COMMONWEALTH OF MASSACHUSETTS
DIVISION OF ADMINISTRATIVE LAW APPEALS

December 15, 2023

Middlesex, ss.

Docket No. CR-17-104

FREDERICK W. WILSON, Petitioner

v.

MALDEN RETIREMENT BOARD, Respondent

DECISION

Appearance for Petitioner:

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Administrative Magistrate:

Mark L. Silverstein, Esq.

Summary of Decision

Retirement- Accidental Disability Retirement - Medical Panel Review- Entitlement to Medical Panel - Evidence - Lung Law presumption, M.G.L. c. 94A- Applicability.

After retiring for superannuation in early 2011, petitioner, a former municipal firefighter, filed an application for accidental disability retirement (ADR) with the Malden Retirement Board pursuant to M.G.L. c. 32, §7 and the "Lung Law," M.G.L. c. 32, § 94A, under which a disabling condition that developed while a firefighter (among others) was still working is presumed to have been work-related. Petitioner based his ADR application upon "prolonged exposure to hazardous exhaust fumes from diesel engines of fire apparatus in the fire station," and to "combustion byproducts of burning materials." He claimed to have developed chronic obstructive pulmonary disease (COPD) as a result of this exposure, and that his COPD prevented him from continuing to work as a firefighter after he last worked, in early August 2010. His treating physician filed a statement supporting the petitioner's ADR application. The Board denied the application without first convening a medical panel. In its view: (1) the petitioner had stopped working on account of an orthopedic condition, not a condition related to his lungs, rendering the Lung Law presumption inapplicable; (2) there was no medical support in the record supporting his claim of exposure to lung-damaging fumes on the job; and (3) as a result, there was no basis on which a medical panel could find that the disability the petitioner alleged was possibly work-related, and no basis on which his ADR application based upon exposure to a work-related hazard could be granted.

Following a hearing, the Board's ADR denial is reversed, and the matter is remanded for medical panel review. The petitioner made out a prima facie case showing, with the benefit of the unrebutted Lung Law presumption, that he developed a likely-permanent, and disabling, COPD as the result of a hazard sustained (exposure while he worked as a firefighter to hazardous fumes and smoke. While his treating physician noted exacerbation of his COPD by cigarette smoking as of 2008, before the petitioner stopped working, he did not state that smoking caused his COPD, and no such finding appears anywhere else in the medical records. No competent evidence shows a non-work-related cause of his COPD that rebuts the Lung Law presumption, or that the disabling COPD developed after the petitioner stopped working as a firefighter in August 2010.

Background

Petitioner Frederick W. Wilson, a former Malden, Massachusetts Fire Department lieutenant and firefighter, stopped working in August 2010 after more than 30 years of service, and stayed out

of work on sick leave until his retirement on February 17, 2011 for superannuation pursuant to M.G.L. c. 32, § 5. On June 2016, he filed an application for accidental disability retirement (ADR) pursuant to M.G.L. c. 32, § 7 and the "Lung Law," *see* M.G.L. c. 32, § 94A, based upon a "hazard sustained" in the course of his employment. Lt. Wilson's application described this hazard as chronic obstructive pulmonary disease (COPD) he attributed to prolonged on-the-job exposure to hazardous exhaust fumes from the diesel engines of fire apparatus at the fire station where he had worked, and prolonged exposure to combustion byproducts of burning materials, between November 1979 and February 2011. On February 16, 2017, the Malden Retirement Board denied Lt. Wilson's ADR application without first requesting review, and the firefighter's examination, by a regional medical panel. In the Board's view, Lt. Wilson had stopped working due to his orthopedic complaints, rather than to a condition related to his lungs, and therefore he could not establish entitlement to ADR.

Lt. Wilson timely appealed the Board's decision to the Division of Administrative Law Appeals (DALA) pursuant to M.G.L. c. 32, § 16(4). On November 17, 2017, the parties filed a joint prehearing memorandum including seven proposed hearing exhibits —Lt. Wilson's Exhs. 1-3, Board Exhs. 4-6, and joint Exh. 7, the medical records of Lt. Wilson's treating physician, Dr. George Feltin. The joint memorandum identified the issue to be decided here as whether Lt. Wilson "has established by the evidence's preponderance a prima facie entitlement to an accidental disability retirement and he is therefore entitled to a regional medical panel examination." It also presented the parties' competing positions on this issue:

(1) Lt. Wilson asserted that after 27 years of work as a firefighter, he was diagnosed with COPD by his primary care physician, Dr. George Feltin, in 2007. (*See* Exh. 7.) COPD is a

progressing, disabling and incurable disease. Although Lt. Wilson continued to work as a firefighter for several more years, his COPD ultimately interfered with normal breathing and rendered him incapable of performing the essential duties of his position as a result of shortness of breath and labored breathing upon exertion despite the use of an inhaler. In his physician's statement supporting the accidental disability retirement application, Dr. Feltin opined that Lt. Wilson's condition was presumed related to exposure to smoke as a firefighter, was likely to be permanent, and left him unable to perform his essential firefighter duties as of the summer of 2010, particularly climbing ladders and stairs with a hose, which he was forced to drag. The medical records show that Lt. Wilson presented to Dr. Feltin for increased shortness of breath and dyspnea (difficult or labored breathing) starting in 2008, and that his breath had become characterized by limited inspiration (drawing in of breath) when a chest x-ray was taken on October 13, 2011. His COPD is disabling because continuing to work as a firefighter, even if Lt. Wilson could do so, would pose a reasonable probability that he would suffocate from inability to breathe, a risk that the Board did not assess when it denied his accidental disability retirement application. Although Lt. Wilson had also suffered from shoulder, hip and back pain, and an MRI in August 2, 2010 revealed a mild degenerative disc disease, these orthopedic conditions had not changed significantly over a three-year period prior to that date, and he was able to work and perform daily living activities despite the pain they had caused him. Accordingly, a combination of the Lung Law presumption and the medical records would allow a factfinder to conclude that Lt. Wilson was totally and permanently unable to perform the essential duties of a firefighter as the proximate result of a personal injury sustained or hazard undergone as a result of, and while in the performance of, his duties, and that a medical panel should have been

convened to assess his disability.

