible that Claimant's mild or persistent depressive disorder was contributed to by his exposures in the war zone, "but it doesn't look like that to me." *Id.* at 174.

## RESPIRATORY INJURY EVIDENCE

*Id.*

**Dr. James Upshaw Treatment Records, Internist (CX 1, 13)** [14]

Dr. James Upshaw is an internist practicing in Atlanta, Georgia. On June 15, 2011, Claimant was treated by Dr. Upshaw while home from Afghanistan. (CX 1 at 1) He was treated for "rash and other nonspecific skin eruption." *Id.*

On December 21, 2011, Claimant was treated by Dr. Upshaw while home from Afghanistan. (CX 1 at 7) Dr. Upshaw stated that Claimant spent six months at a time working as a military contractor in Afghanistan. Claimant was treated for right-sided shoulder pain with certain workout activities, and for rash and other nonspecific skin eruption. *Id.* at 7.

[Claimant's job with Employer ended in August 2013 and he returned to the United States.]

On February 6, 2014, Dr. Upshaw treated Claimant for follow-up of hypertension. Claimant reported that he was feeling well, without complaint, and continued to exercise regularly without difficulty. (EX M at 1) Upon examination, bilateral lungs were clear.

[14] Some of these medical records pertain to high blood pressure, which is no longer a part of this claim. Accordingly, they have been considered, but are not summarized here, and given no weight regarding the current claim.

On February 7, 2014, Dr. Upshaw treated Claimant for follow-up of hypertension. Claimant was without complaint. Upon examination, bilateral lungs were clear. (EX N)

On December 4, 2015, Claimant was treated by Dr. Upshaw following a hospitalization for shortness of breath in September. (CX 1 at 12) Since that hospitalization, Claimant had not experienced shortness of breath. Dr. Upshaw opined that Claimant's shortness of breath was resolved. *Id.*

On March 25, 2016, Claimant was treated by Dr. Upshaw for a respiratory tract infection. (CX 1 at 14) Claimant reported that his symptoms had been present for more than a week. Claimant underwent a chest x-ray which was clear. *Id.*

On May 6, 2016, Dr. Upshaw conducted a yearly examination. (CX 1 at 16) Dr. Upshaw stated, "[Claimant] is taking his medication regularly as directed." *Id.* He stated:

> The patient exercises regularly and without difficulty. Chronic conditions discussed today include: hypertension, overweight status and BPH. Full review of systems discussed. Past medical history, past surgical history, family history and social history were reviewed and updated at this visit.

*Id.*

Physical examination of Claimant's lungs showed: "Expansion normal. Auscultation: CTA bilaterally. Wheezes: no." *Id.* at 16. He assessed seven conditions and number 5 was asthma. "Other asthma; 'minmally [sic] symptomatic. PRN inhaler.'" *Id.* at 17.

On August 26, 2016, Dr. Upshaw stated the reason for appointment was, "[p]atient presents today with documents that need to be reviewed." Dr. Upshaw stated:

> [Claimant] is here asking me to write a note for his employer. It is evident that the patient's blood pressure rises around the time of his travel overseas with work and that his blood pressure is more difficult to treat once he is there. He has had good blood pressure control since being home. There has been some concern about possible exposure at a burn site in Afghanistan where the patient worked for several stints.

(CX 1 at 19)

On August 26, 2016, Dr. Upshaw wrote two letters. Dr. Upshaw wrote a letter opining as to Claimant's high blood pressure, which is not a part of this claim. (CX 13 at 1) Dr. Upshaw wrote another letter opining as to Claimant's high blood pressure, but added a reference to skin disorder and respiratory symptoms. Dr. Upshaw added the following to his letter:

> In addition and of note while [Claimant] was in Afghanistan, he developed recurrent skin infections and asthma. There was an area where refuse was burned within the compound where [Claimant] was stationed. His skin disorder and

> respiratory symptoms could very well be related to these less than sanitary conditions. I think it would be to his detriment physically to place him back in these types of environments.

The court notes that on May 6, 2016, Dr. Upshaw stated Claimant's asthma was "minimally symptomatic." (CX 1 at 17) (CX 1 at 21)

**TMH Medical Services Clinic Records (CX 1)**

On September 25, 2011, Claimant was treated by Dr. Shabani for folliculitis/abscess. *Id.* at 4. Claimant returned for follow-up on September 28, 2011 and October 24, 2011. (CX 1 at 5, 6)

On March 27, 2013, Claimant was treated by Dr. David for a cough productive of whitish sputum. *Id.* at 9. This was associated with nasal congestion, runny nose, and headaches. *Id.* at 9. Claimant reported that he had a cough and cold for five days. *Id.* at 11.

**Dr. Avinesh Bhar, Pulmonologist, Treatment Notes (CX 12, 13)**

Dr. Bhar is a pulmonologist practicing in Macon, Georgia. On February 14, 2017, Dr. Bhar treated Claimant. He stated:

> 41yo M with 1 year h/o cogh and SOb on exertion. wa sin Afghanistan with significant aerosol exposure. no prior pulm issues. when running or working out, he has cough, sob and chest tightness. no allergies or ezema. no wheeze, sputum. [sic]

(CX 13 at 2)

Upon physical examination, Claimant's lungs were "clear to auscultation," and his respirations were "non-labored." Claimant was prescribed Albuterol, Ambien, Effexor, Chlorthalidone, and Lisinopril. (CX 13 at 3)

On April 11, 2017, Dr. Bhar treated Claimant for follow-up. Claimant had "significant improvement" and could run a seven minute mile. (CX 13 at 9) Dr. Bhar stated that per Claimant's history, "During his last visit he had noted shortness of breath and chest tightness following exposure to a burning pit in Afghanistan." *Id.* at 9. He stated that Claimant's pulmonary function test (PFT) results were normal. (Emphasis added since Claimant testified his PFT was abnormal.) He stated that during Claimant's methacholine challenge test, he had a bronchospastic spell when exposed to normal saline, "not even the methacholine." *Id.* Dr. Bhar stated:

> He had a pulmonary function test then a visit with a pulmonary specialist who felt based on his results and his exposure may have constrictive bronchiolitis. He was then prescribed Azithromycin 250 mg per day for 14 days and has felt significant improvement. He is now able to run a mile under 7 minutes. He has also benefited from Albuterol when necessary.

*Id.* at 9.

Physical examination showed that Claimant's lungs were clear to auscultation bilaterally. *Id.* at 9-10. Under the heading "Assessment/Plan," Dr. Bhar stated, "bronchiolitis obliterans." *Id.* at 10. [The court notes that Dr. Bhar determined on August 29, 2017 Claimant did not have bronchiolitis obliterans since Claimant did not respond to Azithromycin. On November 9, 2017, Dr. Bhar diagnosed exercise-induced asthma.]

On April 24, 2017, Dr. Bhar wrote a "Dear Sir/Madam" letter stating that Claimant had been under his care since March 2017. (CX 13 at 15) He stated that Claimant initially came to him with "asthma like symptoms comprising dyspnea on exertion." *Id.* He wrote, "Of note, both his parents have asthma." *Id.* He opined that per Claimant's history, Claimant was "exposed to fumes" overseas, was prescribed by a physician overseas suspecting constrictive bronchiolitis (CB). Dr. Bhar stated: "He has responded well to therapy and feels close to his usual state of health. Though CB requires tissue diagnosis, through his history, I am reasonably confident that he may have had CB." *Id.*

On July 18, 2017, Dr. Bhar treated Claimant for follow-up. (CX 13 at 16) Dr. Bhar stated:

> This is a 42-year-old African-American male who was recently posted to the Gulf states and had acquired a respiratory issue. [The court notes Claimant last worked in Afghanistan in August 2013 and Dr. Bhar opined in July 2017, four years later.] It was preliminarily diagnosed as constrictive bronchiolitis. When he first came to see me upon the function test did not reveal any significant impairment. However on a visit today by a pulmonologist that felt it due to his exposure to hazardous chemicals in his symptoms of shortness of breath and decreased exercise tolerance is consistent with constrictive bronchiolitis. Patient was given azithromycin and responded appropriately. During his last visit he was able to run a mile under 7 minutes. For the last few weeks his excised [sic] tolerance is reduced again. He still feels the shortness of breath on exertion. His excised [sic] tolerance is reduced about 2 miles which is significantly lower to what he used to be. He denies any hemoptysis. He has no wheeze and a dry cough.

(CX 13 at 16)

On July 31, 2017, Dr. Bhar wrote a "Dear Sir/Madam" letter stating that Claimant had been under his care since March 2017. (CX 13 at 19) He stated that Claimant initially came to him with "asthma like symptoms comprising dyspnea on exertion." *Id.* He wrote, "Of note, both his parents have asthma." *Id.* The letter was identical to the April 24, 2017 letter. *Id.* at 19.

On August 29, 2017, Dr. Bhar treated Claimant for follow-up of shortness of breath. Dr. Bhar stated that he prescribed Azithromycin which worked previously, but Claimant had "not had adequate response with improved shortness of breath." *Id.* Claimant reported that his shortness of breath was less apparent during cardio if he first took his Albuterol inhaler. Claimant had not had "as much issue working out at the gym." *Id.* Dr. Bhar opined that "[Claimant] sought a second

opinion for pulmonology and the recommendation was to evaluate for gastroesophageal reflux disease." *Id.* at 3.

Dr. Bhar stated, "We'll evaluate for possible gastroesophageal reflux disease. Another consideration is exercise-induced asthma." (CX 13 at 18) He opined that, "Due to the lack of response to Azithromycin, I doubt this is bronchiolitis obliterans." *Id.*

On November 9, 2017, Claimant was treated by Dr. Bhar, who stated that Claimant had:

> a history of exposure to hazardous materials in the Middle East and subsequent shortness of breath which was initially thought to be due to bronchiolitis obliterans however he did not respond to therapy with azithromycin....

(CX 12 at 1)

He stated that Claimant continued to experience shortness of breath. He stated that the shortness of breath only affected Claimant when doing strenuous exercises, not during mild to moderate activity. Claimant did CrossFit exercise. Claimant reported shortness of breath with chest tightness and intermittent cough. Claimant had no sinus issues. Dr. Bhar stated that Claimant treated with a gastroenterologist and had been on a proton pump inhibitor for one month. Claimant reported this had not helped.

Upon physical examination, Claimant's lungs were clear to auscultation bilaterally. Claimant had no history of childhood asthma or smoking. Dr. Bhar opined that Claimant's shortness of breath "may be due to asthma." *Id.* at 2. He stated, "Have advised patient we will make a presumptive diagnosis of exercise-induced asthma." *Id.* He directed Claimant to continue Albuterol and Singulair, and added Symbicort at highest dose.

**Deposition of Dr. James Upshaw, February 4, 2019 (EX R)**

Dr. James Upshaw was deposed on February 4, 2019. He testified that his practice is internal medicine, and he refers to himself as an internist. (EX R at 6) He testified that he is not a pulmonologist or a pulmonary specialist. *Id.* at 7.

He testified that he had treated Claimant for about ten years. *Id.* He was aware that Claimant worked as a contractor in Afghanistan. *Id.* He did not know Claimant's specific job duties. *Id.* at 8. He testified, "I'm not totally sure what he did. I know he's a contractor of some sort. I don't know if it was something to do with maintenance of equipment, but I'm not really sure." *Id.* He testified that he took Claimant's history, and whatever Claimant complained of that was significant, Dr. Upshaw included in the chart. *Id.* at 9.

Dr. Upshaw testified that he treated Claimant from June 15, 2011 through May 2015 for various conditions. There were no complaints of shortness of breath, lung, or breathing issues. [Claimant last worked in August 2013 and then returned to the United States.] Dr. Upshaw testified he treated Claimant from December 2015 through May 2016. Dr. Upshaw testified there were no

active complaints of shortness of breath, except a respiratory tract infection in March 2016, which resolved.

Dr. Upshaw was asked:

> Q: We've already established you're not a pulmonologist, and we've already established that, apart from a respiratory – a respiratory tract infection, he didn't present to you with any respiratory infection issues, correct?
> A: That's right.

*Id.* at 33.

Dr. Upshaw testified that in August 2016, Claimant asked Dr. Upshaw to write a letter for his workers' compensation claim. Dr. Upshaw wrote two letters – one mentioned the refuse area and one did not. Dr. Upshaw testified he could not explain why there were two different letters written by him.

Dr. Upshaw testified that he treated Claimant on June 15, 2011. Claimant had no complaints of any kind regarding pulmonary or respiratory problems. His lungs were clear upon examination. *Id.* at 10.

