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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 17-2827

CARLTON L. DOOLEY, APPELLANT,

V.

ROBERT L. WILKIE,
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*: Veteran Carlton L. Dooley appeals a July 2017 Board decision that denied disability compensation for a respiratory disability other than recurrent pneumonia, for which he is already service connected. He argues that the Board did not properly apply the presumption of soundness in this case—specifically the requirement that the absence of aggravation of a preexisting condition during service be shown by "clear and unmistakable evidence"—and failed to explain its reasons for finding a negative VA opinion adequate. Because the Board erred in this regard, and because there's no indication that these errors were harmless, the Board decision is vacated and the matter remanded for further proceedings.

I. BACKGROUND

Mr. Dooley entered the Army in June 1971. His entrance examination did not note any respiratory problems. From mid-July to the end of August 1971, however, he was hospitalized after a week of "wheezing and rattling in his chest." R. at 717. "The patient was felt to have an acute exacerbation of his bronchial asthma and a pneumonia of the lingular lobe of the lung." R. at 719. His diagnoses upon clinical discharge were bronchial asthma and bronchiectasis—both

having existed prior to service—and acute left upper lobe pneumonia, which had resolved.[1] Two weeks later, he was found medically unfit for further duty and separated from military service. His separation examination noted that he might continue to have "significant bronchiectasis" in the upper lobe of his left lung that "could be a trigger for repeated pneumonic episodes in the patient's asthma." R. at 762.

In 2007, the veteran sought service connection for respiratory conditions. In the five years preceding this application, he experienced wheezing, shortness of breath, coughing, and painful respiration. A 2008 VA examiner found evidence of rhonchi, wheezing, and shortness of breath on exertion but did not offer an etiological opinion for these problems. The regional office denied service connection for pneumonia, bronchial asthma, and bronchiectasis; Mr. Dooley initiated an appeal to the Board.

In 2012, the Board issued the first of many remand orders to obtain medical evidence it deemed necessary. In the 2012 remand, the Board requested a medical opinion as to the identity of the veteran's current respiratory disabilities and whether any was caused or aggravated by service. An examiner in August of that year diagnosed recurrent pneumonia and, although finding that it preexisted service, opined that the condition increased in disability during service. The examiner also diagnosed bronchiectasis, but stated that it preexisted service and was less likely than not aggravated by service. Based on this opinion, the Board granted service connection for recurrent pneumonia. But it remanded the service-connection claim for a respiratory disability other than pneumonia because the examiner didn't specify whether an absence of aggravation was shown by clear and unmistakable evidence. The Board rejected as inadequate two additional opinions for lack of supporting rationale and factual errors. One opinion did, however, add "bilateral parenchymal disease" to the list of the veteran's current disabilities.[2]

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[1] "Bronchiectasis is a disease in which the large airways in the lungs are damaged. This causes the airways to become permanently wider." *Bronchiectasis*, NAT'L INSTS. OF HEALTH, MEDLINEPLUS MEDICAL ENCYCLOPEDIA, https://medlineplus.gov/ency/article/000144.htm.

[2] The record is not entirely clear, but this appears to be a reference to "diffuse parenchymal lung disease," also called "interstitial lung disease," a lung condition where "the repair process goes awry and the tissue around the air sacs (alveoli) becomes scarred and thickened," making it "more difficult for oxygen to pass into the bloodstream." *Interstitial lung disease*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/interstitial-lung-disease/symptoms-causes/syc-20353108; *see also Diffuse Parenchymal Lung Diseases (Interstitial Lung Diseases)*, ALBANY MED. COLL., https://www.amc.edu/patient/services/pulmonary_medicine/interstitial_lung_disease.cfm ("The term 'interstitial lung diseases' has been replaced by the term 'diffuse parenchymal lung diseases' . . . .").