(2) The Board asserted that even with the benefit of the Lung Law presumption, Lt. Wilson cannot show that he was permanently unable to perform his firefighter duties as of the last day he actively performed them (in August 2010) as a result of his COPD, the condition on which he based his accidental disability retirement application, *citing, inter alia, Vest v. Contributory Retirement Appeal Bd.*, 41 Mass. App. Ct. 191 668 N.E.2d 1356 (1996). None of the medical records showed that Lt. Wilson stopped working in August 2010 due to his COPD, even though he was diagnosed with this condition before that date. His treating physician's records indicate that Lt. Wilson stopped working due to lower back pain and bilateral hip pain. Although he had COPD at that time, this condition was not why he stopped working in August 2010. His post-retirement chest x-ray, on October 13, 2011, was negative, and Dr. Feltin's records include his observation of no change from Lt. Wilson's July 11, 2008 chest x-ray. As a result, his accidental disability retirement claim cannot be established by a preponderance of the evidence, his claim fails, and the Board properly denied it without first convening a medical panel to examine him and review his ADR application.

I held a hearing on June 6, 2018 at the Division of Administrative Law Appeals in Boston. The hearing was recorded digitally. I marked the seven proposed exhibits the parties had filed prior to the hearing in evidence, with no objection. Lt. Wilson testified on his own behalf; the Board called no witnesses. Following Lt. Wilson's testimony, counsel for each party made a closing statement. The evidentiary record closed at that point, except for the receipt of a written hearing transcript the Board agreed to prepare, and any post-hearing memoranda the parties elected to file. The Board had a transcript of the digital hearing recording prepared by an Approved Court Transcriber (Paula R.

Proulx of Catuogno Court Reporting and StenTel Transcription,) and filed it, together with its post-hearing memorandum, on August 27, 2018.[1] Lt. Wilson did not file a post-hearing memorandum, relying instead upon the arguments he asserted in the joint prehearing memorandum and his counsel's closing argument during the hearing.

Findings of Fact

Based upon the testimony, hearing exhibits and other evidence in the record, and the reasonable inferences drawn from them, I make the following findings of fact:

1. Petitioner Frederick W. Wilson began his employment with the Malden Fire Department as a firefighter on November 25, 1979, and was a lieutenant in the Department when he retired for superannuation on February 17, 2011. (Exh. 5: Employer's Statement, dated Aug. 23, 2016, pertaining to Lt. Wilson's Accidental Disability Retirement Application, at 2.)

2. As a Malden firefighter, Lt. Wilson was a Town of Malden employee and a member of the Malden Contributory Retirement System, one of the Commonwealth's public employee retirement systems governed by M.G.L. c. 32. Respondent Malden Retirement Board (the Board) manages the Malden Contributory Retirement System.

3. Lt. Wilson's essential duties as a Malden firefighter were to answer emergency calls to suppress fires, perform search and rescue operations, and respond to hazardous materials-related incidents, as well as respond to calls for medical assistance and other requests for assistance. He

[1]/ I refer to this transcript below using the abbreviation "TR."

worked as a firefighter in continuous eight-day "cycles" that included two 24-hour shifts (24 hours on duty, 24 hours off duty, 24 hours on duty, and five days off.) All of the on-duty shifts involved physical exertion. (Exh. 1: Lt. Wilson's Accidental Disability Retirement Application Dated Jun. 10, 2016; Wilson cross-examination; TR. at 22, lines 13-20.)

4. Although there is no contemporaneous record for the visit, Lt. Wilson was seen on December 6, 2007, when he was 59 years old, by an unidentified provider for complaints of lower extremity discomfort. This was treated with rest and exercise. (Exh. 3: Records of Massachusetts General Hospital, Discharge Report for December 28-29, 2010 admission (*see* Finding 7 below), at 1, unnumbered para. entitled "History and Reason for Hospitalization and Significant Findings.")

5. On April 30, 2008, Lt. Wilson saw Dr. George Feltin, an internist, regarding increased shortness of breath at rest and dyspnea (labored breathing) despite having used an inhaler (Spiriva) over the preceding month. Lt. Wilson also reported having middle back pain (for which he was taking Celebrex three times weekly), pain on walking radiating from the left calf to the left hip, and similar but less intense pain on his right side, although he reported that he was able to walk more than one mile.

5(a). Dr. Feltin assessed Lt. Wilson as having worsening chronic obstructive pulmonary disease (COPD). He noted, per recent lab results, that Lt. Wilson's LDLs were elevated, and that he was not using his Spiriva inhaler consistently. His observations included "lungs clear" and "heart regular no murmurs or gallops," and Dr. Feltin also noted that an MRI showed no stenosis or herniation.

5(b). Dr. Feltin assessed "[w]orsening COPD due to cigarette smoking," and (based

upon recent lab reports) elevated LDL and hyperglycemia, as well as "Probable sciatica" and hypertension.

5(c). Dr. Feltin prescribed Simvastatin 20 mg at bedtime (for reducing total cholesterol, LDL cholesterol, and triglycerides, and for increasing HDL cholesterol.), directed Mr, Wilson to stop smoking, and advised continued use of a Spiriva inhaler (to prevent COPD-caused bronchodilation) and another inhaler as well (Advair, to treat symptoms of asthma and COPD.

5(d). Dr. Feltin's record of this 2008 office visit made no mention of Lt. Wilson's employment as a firefighter. His notes for this office visit did not state that Lt. Wilson was incapacitated from working, and did not include a recommendation that his work cease or be limited in any way.

\(Exh. 7: Dr. Feltin office visit record, Apr. 30, 2008.)

6. Dr. Feltin next saw Lt. Wilson two years later, on April 24, 2010 regarding his hip and shoulder pain.

6(a). Lt. Wilson told Dr. Feltin that using Celebrex had helped with his hip and shoulder pain, and that when he exhausted his prescription, he had pain in his left shoulder and both hips. He rated this pain as a 5 out of a possible 10. He reported being able to perform all activities of daily living. His blood pressure was in the normal range (112/72).

6(b). Dr. Feltin's assessment was mild DJD (degenerative joint disease) and NIDDM (non-insulin dependent diabetes mellitus). He continued Lt. Wilson on Celebrex, 200 mg. daily for his hip and shoulder pain, along with ibuprofen; and switched him to an albuterol

sulfate inhaler for wheezing. He also suggested that Lt. Wilson try glucosamine (for joint pain).

