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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 16-3564

JOAN A. GERHARDSON, APPELLANT,

V.

DAVID J. SHULKIN, M.D.,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before TOTH, *Judge*.

MEMORANDUM DECISION

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

TOTH, *Judge*: The veteran, Roger Gerhardson, served in the Navy from 1956 to 1959 as a machinist mate in the submarine service. He was diagnosed more than fifty years later with chronic obstructive pulmonary disease (COPD). He died in 2011, but before he passed away, he filed a claim asserting that his recurrent pneumonia and COPD were the result of either two bouts of pneumonia he experienced during service or his exposure to asbestos. His wife, Joan Gerhardson, was permitted to substitute for him in his claim. According to the Board, no medical evidence linked his current respiratory disabilities to service; in fact, there was significant evidence to the contrary. For the reasons below, the Court will affirm the Board's decision.

I. FACTS

Mr. Gerhardson was treated twice for pneumonia during service, and VA conceded that his occupational specialty at that time warranted a presumption of asbestos exposure. Upon separation from the Navy, he received an examination, which included a chest x-ray that showed no abnormalities. His wife claims that he suffered from pneumonia two to four times per year since service. Per his private medical records, he was diagnosed with, and began receiving treatment for, COPD around 2007. He filed a claim for a lung condition in 2010 and underwent a VA examination

the following year where he was diagnosed with end-stage COPD. The VA examiner opined that there was no evidence of asbestos lung disease, nor was there any scientific data to support a finding of causation between his in-service pneumonia and his current COPD. Rather, in her opinion, his COPD was most likely due to his fifty-plus years of pack-a-day smoking.

When VA eventually denied his claim, he challenged the ruling because he disagreed with how his smoking habit was characterized and the fact that the opinion was not rendered by a pulmonologist. As the Secretary points out, his medical records are rife with references to his history of smoking.

Mr. Gerhardson died in 2011 before he had a chance to appear before the Board, but Mrs. Gerhardson was substituted as the claimant and testified in his place. She added an amended death certificate to the record, which reflected pneumonia as a contributing factor in addition to the COPD. She also argued during the hearing that the examiner failed to address the contention that his recurrent pneumonia since service was a service-connected condition.

In 2014, the Board found that the 2011 examiner spoke to the cause of Mr. Gerhardson's COPD, but did not offer an opinion as to whether his recurrent pneumonia was related to his in-service bouts of pneumonia. For this reason, the Board determined that an addendum opinion was needed. Mrs. Gerhardson contends that she has consistently argued that an opinion from a pulmonologist was necessary. The Board did not mention any shortcomings in the 2011 examiner's expertise, but on remand it instructed VA to procure an opinion from a pulmonologist as to the likely etiology of his respiratory disorder. Aside from that, the Board merely stated that one of the issues was not addressed and, as such, an addendum opinion was necessary. The examiner was required to both consider Mr. Gerhardson's assertion that he suffered from pneumonia two to four times per year since service and assume that he was exposed to asbestos during service.

Two addendum opinions were ultimately obtained—one in July 2014 from a physician who is board certified in occupational medicine (OM doctor),[1] and the other from a pulmonologist in August 2014. The Board summarized the OM doctor's opinion as follows:

[1] Occupational Medicine is a specialty practice focused "on the health of workers, including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field address the promotion of health in the workplace, and the prevention and management of occupational and environmental injury, illness, and disability." AMERICAN BOARD OF PREVENTIVE MEDICINE, OCCUPATIONAL MEDICINE, https://www.theabpm.org/become-certified/specialties/-occupational-medicine/ (last visited Feb. 19, 2018).

> Rather than due to service, . . . the recurrent pneumonia was due to tobacco abuse, as smoking tobacco was one of the primary events resulting in impairment of pulmonary defense and increased risk of pneumonia. The Veteran had a weakened immune system due to tobacco abuse that made it easier for bacteria to grow in his lungs. . . . The in-service pneumonia episodes were also more likely than not associated with smoking and the recurrent post-service pneumonia was due to the Veteran's COPD, caused by tobacco abuse.