A 2017 VA opinion undergirds all the Board's determinations in this case. That examiner was asked to address (a) whether parenchymal disease was at least as likely as not caused or aggravated by service or service-connected pneumonia; (b) whether bronchial asthma and bronchiectasis clearly and unmistakably existed prior to service; (c) if the answer to question (b) was yes, whether it was "medically undebatable"[3] that these conditions were not aggravated by service; (d) if the answer to question (b) was no, whether it's at least as likely as not that these conditions had their onset during, or were related to, service; and (e) whether it's at least as likely as not that these conditions were caused or aggravated by service-connected pneumonia. In response, the examiner answered question (a) in the negative and question (b) in the affirmative. As to question (c), the examiner concluded that it was medically undebatable that bronchial asthma and bronchiectasis were not aggravated by service because there were "no findings . . . [of] an increase in disability during service and no findings of increased disability due to the natural progression of the pre-existing condition." R. at 27. She continued: "No medical records [were] available for examiner's review until 2003 and chest x-ray show early [chronic obstructive pulmonary disease]. Veteran secured and maintained gainful employment until 2007." *Id*. Question (d) was not applicable in light of the preexistence determination. And for question (e), the examiner wrote: "Same as a., b., c." *Id*. Before concluding, she also volunteered her opinion that pneumonia preexisted service and was not aggravated by it.

These matters returned to the Board, which issued the decision on appeal, denying service connection for a respiratory disability (i.e., bronchial asthma, bronchiectasis, and bilateral parenchymal disease) other than recurrent pneumonia. Determining that the 2017 opinion was adequate to decide the claim, the Board concluded that bronchial asthma and bronchiectasis preexisted and were not aggravated by service and that neither these disabilities nor parenchymal disease were incurred in or aggravated by service or service-connected pneumonia. This appeal followed.

II. ANALYISIS

Mr. Dooley contends that the Board legally erred by failing to determine whether bronchial asthma and bronchiectasis were aggravated by service based on the "clear and unmistakable

[3] Since Mr. Dooley doesn't raise the issue, the Court presumes that the "medically undebatable" standard is synonymous with the "clear and unmistakable" standard.

evidence" standard required by law. He further argues that the Board failed to explain how the 2017 VA opinion was adequate with respect to this and other relevant medical questions, such as whether service-connected pneumonia caused or aggravated bilateral parenchymal disease.

The Board is obliged to provide a statement of reasons or bases that allows the claimant to understand the precise bases for its determinations and facilitates judicial review. 38 U.S.C. § 7104(d)(1). This includes the duty to assess the probative value of the evidence and provide reasons for rejecting material evidence favorable to the veteran. *Urban v. Shulkin*, 29 Vet.App. 82, 92 (2017).

Establishing service connection generally requires medical or, where competent, lay evidence of (1) a current disability, (2) in-service incurrence or aggravation of a disease or injury, and (3) a link between the claimed in-service disease or injury and the current disability. *Harvey v. Shulkin*, 30 Vet.App. 10, 15 (2018). The second element is where the statutory "presumption of soundness" operates. *Horn v. Shinseki*, 25 Vet.App. 231, 236 (2012). This rule states that "every veteran shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment." 38 U.S.C. § 1111; *see* 38 C.F.R. § 3.304(b) (2018). When no preexisting medical condition is noted upon entry into service, a veteran is presumed to have been sound in every respect. *Wagner v. Principi*, 370 F.3d 1089, 1096 (Fed. Cir. 2004). This presumption of soundness is meant to curtail VA's ability to deny a veteran's claim for service connection for an in-service disease or injury by assuming that the injury or disease preexisted service. *Kinnaman v. Principi*, 4 Vet.App. 20, 26-28 (1993).

Where the presumption is applicable, the burden falls on VA to rebut with clear and unmistakable evidence *both* prongs of the presumption: that an injury or disease manifesting during service preexisted it *and* was not aggravated by it. *Wagner*, 370 F.3d at 1096. This last point is critical: "When the presumption of soundness applies, . . . the burden remains on the Secretary to prove *lack of aggravation* and the claimant has no burden to produce evidence of aggravation." *Horn*, 25 Vet.App. at 238.