6(c). Dr. Feltin's notes for this office visit did not identify Lt. Wilson's employment as a firefighter, did not state that Lt. Wilson was incapacitated from working, and did not include a recommendation that his work cease or be limited in any way.

(Exh. 7: Dr. Feltin office visit record, Apr. 24, 2010.)

7. Lt. Wilson saw Dr. Feltin three months later, on July 28, 2010.

7(a). Lt. Wilson complained of lower back pain and bilateral hip and calf pain, stated that he was able to walk one block, and reported obtaining some relief from the lower back pain through occasional use of Celebrex. Lt. Wilson told Dr. Feltin that he had fallen onto his coccyx several weeks earlier, and that while pain in that area was still present, it was getting better, He also complained of aching in his left shoulder since 2009, for which he needed physical therapy.

7(b). Lt. Wilson asked Dr. Feltin for a letter his employer had requested relative to going out on sick leave, advised the doctor that he was retiring as a firefighter in January 2011, and reported being "worried about losing his medical insurance." Dr. Feltin wrote "[t]his is a medical legal case."

7(c). Dr. Feltin's note did not mention Lt. Wilson's COPD or his use of an inhaler or other medications related to breathing issues. The note also did not mention smoking, or any worsening breathing issues related to smoking.

7(d). Dr. Feltin assessed well-controlled diabetes mellitus (Lt. Wilson had reported

following a no-sugar diet, and his most recent A1C (measuring average blood sugar levels over the previous three months) at the time was 5.9 (meaning that it was within the normal range for persons without diabetes). He noted a negative x-ray of the hips, and a negative shoulders x-ray showing mild degenerative joint disease in these areas. However, Lt. Wilson was in pain in the hips, legs and tail bone area. Dr. Feltin made no changes in Lt. Wilson's medications, which were Ibuprofen 800 mg once every 8 hours, and Celebrex 200 mg once daily. He ordered a lumbar spine MRI without contrast, and referred Lt. Wilson for physical therapy.

(Exh. 6: Dr. Feltin office visit record, Jul. 28, 2010.)

8. Lt. Wilson stopped working on August 1, 2010, and went out on sick leave.

8(a). At that time, Lt. Wilson had been working as a Malden firefighter for nearly 31 years. He stopped working because of his breathing difficulties, including shortness of breath. He felt that he could no longer race up a set of stairs to try and rescue someone and that, as a result, he had become more of a hindrance than a help to his firefighting crew, and that he was not doing his job effectively. (Wilson direct testimony; TR. at 14, lines 9-24.)

8(b). Lt. Wilson recalled an incident at some point prior to August 2010 when, because he was out of breath and could not go any further, he had to place a firefighter with whom he had been responding to a fire with a different crew. In part, the lieutenant's breathing difficulties resulted from an empty or nearly empty air tank, but he also felt he could not keep up with his firefighting team partner because his breathing was more labored than usual. (Wilson testimony in response to questions by the Administrative Magistrate; TR.

43, line 4 to 52, line 17.)

8(c). Lt. Wilson had felt his breathing becoming progressively worse starting in 2007. He told Dr. Feltin about it. When the doctor asked how he was doing, told him that it was about the same, going up the stairs, becoming short of breath, but "not dramatically changed." Dr. Feltin noted his COPD, but he understood that his COPD-related breathing difficulties were "the way it's going to be" and that the doctor did not have any alternatives for improving this situation, and so Lt. Wilson saw no point in bringing up his breathing issues during every visit he had with Dr. Feltin, although Dr, Feltin mentioned it sometimes. (Wilson cross-examination; TR. at 19, line 15, to TR. 20, line 13.)

8(d). Lt. Wilson remained out on sick leave until he retired for superannuation on February 17, 2011. (Exh. 5: Employer's Statement, dated Aug. 23, 2016, pertaining to Lt. Wilson's Accidental Disability Retirement Application at 2.)

9. On August 2, 2010, an MRI of Lt. Wilson's lumbar spine without contrast was performed at Dr. Feltin's request. Dr. Peter H. Lee's report of the 2010 MRI noted a history of lower back and bilateral leg pain. He compared the results of the August 2010 MRI with a previous MRI of Lt. Wilson's spine that was performed on July 9, 2007. Dr. Lee interpreted the August 2010 MRI results as showing "minimal degenerative disc disease without canal or foraminal stenosis, or neural impingement." Dr. Lee opined that there had been "no significant change since 7/9/2007." (Exh. 7: Report of MRI performed on Aug. 2, 2020).

10. Dr. Feltin saw Lt. Wilson six weeks after the MRI, on September 14, 2010.

10(a). Lt. Wilson told him that he was not working and had applied to use his sick

time. Lt. Wilson stated that he had seen a physical therapist for low back pain, without relief, and that he had undergone a left hernia repair at Winchester Hospital following pain upon lifting a heavy weight. He complained about continued low back and left inguinal pain.

10(b). Upon examining Lt. Wilson, Dr. Feltin found "the usual shortness of breath." He also noted a blood pressure of 122/78, and a weight of 160 pounds. He noted that Lt. Wilson's lower back pain had improved with ibuprofen use; he was still smoking; his non-insulin dependent diabetes was "well controlled;" and his status was "post-hernia repair." He continued Lt. Wilson's Celebrex and ibuprofen use, and added a prescription for Chantix (to assist with smoking cessation).

10(c). Dr. Feltin's notes for this office visit did not state that Lt. Wilson was incapacitated from working as a firefighter, and did not include a recommendation that his work cease or be limited in any way.

(Exh. 7: Dr. Feltin office visit record, Sept. 10, 2010.)

11. On December 28, 2010, Lt. Wilson was seen by Dr. Robert Schainfeld in the Massachusetts General Hospital's Vascular Clinic for evaluation of lower extremity discomfort, specifically, worsening pain in both legs when walking to the point that he could barely walk two blocks.

11(a). Following a pelvic angiogram that revealed severe high-grade stenoses in the common iliac arteries (showing their blockage, in other words), Lt. Wilson was diagnosed with peripheral artery occlusive disease. The associated diagnoses were hyperlipidemia, diabetes mellitus, gastroesophageal reflux disease (GERD), and hypertensive disorder.