Dr. Upshaw next treated Claimant on December 21, 2011. *Id.* at 11. He testified that Claimant did not complain of lung or breathing issues. If he had, Dr. Upshaw would have checked his lungs. *Id.* Dr. Upshaw testified that on December 12, 2012, Claimant was seen for high blood pressure. *Id.* at 13. Dr. Upshaw testified that he asked Claimant if he had shortness of breath and Claimant said no. *Id.* at 13. Dr. Upshaw testified that he next saw Claimant in July 2013. *Id.* He testified that Claimant complained of high blood pressure and jaw discomfort, but no shortness of breath. *Id.* at 14. He testified that he next saw Claimant in January and February 2014. *Id.* at 14. He testified that Claimant was seen for high blood pressure. *Id.* There was no report of lung problems. *Id.* at 15. Dr. Upshaw testified that he next saw Claimant in May 2015. *Id.* at 15. He testified that Claimant was seen for blood pressure. *Id.* at 17.

Dr. Upshaw testified that he next treated Claimant in December 2015. *Id.* at 17. Claimant stated that he was hospitalized in September with shortness of breath, and had a negative workup. *Id.* He testified that when he checked Claimant's lungs in December 2015, they were clear. *Id.* He testified that his comment at the time was that the problem had resolved itself. *Id.* at 19. He testified that he had requested the records from that hospitalization but did not have them in his notes. *Id.* at 18. He testified that he had no notes in his file as to what caused the September 2015 shortness of breath, or the diagnosis from the hospital visit. *Id.* at 19.

Dr. Upshaw testified that he treated Claimant in March 2016. *Id.* at 20. He testified that Claimant had called requesting treatment for a respiratory tract infection with wheezing and coughing. *Id.* On March 25, 2016, he wrote that Claimant had a respiratory tract infection and symptoms had been present more than a week. *Id.* at 20. Claimant's chest x-ray was clear. Dr. Upshaw prescribed antibiotics, cough syrup, and steroids. *Id.* at 20. He testified that the March 2016 note from the radiologist stated stable chest without evidence of acute pulmonary process. *Id.* at 21.

Q: There was no indication that there was any foreign body pulmonary irritant in that chest x-ray, was there, Doctor?
A: No. There was nothing that seemed out of place.

*Id.* at 21.

Dr. Upshaw testified that he next treated Claimant in May 2016. *Id.* at 21. He testified that Claimant had called in April with a cough. *Id.* at 21-22. He testified that Claimant was exercising regularly without difficulty. Claimant's lungs were clear upon examination. *Id.* at 23.

Dr. Upshaw testified that he next saw Claimant on August 26, 2016 when Claimant asked him to write a letter. *Id.* at 23. He testified that Claimant did not come in with a physical problem that day. *Id.* He testified that Claimant had some paperwork about this legal case. *Id.* at 23. He testified:

> So then the note says – you know, he's talking about blood pressure around the time of travel. It was – and then he was worried he had been exposed to something at a burn site in Afghanistan.

*Id.* at 25.

Dr. Upshaw did not recall exactly what paperwork Claimant showed him. *Id.* at 26. Dr. Upshaw testified that if Claimant showed him something, he did not retain a copy of it. *Id.* at 27. He testified that Claimant's August 22, 2016 phone message that he wanted to come in to discuss paperwork regarding a lawsuit against the employer, was the first time Dr. Upshaw noted any kind of legal activity. *Id.* at 27. Dr. Upshaw testified that when Claimant was seen on August 26, 2016, Dr. Upshaw gave him a physical examination. *Id.* at 29. He testified that Claimant's lungs were clear. *Id.*

Dr. Upshaw testified that he wrote two letters on August 26, 2016. One letter included a sentence about refuse in the area, and the other did not. *Id.* at 31.[15]

Q: Do you know why there are two different letters?
A: No.
Q: Did [Claimant] receive the first letter and then asked you add the line about the refuse area?
A: Okay.
Q: Did that happen is my question.
A: I mean, it possibly did. I don't – I'm trying to think if there's something in here because I didn't see him. Health care provider form. Yes, I don't know. I mean, it's possible.

[15] One letter dated August 26, 2016 discussed Claimant's hypertension and stated: "There was an area where refuse was burned within the compound where [Claimant] was stationed. His skin disorder and respiratory symptoms could very well be related to these less than sanitary conditions." (CX 1 at 21) The other letter dated August 26, 2016 discussed Claimant's hypertension and made no reference to skin or respiratory conditions. (CX 13 at 1)

Q: When the letter was written or typed out, Doctor, was [Claimant] still in the office with you?
A: I don't know. This says August – I don't know that.
...
Q: Okay. Doctor, this statement about or the information about the area where refuse was burned within the compound...that information came from [Claimant] to you, right?
A: That's right.
Q: Okay. And you're not – you can't remember if he showed you any documents about that, right?
A: No, I don't believe he did.
Q: Okay. So it was on his verbal –
A: Right.
Q: -- say so?
A: That's right.

*Id.* 32-33.

Dr. Upshaw testified that the letter he wrote for Claimant was an accommodation at Claimant's request. *Id.* at 34.

Q: He came in he asked you for something and you kind of did him a favor, right?
A: Sure.

*Id.* at 34.

Dr. Upshaw testified regarding previous pulmonary problems mentioned in the August 26, 2016 letter.

Q: And had he had any previous pulmonary problems that you know of, or I think you made some note in that, maybe the August 26, 2016 report.
A: Yes. I believe I have asthma listed at one point. Maybe there was some concern for asthma.

*Id.* at 37.

[The court notes that on May 6, 2016, Dr. Upshaw examined for the annual exam and noted seven conditions, where #5 was asthma "minimally symptomatic." (CX 1 at 17)]

Dr. Upshaw testified that he had not reviewed the pulmonary treatment records of Dr. Bhar or the expert report of Dr. DeMarini, a pulmonologist and internist who evaluated Claimant at Employer's request. *Id.* at 40. Dr. Upshaw testified that he would defer to the findings of Dr. Bhar, a pulmonologist. *Id.* at 34.

**Gastroenterology Associates of Central Georgia (CX 1)**

On October 2, 2017, Claimant was treated at Gastroenterology Associates of Central Georgia, LLC. (CX 1 at 26) The treatment note stated, "Has seen a pulmonary doctor for shortness of breath – sent to [rule out] reflux cause?" *Id.* The note stated that Claimant had shortness of breath with exertion, no cough, no regurgitation, was not on medication, and had no dysphasia.

On November 14, 2017, Claimant was treated at Gastroenterology Associates of Central Georgia. (CX 1 at 33) Claimant was still experiencing shortness of breath, usually occurring with exercise. The report stated: "Has seen pulmonary doctor. Sent here to [rule out] reflux cause." *Id.*

**Dr. Davey Deal, Gastroenterologist, Medical Records (EX Q)**

Dr. Davey Deal is a gastroenterologist practicing in Macon, Georgia. Claimant was referred by Dr. Upshaw, Claimant's internist, to examine Claimant for reflux. On November 11, 2017, Claimant was examined by Dr. Deal. Per Claimant's history, he was having shortness of breath, which usually occurred with exercise. (EX Q at 4) Claimant reported no shortness of breath with meals. He had seen a pulmonologist and was referred by Dr. Upshaw to rule out reflux.

On January 7, 2019, Claimant was examined by Dr. Deal upon referral from Dr. Upshaw. The treatment note stated:

> Referred back by Dr. Upshaw with GERD [gastroesophageal reflux disease] and SOB [shortness of breath]. R/O [rule out] GERD as cause. Pt has seen cardiologist? And Pulmonologist Dr. Bhar in 2018 – sent by his employer. Stress nml. Dr. Deal started Protonix 40mg qd. No change in shortness of breath. Dr. Deal doubted etiology was related to GERD. No longer on PPI. SOB with activity "running real fast;" "high strenuous stuff." Denies N/V, HB, regurgitation, abdominal pain, cough. Employer requesting an UGI [upper gastrointestinal] x-ray to R/O [rule out] GERD. SAIC employer – overseas contractor. ? File under worker's comp – no workers' comp info.

(EX Q at 6)

Impression stated: "SOB with exertion. ? GERD." *Id.* at 7. Plan stated: "UGI." *Id.* at 7.

On January 8, 2019, upper gastrointestinal x-rays showed:

> No focal structures of the esophagus. Mild increase gastric fold in the fundal region hypertrophic gastritis is not excluded. No pooling of contrast in the gastric antrum. Trace gastroesophageal reflux with the maneuvers.

*Id.* at 28.

Dr. Deal did not state his diagnosis in the treatment note.

**Dr. Thomas DeMarini, Pulmonologist, June 9, 2017 Medical Evaluation Report (EX G)**

Dr. Thomas DeMarini is a pulmonologist, practicing in Decatur, Georgia. He examined Claimant on behalf of the Employer on May 26, 2017. Dr. DeMarini made an electronic amendment to this report on June 9, 2017.[16] He opined that Claimant was an "extremely fit" 42-year-old nonsmoker. (EX G at 1) Per Claimant's history, Claimant had been in the military and then worked for a military contractor in Afghanistan. Per Claimant's history, after Claimant's six months in Afghanistan, "he began to develop intermittent severe dry coughing and intermittent attacks of shortness of breath." *Id.* Per Claimant's history, Claimant also had intermittent heartburn symptoms which responded to Prilosec. Per Claimant's history, the "episodes of coughing and shortness of breath seemed to be precipitated by exercise, but also came upon him randomly." *Id.* The episodes did not wake Claimant up at night.

Dr. DeMarini noted in the history of present illness provided by Claimant that per Claimant, "he had probable occupational exposures during his periods of time in Afghanistan. More specifically he was exposed to fumes from a burn pit, fumes from a welding area, and sewage, on a daily basis. All three of these areas were close to where he was housed." *Id.*

Dr. DeMarini stated that per Claimant's history, Claimant continued to work out and exercise, having run 15 miles that morning, and was "scrupulous about his diet." *Id.* He opined that Claimant's symptoms were "somewhat responsive" to Prilosec, ProAir HFA, and antihistamines. *Id.* Dr. DeMarini noted a family history of asthma and obstructive sleep apnea. *Id.* at 2.

Dr. DeMarini performed a physical examination. *Id.* He also ordered a chest x-ray and pulmonary function test. *Id.* at 2-3. He opined, "Technically, by ATS criteria there is no obstruction, however, there is a marked reduction in airflow. There is severe restrictive lung disease, which may be an artifact of the decreased airflows. The diffusing capacity is normal." *Id.* at 4.

Dr. DeMarini opined:

> Per the patient's report and the medical records that are available to me, it seems likely that the patient had environmental exposures to respiratory irritants while in Afghanistan. How this relates to his current symptoms is unclear, and it will require additional workup to sort out what is causing his symptoms and how they relate to the alleged exposures. Having said that, it is possible that he has obstructive blockage in his airway near the level of his vocal cords, and it is also possible that he has developed severe asthmatic spasm due to respiratory exposures.

*Id.* at 4.

Dr. DeMarini recommended that Claimant undergo "an upper GI to evaluate whether reflux is a contributing factor or the controlling factor in the patient's symptoms." *Id.* at 4. He stated that if the test was positive for acid and digestive enzymes in his chest, "then the reflux problem needs to be evaluated further and addressed." *Id.* Dr. DeMarini opined that he was concerned that a hiatal hernia may be contributing to Claimant's symptoms. Therefore, he recommended

[16] The report does not indicate what was changed by amendment on June 9, 2017.

Claimant discontinue all carbonated beverages for one month, and go on daily Prilosec "to see if this helps with either his cough or shortness of breath." *Id.* at 4.

Dr. DeMarini opined that if the upper GI evaluation was unremarkable, Claimant should have an ear nose and throat evaluation and possibly a CT scan of the chest or bronchoscopy "to sort out if there is an obstruction to airflow in his central airways." Dr. DeMarini opined, "It may be worthwhile trying him on a course of Prednisone at 20 mg a day for 2 weeks and then repeat his pulmonary function tests to see if they have improved with steroid treatment." *Id.* at 4. He opined:

> To summarize, my main concern is the patient has gastroesphageal reflux disease causing his severe bronchospasm and leading to his abnormal reading test and his symptoms. If I am correct in this, then further investigation of his airway would be required. At this time I cannot determine if his alleged occupational exposures are related to his current symptoms or not. Further diagnostic testing will be required to settle this question.