In the present case, there is no dispute that the bronchial asthma and bronchiectasis diagnosed during service were not noted upon entry and, therefore, the presumption applies. Nor does the veteran dispute the Board's determination that clear and unmistakable evidence showed

these disabilities preexisted service. Rather, he argues that the Board failed to apply the proper standard regarding the aggravation prong. The Court agrees.

In several places, the Board did not recognize the correct "clear and unmistakable evidence" requirement and applied other standards. In its findings of fact, the Board stated that "the preponderance of the evidence is against finding that . . . bronchial asthma and bronchiectasis [were] aggravated during his active service." R. at 3. Similarly, in its analysis it found "no competent and probative evidence of record demonstrating that the veteran's pre-existing respiratory conditions underwent permanent worsening (aggravated) beyond normal progression during his service." R. at 9. This last finding, by relying on the absence of evidence showing aggravation, also impermissibly transfers the burden of proof to the veteran. As the Court has previously explained:

> [T]he burden is not on the claimant to show that his disability increased in severity; rather, it is on VA to establish by clear and unmistakable evidence that it did not or that any increase was due to the natural progress of the disease. Therefore, VA may not rest on the notion that the record contains insufficient evidence of aggravation. Instead, VA must rely on affirmative evidence to prove that there was no aggravation.

Horn, 25 Vet.App. at 235. Nowhere in the decision on appeal is this legal reality clearly recognized or expressed.

Thus, the Board erred by failing to use the proper standard for determining that bronchial asthma and bronchiectasis were not aggravated by service in this case. Contrary to the Secretary's contention, the veteran's challenge to the Board's aggravation analysis is not simply a disagreement with the weight of the evidence: It is an allegation of legal error, which requires remand to rectify. *See, e.g.*, *id*. at 243.

Even though the Board did not apply the correct standard, the Secretary nevertheless argues that the Court should read the Board decision as if it did so because it relied on the 2017 VA opinion, which said it was "medically undebatable" that bronchial asthma and bronchiectasis were not aggravated by service. (The Secretary does not directly invoke the prejudicial-error rule. *See* 38 U.S.C. § 7261(b)(2).). But, as Mr. Dooley notes, it's not at all clear that the VA examiner understood the proper inquiry in these circumstances. The examiner opined that there were "no findings" of an increase in respiratory disabilities during service. R. at 27. The Secretary characterizes the basis of this opinion as a "lack of documented aggravation," Secretary's Br. at

11, but he doesn't specify how that is different from reliance on "insufficient evidence of aggravation," which *Horn* rejected as inconsistent with section 1111. 25 Vet.App. at 235. It is also not apparent whether the examiner had the proper standard in mind when assessing relevant evidence, such as the August 1971 in-service hospitalization record characterizing Mr. Dooley as having suffered "an acute exacerbation of his bronchial asthma." R. at 719.

A medical opinion is adequate when it is based upon consideration of the veteran's prior medical history and examinations, addresses the questions for which it was requested, and supports its conclusions with adequate rationale, so that the Board's decision on the issue before it will be a fully informed one. *Sharp v. Shulkin*, 29 Vet.App. 26, 31 (2017). In light of the potential problems noted above, the 2017 opinion does not provide the sort of clear evidence that might be used to argue that the Board—despite what it *said*—actually conducted the correct legal analysis.

In the absence of a Board discussion on these issues, the Court is not prepared to find that the 2017 opinion is inadequate. But, now that the proper standard for adjudicating the aggravation prong of the presumption of soundness has been clarified, the Board on remand must determine whether the opinion provides adequate medical evidence to allow that adjudication or whether an additional opinion is necessary.