11(b). Lt. Wilson was admitted to MGH and underwent a procedure to insert bilateral stents to relieve his peripheral artery blockage. The procedure left no residual stenoses in these arteries. He was discharged in improved condition with prescriptions for ASA (aspirin), 325 mg. daily, and Plavix (an anti-platelet medication to help prevent harmful clot formation and keep blood vessels open), 75 mg. daily. Prior to discharge, he walked around the unit where the procedure had been performed, climbed some stairs, and reported that the symptoms for which he was treated had improved. He also stated that he had not smoked for 14 weeks. He was scheduled for a followup visit with Dr. Schainfeld four weeks later (in late January 2011).

(Exh. 3: Records of Massachusetts General Hospital, Discharge Report for December 28-29, 2010 Admission at 2-3.)

12. On February 17, 2011, Lt. Wilson retired for superannuation pursuant to M.G.L. c. 32, § 5. (Joint Prehearing Memorandum, Nov. 30, 2017: Agreed Upon Fact No. 4.)

13. Lt. Wilson saw Dr. Feltin again on April 25, 2011, two months after retiring. Dr. Feltin recorded a blood pressure of 138/76 sitting, and a weight of 190 pounds, both increased since the earlier visit in September 2010. Lt. Wilson complained of hip and left shoulder pain, stated that he napped daily and was fatigued, and reported having obstructive sleep apnea but refused to use a CPAP machine. Lt. Wilson also reported drinking "lots of soda." Dr. Feltin noted that Lt. Wilson had undergone the insertion of iliac artery stents to treat peripheral vascular disease. Dr. Fentin's assessment was fatigue secondary to sleep apnea; he ordered Lt. Wilson to follow a no-sugar diet and referred him to an orthopedist. He continued Lt. Wilson's Ibuprofen and Celebrex medication

regime, but added Spiriva Handihaler Caps (prescribed to prevent lung airway narrowing in adults with COPD). (Exh. 7: Dr. Feltin office visit record, Apr. 25, 2011.)

14. Lt. Wilson saw Dr. Feltin again on October 1, 2011 relative to a sore throat that had started a year earlier but had worsened. He also complained of intermittent left flank pain, for which he was taking Motrin with some relief, dizziness, and shortness of breath that had been present for six months despite having quit smoking cigarettes in late 2010. Lt. Wilson's blood pressure was 140/82, and his weight was 191 pounds, both slightly elevated over what they were during the April 25, 2011 visit. Dr. Feltin planned to check a left kidney ultrasound that was ordered to rule out kidney stones, and to check pulmonary function tests. He referred Lt. Wilson for a laryngoscopy. (Exh. 7; Dr. Feltin office visits record, Oct. 13, 2011.)

15. On June 10, 2016, Lt. Wilson filed an accidental disability retirement application with the Malden Retirement Board pursuant to M.G.L. c. 32, § 7 and the Lung Law, M.G.L. c. 32, § 94A. He claimed to have become disabled by COPD that he developed as a result of a hazard undergone while working—exposure to hazardous exhaust fumes from diesel engines of fire apparatus in the fire station, and prolonged exposure to the byproducts of burning materials. He claimed that as a result of these exposures while working as a firefighter, he developed chronic obstructive pulmonary disease (COPD) that prevented him from performing the essential duties of his job, including responding to "any and all fire suppression incidents," following his last day of work in August 2010. (See Exh. 1: Lt. Wilson's ADR Application dated Jun. 10, 2016 at 2, 5, 6).

16. Dr. Feltin prepared a treating physician's statement in support of Lt. Wilson's ADR Application. (Exh. 2.)

16(a). Dr. Feltin checked "yes" as to whether Lt. Wilson was mentally or physically incapable of perming the essential duties of his job as a firefighter, and stated that Lt. Wilson was last able to perform his essential duties during the summer of 2010.

16(b). He described Lt. Wilson's disability as having been "[p]resumed exposure to smoke since 197[9]," when Lt. Wilson started working as a firefighter.

16(c). He listed Lt. Wilson's diagnoses as "COPD, diabetes mellitus, high blood pressure, peripheral vascular disease, and spinal stenosis cervical" based upon "pulmonary function test, laboratory results and stents inserted [in] iliac arteries."

16(d). He opined that Lt. Wilson's disabling COPD was "permanent."

16(e). He also checked "yes" as to whether there was no evidence of a uniquely predominant non-service connected influence on Lt. Wilson's mental or physical condition and/or a non-service connected accident or hazard that had caused his incapacity.

(Exh. 2: Treating Physician's Statement Pertaining to a Member's Application for Disability Retirement, Jun. 28, 2016.)

17. On February 16, 2017, the Malden Retirement Board voted to deny Lt. Wilson's ADR application because, in its view, "the reason Lt. Wilson stopped working was due to his orthopedic complaints, and not a condition related to his lungs, as the records provided demonstrate." (Joint Prehearing Memorandum, dated Nov. 30, 2017; Agreed Upon Fact 9.)

18. On March 3, 2017, Lt. Wilson timely appealed the Board's denial of his ADR application to DALA.

Discussion

1. Entitlement to Regional Medical Panel Evaluation, Generally

a. Accidental Disability Retirement: What the Applicant Must Prove

A public contributory retirement system member may receive accidental disability retirement benefits when he can show a likely-permanent " personal injury sustained" or "hazard undergone," without misconduct on his part, during the performance of essential job duties. *See* M.G.L. c. 32, § 7(1). The ADR applicant must demonstrate either that a disability "stemmed from a single work-related event or series of events," or, "if the disability was the product of a gradual deterioration, that the employment [had] exposed [the employee] to an identifiable condition . . . that is not common and necessary to all or a great many occupations." *Coughlin v. Lawrence Retirement Bd*., Docket No. CR-17-822, Decision at 8 (Mass. Div. of Admin. Law App., May 29, 2020), *and McDonough v. State Bd. of Retirement*, Docket No. CR-15-98, Decision at 12 (Mass. Div. of Admin. Law App., Sept. 8, 2017), *both quoting Blanchette v. Contributory Retirement Appeal Bd*., 40 Mass. App. Ct. 479, 485, 481 N.E.2d 216, 220 (1985).

b. Role of the Lung Law Presumption in Proving ADR Qualification

M.G.L. c. 32, § 94A provides in pertinent part that:

> any condition of impairment of health caused by any disease of the lungs or respiratory tract, resulting in total disability or death to a uniformed member of a paid fire department . . . shall, if he successfully passed a physical examination on entry into such service or subsequent to such entry, which examination failed to reveal any evidence of such condition, be presumed to have been suffered in the line of duty, as

> a result of the inhalation of noxious fumes or poisonous gases, unless the contrary be shown by competent evidence.

