

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

LISA MARLENE HAYES,)
)
 Claimant,)
)
 v.)
)
 GREAT CLIPS/POTATOCLIPS, INC.,)
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 Employer,)
)
 and)
)
 STATE INSURANCE FUND,)
)
 Surety,)
)
 and)
)
 STATE OF IDAHO, INDUSTRIAL SPECIAL)
 INDEMNITY FUND,)
)
 Defendants.)
 _____)

IC 01-513227

**FINDINGS OF FACT,
CONCLUSION OF LAW,
AND RECOMMENDATION**

Filed: March 3, 2006

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted a hearing in Twin Falls, Idaho, on July 26, 2005. Jeff Stoker of Twin Falls represented Claimant. Neil D. McFeeley of Boise represented Employer and Surety. Thomas B. High of Twin Falls represented State of Idaho Industrial Special Indemnity Fund (ISIF). Employer, Surety, and ISIF are referred to collectively as Defendants. The parties submitted oral and documentary evidence. Two post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on December 13, 2005 and is now ready for decision.

ISSUES

By agreement of the parties at hearing, the issues to be decided are:

1. Whether Claimant's condition is due in whole or in part to a pre-existing and/or subsequent injury/condition;
2. Whether and to what extent Claimant is entitled to the following benefits:
 - a. Disability in excess of impairment;
3. Whether Claimant is totally and permanently disabled;
4. Whether apportionment for a pre-existing or subsequent condition pursuant to Idaho Code § 72-406 is appropriate;
5. Whether the Industrial Special Indemnity Fund is liable under Idaho Code § 72-332; and
6. Apportionment under the *Carey* formula.

CONTENTIONS OF THE PARTIES

Claimant contends that she developed occupational asthma as a result of her work as a cosmetologist for Employer. She argues that her occupational asthma is so severe that she is unable to work. Claimant asserts that she had pre-existing disabilities that combined with her occupational asthma to render her totally and permanently disabled, imposing liability on ISIF for a portion of her total and permanent disability.

Employer and Surety assert that Claimant's exposure to hair styling products caused, at most, a temporary aggravation of her pre-existing condition and is in no way responsible for her current condition. Employer and Surety argue that it overpaid Claimant for her permanent partial impairment (PPI) because her treating physician now attributes only 30% of her

permanent impairment to her workplace exposure.¹ Finally, Employer and Surety contend that Claimant is not totally and permanently disabled, and even if she were, the majority of such disability is the responsibility of ISIF.

ISIF contends that Claimant suffered from chronic obstructive pulmonary disease (COPD) before she went to work for Employer. At most, she suffered temporary aggravation of her pre-existing pulmonary disease while working for Employer. Because she suffered no permanent impairment or disability as a result of working for Employer, her exposure could not combine with her pre-existing conditions to render her totally and permanently disabled. Finally, ISIF argues that Claimant is not an odd-lot worker.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The testimony of Claimant, Eileen Fowler, Catherine Holston and Kevin Hayes taken at hearing;
2. Joint Exhibits A through Z;
3. Employer/Surety Exhibits 1 through 3; and
4. Post-hearing depositions of Ronald K. Fullmer, M.D., and Emil J. Bardana, Jr., M.D.

All objections made during the deposition of Dr. Fullmer are overruled. After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusion of law for review by the Commission.

¹ The issue of repayment of PPI benefits was raised for the first time in Surety/Employer's briefing. The Commission will not address issues raised for the first time during the post-hearing briefing.

FINDINGS OF FACT

1. At the time of hearing, Claimant was 46 years of age,² married, and resided in Buhl, Idaho, with her husband and an adult stepdaughter.

2. Claimant did not graduate from high school, but obtained her GED in 1996. She is licensed as a cosmetologist, maintains a valid commercial drivers' license, and was at one time a certified nurse's aide. She also took, and successfully completed, a computer course at the College of Southern Idaho.

EMPLOYMENT HISTORY

3. Claimant has a long and varied employment history. She has worked parking cars, and at a Tupperware manufacturing plant; she worked in the fast food industry and for local motels in housekeeping. After she obtained her CNA certification, she worked at a nursing home and as a home-health aid. In 1996, Claimant enrolled in Juan's College of Hair Design. She completed her training and was licensed as a cosmetologist in 1997.

4. Claimant went to work for Employer on June 23, 1997 as a stylist. When her performance was good, it was very good, as evidenced by seven commendations in her personnel file in 1997 and 1998, but when she was bad, she could be very bad, receiving warnings or discipline in January 1998 (failure to attend a mandatory meeting), July 1999 (failure to attend a mandatory meeting), December 1999 (failure to abide by a confidentiality agreement by making derogatory remarks about the manager and operators), and January 2000 (use of vulgar language). At some point in her employment she was promoted to assistant manager. At the time of her separation from Employer on December 17, 2001, she was working as manager and stylist.

² At hearing, Claimant testified that she was 47. Her date of birth was November 14, 1958, making her 46 at the time of hearing in July 2005.

5. Claimant remained out of the work force for some time so that she could travel. In September 2002, she went to work as a customer service representative for Dell Computers. Claimant remained at Dell for almost a year. Her termination was the result of a dispute with a customer involving the use of vulgar language.

6. After leaving Dell, Claimant collected unemployment benefits for about six months, certifying that she was ready, willing, and able to work. As her unemployment benefits ran out, Claimant obtained work at Discovery Research Group (Discovery) doing telephone survey work. She remained with Discovery approximately seven months. Claimant terminated her employment with Discovery in a dispute over the use of a personal headset. Neither job performance nor absenteeism were factors in her leaving Discovery's employ.

7. Claimant has not looked for work, nor has she sought assistance in finding work, since she left Discovery. There is some suggestion in the record that Claimant breeds Yorkshire Terriers, but nothing in the record suggests this is a business.

PREVIOUS INDUSTRIAL INJURIES

8. Claimant sustained a work-related left knee injury in 1987. She ultimately had surgery on the knee and was given a PPI rating of 14% of the lower extremity. Restrictions included no squatting and no lifting over twenty-five pounds. Employer/Surety Ex. 2, p. 201.

9. In November 1994, Claimant injured her right knee and her back in an industrial accident. She ultimately had surgery on the knee and was given a PPI rating of 14% of the lower extremity, although half of the 14% rating was attributed to pre-existing, non-industrial conditions. Claimant settled this claim by entering into a lump sum settlement agreement. *Id.*, at p. 94.