Bilateral parenchymal disease, which did not first manifest during service, was not at issue in the presumption of soundness analysis. Instead, the Board considered whether it was at least as likely as not that the condition was etiologically related to service or aggravated by service-connected pneumonia. *See* 38 C.F.R. § 3.310(b) (2018) ("Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected."). Without elaboration or discussion, the Board relied entirely on the 2017 opinion. The examiner provided the following rationale in section (a) to support her opinion against service connection for parenchymal disease:

> The veteran had history of bronchial asthma since early childhood, pneumonia treated age 12, and treated four times for bronchial asthma exacerbation episodes one year prior to military service induction. In fact, the veteran had pneumonia of the left lobe ligula 4/1971 and rejected for military entry until June 1971. Veteran had an acute bronchial asthma exacerbation less than one month after starting boot [camp] at Fort Campbell. The veteran's chest x-rays showed slight acute but mostly chronic and cystic left lung changes. Findings consistent with bronchiectasis and veteran advised this could be a trigger for repeated pneumonia episodes in the patient's asthma.

R. at 26.

It's not apparent what this has to do with parenchymal disease, which is not mentioned anywhere in the rationale. By listing historical details of bronchial asthmas, bronchiectasis, and pneumonia, the examiner evidently believes they are in some way relevant to the question of parenchymal disease's etiology, but that connection is not clearly made. Although a medical opinion need not explicate every step from facts to conclusion in an examiner's reasoning, the general thrust of that reasoning must at least be discernable. *See Taylor v. McDonald*, 27 Vet.App. 158, 165 (2014). Since the Board never specified how it understood the 2017 examiner's rationale on this question, the Court cannot say whether the opinion is adequate in this regard. The Board must resolve this matter.[4] *See, e.g.*, *Atencio v. O'Rourke*, 30 Vet.App. 74, 90 (2018) (remanding for the Board to address a medical opinion that it failed to address adequately in the first place).

One more potential problem the Board should sort out is the adequacy of the 2017 opinion as to the effects of service-connected recurrent pneumonia on any of the veteran's respiratory disabilities. Regarding bronchial asthma and bronchiectasis, the examiner simply referred to the earlier section (a) of her opinion. That section asked whether parenchymal disease was caused or aggravated by pneumonia but, as already discussed, addressed that issue in a less than lucid way. Complicating all these matters is the examiner's unprompted opinion that pneumonia preexisted service, was not aggravated by service, and was "unrelated to" service. R. at 27. Under such an opinion, pneumonia would not be entitled to service connection. But the veteran's pneumonia *is* service connected. There is a reasonable concern that the examiner's contrary conclusion tainted her opinion as to whether parenchymal disease, bronchial asthma, and bronchiectasis could be service connected via pneumonia. When the duty to provide a medical opinion applies, the Board must obtain one that is based on the factual predicate that it has found to be true. *Kahana v. Shinseki*, 24 Vet.App. 428, 442 (2011). Here, the examiner appeared to dispute a basic premise of the medical opinion that she was asked to provide, namely, the service-connection status of

[4] The Secretary responds: "Undoubtedly, the medical opinion could have been more precise and could have discussed the exact impact of his history of asthma, but the crux of the conclusion is apparent and the reasoning supplied need not be ideal or impeccable." Secretary's Br. at 16-17. This is a straw man argument. The potential problem with the 2017 opinion isn't that it falls short of precision or exactitude or ideality or impeccability. Rather, it fails to make a basic connection between its conclusion and the facts it cites.

recurrent pneumonia. The Board must resolve whether this apparent doubt impaired the examiner's medical conclusions.

If on any of these questions the Board determines that the 2017 opinion requires clarification or is inadequate to resolve the claim, it should remand for additional development. *See* 38 C.F.R. § 19.9(a) (2018).

III. CONCLUSION

Based on the foregoing, the July 11, 2017, Board decision is VACATED and the matter REMANDED for additional development, if necessary, and readjudication consistent with this decision.

DATED: March 11, 2019

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