As do the other presumptions made available to firefighters under M.G.L. c. 32, (the heart law presumption of M.G.L. c. 32, § 94, and the cancer presumption made available by M.G.L. c. 32, § 94B), the lung law presumption provided by M.G.L. c. 32, § 94A (if it applies) satisfies the causation-related requirements of M.G.L. c. 32, § 7(1), thus sparing an injured firefighter from having to prove that the disabling condition on which his application is based was the reasonable and proximate result of an injury sustained or hazard undergone while performing his duties. More specifically, if the Lung Law presumption applies, it would spare the firefighter with a lung disease from having to prove that, as a firefighter, he was exposed to a hazard such as diesel exhaust from fire engines in the firehouse where he worked frequently, or to smoke from fires he fought; the hazard was known to cause, or possibly cause, the lung disease he developed; or that the exhaust and smoke to which he was exposed was sufficiently hazardous, and inhaled sufficiently in quantity over a particular time, to have possibly caused his lung disease.[2] However, a firefighter seeking accidental

[2]/ In contrast, eligibility for "killed in the line of duty" benefits made available by M.G.L. c. 32, § 100 to the surviving spouse of a firefighter (or police or corrections officer) requires proof of proximate work-related causation as the result of a single event, without the benefit of the statutory heart, lung or cancer presumptions that might apply in the accidental disability retirement context. The required proof of single-event proximate causation without benefit of the presumption may be very difficult, if not impossible, to produce. *See Smith v. Gloucester Retirement Bd. ("Smith II")*, Docket No. CR-19-493, Decision (Mass. Div. of Admin. Law App., Apr. 22, 2022)(evidence did not establish that a firefighter's death from metastatic cancer, following chemotherapy and radiation that had placed his original Stage IV non-Hodgkins' lymphoma into remission for eight years, was the result of his exposure to toxic smoke and fumes during a single, large fire, to the exclusion of cumulative causation over a firefighting career or to his chemotherapy and radiation treatments; consequently, M.G.L. c. 32, § 100 "killed in the line of duty" benefits were not available to the firefighter's surviving spouse).

disability retirement must show proximate work-related causation without the benefit of the lung (or heart, or cancer) presumption if the presumption is rebutted by competent evidence. *See Crichton v. State Bd. of Retirement*, Docket No. CR-21-00548, Decision at 7 (Mass. Div. of Admin. Law App., Sept. 9, 2023) (discussing the operation of the heart law presumption). Here, for example, competent, rebutting evidence rebutting the Lung Law presumption might include medical records showing that (a) the onset of Lt. Wilson's COPD predated the start of his employment as a firefighter; (b) his cigarette smoking was a uniquely predominant non-service related hazard that caused his incapacity; and/or (c) his COPD developed after the last date on which he performed his essential job duties (on August 2, 2010, when he went out on sick leave prior to retiring for superannuation).

c. Medical Panel Evaluation Requirement for ADR Approval, and What the Regional Medical Panel Determines if Convened

No ADR application may be approved until the applicant has been examined by a medical panel, whose function is to determine medical questions that are beyond the common knowledge and experience of a local retirement board. *Coughlin;* Decision at 8, *citing Malden Retirement Bd. v. Contributory Retirement Appeal Bd*., 1 Mass. App. Ct. 420, 423, 298 N.E.2d 902, 904 (1973). Per M.G.L. c. 32, § 7(1), the panel's physician members must evaluate the applicant's condition and complete a certification answering three questions: (1) "whether or not they find that the member is unable to perform the essential duties of the job"; (2) "whether such incapacity is likely to be permanent;" and (3) "whether or not the disability is such as might be the natural and proximate result of the accident or hazard upon which the retirement application is based." *See Fairbairn v.*

Contributory Retirement App. Bd., 54 Mass. App. Ct. 353, 354, 765 N.E.2d 278, 279 (2002). The medical panel, or its individual members) must also submit a separate narrative describing in detail the findings and recommendations on which the certificate was based, and responding to other questions as instructed on the certificate form. *Id*. The panel's certification of affirmative answers to all three questions "is a 'condition precedent' to accidental disability retirement," *Id*.

Medical panel review assures that a board's decision on an ADR application is medically informed, when there is a material medical issue to be decided. It:

> provides an effective vehicle for determining the preliminary medical question which would normally by beyond the competence of the local board. The local board's fact-finding responsibility is not usurped, because part (3) of the medical certificate as defined in [M.G.L. c. 32, §] 6(3)(a) supplies necessary medical fact without which the local board (or the Appeal Board) could not find the ultimate fact of causal connection. The certification by the medical panel that this incident might have been the cause of the permanent disability is not decisive of the ultimate fact of causal connection. It is "in the nature of evidence before the local retirement board."

Malden; 1 Mass. App. Ct. at 424, 298 N.E.2d at 905, *quoting Wakefield Contributory Retirement Bd. v. Contributory Retirement App. Bd.*, 352 Mass. 499, 502, 226 N.E.2d 245, 247 (1967).

d. Proof Needed to Show Entitlement to Medical Panel Evaluation

On appeal from the denial of an ADR application without convening a medical panel, the applicant must make out a prima facie case showing that he is entitled to accidental disability retirement benefits. *Palmer v. State Bd. of Retirement*, Docket No. CR-17-755, Decision at 32-33 (Mass. Div. of Admin. Law App., Feb. 22, 2021), *citing Coughlin v. Lawrence Retirement Bd*., Docket No. CR-17-822, Decision at 9 (Mass. Div. of Admin. Law App., May 29, 2020); *Poirier v. New Bedford Retirement Bd.*, Docket No. CR-15-503, Decision at 8 (Mass. Div. of Admin. Law

App., Aug. 25, 2017)*; and Lowell v. Worcester Regional Retirement Bd.*, Docket No. CR-06-296, Decision at 23 (Mass. Div. of Admin. Law App., Dec. 4, 2009). To do this, the applicant must present sufficient evidence that, if unrebutted and believed, would allow a factfinder to conclude that he was entitled to accidental disability retirement as a result of total and permanent disability by reason of a personal injury sustained or hazard undergone as a result of, and while in the performance of, his job duties at some definite place and at some definite time. *Palmer*; Decision at 33; *Poirier*; Decision at 8.