10. Claimant injured her left ulnar nerve in an industrial accident in 1998. She

eventually underwent a left ulnar nerve transposition in October 1998. She was given a PPI rating of 5% of the upper extremity for her ulnar nerve injury. Despite surgery, Claimant reported continuing symptoms including numbness in her left hand. *Id.*, at p. 73, Tr., pp. 81-84.

PRE-EXISTING MEDICAL CONDITIONS

11. In addition to her prior industrial injuries, Claimant has a substantial medical history dating back to at least 1989. While much of her medical history is not relevant to this proceeding, the records pertaining to her long history of respiratory problems are considerable.

12. Both of Claimant's parents smoked during her childhood. In 1974, when she was sixteen, she began smoking. Claimant smoked one and a half packs per day until 1992. Claimant's second and third husbands both smoked. Her current husband is also a smoker, as is her stepdaughter who lives in the home. Claimant's history of tobacco use is consistently noted as an issue throughout her health records.

13. Claimant's mother died in 1994 at the age of 56. She was a long-term smoker, and was diagnosed with emphysema and COPD in 1990. Claimant reported that she was advised her mother's COPD was likely to have a hereditary component. One of Claimant's sisters had a history of allergic hay fever and bronchial asthma. Claimant's father died in 1975 at the age of 42 of a massive heart attack.

14. Claimant has a history of hyperlipidemia, gastroesophageal reflux disease (GERD), borderline hypertension, and obesity. Each of these health issues were discussed or addressed consistently throughout Claimant's subsequent medical records.

Medical Records—November 1989 through March 1, 2001

15. Medical records pertaining to Claimant's respiratory problems are substantial. For purposes of brevity, the relevant material leading up to her referral to pulmonologist Dr.

Fullmer is presented in summary form.

16. Claimant's relevant history begins August 30, 1990. She presented at Family Health Services (FHS) in Buhl advising that her mother had been diagnosed with an inheritable form of COPD and it had been recommended that Claimant be tested. On exam Claimant did have coarse, scattered rhonchi and occasional scattered wheezing. Chart notes surmise that the "test" Claimant spoke of was an alpha-1 antitrypsin test. Claimant was given the test and the result was negative.

17. Between April 12, 1991 and May 21, 1991, Claimant returned to the clinic four times. She was diagnosed with and treated for early bronchitis, right otitis media, bilateral otitis media, and possible allergic rhinitis.

18. In April 1992, Claimant was diagnosed with and treated for bronchitis and reactive airways.

19. In the fall of 1992, Claimant was diagnosed with and treated for a viral syndrome, residual bronchitis and mild asthma, and a second viral syndrome or sinus infection. On her October 15 visit, a pulmonary function test (PFT) was recommended and refused by Claimant.

20. In October 1993, Claimant saw Dr. Nofziger, who diagnosed her with and treated her for acute streptococcal tonsillitis. Claimant returned to Dr. Nofziger in February, and was diagnosed with and treated for acute viral upper respiratory infection with broncho-spasm.

21. In October 1994, Claimant was back at FHS, where she was diagnosed with and treated for bronchitis.

22. Claimant started beauty school sometime in June 1996. On June 21, Claimant was diagnosed with and treated for mild acute bronchitis.

23. Claimant saw Dr. Nofziger in October 1997 where she was diagnosed with and

treated for acute viral laryngotracheal bronchitis. Claimant was working for Employer at this time.

24. Claimant made a wellness visit to FHS in March 1998. A slight, bilateral wheeze was noted. Claimant returned on April 13 and was diagnosed with and treated for community acquired pneumonia and upper respiratory infection. She refused to have a recommended chest x-ray. On April 16, Claimant was back and was diagnosed with and treated for “persistent bronchitis with a horrible cough.” Ex. B., April 16, 1998 chart note. Her caregiver noted, “suspect that the cough is secondary to some damage the patient has either done in her larynx or her bronchial tubes. It may be an inflammatory process.” *Id.*

25. In September 1999, Claimant returned to FHS where she was diagnosed with and treated for bronchitis involving an upper respiratory infection. The chart note states, “[Past medical history] is significant for having URIs [upper respiratory infections] and most recently in 1998, had a significant URI which included bronchitis and required antibiotic treatment.” *Id.*, September 2, 1999 chart note.

26. Claimant saw Dr. Nofziger in December, and was diagnosed with and treated for atypical acute bronchitis.

27. In early February 2000, Claimant returned to FHS where she reported that she had shortness of breath, rattles in her chest, and a chronic cough for six weeks.³ The chart note states, “Suspect the [patient] is mostly suffering from RAD [reactive airway disease] or asthma.” Ex. B., February 2, 2000 chart note. Claimant was back at the clinic a number of times through March 6. Several chart notes are relevant. On February 8, the note states:

³ This time line indicates that Claimant did not recover from the atypical bronchitis that took her to Dr. Nofziger at the end of December.

. . . suspect the [Patient] is mostly suffering from just some bronchial spasms. Her bronchial tubes have just become so hyper-reactive, that every time she is around a trigger or starts coughing, she goes into bronchial spasms and has the dry cough.

Id., February 8, 2000 chart note. On February 11, it was recommended that Claimant have a chest x-ray and a pertussis test. Claimant declined the pertussis test. On February 24, the chart note states, “I am considering the possibility of this being an allergic reaction perhaps some hair product, etc.”⁴ By February 27, her bronchitis was resolving.

28. In August, Claimant sought treatment at FHS for a sinus infection. On November 20, Claimant returned complaining of a sinus infection. She was diagnosed with an upper respiratory virus. She returned to the clinic the following day when her symptoms had not improved.

29. On January 25, 2001, Claimant was seen at FHS and diagnosed with and treated for a viral cough.

30. On March 1, Claimant returned to FHS complaining of a cough that she had for three months. Claimant was referred to Dr. Fullmer.

Medical Records—March 6, 2001 Through October 21, 2001

31. Claimant saw Dr. Fullmer on March 6, 2001. She reported a history of “coughing spells” lasting several months, which had been diagnosed as “bronchitis.” Claimant believed that the cough was more common in the winter and was sometimes associated with an upper respiratory infection. She reported occasional heartburn, which she controlled with Tagamet.

⁴ This is the first time Claimant raised a question whether her cough was related to her work: “She works as a hairdresser and she is wondering whether cutting hair is not exacerbating this. She has one client who has a chronic cough and is on a lot of inhalers and every time she comes in [Claimant] seems to get worse. She is wondering if it is related to her. Her husband has a cough but he just developed this recently and he is a smoker. . . . [Claimant] never noticed any triggers except for things like cold air.”