R. at 9. As to asbestos exposure, the Board noted the OM doctor's opinion that Mr. Gerhardson's pneumonia was not caused or aggravated by such exposure, as asbestosis is a *restrictive* lung disorder and his problems were related to *obstructive* lung disease.

The Board also reviewed the pulmonologist's opinion, which concluded that there was no reasonable doubt that COPD was principally responsible for Mr. Gerhardson's severe disability, or that smoking was the principal cause of such disability. The examiner said that "the scientific evidence linking cigarette smoking to the development of emphysema and COPD was overwhelming, and other factors, such as recurrent respiratory infections, at most would play only a minor role." R. at 10. The examiner also conveyed that asbestos exposure did not cause his disability.

The Board, however, found that the pulmonologist failed to adequately address the questions on appeal and his opinion was entitled to limited probative value. It acknowledged that the remand order called specifically for a pulmonologist, but still found that there was substantial compliance with the remand order in light of the OM doctor's well-reasoned opinion and "obvious expertise." R. at 7. The Board again denied his claim in a 2016 decision, which is appealed here.

II. ANALYSIS

A. Compliance with Remand

Mrs. Gerhardson presents several arguments, all of which center on the adequacy of the medical opinions relied upon by the Board. She begins by alleging that the Board failed to ensure compliance with the prior remand order. In 2014, the Board issued a remand order finding that an addendum opinion was needed to address the additional question of whether his "post-service episodes of pneumonia were either related to his in-service pneumonia or to his exposure to asbestos during service." R. at 32. Mrs. Gerhardson acknowledges that VA procured such an opinion in August 2014, but she argues that because the Board did not rely on the pulmonologist's opinion, the remand order went unfulfilled. She alleges error because a pulmonologist's opinion

was critical to navigate the interplay of numerous in-service and post-service exposures and respiratory ailments.

The Board errs if it fails to ensure compliance, so the question is whether the medical opinions obtained substantially complied with the remand order. *Mathews v. McDonald*, 28 Vet.App. 309, 315 (2016). "As with any finding on a material issue . . the Board must support its substantial compliance determination with an adequate statement of reasons and bases that enables the claimant to understand the precise basis for that finding and facilitates review in this Court." *Id*. Of course, this determination is subject to review for prejudice. *Id*. at 316; 38 U.S.C. § 7162(b)(2).

The Board specifically addressed the issue of substantial compliance, but it did so in a summary manner. Without saying more, the Board concluded that the pulmonologist did not adequately discuss all the issues on appeal. Alternatively, it found that the OM doctor's opinion was of substantial probative value. It recognized that the physician was board certified in occupational medicine and not a pulmonologist, but still chose to rely on it because it was well-reasoned and was delivered by someone with obvious expertise.

Mrs. Gerhardson says there is no evidence that the examiner had the relevant expertise to address lung disorders and so could not have served as a substitute for a pulmonologist. Although she challenges the Board's decision to classify the examiner as an expert, she offers no argument to rebut that determination. She points to no evidence that suggests a board-certified physician in occupational medicine (one who focuses on health outcomes of environmental exposures) is unqualified to opine on, for example, whether his respiratory disorder was related to his exposure to asbestos during service—a question specifically put to the examiner on remand. She merely says that the Board did not justify its substantial compliance finding with a discussion related to the nature and extent of the OM doctor's expertise. Her argument really boils down to an alleged reasons and bases error, which banks on whether the Board explained its decision to not rely strictly on a pulmonologist in a way that facilitates review. *Id*. at 315.

The Court finds that the limited discussion on this point frustrated review, which renders the Board's reasons and bases insufficient. *See Mathews*, 28 Vet.App. at 315 (finding error in the Board's failure to explain why one oncologist's opinion was sufficient after previously determining on remand that a panel of three oncologists was required in light of the medical complexity involved).