An ADR application supported by the statement of a treating physician who states that the applicant was disabled by the injury in question, that the injury is likely to be permanent, and that the injury was job-related—in other words, that the applicant likely suffered a permanent, disabling injury while he was performing his job duties as a result of an incident, series of incidents, or unusual job hazard—"would appear to be sufficient to make out a prima facie case" entitling the applicant to be examined by a medical panel. *Palmer*; Decision at 33, *quoting Coughlin*; Decision at 9.

The applicant's burden to make out a prima facie case showing entitlement to medical panel review derives from his burden to show that he qualifies for ADR benefits. That must be done with competent evidence showing the possibility that the disability is permanent and resulted from injuries sustained, or a hazard undergone, by the applicant while in the performance of his duties. *Lowell*; Decision at 23. The proof must show competently, then, the *possibility*, but not the certainty, of these elements.

Similarly, what the medical panel decides per M.G.L. c. 32, § 6(3)(a) is whether there is "the medical possibility of a service connection between the injury alleged and the accident or hazard

undergone," as a result of which an affirmative response by the panel "would indicate only the medical possibility of service connection," and a negative response "would indicate that the medical panel is unable to say that such a possibility even exists." *Malden*; 1 Mass. App. Ct. 420, 426 n. 7, 298 N.E.2d 902, 906 n. 7.

If the petitioner does not show these possibilities under any set of facts, the ADR application may be denied as a matter of law, with or without medical panel review. *Id*. However, if the applicant who was denied ADR without a medical panel review makes out the required prima facie case by showing the medical possibility of a connection between the claimed injury or hazard undergone and the performance of his work duties, the ADR denial must be vacated and the matter remanded for the convening of a medical panel. *Palmer* at 34, *citing Coughlin*; Decision at 22.

It bears reiterating that "the proof required to show entitlement to that medical panel review is not the strict causation standard; it is, instead, the medical *possibilit*y of a connection between the claimed injury or hazard undergone and the performance of his work duties, which suffices to make out a prima facie case for medical panel review." *Palmer*; Decision at 36. *Blanchette* recites no contrary rule, as it decided what proof was needed to show entitlement to ADR, not what proof was required to show entitlement to medical panel review. *Id*. at 35-36. The lower level of proof required of the ADR applicant to secure medical panel review makes sense in the context of overall ADR application review under M.G.L. c. 32, § 7(1). It is the panel's affirmative opinion on all three questions posed to it that the applicant must have to qualify for ADR; it is also an essential element of the proof needed to show, by a preponderance of the evidence, that the work-related injury or exposure was "a significant contributing cause" of his incapacity, per *Campbell* and *Blanchette*. As

a practical matter, the proof needed to obtain this essential evidentiary component cannot be as high as the evidentiary whole—the proof needed to satisfy the ADR prerequisites of M.G.L. c. 32, § 7(1).

2. Sufficiency of Lt. Wilson's Prima Facie Case for Medical Panel Evaluation Purposes

Lt. Wilson presented a prima facie case showing, with competent evidence, the possibility that he developed a likely-permanent and disabling COPD while he was still working as a firefighter as a result of a hazard undergone while he was performing his essential job duties as a firefighter. There is no competent evidence showing non-work-related causation of Lt. Wilson's COPD (cigarette smoking) or that his COPD did not develop, or was not disabling, until after he ceased working.

a. Work-Related Hazard Undergone and Development of Related COPD

A key issue here was whether Lt. Wilson developed COPD while he worked as a firefighter (which would support his ADR theory of a work-related hazard undergone), or whether it developed or became disabling after he last performed the essential duties of his position (in early August 2010), which would not satisfy ADR eligibility requirements.[3]

Lt. Wilson asserted that after 27 years of working as a firefighter, he was diagnosed with COPD on May 14, 2007. This assertion was made at least twice in the petitioner's proposed facts and petitioner's legal arguments portions of the Joint Prehearing Memorandum (at 2 and 5,

[3]/ There is no allegation of misconduct on Lt. Wilson's part relative to his exposure to hazardous fumes and smoke, or to his development of COPD, and therefore no evidence on this point was required of him.

respectively). The record does not show a COPD diagnosis in 2007; however, they do show a confirmation of Lt. Wilson's COPD by his treating physician in 2008, while he was still working as a firefighter.[4]

Dr. Feltin's note for his April 30, 2008 examination of Lt. Wilson addressed his complaint of increased shortness of breath at rest, and labored breathing (dyspnea), despite having used his prescribed Spiriva inhaler over the preceding month. (*See* Finding 5.) Lt. Wilson also voiced non-COPD-related complaints to Dr. Feltin—middle back pain, and pain on walking radiating from the left calf to the left hip, and similar but less intense pain on his right side. (*Id*.)

Dr. Feltin's April 30, 2008 note unquestionably mentions Lt. Wilson's COPD, and states that it was worsening due to cigarette smoking. (*See* Findings 5(a) and (b).) The note does not state that a COPD diagnosis was first made during Lt. Wilson's April 28, 2008 visit to Dr. Feltin; nor does it state when COPD was first diagnosed. It also does not state, or reference, anything from which it could be inferred reasonably that Lt. Wilson's COPD predated the start of his Malden Fire Department employment on November 25, 1979. There is no record (or allegation) of a physical

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[4]/ The origin of the 2007 COPD diagnosis date may be Lt. Wilson's answer, in in his ADR application, as to when he ceased being able to perform all of the essential duties of his position. His answer began with the statement that "[i]nitial onset of COPD in 2007 proved to be challenging." (Exh. 1: ADR Application dated Jun. 10, 2016 at 2.) The alleged 2007 COPD diagnosis was not supported by a reference to any of the hearing exhibits, including the medical records. The medical records do not show a COPD diagnosis for 2007; in fact, there are no medical records from 2007. The only reference to an assessment of Lt. Wilson's health that was made in 2007 appears in Exhibit 3, at the patient history section of the MGH Discharge Report for the December 28-29, 2010 insertion of stents in his iliac arteries. This history mentions a December 6, 2007 evaluation, by an unidentified provider, of Lt. Wilson's lower extremity discomfort, which was treated at that time with rest and exercise. (*Id*.) However, this history does not mention a COPD diagnosis.