*Id.* at 4.

**Deposition of Dr. Thomas DeMarini[17] (EX P)**

Dr. Thomas DeMarini was deposed on December 14, 2018. (EX P) Dr. DeMarini testified that he is an internist with a specialty in pulmonary medicine and critical care. He testified that 80 to 90% of his time is spent practicing clinical medicine and treating patients.

Dr. DeMarini testified that he conducted a medical evaluation of Claimant in May 2017. He conducted a history intake, physical examination, and reviewed records. (EX P at 11)

Dr. DeMarini concluded that Claimant's respiratory complaint was due to gastroesophageal reflux and not due to any chemical exposure overseas. He testified that when a person is exposed to chemicals, they "come" on during the time of exposure or shortly thereafter, "hours, or days." *Id.* at 12, 13. Dr. DeMarini testified that if Claimant had work-related respiratory problems, the symptoms "come" on during the time of exposure, not months or years later." *Id.* at 14. Dr. Marini opined that neither reflux nor hiatal hernia could be caused or aggravated by exposure in Afghanistan. *Id.* at 28-29.

Dr. DeMarini opined that while Dr. Bhar initially diagnosed bronchiolitis, Dr. Bhar ultimately found gastroesophageal reflux disease which was "entirely consistent" with Dr. DeMarini's diagnosis.

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[17] Dr. Thomas DeMarini's *curriculum vitae* shows that he earned his medical degree from Northwestern University Medical School. He completed an internship and residency in Internal Medicine at Northwestern at Evanston Hospital in 1986. He was Chief Medical Resident from 1986-1987. He completed a fellowship in pulmonary and critical care in 1989. He is Board-certified in internal medicine and pulmonology. He has been Principal Investigator in numerous clinical trials, some involving pneumonia, bronchoscopy procedures, chronic obstructive pulmonary disease, idiopathic pulmonary fibrosis, and asthma. (EX P)

Dr. DeMarini testified that Claimant complained of intermittent shortness of breath and intermittent heartburn. Per Claimant's history, Claimant stated he lived near a burn pit, and "was exposed to a welding area," with minimal exposure. *Id.* at 11. "His main complaint was about the burning trash pit." *Id.* at 10-11.

Dr. DeMarini testified that, per Claimant's history:

> A: My impression was the shortness of breath was fairly recent. He is extremely fit. He runs, he lifts weights. I give him tremendous credit for the time and energy he spends taking care of his body. But the shortness of breath had come about since he had left Afghanistan. And he had told me that he had had a bad episode in 2015, where he had been hospitalized, but he couldn't give me any more detail than that. He just said he was hospitalized for shortness of breath.
> Q: Okay.
> A: But it wasn't really important to me anyway.
> Q: Well, I want you to assume, Doctor, that he was seen in the ER in September 2015 for shortness of breath, and I want you to further assume that that is the first real instance that's documented in this case of a severe shortness of breath. Does that have an effect on your opinion, just based on the history of when he was exposed, when he stopped being exposed, and when the shortness of breath came on?
> A: Well, it clearly dovetails with my opinion, that the source of his respiratory complaint is gastroesophageal reflux with an aspiration syndrome, and –
> Q: As opposed to exposure overseas.
> A: Yes. I think the point you're asking about is, does somebody who gets chemical exposure develop problems at that time as opposed to later, and the answer is almost always yes. It's during the acute phase that they usually have a problem. That isn't to say they won't have problems later. It's just that it comes on during the time of exposure, or shortly thereafter: hours, or days.

*Id.* at 12-13.

Dr. DeMarini was asked:

> Q: And not to put too fine a point on it, but is it your professional opinion, within a reasonable degree of medical certainty, that it's normally the case that your symptoms – your pulmonary symptoms that result from an exposure of the type complained of by [Claimant], would more likely than not manifest themselves closer to the time of the exposure, than two years after?
> A: I believe that that's a restatement of what I said just a question or two ago. I would expect, if he was having respiratory symptoms, they would have

developed at or around the time of the exposure, and not months or years later.

*Id.* at 14.

Dr. DeMarini testified that when Claimant told him at the intake that he had just run 15 miles, Dr. DeMarini considered Claimant had an aspiration issue. *Id.* at 14. He testified that running 15 miles is not consistent with asthma or constructive airway disease. *Id.* at 15. "But patients with these aspiration syndromes will have intermittent shortness of breath episodes that can be quite severe. Having said that, they frequently can run through it, for reasons that are not quite clear." *Id.* at 15.

Dr. DeMarini testified that Claimant's physical examination findings were essentially normal. *Id.* at 15. He testified that Claimant's x-ray was not consistent with asthmatic spasm and with a restrictive process. He testified that Claimant had "very abnormal pulmonary function tests." *Id.* at 18. He testified that the pulmonary function test findings were consistent with an aspiration syndrome. *Id.* at 18. He testified that patients with an aspiration syndrome frequently "have terrible spasms in their lung when they're exposed to nonspecific respiratory irritants." *Id.* at 18. He testified that this can "look just like asthma." *Id.* He testified that when he reviewed Claimant's spirometry records, some results were normal and some were "wildly abnormal ... and one would not expect that in asthma." *Id.*

Dr. DeMarini testified that Claimant's lungs were clear upon examination.

Q: If someone was exposed in the way that [Claimant] alleges to have been exposed, and had an issue – a pulmonary issue, as a result of that exposure, would you have expected to have had uniformly clear chest exams?
A: No.
Q: Why not?
A: Well, you would hear the obstruction of the airflow. It's generally described as wheezing, or whistling in the lungs, and he just didn't have that.

*Id.* at 20.

Dr. DeMarini testified that the pulmonary function test he administered on May 26, 2017 was abnormal. *Id.* at 20. Dr. DeMarini attributed that abnormality to reflux, "because it was quite severe," and had dissipated by the time Dr. DeMarini saw him, about 30 minutes after the test. *Id.* at 21. He testified that it is common to have "big swings" in which a patient may be having shortness of breath, wheezing, chest tightness, and cough, and then thirty minutes later, would be normal. *Id.* at 21.

Dr. DeMarini testified that he advised Claimant to discontinue caffeinated and carbonated beverages, recommended he sleep with a wedge pillow, and avoid eating within three hours of going to bed. *Id.* at 22. He testified, "I also told him that he would require testing for this. And I called his gastroenterologist [Dr. Deal] on five occasions and never got a call-back, trying to

explain to him what this syndrome involved, and how it needed to be worked up." *Id.* at 24. Dr. DeMarini was asked:

> Q: Doctor, is there any indication that reflux was ruled out by this doctor?
> A: No.

*Id.* at 25.

> Q: Do the gastroenterologist's records confirm your suspicions about reflux? Do they affect them in any way?
> A: No, not particularly. You know, he has a – I'll just read it into the record. 'Reflux cause,' question mark, which indicated to me that the doctor is not aware of the relationship between reflux and the aspiration syndromes, and the respiratory problems. And I'm not disparaging the doctor. The vast majority of gastroenterologists are not aware of how this works.

*Id.* at 23-24.

Dr. DeMarini testified that Claimant was also treated by Dr. Kamean[18]. *Id.* at 26. He testified that Dr. Kamean opined that it was not clear why Claimant was experiencing his symptoms, and that there was no finding leading to asthma. *Id.* at 26-27. He testified that Dr. Kamean opined that testing was required to evaluate "potential silent reflux" which could cause bronchospasm and airway disease. *Id.* at 27. Dr. DeMarini testified that this testing was never done. Dr. DeMarini opined that the tests would have revealed reflux, and may have revealed a hiatal hernia. *Id.* at 27. He opined that Claimant could have a lax sphincter, esophageal dysfunction, or a spasm of the esophagus. *Id.* at 28-29. He testified that no testing had been done to test for any of those conditions. *Id.* at 28.

Dr. DeMarini was asked:

> Q: Would either the reflux or the hiatal hernia have been caused, or aggravated, or disturbed by any exposures he suffered in Afghanistan?
> A: No. Hiatal hernias are a natural consequence of living. By age 50, 50 percent of the population has some degree of hiatal hernia. So they're very common. Most people have minimal symptoms, unless their hernia is refluxing badly.

*Id.* at 28-29.

Dr. DeMarini testified that Claimant had an abnormal PFT and a normal PFT. He opined that showed that Claimant's respiratory condition was not caused by chemical exposure.

Dr. DeMarini was asked:

[18] Dr. Jeffrie Kamean is a gastroenterologist in Decatur, Georgia, who evaluated Claimant for his shortness of breath.

Q: If [Claimant] was suffering from an illness – a respiratory illness, a lung illness, as a result of his exposures in Afghanistan, would it be normal, or expected, to have a normal pulmonary function test in March 2017, and then an abnormal one in May of 2017?
A: That would not be expected.
Q: Why not?
A: If he had chemical exposure that caused restriction of the lung, that would continue to be present. That doesn't come and go. I know, in some of the notes, there's a comment about bronchiolitis obliterans, and that doesn't come and go on pulmonary function tests. If this was an obstructive process due to asthma, you can see patients who have completely normal pulmonary function tests, but that's very unusual. Usually you don't get complete reversal of the spasm. In his case, when I saw him, he apparently had severe airway obstruction. But when I visited him in the office a half hour later, that had gone away.

*Id.* at 33-34.

Dr. DeMarini testified that the March 31, 2017 pulmonary function test was "very abnormal." *Id.* at 36. He testified that it "demonstrates severe airway obstruction, and a significant response to bronchodilator." *Id.* He testified that inhaled medication to relax Claimant's airway and open his lungs improved his response dramatically. *Id.*

Q: And what does that tell you about whether or not this is causally related to his job in Afghanistan?
A: I don't think it tells me much of anything. It could be argued that he has severe asthma, and it's reversible to medication. Once again, that's entirely consistent with an aspiration syndrome as well. So I say that it shows that he has reversible airway disease, but it does not speak to the cause of that reversible airway disease.

*Id.* at 36-37.

He testified that Claimant's pulmonary function test on April 11, 2017[19] showed that he had "significant improvement" with Azithromycin. *Id.* at 35. He testified that Azithromycin was an antibiotic and he would not have expected it "to clear up a chemically related exposure problem." *Id.* at 36.

Dr. DeMarini testified that he "completely disagree[d]" with Dr. Bhar's April 24, 2017 medical opinion that Claimant may have had constrictive bronchiolitis. *Id.* at 38. He testified that "usually, constrictive bronchiolitis will show up, both on pulmonary function tests, and on chest x-ray, and certainly on CAT scan." *Id.* He testified that "the fact that [Claimant was] having intermittent attacks of shortness of breath that are entirely reversible, that is not consistent with restrictive bronchiolitis." *Id.* at 37. Dr. DeMarini testified that he did not understand Dr. Bhar's statement that "patient was given Azithromycin and responded appropriately," "because Azithromycin is not a treatment for constrictive bronchiolitis." *Id.* at 39.

[19] The actual date of this PFT was April 7, 2017. April 11, 2017 is the date of the office visit following the PFT.

Dr. DeMarini testified that Dr. Bhar's treatment notes showing that Claimant had previously been able to run a seven minute mile, but was experiencing reduced exercise ability again, showed a "waxing and waning pattern...much more consistent with an aspiration syndrome than a chemical exposure." *Id.* at 40. Dr. DeMarini testified that positive response to an antibiotic such as Azithromycin was not consistent with constrictive bronchiolitis or chemical exposure. *Id.* at 41.

Dr. DeMarini recommended surgery to treat aspiration syndrome. He testified that Claimant could most likely return to work in Afghanistan if he underwent the surgery. *Id.* at 42. Dr. DeMarini read aloud Dr. Bhar's August 29, 2017 treatment note recommending evaluation for gastroesophageal reflux disease. Dr. DeMarini testified that, "It is entirely consistent with what I believe he has." *Id.* at 45.

Dr. DeMarini testified that Claimant's work in Afghanistan did not contribute to or cause Claimant's pulmonary condition. *Id.* at 48.

> Q: Within a reasonable degree of medical certainty, did anything that happened to this man, based on anything you've reviewed in this case, including your examination and interview of him, have anything to do with his exposures in Afghanistan?
> A: In my opinion, no.

*Id.* at 47.

Dr. DeMarini testified it was "possible" Claimant had gastroesophageal disease and asthma from his exposure, but "I don't believe that that's what he has." *Id.* at 51. Dr. DeMarini testified that he agreed with his notes that per Claimant's history, Claimant had occupational exposures in Afghanistan, including fumes from a burn bit, welding arc, and sewage. *Id.* at 49-50. He testified that he agreed as true that it seemed likely that, per Claimant's history, Claimant had environmental exposures to respiratory irritant while in Afghanistan. *Id.* at 50.