However, Mrs. Gerhardson has equally failed to demonstrate any resulting prejudice. The Board concluded that the OM doctor's opinion was of significant probative value based on the quality of the opinion itself, as well as her "obvious expertise." It provided additional reasons as well. Although the pulmonologist's opinion was of limited probative value because it did not fully address the issues on appeal, that expert's findings still played a role in the Board's decision to rely on the OM doctor's opinion. There is nothing out of bounds here because, even if the pulmonologist's medical opinion was inadequate to decide the claim, "it does not necessarily follow that the opinion is entitled to absolutely no probative weight." *Monzingo v. Shinseki*, 26 Vet.App. 97, 107 (2012). An inadequate opinion can still be useful, as it was here where the Board stated that the pulmonologist's conclusions, although incomplete, nonetheless support wholly the conclusions in the OM doctor's report.

The pulmonologist laid essentially the same foundation for the OM doctor's conclusion—that Mr. Gerhardson's recurrent pneumonia was due to COPD, not his in-service bouts of pneumonia. The pulmonologist said smoking caused his COPD, and his COPD caused his severe disability. The OM doctor said his smoking caused his COPD, and his COPD caused his recurrent pneumonia. When this information is coupled with the nature and detail of the OM doctor's opinion, where she easily dissected the interplay of numerous potential causes, the Court finds that Mrs. Gerhardson fails to demonstrate prejudicial error in the Board's reasons and bases for finding that the opinion substantially complied with the remand order.

B. Other Adequacy Arguments

Mrs. Gerhardson also makes other arguments regarding the adequacy of the medical opinions, none of which is persuasive. A medical opinion is adequate if it sufficiently informs the Board of the examiner's judgment on a medical question and the essential rationale for that conclusion. *Monzingo*, 26 Vet.App. at 105. It must be based on the veteran's medical history and describe the disability in sufficient detail so that the Board's decision will be fully informed. *Id*. at 106. She says neither examiner considered the fact that Mr. Gerhardson quit smoking intermittently throughout his life, and thus the opinions were based on an inaccurate factual premise. An inaccurate factual premise can undermine a medical opinion, *see id*. at 107, but she does not develop this argument in any way that would suggest that this is more than an attempt to downplay the amount of cigarettes Mr. Gerhardson smoked over the years. Put another way, she demonstrates no prejudice, even if she is correct.

She next suggests that the examiners provided no rationale for their opinions, and they did not consider relevant lay statements as to his recurrent bouts of pneumonia since service. A plain reading of the Board's decision dispenses with both of these claims. The Board noted that the July opinion's "rationale was that the post-service recurrent pneumonia and COPD were due to tobacco abuse, as smoking tobacco was one of the primary events resulting in impairment of pulmonary defense and increased risk of pneumonia." R. at 11. Similarly, the August opinion's "rationale was that the scientific evidence linking cigarette smoking to the development of emphysema and COPD was overwhelming and other factors, such as recurrent respiratory infections, at most would play only a minor role." R. at 10. The rationales are clearly identified and they also expose the fact that his statements about recurrent bouts of pneumonia were not only considered but accepted as true.

Finally, citing *El Amin v. Shinseki*, 26 Vet.App. 136 (2013), Mrs. Gerhardson suggests that the medical opinions are inadequate because the examiners did not consider secondary service connection as a theory under which she might prevail. The Court's best interpretation of this argument is that the examiners did not consider the possibility that Mr. Gerhardson's in-service pneumonia led to service-connected recurrent pneumonia, which in turn contributed to non-service-connected COPD. Secondary service connection is precluded in this case, though, because it is only appropriate where the condition results from, or is aggravated by, a service-connected disability, which he did not have. *See* 38 C.F.R. § 3.310 (2017).

Mrs. Gerhardson closes with an assertion that the Board's reasons and bases were inadequate. As demonstrated above, the Court was able to identify the precise basis for the Board's decision—Mr. Gerhardson's conditions were more likely caused by a lifetime of smoking than any in-service pneumonia or exposure to asbestos.

III. CONCLUSION

For the reasons above, the July 7, 2016, Board decision is AFFIRMED.

DATED: March 9, 2018

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