STATE OF RHODE ISLAND

PROVIDENCE, SC.

WORKERS' COMPENSATION COURT
APPELLATE DIVISION

DENISE (GOODINSON) DELOMBA	)	
	)	
VS.	)	W.C.C. No. 2017-07262
	)	
THE MIRIAM HOSPITAL	)	

FINAL DECREE OF THE APPELLATE DIVISION

This matter came on to be heard by the Appellate Division upon the claim of appeal of the petitioner/employee and upon consideration thereof, the employee's appeal is denied and dismissed, and it is hereby

ORDERED, ADJUDGED, AND DECREED:

That the findings of fact and the orders contained in a decree of this Court entered on April 1, 2019 be, and they hereby are, affirmed.

Entered as the final decree of this Court this 27th day of July 2022.

PER ORDER:

/s/ Nicholas DiFilippo
Administrator

ENTER:

/s/ Olsson, J.

/s/ Feeney, J.

/s/ Conte, J.

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DECISION OF THE APPELLATE DIVISION

OLSSON, J. This matter is before the Appellate Division on the employee's appeal from the trial judge's decision and decree denying the employee's original petition. The employee alleged that she developed airways disease due to exposure to noxious fumes at work on July 30, 2015, resulting in total or partial disability from November 11, 2016 and continuing. After a thorough review of the record and consideration of the arguments of both parties, we deny and dismiss the employee's appeal and affirm the trial judge's decision and decree.

Denise Delomba (the employee) testified that she had worked as a registered nurse at Miriam Hospital (the employer) since 2000. Since 2007, her job duties required her to provide care to patients undergoing testing procedures in the endoscopy unit of the hospital.

Upon her arrival at work on July 30, 2015, the employee entered a breakroom where two (2) co-workers were also present. One co-worker was putting her purse in her locker and the other was making coffee in a Keurig coffee machine. The employee testified that the breakroom was cool, and that she did not notice any smells or odors. She did not eat or drink anything while in the breakroom. Within a few minutes of entering the room, as the employee was putting her

lunch into the refrigerator, she suddenly felt lightheaded and dizzy, as if she might faint. The co-workers also simultaneously fell ill. The employee exited the room and vomited.

The three (3) women were transported by wheelchairs to the hospital emergency room, which was next to the breakroom, for evaluation. The employee recalled complaining of headache, dizziness, and shortness of breath in the emergency room. She also asserted that she was given oxygen and placed on a heart monitor. After several hours of observation, the employee was discharged home. The employee testified that she returned to work the next day. In the days following the incident, she continued to perform her regular job duties despite suffering from headaches, dizziness, and persistent shortness of breath.

The employee stated that, on the day of the incident, she observed construction trucks outside as well as workers on the hospital grounds and on the roof of the building. She also believed that remodeling was taking place inside the building, adjacent to the break room, perhaps twelve (12) to fifteen (15) feet away.

On August 11, 2015, the employee saw Dr. Anthony Rocha, her primary care physician, for her annual physical. She informed Dr. Rocha that she was experiencing headaches and dizziness, which she attributed to a possible sinus infection. Around the third week of August 2015, she left her job with the employer and commenced a similar position with Bayside Endoscopy. The employee stated that she continued to treat with Dr. Rocha for worsening symptoms of headache, shortness of breath, cough, and mucus production. At the time, the employee believed that she was suffering from bronchitis and a sinus infection. She described her sinus infections as a "chronic" problem that would affect her several times a year. Trial Tr. 26:4. She also suffered previous episodes of bronchitis.

On referral from Dr. Rocha, the employee had an initial office visit with Dr. Michael Blundin, a pulmonologist, on October 19, 2016. The employee did not tell Dr. Blundin about the July 30, 2015 incident at that time. The doctor ordered testing and nebulizer treatments. The employee returned to Dr. Blundin on November 10, 2016 and complained of severe shortness of breath and a cough with mucus production so significant that she was required to leave work. Dr. Blundin did not give her a firm diagnosis during that appointment. After a CAT scan revealed that the employee's sinuses were full of mucus, Dr. Blundin referred her to Dr. Robert McRae, who performed sinus surgery in January of 2017. This procedure did provide some headache relief. The employee made a brief, unsuccessful attempt to return to work at Bayside Endoscopy in February 2017; however, she experienced repeated episodes of severe shortness of breath which caused her to stop working entirely.