> Q: So is it possible to have both the gastroesophageal disease, and the development of some sort of asthmatic condition from respiratory exposures?
> A: Good question. I certainly believe it is possible. I don't believe that that's what he has – I'll just put that on the record. But I would say that is possible.

*Id.* at 51.

Dr. DeMarini testified that if Claimant had asthma, it was not caused by chemical exposure in Afghanistan because the symptoms were not immediate and appeared later. Dr. DeMarini testified that it was common with asthma to have a clear pulmonary test one day and be hospitalized another. *Id.* at 61. He testified that about 60% of asthmatic patients have some allergic involvement, and nonspecific respiratory irritants can also cause bronchospasm. *Id.* at 61.

> Q: ...if it is asthma, is it caused by – is his asthma – his specific asthma, assuming it is asthma, caused by exposures from overseas?

A: I don't believe so.
Q: All right. And that has to do with the timing of its development, Doctor?
A: Yes. The fact that he didn't appear to have symptoms until later.

*Id.* at 62.

Dr. DeMarini testified that if Claimant did have asthma, it was not related to any exposures in Afghanistan. *Id.* at 62. He testified that he did not believe Claimant had asthma.

> And even if he does have asthma, I don't believe that has any relationship to his exposures outside of the country, or his employment, as best as I can determine.

*Id.* at 63.

He testified that Claimant's symptoms and the timeline of his symptoms were "much more consistent with gastroesophageal reflux with aspiration syndrome." *Id.* at 62. Dr. DeMarini testified:

> I do not believe that he has asthma. I do believe that he has an aspiration syndrome with bronchospasm that causes cough, wheezing, and shortness of breath. And even if he does have asthma, I don't believe that has any relationship to his exposures outside of the country, or his employment, as best I can determine.

*Id.* at 63.

Dr. DeMarini testified that if it was true that Claimant never sought respiratory treatment in Afghanistan, then it was "medically overwhelmingly unlikely that an occupational exposure in Afghanistan caused his current symptoms." *Id.* at 67.

Dr. DeMarini reviewed records from the time that Claimant worked in Afghanistan. He testified that review of those records did not change his medical opinion. He testified that the records did not mention any kind of pulmonary problems, "other than two or three episodes of respiratory tract infections," or common colds. *Id.* at 74.

He testified that based on his reading of Dr. Bhar's notes, Dr. Bhar agreed with this medical opinion. *Id.* at 63.

He noted that Claimant had a parental history of asthma. Id. at 63. Dr. DeMarini testified that when a person's parents had asthma, the onset for the child tended to be in childhood. In two-thirds of patients, it went away after high school and then tended to return in the person's thirties or forties. *Id.* at 65. He testified, "So it's hard for me to tie that hypothesis into an occupational exposure in Afghanistan." *Id.* at 65.

**Dr. Gregory Cox, Dermatologist, Undated Report (EX H)**

Dr. Gregory Cox is a dermatologist practicing in Atlanta, Georgia. Dr. Cox wrote an undated letter stating that Claimant had been seen for a dermatologic medical examination. (EX H at 1) Dr. Cox stated that he noted hyperpigmentation along Claimant's hairline "that clinically is seborrheic dermatitis." *Id.* Claimant showed Dr. Cox "a 7mm linear scar that is superficial and barely visible where what sounds like an incision and drainage was performed for an infection or sebaceous cyst." *Id.* Claimant told Dr. Cox that this occurred during Claimant's three years in Afghanistan, seven to eight years prior. Dr. Cox noted a 6mm well-healed linear scar on his right forearm that resulted from an incision of a skin infection. *Id.* Claimant stated this wound required packing. Dr. Cox also noted a 2 cm well-healed round scar on Claimant's leg that Claimant said resulted from a similar infection.

Dr. Cox opined that the scars were all older than one year. He stated that there were no objective findings to show what caused the scars. *Id.* He opined, "I see nothing from a dermatologic standpoint that would preclude his returning to work in Afghanistan. He has not experienced any other infections, boils, or cysts since returning home from Afghanistan. I saw no other abnormalities from a dermatologic standpoint." *Id.*

**Dr. Michael Nocero, Jr., Internist, October 23, 2017 Report (EX I)**

Dr. Michael Nocero is an internist who specializes in cardiovascular disease, practicing in Altamonte Springs, Florida. Dr. Nocero evaluated Claimant on October 23, 2017 regarding Claimant's hypertension.[20] He opined that as a Board-certified specialist in cardiovascular medicine, it was his opinion that Claimant did not have an underlying coronary artery disease, cardiomyopathy, or valvular heart disease. He opined that Claimant had well-controlled hypertension. He opined that Claimant's "further evaluation should include a GI workup and then possibly a CT scan of the lungs and a pulmonology evaluation." *Id.* at 3.

On October 30, 2017, Dr. Nocero wrote an addendum after it was brought to his attention that Claimant was claiming his hypertension prevented him from returning to work overseas. Dr. Nocero opined, "I see nothing on my review of his history and all of his office visits and physical examinations including the independent medical evaluation by Dr. Thomas DeMarini that would preclude him from returning to work overseas as far as hypertension is concerned." *Id.* at 3. Dr. Nocero opined:

> However, he does have, as mentioned by Dr. DeMarini, problems with either gastroesphageal reflux disorder or pulmonary disease that need further evaluation but this has nothing to do with his hypertension which is being well-controlled or his cardiovascular state which is stable.

*Id.* at 4.

**Dr. Jeffrie Kamean, Gastroenterologist, February 6, 2018 Report (EX J)**

[20] As hypertension is not a part of this claim, this report has been reviewed and considered, but the majority of the report pertaining to hypertension has not been extensively summarized in this decision.

Dr. Jeffrie Kamean is a gastroenterologist practicing in Decatur, Georgia. On February 6, 2018, Dr. Kamean examined Claimant and evaluated Claimant for shortness of breath. Dr. Kamean stated that per Claimant's history, Claimant was a runner, did CrossFit, and "had been very outdoorsy" until 2009 when he was deployed as a government contractor. (EX J at 1)

Dr. Kamean performed a physical examination. He opined that Claimant's lungs were bilaterally clear to auscultation and lymphadenopathy. *Id.*

Dr. Kamean opined, "At this point, it does not appear that we have any answers to why this is going on." *Id.* at 2. He opined that there was "not a finding of hard core scientific results leading to asthma." *Id.* He opined, "At this point I think that he has no symptoms, my suggestion would be to do an upper endoscopy with BRAVO placement." *Id.* at 2. He stated that, "This would give us scientific information as to whether or not reflux was just an imitation." *Id.*

**Department of Veterans Affairs Memorandum Regarding Environmental Hazards, April 26, 2010 (CX 7)**

Claimant submitted this report regarding air quality in Iraq and Djibouti, though Claimant worked in Afghanistan. Employer objected to the admission of this exhibit at the hearing. The exhibit was admitted, with the ruling that it would be given the weight to which it was entitled. The undersigned gives this record little weight because this air quality testing was conducted three years before the alleged date of injury, and the air sampling results were from Iraq and Djibouti, not Afghanistan, the location of Claimant's overseas employment.

This memorandum from the Director to all VA regional offices, dated April 26, 2010, stated that the military used burn pits from 2001 to the date of the report, April 26, 2010. (CX 7 at 2).

The April 26, 2010 memorandum described air sampling test results from Iraq. *Id.* at 4.

**Air Sampling Results, April 4, 2013 (CX 6)**

This record from the Joint Program Office dated April 4, 2013 had the subject line: "Air Sampling Results for Kandahar MaxxPro Survivability Upgrade (MSU) Operations." (CX 6 at 1) The report stated that air sampling was conducted at Kandahar MSU facility "during the period 1-5 March." *Id.*

Employer objected to the entry of this exhibit at the hearing. The exhibit was admitted, with the ruling that it would be given the weight to which it was entitled. The undersigned gives this record little weight because the sampling was conducted in Kandahar during the time period Claimant testified he was at Camp Nathan Smith. He returned to Kandahar in June 2013, three months after the air sampling was conducted.

The report stated:

> Examination of results indicates there are occupational exposures to workers in the MSU that can be attributed to the welding and grinding operations.

Specifically observed are '21 Metal' exposures exceeding ACGIH Standards, as well as individual exposures to Iron Oxide and Manganese. These results are similar to the observations made at the Bagram MSU1 and MSU2 facilities.

## CONCLUSIONS OF LAW

The issues are whether Claimant sustained a psychological injury that arose out of his employment in Afghanistan, and whether Claimant sustained a respiratory injury that arose out of his employment in Afghanistan. If it is determined that Claimant sustained injuries arising out of his employment, then the issue is whether he is entitled to disability and medical treatment for those injuries.

The ultimate finding is based on the evidence in the record, and is no reflection on Claimant's service supporting the military in Afghanistan.

### I. Injury Arising Out Of Employment

Section 2(2) of the LHWCA defines an "injury" as an

> 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, and includes an injury caused by the willful act of a third person directed against an employee because of his employment.
>
> 33 U.S.C. § 902(2)

It is well established that a work-related psychological impairment or injury may be compensable under the Act, regardless of whether the claimant also suffers underlying physical harm. Swinton v. J. Frank Kelly, Inc., 554 F.2d 1075, 1082 (D.C. Cir. 1976), cert. denied, 429 U.S. 820 (1976); R.F. [Fear] v. CSA Ltd., 43 BRBS 139 (2009).

The Claimant bears "the burden of proving the existence of an injury or harm and that a work-related accident occurred or that working conditions existed which could have caused the harm, in order to establish a *prima facie* case." Bolden v. G.A.T.X. Terminals Corp., 30 BRBS 71 (1996) (citing Obert v. John T. Clark & Son of Maryland, 23 BRBS 157 (1990)); see U.S. Indus./Fed. Sheet Metal, Inc., v. Dir., OWCP, 455 U.S. 608 (1982); Hargrove v. Strachan Shipping Co., 32 BRBS 11 (1998) (Claimant need not prove impairment was "work-related" at this juncture only that conditions existed that could have caused it). An injury need not involve an unusual strain or stress; it makes no difference that the injury might have occurred wherever the employee may have been. See Wheatley v. Adler, 407 F.2d 307 (D.C. Cir. 1968); Glens Falls Indem. Co. v. Henderson, 212 F.2d 617 (5th Cir. 1954). The Claimant must establish each element of his *prima facie* case by affirmative proof. Kooley v. Marine Indus. Northwest, 22 BRBS 142 (1989); see also Dir., OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

## A. Claimant Has Successfully Raised The Section 20(a) Presumption

Claimant has presented evidence to invoke the presumption that he suffered psychological harm and that conditions existed during his employment that could have caused the harm.

Section 20 (Section 920(a)) of the Act provides a claimant with a presumption that his condition is causally related to his employment if he establishes a *prima facie* case by proving that he suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. See U.S. Industries/Federal Sheet Metal v. Director, OWCP (Riley), 455 U.S. 608, 615, 14 BRBS 631, 633 (1982), rev'g Riley v U.S. Industries/Federal Sheet Metal, 627 F.2d 455, 12 BRBS 237 (D.C. Cir. 1980); Newport News Shipbuilding & Dry Dock Co. v. Holiday, 591 F.3d 219, 225, 43 BRBS 67 (CRT) (4th Cir. 2009). Once a *prima facie* case is established, a presumption is created under Section 20(a) of the LHWCA that the employee's injury or death arose out of employment. 33 U.S.C. § 920(a). This presumption applies only "to the issue of whether an injury arises in the course of employment and, thus, is work-related;" not to the issues of the nature and extent of disability. Carlisle, 33 BRBS 133 (citing Jones v. Genco, Inc., 21 BRBS 12 (1998)).

The Claimant need not introduce affirmative medical evidence that the working conditions in fact caused the harm to obtain the benefit of the § 920(a) presumption; rather, he need only show that working conditions existed which could have caused the harm. U.S. Industries/Federal Sheet Metal, 455 U.S. at 608, 14 BRBS at 631.

Based on Claimant's testimony and the medical evidence presented, Claimant has established that he sustained harm, his alleged PTSD and his alleged respiratory condition, and that working conditions existed that could have caused the alleged harm working overseas in Afghanistan.