Claimant also described a “history of cigarette use of one to one-and-a-half packs per day for about ten years and quit smoking thirteen years ago.” Ex. G, March 6, 2001 chart note.⁵ Under “Occupational History” on the chart note, Dr. Fullmer states:

Patient works as a beautician, she does notice increased difficulty with her breathing with exposure to some of the chemicals she uses in the shop, particularly with the one giving perms.

Id. Claimant had pre and post bronchodilator spirometry immediately following her initial visit with Dr. Fullmer. Reviewing the spirometry results, Dr. Fullmer opined:

Impression is a moderate restrictive ventilatory defect manifest by a moderate reduction in spirometry volumes. There is also moderate to severe reduction in flow rates and severe reduction in the MVV [maximal voluntary ventilation]. Significant improvement is noted in the FVC [forced vital capacity] and many of the flow rates and MVV following the bronchodilator. This would suggest reversible obstruction/asthma.

Id. Dr. Fullmer also opined that her test results might indicate a restrictive component to her respiratory problems, but that finding might just be the result of Claimant’s obesity. Dr. Fullmer noted that Claimant’s condition was reasonably controlled with Flovent, Singulair and Albuterol, and suggested that she use the Albuterol prophylactically prior to working with chemicals used in giving perms. Dr. Fullmer also noted that Claimant had infrequent reflux symptoms for which she used Tagamet, and observed that better control of her reflux might be helpful in reducing her cough symptoms. Claimant was advised to return in three months.

32. Claimant returned to Dr. Fullmer two weeks later, on March 20, complaining of increased cough symptoms. The chart note indicates that Claimant had improved with a short course of prednisone. Dr. Fullmer continued to diagnose probable bronchial asthma, prescribed a longer steroid taper, an inhaled bronchodilator (Serevent), and increased her dosage of her

⁵ Actually, Claimant had an eighteen-year history of active smoking, and she had quit just nine years previously, in 1992.

steroidal inhaler (Flovent). Claimant was advised to return in one month for a full pulmonary function test (PFT).

33. Claimant returned April 11, complaining that her cough was getting worse. On exam, she had scattered wheezes with a fairly good airflow. Dr. Fullmer increased her prednisone, and prescribed an additional bronchodilator that was taken by mouth rather than inhaled (Uniphyl or its generic equivalent, theophylline). She was told to return in three to four weeks.

34. On May 4, Claimant returned to Dr. Fullmer. She was improved and her lungs were clear. Dr. Fullmer replaced her inhaled bronchodilator and inhaled steroid with an Advair inhaler which combined the bronchodilator of Serevent and the steroid of Flovent into one medication. Claimant had a PFT the same day. It showed that her spirometry volumes were slightly improved and her flow rates were slightly reduced. Her MVV was significantly reduced. Following the bronchodilator, spirometry volumes were unchanged but flow rates improved. The results suggested that air was being trapped in her lungs as a result of her obstructive disease.

35. Claimant returned to see Dr. Fullmer on July 5 complaining of continued cough. On exam, she had good bilateral airflow with minor wheezes. Dr. Fullmer suspected that the cough was indication of an early infection and prescribed antibiotics and a two-week prednisone taper. Dr. Fullmer also gave Claimant a rescue inhaler.

36. Claimant returned again on August 13 complaining of continued severe coughing paroxysms and shortness of breath. Claimant stated that she had been off work a week and was much better then got worse as soon as she returned to work. Dr. Fullmer noted:

The patient has continuing symptoms of bronchial asthma. She appears to have a component of occupational asthma associated with her work at the hair salon. It

seems unlikely that she will be able to continue this work if she continues to have such severe problems. I suggested she consider the possibility that she may have to change occupations and might have to go into vocational rehab. We will obtain a hypersensitivity pneumonitis panel just to rule out the possibility of some type of building associated allergen such as aspergillus in the heating or cooling system. However it seems unlikely that this is the cause of her symptoms as she notes exacerbations associated with exposures to some of the various hair sprays and other agents used in the salon. The patient will be given another steroid taper
...

Id., August 13, 2001 chart note. Dr. Fullmer also gave Claimant a peak flow meter to begin monitoring her peak flows. He suggested she monitor twice daily.

37. Claimant returned on August 30, complaining of pain in her left and right lateral chest. She also brought in her peak flow results. Peak flows varied from 240 to 330 with no consistent pattern and no relation to the steroid taper. Dr. Fullmer opined:

The patient continues to have significant asthma symptoms. Some of these seem to be clearly related to her occupation as a beautician. The other work up we did with hypersensitivity pneumonitis panel was negative which would go against an environmental [sic] or building type problem. Her IGE level also was normal at 10, which would go against allergic asthma.

Id., August 30, 2001 chart note.

38. Claimant filed a First Notice of Injury or Illness on October 21, 2001, attributing her respiratory problems to hairsprays, perm solutions, and other hair care products used at Employer's place of business, and dating the onset of her symptoms to March 2001.

Medical Records – From First Notice of Injury to Hearing

39. On November 11, Claimant returned to see Dr. Fullmer. Claimant had brought in peak flow readings earlier in the month that included measurements taken while at work as well as ones taken while Claimant was on vacation in Seattle. Claimant's flow rates were generally in the 200-range while at work and improved to the 400-500-range while she was in Seattle. Dr. Fullmer opined: "The patient's peak flows demonstrate a definite occupational component to her

asthma.” *Id.*, November 11, 2001 chart note. He placed Claimant on a slow prednisone taper.

40. Claimant returned to Dr. Fullmer on December 18. Her condition was unchanged from her previous visit. Claimant reported that she had quit her job with Employer the preceding day, December 17. She was almost done with her prednisone taper and her peak flows ranged from 210 to 280. Dr. Fullmer observed, “I really cannot see much improvement in the peak flows from her baseline before going on the steroid taper.” *Id.*, December 18, 2001 chart note. Subjectively, Claimant did not note much improvement either. Dr. Fullmer expressed optimism that Claimant would notice “significant improvement” in her symptoms now that she was no longer working for Employer.

41. Claimant continued to treat with Dr. Fullmer on a regular basis through May 31, 2005. In addition to office visits, Claimant frequently called the office regarding her symptoms and much of her ongoing treatment was handled telephonically. Claimant was seen seven times in 2002. Initially, she showed slight but slow improvement, mostly with reduction of her cough. By August 2002, she was once again having severe symptoms. In October, she had a complete PFT, which showed mild obstruction and mild restrictive ventilatory changes. Spirometry improved after administration of a bronchodilator. Overall, her pulmonary function had declined from previous tests.