examination preceding Lt. Wilson's 1979 entry into service that revealed a preexisting COPD or any other lung condition.[5]

The evidence shows sufficiently that the onset of Lt. Wilson's COPD followed his entry into service as a firefighter on November 25, 1979, and was diagnosed at some point before April 28, 2008, when Lt. Wilson was still working as a Malden firefighter.

b. Whether Lt. Wilson's COPD was Disabling When he Stopped Working

The Board contended, and its cross-examination of Lt. Wilson during the hearing emphasized, that Dr. Feltin's records include no notation that the lieutenant's COPD was disabling, meaning that it was preventing him from performing his essential firefighter duties. In addition, Dr. Feltin noted complaints by Lt. Wilson about his leg and hip pain during his visits, but recorded much less about his breathing difficulties, When asked about this on cross-examination, Lt. Wilson explained that Dr. Feltin knew about his COPD and breathing difficulties in 2007 and after; and that aside from prescribing medication to prevent or relieve bronchospasm and make breathing easier, there was nothing else that could be done about the firefighter's COPD. In these circumstances, Lt. Wilson concluded at the time that there was no point in complaining about his breathing during every visit with Dr. Feltin, and so he did not do so, although on occasion Dr. Feltin asked about it. (*See* Finding 8(c).)

I find Lt. Wilson's explanation credible, as I do his testimony that he felt his breathing

[5]/ The record is without evidence that the firefighter passed a physical examination prior to his November 1979 entry into service, but there is also no allegation that he failed to do so or that the examination revealed a lung condition.

becoming more labored, and was concerned, prior to August 2010, about not being able to keep up with his firefighting team when responding to a fire. It is fully believable that a firefighter would sense more labored breathing, and be concerned about not being able to keep pace with his fire suppression crew, after a long firefighting career such as Lt. Wilson had (over 31 years) and in the course of performing 24-hour shifts as he had done when he was younger. What Lt. Wilson sensed was also corroborated sufficiently by Dr. Feltin's notations about Lt. Wilson's COPD and breathing issues. While these notations are somewhat spare, they appear in Dr. Feltin's office visit records starting in 2008. They show that Dr. Feltin was aware of the COPD and Lt. Wilson's breathing difficulties, and that these conditions were not improving. Inhaler-administered medications, such as Dr. Feltin prescribed for Lt. Wilson from at least 2008 on, provided some relief; however, little more could be done for the lieutenant's COPD, as the condition was chronic, without a known cure, and likely to worsen over time. It was also making his breathing difficult, limiting his ability to perform his firefighting duties, and making him more tired. The nature of COPD and its progression, which are not disputed here,[6] explain why Lt. Wilson (and apparently, Dr. Feltin) saw little need to belabor the COPD diagnosis, its adverse effects upon the lieutenant, and the limitations of available relief, which was to make breathing somewhat easier by using medication such as the doctor continued to prescribe. The brevity of Dr. Feltin's notations do not, as a result, undercut the credibility of his equally terse opinion, in his supporting physician's statement, that Lt. Wilson's

[6]/ As to the nature of COPD and its progression generally, *see, e.g.*, Centers for Disease Control and Prevention, *Chronic Obstructive Pulmonary Disease (COPD)*, https://www.cdc.gov/copd/index.html.

COPD was likely permanent and was disabling by the time the lieutenant ceased working as a firefighter in early August 2010, leaving him unable to perform his essential duties as a firefighter. (*See* Exh. 2 at 2, 3.)

At least for the purpose of showing that medical panel review was warranted, Dr. Feltin's treating physician's statement itself suffices to show that the lieutenant's COPD-related disability had become disabling, likely permanently, before he stopped working as a firefighter and went out on sick leave, and did not "mature subsequently." *See Palmer*, Decision at 33; and *Coughlin*, Decision at 9 (discussed above at 20-21). The evidence therefore suffices to remove any *Vest*-related barrier to applying the Lung Law presumption here in Lt. Wilson's favor, or to medical panel review.

c. No Competent Evidence of COPD's Non-Work-Related Causation

The Board also attempted to excise the Lung Law presumption from this case, and justify ADR denial without convening a medical panel, based upon non-work-related COPD causation (Lt. Wilson's cigarette smoking). This ground neither rebuts the Lung Law presumption nor justifies ADR denial without benefit of a medical panel's opinion.

The medical records include notations to the effect that Lt. Wilson had smoked cigarettes for many years, with several efforts made to cease doing so through late 2011, and that smoking had exacerbated his COPD as of 2008. As noted above, Dr. Feltin's April 30, 2008 assessment was that Lt. Wilson's COPD had worsened due to his cigarette smoking. (*See* Finding 5(b).)

Lt. Wilson's ADR application was not based on the exacerbation of a preexisting COPD by exposure to combustion fumes from fire trucks or from fires. He alleged, instead, COPD causation

based upon on-the-job exposure to this hazard. There is no evidence rebutting the presumption that this exposure occurred during the course of Lt. Wilson's firefighting work. Dr. Feltin's treating physician's statement supporting Lt. Wilson's ADR application asserts that the lieutenant developed COPD as a result of his work exposure as a firefighter to diesel fumes and smoke. Dr. Feltin did not state in his April 28, 2008 visit notes, or in any of his other records for prior or subsequent visits by Lt. Wilson, that cigarette smoking was a uniquely predominant non-service connected cause of, or influence upon, the development of the lieutenant's COPD. No such assessment appears in any of the other medical records. The Board offered no other evidence of a non-service- connected COPD causation, let alone one that was uniquely predominant.