The alleged psychological harm is supported by Dr. Samuel who opined that Claimant had post-traumatic stress disorder and major depressive disorder. (CX 1 at 25) He testified that Claimant's employment as a military contractor in Afghanistan met Criteria A for post-traumatic stress disorder. (CX 1 at 12) Claimant received treatment from Dr. Samuel for post-traumatic stress disorder and major depressive disorder from February 2017 through October 17, 2018. (CX 1; CX 14 at 11).

Claimant's testimony and Summary of Events in Afghanistan (CX 8), as well as his statements to Dr. Samuel and Dr. Spector, supports that conditions existed that could have caused the alleged psychological harm. (CX 8; TR at 48; 52; 54; 70).

Accordingly, the undersigned finds that Claimant has met the Section 20 presumption that he suffered an alleged harm (PTSD) and that working conditions existed that could have caused the harm when working for Employer.

The alleged respiratory harm is supported by Dr. Upshaw. Dr. Upshaw wrote a letter stating that Claimant developed asthma while in Afghanistan. (CX 1 at 21) He stated that per Claimant's history, there was an area where refuse was burned within the compound where Claimant was working. He opined that Claimant's "respiratory symptoms could very well be related to these

less than sanitary conditions." *Id. (Emphasis added)* The court notes that Dr. Upshaw wrote another letter not mentioning burn pits which will be addressed later in this Decision and Order.

Claimant's testimony that he lived approximately ten minutes from burn pits supports that conditions existed that could have caused the alleged respiratory condition. (TR at 51-42)

Accordingly, the undersigned finds that Claimant has met the Section 20 presumption that he suffered an alleged harm (respiratory complaints including shortness of breath) and that working conditions existed that could have caused the harm when working for Employer.

**B. Employer Rebutted the Section 20(a) Presumption Of Causation for Claimant's Alleged Psychological Condition and Respiratory Condition.**

If a Claimant invokes the Section 20(a) presumption of causation, the burden shifts to the Employer to rebut the presumption with competent countervailing evidence. Swinton v. J. Frank Kelly Inc., 554 F.2d 1075, 1081, 4 BRBS 466, 474-75 (D.C. Cir.), cert. denied, 429 U.S. 820 (1976); see also Newport News Shipbuilding & Dry Dock Co. v. Holiday, 591 F.3d 219, 225, 43 BRBS 67 (CRT) (4th Cir. 2009); Universal Maritime Corp. v. Moore, 126 F.3d 256, 262, 31 BRBS 119, 123 (CRT) (4th Cir. 1997). Since Claimant has made the requisite *prima facie* showing of harm and conditions existed which could have caused or aggravated the harm, Employer must overcome the force of the presumption by producing substantial evidence severing the presumed connection between Claimant's injury and his employment. Del Vecchio v. Bowers, 296 U.S. 280, 286-87 (1935); Holiday, 591 F.3d at 225; Moore, 126 F.3d at 262; Volpe v. Northeast Marine Terminals, 671 F.2d 697, 700, 14 BRBS 538 (2d Cir. 1982). Evidence is substantial if it is the kind that a reasonable mind might accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1971); Moore, 126 F.3d at 263.

Thus, once the Section 20(a) presumption applies, the relevant inquiry is whether the Employer succeeded in establishing the lack of a causal nexus. Dower v. General Dynamics Corp., 14 BRBS 324 (1981). The Employer must produce facts, not speculation, to overcome the presumption of compensability, and reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created in Section 20(a). Dearing v. Director, OWCP, 27 BRBS 72 (CRT) (4th Cir. 1993) (Unpublished) (medical evidence constituted substantial evidence to support Employer's rebuttal and sole medical evidence on Claimant's behalf was equivocal); Steele v. Adler, 269 F. Supp. 376 (D.D.C. 1967). See Smith v. Sealand Terminal, 14 BRBS 844 (1982); Dixon v. John J. McMullen & Assocs., 13 BRBS 707 (1981). Highly equivocal evidence is not substantial and will not rebut the presumption. Dewberry v. Southern Stevedoring Corp., 7 BRBS 322 (1977), aff'd mem., 590 F.2d 331, 9 BRBS 436 (4th Cir. 1978).

"If an Employer does not offer substantial evidence to rebut the presumption . . . the presumption provided by Section 20 will entitle a Claimant to compensation."[21] Universal Maritime Corp. v. Moore & Dir., OWCP, 126 F.3d 256 (4th Cir. 1997) (citing Del Vecchio v. Bowers, 296 U.S. 280, 284-285 (1935)); see Duhagon v. Metro. Stevedore Co., 169 F.3d 615 (9th Cir. 1999).

[21] Substantial evidence requires "more than a mere scintilla." Richardson v. Perales, 402 U.S. 389, 401 (1971). It requires "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Id., (1971); see Sprague v. Dir., OWCP, 688 F.2d 862, 865-66 (1st Cir. 1982).

However, if the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. Del Vecchio, 296 U.S. 280. When the evidence as a whole is considered, it is the proponent (Claimant) who has the burden of proof. See Dir., OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

Employer presented persuasive evidence from Dr. Spector, who performed a psychological evaluation of Claimant, to rebut the §20(a) presumption for the alleged psychological injury arising out of employment. Dr. Spector opined that Claimant manifested "symptoms of a mild affective disorder, most likely a persistent depressive disorder with anxious arousal." (EX F at 5) Claimant worked for Employer from 2009-2013. He opined, "I do not believe that his current, mild psychiatric symptoms were caused by his contract work in Afghanistan, which ended more than four years ago." *Id.* Dr. Spector relied in part on the fact that, per Claimant's report, it was not until February 2017 or March 2017 that Claimant first experienced nightmares and intrusive daytime experiences that Claimant attributed to his time in Afghanistan. *Id.* Dr. Spector opined:

> [Claimant's] experiences in Afghanistan may well have been distressing, but are believed to have fallen well short of those imminent threats to life and limb typically associated with post-traumatic stress disorders. Performance on a standardized measure of post-traumatic stress revealed surprisingly few PTSD-related complaints.

(EX F at 5)

The undersigned finds that Employer has presented sufficient evidence to rebut the presumption that there is a causal nexus between Claimant's alleged work-related psychological injury and his employment conditions with Employer.

Employer has presented persuasive evidence from Dr. DeMarini, who performed a pulmonary evaluation of Claimant, to rebut the §20(a) presumption for the alleged pulmonary injury arising out of employment. Dr. DeMarini opined that Claimant had gastroesophageal reflux disease with an aspiration syndrome. He recommended more testing to confirm this diagnosis. (EX G at 4) He testified that the further testing may also reveal a hiatal hernia. (EX P at 27) He testified that while this recommended testing was never done, neither reflux nor a hiatal hernia could have been caused or aggravated by exposures in Afghanistan. (EX P a 29) He opined that Claimant's respiratory condition was not related to his work in Afghanistan. (EX P at 47-48) Dr. DeMarini opined Claimant did not have asthma. He testified that if Claimant had asthma, it was not related to his exposures in Afghanistan. (EX P at 62) This was based on Claimant's medical treatment history in Afghanistan, physical fitness routine running 15 miles, chest x-ray, and pulmonary function tests.

The undersigned finds that Employer has presented sufficient evidence to rebut the presumption that there is a causal nexus between Claimant's alleged work-related respiratory condition and his employment in Afghanistan.

**C. Evidence Weighed as a Whole**

Once the Employer has rebutted the presumption, the presumption falls from the case and the evidence is considered as a whole. Universal Maritime Corp. v. Moore, 126 F.3d 256 (4th Cir. 1997) (citing Del Vecchio v. Bowers, 296 U.S. 280, 284-285 (1935)); see Duhagon v. Metro. Stevedore Co., 169 F.3d 615 (9th Cir. 1999). When the evidence as a whole is considered, it is the proponent (Claimant) who has the burden of proof. See Dir., OWCP v. Greenwich Collieries, 512 U.S. 267(1994).

In arriving at a decision, the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom and is not bound to accept the opinion or theory of any particular medical examiner. Duhagon v. Metro. Stevedore Co., 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atl. Marine, Inc. and Hartford Accident & Indem. Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Ass'n, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968). The Benefits Review Board has held that it will not disturb the administrative law judge's credibility determinations unless they are "inherently incredible or patently unreasonable." Cordero v. Triple A Machine Shop, 580 F.2d 1331, 8 BRBS 744 (9th Cir. 1978), cert. denied, 440 U.S. 911 (1979); Hampton v. Bethlehem Steel Corp., 24 BRBS 141, 145 (1991).

Weighing the evidence as a whole, Claimant has not established by persuasive medical or testimonial evidence that he suffers from post-traumatic stress disorder that was caused or contributed to by his employment in Afghanistan. Claimant has not established by persuasive medical evidence or testimonial evidence that he suffers from a respiratory condition that was caused or contributed to by his employment in Afghanistan.

**Psychological Injury**

Claimant claimed a post-traumatic stress disorder (PTSD) psychological injury arising from his employment in Afghanistan from 2009-2013. His first psychological evaluation was in 2017, four years after he left Afghanistan. Claimant alleged that while at various bases in Afghanistan, there were rocket and ground attacks during which he had to seek shelter. He did not claim that he witnessed any deaths or injuries during these attacks. He alleged that during one ground attack, two people were killed and six were injured. He did not state that he witnessed these deaths or injuries; rather that he had to shelter in a bunker during this attack. Claimant stated that as part of his job in Afghanistan, he inspected vehicles that had been hit by bombs or improvised explosive devices. He inspected these damaged vehicles to make damage estimates. He testified that he found this disturbing. (CX 8; TR at 48; 52; 54; 70) Claimant testified that he did not seek treatment for any psychological symptoms while in Afghanistan, or while home on R&R during the term of his contract. (TR at 93) There is no medical record of psychological complaints during this time period. Claimant's contract in Afghanistan ended in August 2013. He found employment in the United States approximately five to seven months after returning to the United States. (TR at 80-82) At the time of the hearing, he had worked that job as a supervisor for four years. (TR at 80) Although Claimant testified that his wife noticed psychological symptoms about two or three months after he returned to the United States, Claimant did not seek psychological treatment until approximately four years later. (TR at 58; CX 1 at 24; CX 14 at 6) There is no medical record of any psychological complaints until Claimant's February 10,

2017 evaluation with Dr. Samuel Samuel, four years after he left employment in Afghanistan in 2013.

Dr. Samuel met with Claimant four times, by Skype, and evaluated Claimant's psychiatric condition. (CX 1 at 24; CX 14 at 3) During the first evaluation on February 10, 2017, Claimant denied suicidal ideation, self-injurious impulses, homicidal ideations, hallucinations, and delusions. Dr. Samuel opined that Claimant showed signs of "moderate depression" and that Claimant appeared "sad" and "glum." (CX 1 at 22) Claimant told Dr. Samuel that after returning home from working overseas in Afghanistan, he began having mood swings, felt irritable, and had a "low tolerance of things he used to be able to tolerate." *Id.* Claimant told Dr. Samuel that his wife suggested he seek treatment. (CX 1 at 22) Claimant reported that he sometimes thought about his experiences in the Middle East. *Id.* at 22. Claimant did not describe those experiences, or explain the nature of those experiences. When Dr. Samuel was later deposed, he testified that Claimant did not give any specifics beyond "hostile work environment." (CX 14 at 7) While Dr. Samuel's findings upon evaluation were "signs of moderate depression," Dr. Samuel opined that Claimant had "major depressive disorder, recurrent episode, mild." (CX 1 at 23) Dr. Samuel did not explain the reasoning behind finding "major depressive disorder" with signs of only moderate depression, other than to characterize this "major depressive disorder" as "mild." *Id.*

On June 5, 2017, Dr. Samuel wrote a letter opining that Claimant had major depressive disorder, recurrent episode, and post-traumatic stress disorder. (CX 1 at 25) In his report, Dr. Samuel did not state the basis of his diagnosis of PTSD, nor discuss the elements of the DSM IV appendix criteria and how it applied to Claimant. He opined that Claimant's short-term prognosis was satisfactory with continued medication and treatment, and his long-term prognosis depended on "what kind of new trauma or stressors" he came across in the future. (CX 1 at 25) Dr. Samuel testified that he wrote this letter upon Claimant's request. (CX 14 at 13)

Dr. Samuel testified at deposition that the DSM IV Appendix E criteria is used to diagnose post-traumatic stress disorder. (CX 14 at 7) He testified regarding some of the criteria for that diagnosis.