42. Claimant saw Dr. Fullmer five times in 2003. In February, Dr. Fullmer advised Surety that Claimant “is on fairly maximal outpatient therapy for her chronic persistent asthma.”

Id., February 26, 2003 letter. A PFT conducted in July was interpreted by Dr. Fullmer:

Moderate obstructive airways disease manifest by the moderate reduction in the FEV1 [Forced Expiratory Volume in One Second] along with a reduction in flow rates. There is some improvement noted post bronchodilator. Suggest clinical correlation. There has been no significant [change?] since the previous study of 2/2002.

Id., July 21, 2003 PFT. In October, Claimant was seen in the emergency room at Magic Valley Regional Medical Center (MVRMC) complaining of increased shortness of breath. She was diagnosed with interstitial pneumonia, treated and released with instructions to follow up with Dr. Fullmer. When she saw Dr. Fullmer later in the month he diagnosed viral or atypical pneumonitis but noted that hypersensitivity pneumonitis or interstitial disease should also be considered as possible causes of Claimant's most recent increase in symptoms.

43. Dr. Fullmer saw Claimant eight times in 2004. In March, Dr. Fullmer noted an increase in Claimant's symptoms and observed, "[u]nfortunately the patient was already on fairly maximal therapy." On May 12, Dr. Fullmer had Claimant admitted to MVRMC with increased cough, wheezing and shortness of breath. In his admitting documents, Dr. Fullmer made the following assessment:

Chronic persistent asthma with significant exacerbation. The patient has a significant exacerbation of her asthma failing to respond to outpatient therapy with the doxycycline and oral prednisone.

Id., May 12, 2004 chart note. Claimant was discharged on May 15 with a small volume nebulizer for her use at home. On May 24, Dr. Fullmer advised Surety of Claimant's condition:

At present she is on essentially maximal out-patient therapy for her asthma. She had a recent hospitalization here at MVRMC for an exacerbation of her asthma.

Id., May 24, 2004 letter. In July, Dr. Fullmer advised the Disability Determination Service Division that Claimant's condition "is not adequately controlled as far as her asthma symptoms despite aggressive therapy." *Id.*, July 19, 2004 letter. Claimant's symptoms worsened in the fall of 2004. A PFT was conducted on December 27, 2004. The test results were interpreted by Dr. Fullmer to show both mild restrictive and moderate obstructive ventilatory defects. There was no significant change compared to previous PFT studies. *Id.*, December 17, 2004 PFT report.

44. Four visits to Dr. Fullmer are documented through May 31, 2005. Claimant's

condition was essentially unchanged. The last medical record from Dr. Fullmer notes:

Chronic persistent asthma, fair control on patient's extensive medical regimen. She currently is on multiple agents including theophylline, Advair, cromolyn [an asthma prophylactic], DuoNeb [a combination bronchodilator/steroidal inhaler], Singulair, Spiriva [a bronchodilator] and prednisone . . . I think that her asthma probably was exacerbated by her occupational exposures at the beauty salon but she has been out of this workplace for a considerable period of time. At this point it seems unlikely that occupational factors are contributing to her continued asthma and she probably has basically chronic persistent severe asthma, which is difficult to control despite the progressive regimen.

Id., May 31, 2005 chart note.

45. Claimant is a credible witness, but an unreliable historian. For this reason, the Referee finds that the medical records are the most probative evidence of chronology, dates, and the type and severity of symptomatology reported.

IMEs

Richard K. Oehlschlager, M.D.

46. In December 2001, Surety arranged for Claimant to undergo an Independent Medical Evaluation (IME) with Dr. Oehlschlager, a Boise area pulmonologist. Claimant saw Dr. Oehlschlager on December 20, 2001. He issued his report on January 11, 2002. On the date of the IME, her complaints were: cough, abnormal sputum, wheezing, malaise, episodes of feeling hot, chest tightness, sore chest with cough, falling during paroxysmal coughing, and labored respiration. Claimant told Dr. Oehlschlager that:

. . . onset of these symptoms was nine months ago and was associated with the introduction of several new product lines of hair salon products at her place of employment identified as Great Clips. None of the products used in her shop at Twin Falls prior to the spring of 2001 were associated with respiratory symptoms.⁶

Ex. I, January 11, 2002 IME report, p. 1. Claimant described an incident at a hair show she

⁶ Claimant's report to Dr. Oehlschlager regarding onset of her respiratory problems is not supported by the medical records, as previously discussed in the findings of fact.

attended in Boise in the spring of 2001 as the specific event that initiated her respiratory problems. Claimant started coughing within ten to fifteen minutes when a representative for the product sprayed it around the table. She was unable to catch her breath and finally had to step outside. The incident preceded her first visit to Dr. Fullmer. Claimant denied any prior lung disease, including pneumonia, asthma or hay fever. She reported that she had smoked one-and-a-half packs of cigarettes per day from 1974 to 1990.

47. Dr. Oehlschlager reviewed medical records from Dr. Fullmer, which included eight visits beginning March 6, 2001, including at least two PFT reports, chest x-rays, and blood test results. Dr. Oehlschlager also had access to medical records concerning Claimant's knee injuries and ulnar neuropathy, and chiropractic and physical therapy records concerning her right shoulder and neck pain. Dr. Oehlschlager reviewed material safety data sheets (MSDS) for products used at Employer's place of business. He was only able to match one product Claimant identified with an MSDS. The MSDS for that product stated that no respiratory protection was required, that the product was unlikely to form a mist but upper respiratory *irritation* could occur, and that inhalation was not an expected route of exposure. The primary constituent of the product was volatile alcohol. On exam, Claimant's vital signs were normal, and her weight was 221 pounds. She had good breath sounds bilaterally and no wheezing or inspiratory crepitation.

48. Dr. Oehlschlager's impression of Claimant's symptoms was "reactive airways disorder," (RAD). *Id.*, p. 5.

49. In response to questions posed by Surety, Dr. Oehlschlager opined:

- With the possible exception of esophageal reflux, there were no other conditions found that "directly or materially" related to her RAD. *Id.*, p. 8.
- There was a causal relationship between workplace chemicals and Claimant's condition.

Claimant denied any prior condition similar to her present symptoms, therefore exacerbation of pre-existing condition was not a factor in her condition.

- Claimant's treatment was "necessitated by exposures at her place of employment," is appropriate, has been "somewhat successful," and should be adequate. *Id.*
- Claimant should not return to her work with Employer, and it was highly unlikely that she could continue her cosmetology work with any other employer.