As a result, the record is without competent evidence rebutting the presumption that Lt. Wilson's COPD was "suffered in the line of duty." The Lung Law presumption therefore stands unrebutted. As a result, Lt. Wilson was not required to prove, independent of the presumption, that as a firefighter he was exposed to a hazard such as diesel exhaust from fire engines in the firehouse where he worked frequently, or to smoke from fires he fought. Nor was he required to prove, independent of the presumption, that this exposure was known to cause, or possibly cause, the lung disease he developed. As a result, medical panel review cannot be denied here because the record does not present independence evidence that his exposure to diesel exhaust and combustion smoke over time sufficed to have possibly caused his disabling COPD.[7]

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[7]/ By adding the heart, lung and cancer presumptions to Chapter 32, the legislature spared firefighters (and specified police and public safety employees) disabled by these diseases from having to prove, independently, a causal nexus between their exposure to hazardous fumes or substances and their disabling illnesses in order to qualify for accidental disability retirement

A combination of evidence shows work-related causation by on-the-job exposure to a hazard sufficiently to secure medical panel review of Lt. Wilson's ADR application. In addition to including the unrebutted Lung Law presumption, this evidence also includes Dr. Feltin's medical records noting Lt. Wilson's COPD in 2008, and his treating physician's statement supporting the ADR application. Dr. Feltin's physician's statement includes his opinions that (a) Lt. Wilson's COPD was disabling, likely permanently, and prevented Lt. Wilson from performing the essential duties of his job as a firefighter after August 2, 2010; and (b) there was no competent evidence that a non-service related connected accident or hazard (such as cigarette smoking) caused, or more likely caused, the lieutenant's lung disease-related incapacity.

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unless the presumption was rebutted by competent evidence. (*See* above at 17.)

The presumption is critical in establishing possible causation for ADR purposes without resort to extensive (and expensive) efforts to prove actual work-related causation, or even its possibility. Without the presumption, such proof may not be possible even with extensive expert testimony. For example, although firefighters are known to be exposed to toxic fumes and smoke in the course of their work, and many become disabled by lung conditions (and by heart and cancer conditions as well) over the course of working, and it is possible to correlate this exposure with the risk of developing these diseases, it remains difficult to prove a causative nexus between work-related exposure to hazardous materials and substances with a firefighter's lung, heart or cancer. In the context of a firefighter's lung disease, one unresolved uncertainty is how to differentiate accurately among the different components of smoke and fumes and their various toxicities, in order to evaluate their individual and combined contribution to a particular firefighter's lung-related disability. The most reliable methodology for performing this differentiation remains uncertain as well. *See* J.V. Barbosa *et al.*, *The Effect of Fire Smoke Exposure on Firefighters' Lung Function: A Meta-Analysis*, 20 INT. J. ENVIRON. RES. PUB. HEALTH (International Journal of Environmental Research and Public Health) 14; 16799 (Dec. 2022); available at National Institutes of Health, National Center for Biotechnology Information, National Library of Medicine online, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9779288/.

Conclusion

Lt. Wilson made out a prima facie case showing his entitlement to medical panel evaluation of his ADR application before the Board decides it. The convening of a medical panel to review the medical and other relevant records, examine Lt. Wilson, and answer the statutory questions of disability, its likely permanence and a possible work-related causation, taking into account the Lung Law's presumption, will insure (as Chapter 32 intends) that the Board's decision is medically informed.

Disposition

For the reasons stated above, the Malden Retirement Board's denial of Lt. Wilson's ADR application without convening a medical panel is vacated, and the matter is remanded to the Board for the purpose of convening a a regional medical panel to examine Lt. Wilson and evaluate his ADR application before the Board decides it.[8]

SO ORDERED.

Notice of Rights of Further Review and Appeal

This is the Final Decision of the Division of Administrative Law Appeals (DALA) in this matter. It may be appealed to the Contributory Retirement Appeal Board (CRAB) no later than

[8]/ The parties did not suggest the medical panel's composition as to specialty, such as pulmonology. The medical panel's composition is to be determined by the Public Employee Retirement Administration Commission (PERAC). *See* M.G.L. c. 32, §§ 6 and 7.

fifteen (15) days following the date of the DALA Decision.

M.G.L. c. 32, § 16(4) provides in pertinent part that a retirement appeal decision such as this Decision:

> shall be final and binding upon the board involved and upon all other parties, and shall be complied with by such board and by such parties, unless within *fifteen day*s after such decision, (1) either party objects to such decision, in writing, to the contributory retirement appeal board, or (2) the contributory retirement appeal board orders, in writing, that said board shall review such decision . . . .

(Emphasis added.)

A party objecting to this Decision shall mail specific objections to Uyen M. Tran, Esq., Assistant Attorney General, Chair, Contributory Retirement Appeal Board, Office of Attorney General, One Ashburton Place, 18th floor, Boston, MA 02108. Copies must be sent to the Division of Administrative Law Appeals, 14 Summer St., 4th floor, Malden, MA 02148, and to the other party or parties involved in the case.

Proceedings before CRAB are governed by CRAB Standing Orders, which may be found at: https://www.mass.gov/how-to/file-a-public-employment-retirement-appeal. Pursuant to CRAB Standing Order 2008-1, para. 4.a(2), the notice of appeal must include (a) the date of this DALA Decision; (b) a copy of the DALA Decision; and (c) a statement of the part or parts of the DALA Decision to which objection is made.

The notice of objection must be postmarked or delivered in hand to CRAB no later than fifteen days following the date of the DALA decision. Electronic submissions do not satisfy this filing requirement.

Pursuant to CRAB Standing Order 2008-1, paragraph 4.a(3), within forty days following the

date of the DALA decision, the appellant (the party who filed the Notice of Objection to the DALA Decision) must supplement the Notice of Objection by filing with the Chair of CRAB three copies each, and by serving on each other party one copy, of:

> (a) All exhibits admitted into evidence before DALA, numbered as they were numbered on admission;
>
> (b) A memorandum of no more than twenty pages containing a clear and precise statement of the relief sought and the findings of fact, if any, and legal conclusions to which objection is made, together with a clear and precise statement of the particular facts, with exact references to the record, and authorities specifically supporting each objection; and
>
> (c) If CRAB's passing on an objection may require a review of oral proceedings before DALA, the transcript of the relevant portion of those proceedings.

Do not send any such supplementary materials or exhibits to DALA. Failure to follow CRAB's procedures could lead to sanctions, including dismissal of the appeal.

DIVISION OF ADMINISTRATIVE LAW APPEALS

/s/ Mark L. Silverstein

Mark L. Silverstein
Administrative Magistrate

Dated: December 15, 2023