He testified that one of the criteria[22] was that a person had been exposed to a traumatic event that involved actual threatened death or serious injury, and that the person must have had an intense reaction of fear, horror, or helplessness. (CX 14 at 7) Dr. Samuel testified that there was no note in his treatment records that Claimant experienced an intense reaction of fear, helplessness, or horror. (CX 14 at 7) He also testified that the most important part of post-traumatic treatment was the specific exposure. *Id.* at 8. Despite this, he did not ask Claimant about the specifics of his exposure while working in Afghanistan. He testified that he did not ask Claimant about his occupational functioning, testifying, "I wish I had asked him. It's very important." (CX 14 at 9) He testified that another criteria was persistent avoidance of stimuli. (CX 14 at 8) He testified that Claimant's applying for additional jobs in Afghanistan after leaving Employer would be unusual for persistent avoidance. *Id.* He did not know that Claimant continued to seek overseas employment in war zones after his work with Employer ended. *Id.* at 5. He testified that this would be inconsistent with someone who had a continuing psychological disability, "especially a severe type of disability." *Id.* at 5. He testified that Claimant's mental health condition improved

[22] Criteria A. (Appendix E: DSM-IV-TR Criteria for Posttraumatic Stress Disorder)

with successful treatment and that Claimant denied psychological problems on February 9, 2018 and April 10, 2018. Dr. Samuel saw no signs of anxiety or depression on April 10, 201 8. *Id.* at 10-11. Dr. Samuel testified that many people show rapid improvement with Effexor, and Claimant's "issue" was "more or less resolved" with the help of medication. *Id.* at 11.

Dr. Samuel testified that Claimant met Criteria A for post-traumatic stress disorder (exposure to a traumatic event)[23] because he worked in Afghanistan as a military contractor. *Id.* at 12. He testified that Claimant met Criteria B, intrusive symptoms such as persistent nightmares, unwanted upsetting memories, flashbacks, and emotional distress. *Id.* at 12. However, Dr. Samuel did not explain which of these symptoms Claimant experienced. Additionally, Dr. Samuel testified that he did not use the word "flashback" in any of his reports. (CX 14 at 13) He testified that there was no history of exposure included in his reports. *Id.* at 13. He testified that Claimant met Criteria D, negative alterations of mood. *Id.* He testified that for Claimant, the most serious of these symptoms was being quick to anger. *Id.* Dr. Samuel testified that Criteria E included irritability, aggression, and difficulty sleeping. He prescribed Claimant Ambien to treat his sleeping concerns. *Id.* Dr. Samuel testified that Claimant met Criteria F as his symptoms had lasted for more than one month. *Id.* Dr. Samuel testified, "that DSM thing is good, but it's not everything." (CX 14 at 8)

Dr. Samuel had four tele-psychiatry meetings with Claimant. Dr. Samuel stated that PTSD requires direct exposure to the trauma and actual death or serious injury. However, Dr. Samuel stated he never asked Claimant about his exposure in Afghanistan. He stated he never asked Claimant about his occupational functioning in Afghanistan. Most importantly, Dr. Samuel stated his medical treatment notes never mentioned if Claimant had a reaction of fear, helplessness, or horror, which Dr. Samuel opined was a crucial element in diagnosing PTSD. He did not know that Claimant applied to jobs overseas after his contract with Employer ended. He did not explain how Claimant met the "intrusive symptoms" of Criteria B in the DSM IV, when he testified that Claimant did not report flashbacks or persistent nightmares. He did not explain his contradictory opinion that Claimant showed signs of moderate depression, and had "mild" major depressive disorder.

Based on the evidence in the record, Dr. Samuel's medical opinion that Claimant had major depressive disorder and post-traumatic stress disorder from working in Afghanistan is not well-documented and not well-reasoned. Dr. Samuel's opinion is not consistent with the DSM IV criteria. Dr. Samuel's opinion is not consistent with Claimant's medical history and treatment. Dr. Samuel's opinion is not consistent with the well-documented, well-reasoned, and thorough opinion of Dr. Spector. Dr. Samuel's opinion and diagnoses are not persuasive. Therefore, his medical opinion that Claimant had major depressive disorder and PTSD arising out of his employment in Afghanistan is entitled to little weight. Dr. Samuel's medical opinion that

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[23] Criteria A:

> The person has been exposed to a traumatic event in which both of the following were present:
>
> (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
>
> (2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

(Appendix E: DSM-IV-TR Criteria for Posttraumatic Stress Disorder)

Claimant's symptoms of anxiety and depression resolved through successful mental health treatment is consistent with his treatment notes and the medical record.

Dr. Spector provided a neuropsychological evaluation of Claimant on September 8, 2017. (EX F) Dr. Spector opined that Claimant's experiences in Afghanistan fell "well short of those imminent threats to life and limb typically associated with post-traumatic stress disorders." (EX F at 5) He opined that Claimant's performance on a standardized measure of post-traumatic stress disorder "revealed surprisingly few PTSD-related complaints." *Id.* He opined that Claimant had a mild affective disorder, which he characterized as "most likely a persistent depressive disorder with anxious arousal." *Id.* at 5.

Dr. Spector noted Claimant's medical history. Dr. Spector noted Claimant's work history from 2009-2013 in Afghanistan and his exposure to rocket attacks. Dr. Spector reviewed "[a]n array of objective testing" conducted by his associate. (EX F at 3) Dr. Spector performed all data analysis, and conducted a clinical interview, behavioral observations, and review of records. *Id.* He prepared a report of that evaluation on November 15, 2017. Dr. Spector concluded Claimant did not have PTSD. He did not complain of PTSD symptoms until after he returned to the United States and his first treatment was four years later in 2017. Dr. Spector opined Claimant did not meet the DSM criteria for PTSD such that it could not arise out of employment. Dr. Spector concluded Claimant's mild affective disorder was not related to his employment in Afghanistan, which ended four years earlier.

Dr. Spector opined that Claimant may have:

> warranted the diagnosis of a non-disabling stress reaction at various times in the course of his 4 year contract employment in Afghanistan. However, he never complained of PTSD symptoms nor sought treatment for them until well after his contract had ended and he had returned to the United States. His experiences in Afghanistan may well have been distressing, but are believed to have fallen well short of those imminent threats to life and limb typically associated with post-traumatic stress disorders. Performance on a standardized measure of post-traumatic stress revealed surprisingly few PTSD-related complaints.
>
> [Claimant] manifests symptoms of a mild affective disorder, most likely a persistent depressive disorder with anxious arousal. I do not believe that his current, mild psychiatric symptoms were caused by his contract work in Afghanistan, which ended more than four years ago.

*Id.* at 5.

Dr. Spector noted that Claimant denied hallucinations, delusions, paranoid ideations, ideas of reference, and suicidal and homicidal ideation. *Id.* at 3. Dr. Spector stated that psychological function testing included the MMPI-2 and the TSI-2. *Id.* at 4. Dr. Spector opined that Claimant "appeared to have exaggerated his psychiatric symptoms, presenting his condition in an improbably poor light." *Id.* at 4. He opined that Claimant's responses were "suggestive of modestly exaggerated complaints of cognitive and functional impairment." *Id.* In contrast, he

opined that "clinical scale elevations on the MMPI-2 and TSI-2 suggest that [Claimant] is experiencing minimal levels of emotional distress." *Id.* at 4. He opined that "there was scant objective evidence of a post-traumatic stress disorder at the time of the...evaluation." *Id.* at 5.

Dr. Spector testified at the hearing. Dr. Spector testified that Claimant left Afghanistan in 2013 when his position was terminated due to a drawdown in Afghanistan, and not due to injury or illness. *Id.* at 141. He testified that "the majority of Claimant's symptoms and complaints...did not manifest until 2017." *Id.* This was four years after Claimant left Afghanistan. He testified that the symptoms for post-traumatic stress disorder typically present soon after exposure to the traumatizing event. *Id.* at 143. He testified that only about 3% of cases present as "delayed post-traumatic stress which is when there is a period of six months or longer between the time of exposure to the stressful stimulus and the time of the stress-related complaints." *Id.* He testified that these cases are "exceedingly rare." *Id.* He further testified that the factors predisposing a person to delayed post-traumatic stress disorder were not present in this case. *Id.* Dr. Spector testified that these factors were advanced age, a later severe stressor that triggered the symptoms of the earlier stressor, and social isolation following subclinical or partial stress disorder in the intervening years. *Id.* at 144. Dr. Specter testified that Claimant did not meet the factors for delayed post-traumatic stress disorder. *Id.* at 157-158.

Dr. Spector testified regarding the factors needed to meet the criteria for PTSD. *Id.* at 154-155. Dr. Spector testified that of the twelve clinical scales that could have been elevated on the TSI, two were elevated for Claimant. One was not relevant to this claim; the other was intrusive ideation, such as flashbacks and nightmares. *Id.* at 154. He testified that "intrusive ideation is associated with PTSD. It's not the only – you need to have a lot more than that to meet criteria for PTSD." *Id.* at 154. He testified that other criteria needed for a PTSD diagnosis included anxious arousal and defensive avoidance, or avoidance of "the sorts of situations that would – to which the PTSD is attributed in the first place." (TR at 154) For example, the patient "would be pretty explicit that [he] didn't want to go back to where there were things exploding and people dying." *Id.* He testified that another criteria would be dissociation, and "[t]here was no report that he made either in interview or of course on this instrument to suggest that he was." *Id.* at 155. Dr. Spector testified that it would be difficult to hold down a job with dissociation, as there are often physical symptoms such as seizures, sleepwalking, and periods of absence. *Id.* at 155. Dr. Spector was asked whether Claimant's workout regimen factored into his opinion that Claimant did not meet the criteria. Dr. Spector testified that participation in fitness activities did not affect his opinion at all, opining, "You can have a mental illness and as part of your therapeutic regimen, throw yourself into fitness activities...[Claimant] appears to be into fitness activities and that's admiral [sic] and affects my opinion neither one way nor the other." *Id.* at 156-157.

Based on his review of the records from Dr. Samuel, Dr. Spector testified that Claimant had remained functional. *Id.* at 147. He testified that Claimant "presented as somewhat depressed, anxious and emotionally distraught," and that this was consistent with Dr. Samuel's identification and treatment of depression and anxiety. *Id.* at 152. Dr. Spector testified that he believed Claimant and did not find him to be underreporting or exaggerating his experiences. *Id.* at 147.

Dr. Spector testified Claimant underwent extensive objective testing. He testified that objective testing showed "somewhat of an exaggeration of cognitive and functional impairment," but "not enough to invalidate the process." *Id.* at 152-153. Dr. Spector testified that to diagnose post-traumatic stress disorder without using objective testing to measure cognitive, motivational, and emotional functions, one would be "flying a little blind." *Id.* at 148. He testified that especially when the symptoms were delayed by a significant period of time, "other things could be at play," such as life changes, family relationship changes, and a dramatic change in income. *Id.* at 149.

The hearing transcript included a statement from Dr. Spector that Claimant had post-traumatic stress disorder. (TR at 157-158) The remainder of the testimony, consistent with Dr. Spector's evaluation report, shows this was a misstatement or transcription error. At the hearing, Dr. Spector testified regarding Claimant's performance on the Trauma Symptoms Inventory, Second Edition (TSI). Dr. Spector testified that the TSI "is a multi-skill self-report instrument sensitive to the full range of PTSD related symptoms and complaints." (TR at 153) Dr. Spector testified that Claimant's performance on the TSI seemed to be an "honest and accurate appraisal of his symptoms." (TR at 153) During his testimony, Dr. Spector was interrupted by Employer's counsel while testifying as to what he considered in forming his medical opinion. The transcript shows that Dr. Spector stated that Claimant had post-traumatic stress disorder. However, the substance of the testimony in which Dr. Spector was quoted as saying Claimant had post-traumatic stress disorder was testimony in which Dr. Spector was enumerating all of the ways in which Claimant did <u>not</u> meet the criteria for post-traumatic stress disorder. In light of the remainder of Dr. Spector's testimony that Claimant did not meet the criteria for post-traumatic stress disorder, the undersigned finds that Dr. Spector's testimony and opinion is that Claimant did <u>not</u> have post-traumatic stress disorder. Based on the evidence in the record, the statement that he did have post-traumatic stress disorder was either a misstatement or a transcription error. Therefore, that statement is given no weight.

Dr. Spector testified that Claimant's psychological condition was not caused by his work in Afghanistan. *Id.* at 162. He testified that if Claimant's psychological symptoms were due to his work in Afghanistan, they would have surfaced sooner, been more severe, and "in their final form upon his arrival in the States and not years later barring other stressors that I'm not aware of." *Id.* at 164-165.