50. In December 2004, Surety provided Dr. Oehlschlager with additional medical records on Claimant from FHS in Buhl. Along with the records were three questions for Dr. Oehlschlager:

- After reviewing the additional medical records that pre-dated Claimant's treatment with Dr. Fullmer, do you still believe Claimant suffers from occupational asthma resulting from exposure to chemicals allegedly present in her workplace?
- After reviewing the additional medical records do you still believe that Claimant has sustained an impairment in connection with her diagnosis of occupational asthma, and if so, should any of her impairment be apportioned to pre-existing medical conditions?
- Given that Claimant has been removed from the workplace for several years, do you believe that she still needs treatment for occupational asthma?

51. Dr. Oehlschlager's thoughtful and lengthy response begins with a recap of his January 2002 report and his statement that he evaluated four possible stimuli for Claimant's respiratory complaints, including workplace exposures, tobacco and environmental exposures, aspiration insults (esophageal reflux), and associations with hereditary and familial factors.⁷ Dr.

⁷ While Dr. Oehlschlager claims to have considered each of these possible causes in reaching his original conclusions, his report contains no discussion of any possible cause other than workplace exposure.

Oehlschlager then reviewed the new records, focusing on those from FHS. He notes that the FHS records first mention pulmonary concerns in August 1990 followed by “eleven years of increasingly frequent medical intervention devoted to recurrent pulmonary illness usually characterized by productive cough.” *Id.*, February 11, 2005 letter. Dr. Oehlschlager noted that the majority of respiratory complaints dated from 1996.

52. With little explanation, Dr. Oehlschlager dismissed genetics and heredity out of hand as contributors to Claimant’s condition. He agreed that in light of the FHS records, tobacco exposure would need to be considered in explaining Claimant’s respiratory problems. He continued to believe that a gastroenterological contribution to Claimant’s asthma remained possible but speculative. Dr. Oehlschlager discussed the FHS records regarding workplace exposure in detail. He noted significant differences between FHS records, Dr. Fullmer’s records, and his own records regarding the onset and severity of Claimant’s exposure to hair care products, but believed all were correlated with her enrollment in beauty school and her subsequent work for Employer. Dr. Oehlschlager concluded that both tobacco abuse and exposure to cosmetic hair products were related to Claimant’s condition.

53. Dr. Oehlschlager addressed but did not answer Surety’s second question pertaining to impairment.

54. Finally, Dr. Oehlschlager opined that Claimant should continue to avoid exposure to known causes of her respiratory complaints, and should not return to work in a beauty shop environment. He was somewhat less clear, however, regarding the need for on-going treatment for her “occupational asthma.” He noted that asthma is inherently episodic, and that assessing her continued need for treatment rested with Dr. Fullmer.

Dr. Bardana

55. ISIF referred Claimant to Dr. Bardana for an IME. Dr. Bardana is affiliated with the Oregon Health and Science University (OHSU) in Portland, Oregon. A professor of medicine in the division of allergy and clinical immunology, Dr. Bardana is board certified in internal medicine and in allergy and immunology. He has practiced at OHSU since 1971. He has a special interest in occupational and environmental allergy, and occupational asthma.

56. Dr. Bardana reviewed and excerpted Claimant's medical records dating from May, 1987 (her first knee surgery) through February 11, 2005 (Dr. Oehlschlager's letter to Surety). Dr. Bardana had an opportunity to meet with and examine Claimant on February 7, 2005. In addition to the exam, Dr. Bardana took a full patient history from Claimant and obtained laboratory, imaging and pulmonary function studies. He also reviewed approximately 500 pages of MSDS related to products used in the beauty industry.

57. Past Medical History. Claimant's medical history, as reported to Dr. Bardana, is more notable for what is omitted than what is included. She denied any history of swollen or painful joints or arthritis, headaches or migraines, ear, nose or throat complaints, hearing loss, chronic or frequent colds, sinusitis, pneumonia, hypertension, indigestion or ulcer, broken bones or torn ligaments, and nervousness, irritability or anxiety, all of which are documented in her medical records.

58. Industrial Hygiene Data. In reviewing the MSDS materials, Dr. Bardana focused on the products that Claimant had identified. He was able to co-relate five of the seven products mentioned by Claimant with material safety data information. These products included Shinz Spray Gloss, Great Clips 55% VOC Seeze Sculpting Spray (gel), Great Clips 55% VOC Hairspray, Performa, and Opticurl.

59. Physical Exam. Dr. Bardana described Claimant as “in some distress with cough and dyspnea [labored respiration] upon any type of walking.” *Id.*, p. 49. Her weight was 262 pounds, and her blood pressure was elevated. Chest exam showed “diminished lateral excursion with reduced diaphragmatic excursion.” *Id.* Dr. Bardana reported hearing bronchial breathing with terminal end expiratory wheezes throughout her lungs.

60. Laboratory Testing. A check of Claimant’s theophylline level (her systemic bronchodilator) showed no theophylline in her system. Claimant was tested for a number of common allergens and with the exception of mixed grass pollen, to which she exhibited a high level of antibodies, the tests were negative. Her serum IgE (the antibody associated with allergic asthma) was measured at the lowest normal level. A high resolution CT scan of Claimant’s chest revealed “minimal central airway thickening likely secondary to reactive airways disease.” *Id.*, p. 51. Claimant’s lungs were clear and there was some evidence of air trapping from small airways disease.

61. PFT. Pulmonary function studies were interpreted by Dr. Bardana to show “a mixed obstructive/restrictive pattern with diminished total lung capacity and residual volume.” *Id.* Administration of bronchodilators resulted in insignificant improvement of the FEV1. Bronchodilators did result in some significant improvement in the smaller airways. A six-minute walk test showed that Claimant was physically debilitated and deconditioned. Dr. Bardana found little change in Claimant’s PFT results between March 2001 and February 2005.

62. Assessment. Dr. Bardana’s assessment of Claimant’s condition identified eighteen separate medical issues. The conditions most relevant to the issues before the Commission are COPD with irreversible and reversible components, gastroesophageal reflux, and morbid obesity.

63. COPD. Dr. Bardana opined that Claimant's COPD had several components:

a) The major irreversible component of [Claimant's] COPD is chronic obstructive bronchitis secondary to between 28 and 42 pack years of cigarette smoking, i.e., 1964 to 1992 at 1 1.5 ppd;⁸

b) There is a minor reversible component in the smallest airways which is consistent with adult-onset, non-allergic bronchial asthma (possibly cough variant asthma) with major triggers being viral respiratory infections, exercise, and a variety of nonspecific environmental irritants;

c) Morbid obesity adds a component of reduced lung capacity by amplifying the restrictive pattern seen on pulmonary function testing;

d) There may also be an element of lack of compliance with medication, i.e., no detectable theophylline.

Id., pp. 53-54. Dr. Bardana also opined that Claimant's history of peptic ulcer disease with gastritis and gastroesophageal reflux made it highly likely that Claimant had a hiatal hernia with reflux causing episodic bronchospasm and microaspiration of gastric juices.

64. Dr. Bardana's report specifically addressed three questions posed by ISIF in its referral. He opined:

- That “. . .the majority of [Claimant's] pulmonary condition is the result of chronic obstructive bronchitis associated with chronic obstructive pulmonary disease (COPD) which is totally caused by her phenotypic predisposition to rapidly advancing chronic bronchitis. This was precipitated by her smoking habit . . . I am not entirely certain that she also has adult-onset bronchial asthma. . . . even if she did have asthma, I am absolutely certain that she does not have an occupational form of asthma. At best, her exposures at Great Clips may have caused some transient symptomatic expression of her underlying chronic obstructive pulmonary disease, but did not add to the permanent morbidity of the disease. The materials she was exposed to are capable of being transient irritants,

⁸ Dr. Bardana's calculation of Claimant's total exposure to tobacco smoke contains an error. It is clear from his discussion that he calculated her exposure based only on her active smoking, which occurred from 1974 (not 1964) through 1992. This is an eighteen-year active smoking history, which converts to between 18 and 27 pack years. Dr. Bardana opined that Claimant's exposure to second hand smoke, through her parents from the time of her birth, and subsequently several husbands was not insignificant, through he made no attempt to quantify her passive exposure.

but there was nothing that she was exposed to that was sensitizers or respiratory corrosives.

Id., p. 58.

- That Claimant's non-occupational COPD was chronic, and her condition will continue to deteriorate. Any exposure she may have experienced as a cosmetologist would have been a transient irritation with transient symptoms that might have lasted hours or days, but would not contribute to the morbidity of her COPD.
- And that Claimant was significantly impaired, agreeing with the impairment rating established by Dr. Fullmer, but attributing none of the impairment to her work for Employer.

DISCUSSION AND FURTHER FINDINGS

CAUSATION

65. Although the parties identified a number of issues to be decided in this proceeding, the crux of the claim pertains to causation. Claimant contends that her respiratory problems were caused by her exposure to hair care products during her work for Employer. Defendants assert that Claimant's respiratory problems pre-existed her work with Employer and are the result of her long-term tobacco use. Ultimately, the burden of proving causation rests with the Claimant.

The claimant carries the burden of proof that to a reasonable degree of medical probability the injury for which benefits are claimed is causally related to an accident occurring in the course of employment. Proof of a possible causal link is insufficient to satisfy the burden. The issue of causation must be proved by expert medical testimony.

Hart v. Kaman Bearing & Supply, 130 Idaho 296, 299, 939 P.2d 1375, 1378 (1997) (internal citations omitted). "In this regard, 'probable' is defined as 'having more evidence for than against.'" *Soto v. Simplot*, 126 Idaho 536, 540, 887 P.2d 1043, 1047 (1994).

The record contains more than ample documentation regarding Claimant's condition. What makes this case a difficult one is that three specialists seem to reach differing conclusions as to Claimant's diagnosis and its etiology. Dr. Fullmer, Claimant's treating pulmonologist, is of the opinion that Claimant suffers from occupational asthma as a result of her work for Employer. Dr. Oehlschlager, who examined Claimant in December 2001 at the request of Employer/Surety, diagnosed Claimant with restrictive airway disease (asthma), caused by exposure to the hair care products at Employer's workplace. Dr. Bardana opines that Claimant suffered from the early stages of COPD for a number of years before going to work for Employer, and that her COPD is the result in major part of a long-term cigarette habit by an individual particularly susceptible to the effects of smoking, exacerbated by morbid obesity and perhaps by uncontrolled acid reflux disease.

66. After a thorough review and analysis of the medical records and the opinions of Drs. Fullmer, Oehlschlager, and Bardana, and for the reasons discussed below, the Referee finds that Dr. Bardana's opinions and supporting rationale the more persuasive medical evidence in this proceeding.

EXPERT TESTIMONY

67. While Dr. Fullmer's medical records are extensive and Dr. Bardana's IME report is remarkably thorough, it is the post-hearing deposition testimony of these two doctors that the Referee found most helpful in reaching a decision in this case.⁹ While seemingly at odds as to

⁹ Dr. Oehlschlager's initial opinion was remote in time and lacked much of the medical history that was relevant to the issue of causation. Dr. Oehlschlager did update his opinion in light of more complete medical records, but because he was not deposed, he did not have the opportunity to explicate his rationale or reasoning. Left to stand on their own, Dr. Oehlschlager's reports are less influential than those of Drs. Bardana and Fullmer.

the cause of Claimant's illness, the two doctors are actually in agreement regarding much of the medical evidence and its meaning.

Drs. Bardana and Fullmer Agree

68. Obstructive Lung Diseases. Both doctors agree that COPD and asthma are obstructive lung diseases:

Both diseases represent obstructive disease of the lungs. Both chronic bronchitis/emphysema and asthma represent disorders that can be characterized as obstructive lung disorders. They obstruct the airflow into the lungs.

Dr. Bardana Depo., p. 55; see also, Dr. Fullmer Depo., p. 27.

69. Similar Symptoms. Both doctors agree that because COPD and asthma obstruct airflow in the lungs, the symptoms of the two diseases can be quite similar, and it can be difficult to tease out the features that distinguish the two diseases—reversibility of symptoms being chief among them.

The distinguishing features between COPD and asthma are that COPD represents an irreversible condition. Once you have it, you're on this downward trend and you do not revert to normal. And asthmatics tend to have all or a portion of their disease be reversible.

Dr. Bardana Depo., p. 55; see also, Dr. Fullmer Depo., p. 27.

70. Non Allergic. Both doctors discounted allergy as a cause of Claimant's respiratory problems. Claimant was tested for a number of allergens and, except for grass pollen, was non-reactive. Further, her blood work showed that her IgE level, the factor that measures allergic antibodies, was at the lowest normal level. If Claimant was allergic and had frequent exposure to allergens, her allergic antibody level would have been high.

71. Use of PFTs For Diagnosis. Both doctors agree that the way to measure lung function and reversibility of obstructive lung disease is by using pulmonary function tests, of which spirometry is a part. A patient with asthma will have significant improvement in flow

rates after a bronchodilator is used to dilate the bronchial tubes. Both doctors agree that Claimant's PFT results were stable over time (2001 to 2005), and showed little reversibility except in her smaller airways.