Dr. Spector is a Board-certified clinical neuropsychologist. He has extensive experience with post-traumatic stress disorder and head and brain injuries, including investigations of traumatic brain injuries for the U.S. Army. (TR at 136-137) He testified that he worked with post-traumatic stress disorder patients continuously since 1983. *Id.* at 137. His evaluation of Claimant included a clinical history, work history, review of treatment records, and objective testing. His report and testimony showed that he was familiar with Claimant's experiences and work in Afghanistan. Dr. Spector gave a well-reasoned, well-documented, and thorough neuropsychology opinion. He applied the elements of the DSM and TSI for PTSD to Claimant and explained how it applied to Claimant. Dr. Spector has impressive professional credentials and experience with PTSD patients. Dr. Spector's opinions are very persuasive as they are consistent with the credible treatment records in evidence. Accordingly, the undersigned finds that Dr. Spector's neuropsychology opinions are entitled to significant weight.

As discussed above, Dr. Samuel's medical opinion that Claimant has PTSD arising out of employment is entitled to little weight. He did not review any medical records other than his own reports. (CX 14 at 3) He did not know Claimant's job title in Afghanistan. (CX 14 at 4) He did not know that in May 2008, Claimant became a supervisor of over 100 employees. *Id.* His medical opinion was internally inconsistent as discussed above. Conversely, Dr. Spector's neuropsychology opinion was well-documented and well-reasoned. He provided a balanced and neutral opinion that was consistent with the treatment records. Dr. Spector opined that Claimant did not meet the criteria for post-traumatic stress disorder or delayed post-traumatic stress disorder. Dr. Spector opined that Claimant had a mild affective disorder, which he characterized as "most likely a persistent depressive disorder with anxious arousal." (EX F at 5) Dr. Spector opined that Claimant's psychological condition was not caused by his work or any exposure to a traumatic event as required for PTSD diagnosis, while working in Afghanistan. (TR at 162)

The records show that Claimant left Afghanistan in 2013 when his employment contract with Employer ended due to a drawdown in Afghanistan. Claimant did not report psychological symptoms until February 2017, four years later. While Claimant testified at the hearing that he experienced nightmares overseas, the medical record does not support this testimony. (TR at 93) He testified that he did not seek treatment for psychological symptoms while overseas, or while home on R&R during that time period. (TR at 93) The record does not show that Claimant complained of any psychological symptoms while in Afghanistan. Claimant successfully found a job several months after returning to the United States and at the time of the hearing, had worked that job continuously for four years. Dr. Samuel testified that if Claimant never missed a shift, this would be inconsistent with a severe psychological trauma. (CX 14 at 5) He testified that for Claimant to work four years uninterrupted for the same employer would be counterintuitive to a finding of severe psychological disability. (CX 14 at 3) He testified that he did not know that Claimant continued to seek overseas employment in war zones after his work with Employer ended. (TR at 82-83) He testified that this would be inconsistent with someone who had a continuing psychological disability. (CX 14 at 5) The medical opinion of Dr. Samuel regarding successful and continuing work for four years in the U.S. versus psychological impairment, and the opinion of Dr. Spector that Claimant did not meet the elements of PTSD, shows that Claimant has not met his burden to show that he has post-traumatic stress disorder arising out of his employment in Afghanistan.

Accordingly, the undersigned finds that Claimant has not established by a preponderance of the evidence that his mental health condition or post-traumatic stress disorder arose out of his employment in Afghanistan with the Employer.

**Respiratory Condition**

Claimant alleged that he suffered a respiratory injury arising out of his employment in Afghanistan. Claimant testified that he lived approximately a ten minute walk from burn pits in Kandahar. (TR at 51-52) Claimant testified that while in Afghanistan, he experienced shortness of breath. (TR at 63) He testified that he sought treatment approximately four or five times between 2009 and 2013 for respiratory issues. (TR at 71) No medical records were provided for this time period. He testified that he did not miss any work for these treatment visits while in Afghanistan. (TR at 80) Claimant testified that he did not have pulmonary problems or shortness

of breath prior to working in Afghanistan. (TR at 49) Claimant testified that there were dust storms while he was working in Afghanistan. (TR at 68) There is no opinion in the record linking dust storms in Afghanistan to Claimant's respiratory condition.

Claimant testified that he underwent two pulmonary function tests, and both had abnormal results. (TR at 100) He testified that no doctor has told him why those results were abnormal. *Id.*

Dr. Upshaw is an internist who treated Claimant from 2011-2016. (CX 1; EX R at 6-7) He testified that he was not a pulmonologist or a pulmonary specialist. (EX R at 7) Dr. Upshaw treated Claimant in June 2011; December 2011; July 2013; January 2014; February 2014; and May 2015. (EX R at 10-17) Dr. Upshaw testified that Claimant did not report lung or respiratory problems during any of those visits. *Id.* Dr. Upshaw treated Claimant in December 2015. *Id.* at 17. Dr. Upshaw testified that Claimant reported that he had been hospitalized in September for shortness of breath, and had a negative workup. *Id.* Dr. Upshaw examined Claimant and opined that the problem had resolved itself. (EX R at 19; CX 1 at 12) Dr. Upshaw treated Claimant in March 2016 for respiratory complaint. *Id.* at 20. Claimant had a clear chest x-ray and no indication of a foreign body pulmonary irritant. (EX R at 20-21) Dr. Upshaw prescribed antibiotics, cough syrup, and steroids. *Id.* at 20. Dr. Upshaw treated Claimant in May 2016 and opined that Claimant's lungs were clear upon examination. *Id.*at 23. At that visit, Dr. Upshaw assessed Claimant with "minimally symptomatic" asthma. *Id.* at 17.

Dr. Upshaw testified that Claimant came to see him on August 26, 2016. *Id.* at 23. He testified that Claimant was not asking for medical treatment; rather, he was asking about paperwork related to his legal case. *Id.*at 23. Dr. Upshaw testified that he wrote two letters for Claimant on August 26, 2016. One letter included a sentence about burning refuse in the area, and the other did not. *Id.* at 31. Dr. Upshaw testified that the information he mentioned regarding refuse burned in the area came from Claimant's statements. *Id.* at 32-33. In the August 26, 2016 letter, Dr. Upshaw stated Claimant developed asthma while in Afghanistan. (CX 1 at 21)

Dr. Upshaw testified that he did not know what job Claimant worked in Afghanistan. (EX R at 7) He stated that per Claimant's history, Claimant lived near an area where refuse was burned. He opined that per Claimant's history, Claimant's "respiratory symptoms could very well be related to these less than sanitary conditions." *Id.*

Dr. Upshaw testified that he never reviewed records from pulmonologist Dr. Bhar or pulmonologist Dr. DeMarini. *Id.* at 40. Dr. Upshaw did not explain the reasoning for his opinion that Claimant's respiratory complaints could be due to the burn pits overseas. He did not recall reading any documents about this refuse. *Id.* at 32-33. His treatment records show very limited respiratory findings and very limited complaints by Claimant. His testimony supports that he wrote a letter linking Claimant's asthma to burn pits upon Claimant's request, as a "favor" to Claimant, rather than based on any objective findings, medical treatment records, or medical or scientific literature. (CX 1 at 34) More importantly, Dr. Upshaw wrote two different letters – one mentioned the burn pits and one did not. As a result, Dr. Upshaw's opinions regarding diagnosis and causation are not persuasive. Dr. Upshaw's opinions regarding causation are not well-documented, not well-reasoned, and not persuasive. Therefore, Dr. Upshaw's medical opinion

that Claimant's respiratory impairment "could very well be related" to employment in Afghanistan is equivocal and is entitled to very little weight.

Dr. Bhar is a pulmonologist who treated Claimant for shortness of breath in 2017. (CX 12, 13) On February 14, 2017, Claimant reported that he had a one year history of cough and shortness of breath. (CX 13 at 2) Claimant reported to Dr. Bhar that he had "significant exposure to aerosol" and "exposure to a burning pit in Afghanistan." (CX 13 at 2, 9) Claimant's lungs were clear upon physical examination on February 14, 2017 and April 11, 2017. (CX 13 at 3, 10) On April 11, 2017, Dr. Bhar opined, "He had a pulmonary function test then a visit with a pulmonary specialist who felt based on his results and his exposure may have constrictive bronchiolitis." (CX 13 at 9)

Dr. Bhar assessed bronchiolitis obliterans. On April 24, 2017, Dr. Bhar wrote a letter opining that per Claimant's history, Claimant had been exposed to fumes and other substances overseas "which may have triggered his bronchospastic lungs." *Id.* at 15. He stated that per Claimant's history, Claimant had been prescribed Azithromycin by a physician overseas on suspicion of constrictive bronchiolitis (CB), and had responded well to therapy. Dr. Bhar stated, "Though CB requires tissue diagnosis, through his history, I am reasonably confident that he may have had CB." *Id.* at 15. [Dr. Bhar later amended his diagnosis to possible gastroesophageal reflux and exercise-induced asthma.]

On August 29, 2017, Dr. Bhar noted that a second pulmonology opinion recommended Claimant be evaluated for gastroesophageal reflux disease. *Id.* at 18. Dr. Bhar opined that he had prescribed Azithromycin as it had worked previously, but Claimant was not responding to it this time. He opined, "Due to the lack of response to Azithromycin, I doubt this is bronchiolitis obliterans." *Id.* He opined that Claimant's symptoms could be due to gastroesophageal disease or exercise-induced asthma. *Id.*

On November 9, 2017, Dr. Bhar stated that Claimant's shortness of breath was "initially thought to be due to bronchiolitis obliterans however he did not respond to therapy with Azithromycin...." (CX 12 at 1) Upon physical examination, Claimant's lungs were clear. Dr. Bhar made "a presumptive diagnosis of asthma." *Id.* at 2.

Dr. Bhar reviewed medical records and examined Claimant over the course of a year. During that treatment, he modified his medical opinion from constrictive bronchiolitis to gastroesophageal reflux disease and exercise-induced asthma. His initial medical opinion diagnosing constrictive bronchiolitis is entitled to little weight as he later changed his opinion upon further evaluation of Claimant, and constrictive bronchiolitis is not consistent with the credible medical opinion of Dr. DeMarini. On November 9, 2017, Dr. Bhar noted Claimant's physical fitness regimen and that he participated in Crossfit, could run a mile in seven minutes, and worked out at the gym. Dr. Bhar's medical opinion regarding possible gastroesophageal reflux and exercise-induced asthma is not well- documented and not well-reasoned. It is entitled to little weight as it is not consistent with the credible medical opinion of Dr. DeMarini that Claimant suffered from aspiration syndrome, which did not arise out of employment.

Dr. Deal is a gastroenterologist. Claimant was referred to Dr. Deal to rule out reflux as the cause of his shortness of breath. (EX Q at 4) Dr. Deal examined Claimant in November 2017 and January 2019. (EX Q) In January 2019, Dr. Deal ordered a series of upper gastrointestinal x-rays. The x-rays showed no abnormal intra-abdominal calcifications; no hiatal hernia; normal motility of the esophagus without focal structures; mild increase of the gastric folds in the fundal region, "hypertrophic gastritis is not excluded;" and trace gastroesophageal reflux with maneuvers. (EX Q at 28) Dr. Deal provided no diagnosis such that his treatment notes have little value and are given no weight.

Dr. DeMarini is a pulmonologist. He examined Claimant on May 26, 2017, and wrote a report of his findings with an addendum dated June 9, 2017. (EX G) He reviewed Claimant's medical records and performed a physical examination. He opined that based on his review of records and the history provided by Claimant, Claimant had gastroesophageal reflux and aspiration syndrome which did not arise out of employment. Per Claimant's history, he had "probable occupational exposures during his time in Afghanistan" to a burn pit, a welding area, and sewage. (EX G at 1) Dr. DeMarini opined, "How this relates to his current symptoms is unclear, and it will require additional workup to sort out what is causing his symptoms and how they relate to the alleged exposures." (EX G at 4) He opined that Claimant could have obstructive blockage in his airway, or he could have "developed severe asthmatic spasm due to respiratory exposures." *Id.* Dr. DeMarini ordered a chest x-ray and a pulmonary function test. He recommended that Claimant undergo an upper gastrointestinal evaluation to determine "whether reflux was a contributing factor or the controlling factor in this patient's symptoms." *Id.* He opined that if the upper gastrointestinal evaluation was unremarkable, Claimant should have an Ear, Nose, and Throat evaluation, and a course of steroids could be worthwhile. *Id.*

Dr. DeMarini testified that Claimant's respiratory condition is not related to chemical exposure because of the later timing of his symptoms.