72. Use of Peak Flows. The doctors agree that peak flow measurements may not be the most reliable of diagnostic tools. Dr. Bardana raised substantive concerns about how the tests were performed, and cited studies questioning the reliability of peak flow monitoring in diagnosing occupational asthma. Dr. Bardana opined that "cross-shift spirometry before and after a workshift over the course of a week or two" was necessary in order to obtain reliable results for diagnostic use of spirometry. Ex. 2 to Dr. Bardana Depo., p. 57. While he didn't address Dr. Bardana's substantive concerns, Dr. Fullmer agreed that peak flow results were of uncertain reliability:

Yeah. Well, the problem with the peak flows are that they're effort dependent. If a person doesn't make a good effort, they're not going to be as good. And so it's a, you know, it's a limited tool, because you, the person can change the figures just by how much effort they make [sic]. So you know, you have to, you have to take that into consideration.

Dr. Fullmer Depo., p. 54.

73. Claimant's Condition. Finally, both doctors are in general agreement about Claimant's condition at the time of their depositions in 2005. Dr. Fullmer opined:

Well, I think at this point she probably has a component of C.O.P.D., chronic obstructive pulmonary disease. She, I think she probably does have some chronic persistent asthma, which is basically more severe asthma, where the person has daily symptoms, they have a lot of airway inflammation and cough. And she has chronic bronchitis, basically because she has a chronic cough all the time, which actually, the cough is probably her most significant, has been her most significant complaint throughout all this. She has intermittent flare-ups with more severe cough, cough's been difficult to control, it's interfered with her ability to do other kinds of work, too.¹⁰ So I think she probably has a component

¹⁰ Nothing in the record supports Dr. Fullmer's statement that Claimant's cough interfered with her work at Dell or Discovery.

of C.O.P.D. and chronic persistent asthma or has a combination of those two problems.

Dr. Fullmer Depo., p. 19. This opinion is remarkably consistent with the opinion offered by Dr. Bardana in his report, Exhibit 2 to Dr. Bardana Depo., p. 58, and in his deposition. Dr. Bardana Depo., pp. 33-34.

74. Where Drs. Fullmer and Bardana differ in their opinions is how Claimant came to be in her present condition.

Dr. Fullmer

75. Dr. Fullmer admitted in his deposition that occupational factors were not contributing in any way to Claimant's respiratory complaints by August 2005, and that probably seventy percent of Claimant's respiratory problems *pre-existed* her work with Employer. Dr. Fullmer continued to believe, however, that thirty percent of Claimant's current condition was attributable to exposure to hair care products in her workplace. Dr. Fullmer based this belief on two factors. First, Dr. Fullmer believed that Claimant's peak flow data was hard evidence of a work connection to her respiratory problems. Second, he saw an increase in the frequency, severity, and difficulty of treating her respiratory complaints starting in 1996, about the same time she enrolled in beauty school. Neither of these factors establish a causal connection between Claimant's symptoms and her employment on a more likely than not basis.

76. Peak Flows. As discussed previously, Dr. Bardana raised substantive questions regarding the methodology by which the peak flow data was collected, its reliability given the way it was collected, and the validity of using serial peak flow measurements as a diagnostic tool in workers' compensation cases. Dr. Fullmer agreed that peak flow data could be unreliable, and expressed no disagreement with Dr. Bardana regarding the method of collection or the usefulness of peak flow data as a diagnostic tool in cases like Claimant's. Peak flow data,

therefore, is evidently of little help in establishing a direct connection between Claimant's symptoms and her work.

77. Frequency, Severity, Responsiveness to Treatment. Dr. Fullmer believed that Claimant's respiratory problems became more frequent, more severe, and more resistant to treatment about the time that Claimant started beauty school and was exposed to hair care products on a regular basis. The medical records tend to support Dr. Fuller's assumption.

Without more, however, such a temporal connection falls far short of establishing causation. As Dr. Bardana noted, one would expect that an individual with COPD would become more symptomatic over time. Claimant herself told several different versions of when her respiratory problems became worse. The first evidence of Claimant making a connection between her work and her symptoms occurred in February 2000, nearly three years after she started working for Employer and four years since she entered cosmetology school. At that time, she believed her symptoms were related to a particular client. When she first saw Dr. Fullmer, she associated her symptoms with cold weather and upper respiratory infections. When she saw Dr. Oehlschlager, she dated the onset of her symptoms to the introduction of a new product line in the spring of 2001.

Dr. Bardana

78. Dr. Bardana addressed a number of factors in Claimant's history and records that support his opinion that Claimant's upper respiratory symptoms were neither caused nor worsened by her work for Employer. Those factors are briefly summarized in the following findings.

79. Asthma/COPD. Dr. Bardana's testimony regarding the disease called asthma was particularly useful in analyzing the evidence in this case. Dr. Fullmer stated that asthma is just

one form of COPD. Dr. Bardana took a great deal of care during his deposition to tease out the underlying differences in the two illnesses, and discussed their differing etiologies. In doing so, he provided a logical and persuasive foundation for his ultimate two-part diagnosis of COPD with (perhaps) a small component of nonallergic adult-onset asthma.

Dr. Bardana clarified that while COPD and asthma are both obstructive lung disorders, they are very different diseases. COPD is chronic obstructive bronchitis, or at its worst, emphysema. Asthma manifests in many different forms, and an asthmatic reaction can be turned on by a number of switches that vary from individual to individual. Asthma can be the result of an allergic reaction, or can be brought on by other activities or events such as exercise, respiratory or sinus infections, or pollution. Individuals with a personal or family history of allergy are more likely to develop allergic asthma. Dr. Bardana opined that based on her medical records, Claimant's symptoms seemed to be triggered by viral infections, and as her symptoms worsened, exercise. This observation is consistent with what Claimant related to Dr. Fullmer when she first saw him.

80. Occupational Asthma. Dr. Bardana discussed two variants of what Dr. Fullmer termed "occupational asthma": *De novo* or new-onset occupational asthma—when an individual develops asthma *for the first time* as a result of occupational exposure, and asthma that is pre-existing, but worsened in the workplace.

81. De Novo Occupational Asthma. Dr. Bardana described two ways that new-onset occupational asthma can develop. One way is by an overwhelming single exposure to a toxicant. For example, a worker with no history of asthma or other obstructive disease who is exposed to a large amount of chlorine gas as a result of an industrial accident could suffer corrosive change in the airways resulting in asthma. Claimant was not subjected to an overwhelming single exposure

to a known toxicant, so this potential cause of *de novo* occupational asthma can be eliminated.

Another way to develop new-onset occupational asthma is for an individual to become sensitized to a substance at work, become allergic to the substance, and then develop allergic occupational asthma. Dr. Bardana opined that the etiology of Claimant's asthma was not consistent with this type of causation for several reasons. First, there was not a strong family or personal history of allergy. Claimant's respiratory complaints were pre-existing and *did not* have an allergic component.

82. Pre-existing Asthma Impacted by Occupational Exposure. Having eliminated *de novo* onset of occupational asthma based on Claimant's history and test results, Dr. Bardana next addressed a second type of occupational asthma—where pre-existing asthma is impacted by work. He explained that there are several ways that the condition of an individual with pre-existing asthma can be impacted by work.

First, a person with a long history of allergic asthma may encounter a new allergen in the workplace that results in a worsening of their condition. For example, an individual who has allergic asthma in response to grass and cats becomes a health care professional, is exposed to latex, and develops an allergy to latex that worsens her allergic asthma. Claimant's asthma was not allergic in nature, excluding this possible cause of her complaints.

Second, a person with pre-existing asthma could be subjected to a single overwhelming exposure. For example, a worker with pre-existing asthma inhales toxic fumes from a chemical spill, permanently worsening their asthma. Claimant sustained no single overwhelming exposure that could have worsened her pre-existing condition.

Finally, a person with pre-existing COPD or asthma can encounter irritants in the workplace that cause temporary symptoms but without long-term impact. For example, a worker

notices a temporary increase in symptoms when a co-worker in an adjacent cubicle uses a particular aerosol cleaner to clean her office. The symptoms resolve fairly quickly (hours or days) once the offending aerosol has cleared, leaving no change in the individual's baseline condition. This, Dr. Bardana asserts, is precisely what Claimant experienced.

83. Material Safety Data (MSDS). Further mitigating against an occupational exacerbation of Claimant's respiratory problems is the nature of the material to which she was exposed and for which she blames her current condition.

The material safety data for the hair products in question established that the products did not cause permanent respiratory changes. None of the materials required respiratory protection, most were used in a form that was not readily inhaled, and only two were noted to cause "mild upper respiratory irritation" if inhaled. Ex. 2 to Dr. Bardana Depo., pp. 46-47. None of the MSDS information identified any of the products or constituents to be capable of causing an immune response and an allergy. Of all the materials safety data that Dr. Bardana reviewed, only one product, Opticurl, an anhydrous permanent wave lotion, was noted to "cause symptomatic expression of preexisting respiratory conditions such as bronchial asthma and/or chronic bronchitis" when inhaled in excessive amounts. *Id.* Nothing in the MSDS for Opticurl indicated that it could be the *de novo* cause of either bronchial asthma or chronic bronchitis or that it could permanently exacerbate pre-existing bronchial complaints. *Id.*

84. Lack of Baseline Pulmonary Function. Noting that Claimant's first PFT was in 2001, almost four years *after* she went to work for Employer, Claimant challenged Dr. Bardana's finding that Claimant's condition was unrelated to workplace exposure. Without pre-employment pulmonary function data, Claimant asserts, it is not possible to determine whether Claimant's condition permanently deteriorated between the time she started work for Employer

and when she had her first PFT.

In response, Dr. Bardana noted that Claimant had refused a PFT as early as 1992. While Claimant disputes this in her brief, the Referee finds the medical record to be the most reliable evidence on this point. Ultimately, Claimant's refusal to take a PFT when first recommended is not dispositive, but at least Claimant should not be heard to complain because of the lack of pre-employment test data.

Dr. Bardana then explained that while a pre-employment PFT might have been helpful, it would still not prove a causal relationship. As noted earlier, Claimant's permanent condition would be expected to decline, so testing might establish a functional decline, but not the reason for the decline. Further, Dr. Bardana noted the testing that *had* been done, including the allergy sensitivity and the IgE results, ruled out allergic asthma. The MSDS information ruled out the workplace chemicals as a cause of *de novo* occupational asthma. The MSDS informal also ruled out that any of the workplace chemicals could cause a permanent exacerbation of Claimant's condition. Claimant's history ruled out single exposure to an identified toxicant. Finally, Dr. Bardana noted, if Claimant's condition was the result of her almost daily exposure to hair care products, her symptoms should have improved after leaving Employer. Instead, her symptoms became worse.

85. Conclusion. Ultimately, Dr. Bardana concluded that while it was possible some small component of Claimant's diagnosis might include adult-onset non-allergic asthma not associated with her work as a cosmetologist, COPD was the primary diagnosis. A diagnosis of COPD was consistent with her personal and family history, particularly as it related to tobacco use, and her history of chronic bronchitis. Dr. Bardana noted that a certain percentage of smokers have a predilection to develop severe COPD and that Claimant was at high risk for

being in this group because of her mother's history of COPD. The development of Claimant's COPD was consistent with her medical history, beginning long before she went to work for Employer—Claimant's symptoms worsened over the years despite aggressive treatment and several different working environments—and did not improve when she left Employer. The facts that Claimant was not allergic, that the chemicals to which she was exposed could not cause respiratory damage, and that her symptoms were largely irreversible, all militate against a diagnosis of asthma. Morbid obesity and acid reflux disease may be exacerbating her condition. While exposure to irritants in her workplace undoubtedly resulted in transient symptomatic expression of her pre-existing COPD, her workplace neither caused nor contributed to her current condition.

CONCLUSION OF LAW

1. Claimant's condition was wholly the result of her pre-existing COPD; any respiratory complaints she experienced while working for Employer were transient symptomatic expressions of her underlying illness, and resulted in no permanent injury. This conclusion renders all other issues moot.

RECOMMENDATION

The Referee recommends that the Commission adopt the foregoing findings of fact and conclusion of law and issue an appropriate final order.

DATED this 23 day of February, 2006.

INDUSTRIAL COMMISSION

/s/ _____
Rinda Just, Referee

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 3 day of March, 2006 a true and correct copy of **FINDINGS OF FACT, CONCLUSION OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon:

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djb

expressions of her underlying illness, and resulted in no permanent injury. This conclusion renders all other issues moot.

2. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this 3 day of March, 2006.

INDUSTRIAL COMMISSION

/s/ _____
Thomas E. Limbaugh, Chairman

/s/ _____
James F. Kile, Commissioner

/s/ _____
R.D. Maynard, Commissioner

ATTEST:

/s/ _____
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 3 day of March, 2006, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

R JEFFREY STOKER
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djb /s/ _____