> Q: Well, I want you to assume, Doctor, that he was seen in the ER in September 2015 for shortness of breath, and I want you to further assume that that is the first real instance that's documented in this case of a severe shortness of breath. Does that have an effect on your opinion, just based on the history of when he was exposed, when he stopped being exposed, and when the shortness of breath came on?
>
> A: Well, it clearly dovetails with my opinion, that the source of his respiratory complaint is gastroesophageal reflux with an aspiration syndrome, and –
>
> Q: As opposed to exposure overseas.
>
> A: Yes. I think the point you're asking about is, does somebody who gets chemical exposure develop problems at that time as opposed to later, and the answer is almost always yes. It's during the acute phase that they usually have a problem. That isn't to say they won't have problems later. It's just that it comes on during the time of exposure, or shortly thereafter: hours, or days.
>
> ...

Q: And not to put too fine a point on it, but is it your professional opinion, within a reasonable degree of medical certainty, that it's normally the case that your symptoms – your pulmonary symptoms that result from an exposure of the type complained of by [Claimant], would more likely than not manifest themselves closer to the time of the exposure, than two years after?

A: I believe that that's a restatement of what I said just a question or two ago. I would expect, if he was having respiratory symptoms, they would have developed at or around the time of the exposure, and not months or years later.

*Id.* at 12-14.

On December 14, 2018, Dr. DeMarini testified that "the source of [Claimant's] respiratory complaint was gastroesophageal reflux with an aspiration syndrome," rather than overseas exposure to irritants. (EX P at 13)

Dr. DeMarini testified that he considered Claimant had an aspiration syndrome when Claimant told him at the evaluation that he had just run fifteen miles. (EX P at 14) Dr. DeMarini testified that while the ability to run fifteen miles was not consistent with asthma or constructive airway disease, patients with aspiration syndrome can "frequently run through" their intermittent shortness of breath episodes. *Id.* at 15. He testified that Claimant had a normal chest x-ray which was not consistent with asthmatic spasm and restrictive process. *Id.* at 15. He testified that physical examination was essentially normal.

Dr. DeMarini testified that Claimant's lungs were clear upon examination.

Q: If someone was exposed in the way that [Claimant] alleges to have been exposed, and had an issue – a pulmonary issue, as a result of that exposure, would you have expected to have had uniformly clear chest exams?

A: No.

Q: Why not?

A: Well, you would hear the obstruction of the airflow. It's generally described as wheezing, or whistling in the lungs, and he just didn't have that.

*Id.* at 20.

Dr. DeMarini opined that the pulmonary function test findings were "very abnormal" and were consistent with an aspiration syndrome. *Id.* at 18. He opined that aspiration syndrome spasms can "look just like asthma." He testified that Claimant's spirometry records varied between normal and "wildly abnormal... and one would not expect that in asthma." *Id.*

Dr. DeMarini opined that if Claimant had a respiratory illness as a result of chemical exposure in Afghanistan, he would not have been expected to have a normal pulmonary function test in

March 2017 and then an abnormal test in May 2017. Restriction of the lung caused by chemical exposure does not come and go. *Id.* at 34. Dr. DeMarini noted that the records showed that Claimant had significant improvement with Azithromycin, which was an antibiotic, and should not have cleared up a chemically-related exposure problem. *Id.* at 36. He testified that Claimant's "significant response to bronchodilator" was consistent with aspiration syndrome but "does not speak to the cause of that reversible airway disease." *Id.* at 37.

Dr. DeMarini reviewed records from Claimant's treating and examining physicians. Dr. DeMarini was asked about Dr. Deal's evaluation.

> Q: Doctor, is there any indication that reflux was ruled out by this doctor?
> A: No.

*Id.* at 25.

Dr. DeMarini opined that gastroenterologists generally do not know about the relationship between reflux and aspiration syndrome. *Id.* at 24-25. Dr. DeMarini testified that Dr. Kamean recommended further testing to evaluate "potential silent reflux" which could cause bronchospasm and airway disease, but this testing was never performed. *Id.* at 27. Dr. DeMarini opined that he "completely disagree[d]" with Dr. Bhar's original April 24, 2017 medical opinion that Claimant may have constrictive bronchiolitis. *Id.* at 38. [Dr. Bhar later modified his diagnosis to <u>possible</u> reflux and exercise induced asthma.] Dr. DeMarini explained his disagreement, opining that constrictive bronchiolitis usually shows up on pulmonary function tests and chest x-rays. Reversible intermittent attacks of shortness of breath such as Claimant experienced were not consistent with restrictive bronchiolitis. *Id.* at 37. He also opined that Dr. Bhar's opinion that Claimant "responded appropriately" to the antibiotic Azithromycin did not make sense, because the antibiotic was not a treatment for constrictive bronchiolitis. *Id.* at 39.

Dr. DeMarini testified that Dr. Bhar's later August 29, 2017 treatment note recommending evaluation for gastroesophageal reflux disease "is entirely consistent with what I believe he has." *Id.* at 45.

> Q: And this is the chart note that preceded – well, this is the same date of service of the chart note of Dr. Bhar, that walks back the obliterans diagnosis.
> A: Yes.

*Id.* at 45.

Dr. DeMarini reviewed records from the time period that Claimant worked in Afghanistan. He opined that these records did not show any pulmonary problems, other than a few episodes of respiratory tract infection or common cold. *Id.* at 74.

He testified that Claimant's symptoms and the timeline of his symptoms were "much more consistent with gastroesophageal reflux with aspiration syndrome." *Id.* at 62. Dr. DeMarini testified:

> I do not believe that he has asthma. I do believe that he has an aspiration syndrome with bronchospasm that causes cough, wheezing, and shortness of breath. And even if he does have asthma, I don't believe that has any relationship to his exposures outside of the country, or his employment, as best I can determine.

*Id.* at 63.

Dr. DeMarini testified that if it was true that Claimant never sought respiratory treatment in Afghanistan, then it was "medically overwhelmingly unlikely that an occupational exposure in Afghanistan caused his current symptoms." *Id.* at 67.

Dr. DeMarini noted that Claimant had a parental history of asthma. *Id.* at 63. He testified that when a person's parents had asthma, the onset for the child tended to be in childhood. In two-thirds of patients, it went away after high school and then tended to return in the person's thirties or forties. *Id.* at 65. He testified, "So it's hard for me to tie that hypothesis into an occupational exposure in Afghanistan." *Id.* at 65.

Dr. DeMarini opined, "I do believe that he has an aspiration syndrome with bronchospasm that causes cough, wheezing, and shortness of breath." *Id.* at 63.

Dr. DeMarini conducted a thorough and comprehensive evaluation of Claimant's pulmonary condition. He was familiar with Claimant's relevant medical records and medical opinions from other treating and examining physicians. He ordered and recommended a course of investigative and diagnostic testing to confirm the gastroesophageal reflux diagnosis. His medical opinion was well-documented, well-reasoned, and persuasive. Therefore, it is entitled to significant weight.

Dr. Kamean evaluated Claimant for shortness of breath. (EX J) He performed a physical examination. He opined that, "There was not a finding of hard core scientific results leading to asthma." (EX J at 2) He opined, "At this point, it does not appear that we have any answers to why this is going on." *Id.* at 2. He opined, "At this point I think that he has no symptoms, my suggestion would be to do an upper endoscopy with BRAVO placement." *Id.* at 2. He stated that, "This would give us scientific information as to whether or not reflux was just an imitation." *Id.*

Dr. Kamean's opinion that Claimant does not have asthma but may have reflux is consistent with Dr. Bhar and Dr. DeMarini. Dr. Kamean's opinion is given significant weight.

There is no medical evidence in the record that Claimant received treatment during his time in Afghanistan from 2009 to 2013 for a pulmonary condition, other a few visits for cold or respiratory infection. He did not report respiratory complaints to his treating physician, Dr. Upshaw, until December 4, 2015, other than a March 27, 2013 complaint of cough. Dr. Upshaw did not relate these complaints to Claimant's work in Afghanistan until Claimant asked him to write a letter on August 26, 2016 which was contradicted by a second letter. Dr. Upshaw is an internist, not a pulmonologist. For the reasons discussed above, his medical opinion is entitled to little weight. Dr. DeMarini is a pulmonologist and provided a well-reasoned, well-documented,

and persuasive medical opinion that Claimant had gastroesophageal disease with an aspiration syndrome, and that Claimant's respiratory condition was not caused or contributed to by his work in Afghanistan. Dr. DeMarini's medical opinion that Claimant had gastroesophageal reflux was supported by the other medical evidence in the record. Dr. Bhar's medical opinion of constrictive bronchiolitis, while entitled to less weight, later evolved to gastroesophageal reflux which was consistent with Dr. DeMarini's diagnosis.

**Claimant's Credibility Regarding Physical Fitness**

The ALJ has "the discretion to evaluate the credibility of a claimant and to arrive at an independent judgment, in light of medical findings and other evidence." Pietunti v. Dir., OWCP, 119 F.3d 1035, 1042 (2d Cir. 1997)(citations omitted).

On February 6, 2014, Claimant report to Dr. Upshaw that he continued to "exercise regularly and without difficulty." (EX M at 1) On May 6, 2016, Claimant told his primary care physician, Dr. Upshaw, that he exercised "regularly and without difficulty." (CX 1 at 16) On April 11, 2017, Claimant told his treating pulmonologist Dr. Bhar that he ran a seven minute mile. (CX 13 at 9) On May 26, 2017, Claimant told examining physician Dr. DeMarini that "[h]e continues to workout and exercise, having just run 15 miles this morning after using his inhaler." (EX G at 1) At the hearing, Claimant was asked about his May 6, 2016 statement to Dr. Upshaw that he exercised regularly and without difficulty. Claimant testified, "[e]xercising could be walking...You mean exercising? You mean walking? I mean, exercising could be yoga, could be -- ...it could be anything." *Id.* at 110. Claimant testified he last did Crossfit in 2013 or 2014. (TR at 95) However, Dr. Bhar noted during his November 9, 2017 examination that "[h]e does Crossfit." (CX 12 at 1) The undersigned finds that Claimant's testimony is not persuasive, as his statements regarding his ability to exercise, the nature of his exercise, and the timing of his exercise, were not consistent.

**Evidence Conclusion**

The court analyzed and weighed the VA Air Sampling records above and afforded it little weight. It will not be addressed again here.

Based on the medical evidence and the testimony discussed, analyzed, and weighed above, and weighing the evidence as a whole, Claimant has not submitted the necessary evidence to show that his alleged PTSD and psychological condition or alleged respiratory condition arose out of employment with Employer.[24]

## II. Claimant is Not Entitled to Section 7 Medical Benefits

Based on the evidence in the record, Claimant did not establish that his alleged PTSD and psychological injury and alleged respiratory injury arose out of his employment with Employer in Afghanistan. Claimant must establish that the medical expenses are for treatment for a

[24] While timeliness was an issue raised in this claim, that issue is not addressed at this time. The court finds that the claimed injuries did not arise out of employment.

compensable work injury. Pardee v. Army & Air Force Exchange Service, 13 BRBS 1130 (1981). Accordingly, Claimant is not entitled to medical benefits under Section 7 of the Act.

## CONCLUSION

Claimant met the Section 20(a) presumption that a harm occurred and that working conditions existed that could have caused or contributed to the harm. Employer presented substantial evidence to rebut this presumption. Once the presumption is rebutted, it falls from the case and the evidence must be weighed as a whole. Based on the persuasive evidence in the record and weighing the evidence as a whole, the preponderance of the evidence is that Claimant has not submitted sufficient evidence that post-traumatic stress disorder or a respiratory condition arose out of his employment in Afghanistan with Employer.

While he suffers from personal health conditions, the evidence as a whole does not support they arose out of employment.

## ORDER

It is hereby **ORDERED** that the claim for post-traumatic stress disorder and respiratory injury arising out of employment is **DENIED.**

**SO ORDERED.**

Digitally signed by Dana A. Rosen
DN: CN=Dana A. Rosen, OU=Administrative Law Judge, O=US DOL Office of Administrative Law Judges, L=Newport News, S=VA, C=US
Location: Newport News VA

DANA ROSEN
Administrative Law Judge

DR/SCS/mjw
Newport News, Virginia