The employee saw Dr. Blundin again in February of 2017. After reviewing the employee's test results, symptoms, and examination findings, Dr. Blundin diagnosed the employee with bronchiectasis. At that appointment, during a discussion of the possible causes of the condition, Dr. Blundin mentioned chemical inhalation as a possible cause, and the employee told him about the July 30, 2015 incident at the hospital. The employee has continued her treatment with Dr. Blundin, and reported some improvement in her condition, but she believes that she remains unable to perform her regular job.

On cross-examination, the employee acknowledged that she applied for and received Temporary Disability Insurance (TDI) benefits after leaving work in 2016, and that she only pursued the workers' compensation claim after her TDI benefits expired in November 2016. The employee stated that she did not recall telling the emergency room personnel that the break room was warm; rather she recalled that the air conditioning was on because it was summer, and the

room was cool. The employee testified that she could not identify anything in the break room that may have caused the episode.

David Britland, the Director of Facilities at Miriam Hospital, testified that his job duties included responding to air quality issues in the hospital. He recalled reporting to the endoscopy break room on July 30, 2015, around the same time that the Providence Fire Department arrived. He noticed an "overwhelming" smell of coffee upon entering the room, which he estimated was only eight (8) feet by ten (10) feet in size. Trial Tr. 73:10-11, 74:1-2. Mr. Britland testified that the odor emanated from a K-Cup inside the Keurig machine and explained that the odor dissipated once the K-Cup was removed. The fire department tested the air quality of the entire endoscopy suite, including the break room, using a meter that checks for gasses and some chemicals, such as oxygen, carbon monoxide, hydrogen sulfide, NCO, and volatile organic compounds (VOC). Mr. Britland testified that, within approximately twenty (20) to thirty (30) minutes after their arrival, the fire department declared the entire area "all clear" of anything that could pose a threat to life. Trial Tr. 74:7-17.

Mr. Britland stated that the incident was primarily investigated by the Providence Fire Department. At the time of the incident, the hospital's policy was to create a report only if some type of hazardous condition was found. The hospital did not generate any internal documentation for the July 30, 2015 event because the air quality test results were normal. Mr. Britland also stated that construction was not taking place either inside or outside of the building on July 30, 2015. Furthermore, aside from usual maintenance activity, there had been no construction performed on site since 2014. The employer introduced into evidence a document entitled "The Miriam Hospital Schedule to Complete," which showed that the work in the endoscopy area began in January of 2014 and concluded on May 25, 2014. *See* Er's Ex. F. Mr.

Britland stated that there had been no air quality issues in that area since the incident on July 30, 2015.

The records of the Providence Fire Department indicate that at 8:16 a.m. on July 30, 2015, they received a call advising that three (3) nurses "got sick" in the endoscopy department of the hospital. Er's Ex. C at 16. The firefighters arrived on site at 8:27 that morning. They tested the air and found no readings of concern. They advised the hospital maintenance staff to circulate the air and to install a carbon monoxide detector in the room.

The medical evidence considered by the trial judge consists of the employee's medical records from Miriam Hospital on the day of the incident, the deposition and records of Dr. Joseph Lauro, the affidavit, records, and deposition of Dr. Anthony Rocha, the deposition and records of Dr. Michael Blundin, and the employee's records from the office of Dr. Robert McRae.

Dr. Lauro, a specialist in emergency medicine and emergency medical services, testified that he was the physician in charge of the employee's care when she was brought to the Emergency Department on the date of the incident. Upon the employee's arrival, her chief complaint was dizziness. The employee also informed the doctor that she felt hot and nauseous in the nurses' break room. The physical examination did not reveal any significant findings, though the employee reported blurred vision, nausea, vomiting, and sweating. Her chest exam was normal without any wheezes or rales. Dr. Lauro stated that he would have ordered a chest X-ray if there had been anything unusual about the employee's breathing. As the employee did not have any lung, breathing, or respiratory complaints, a chest X-ray was not performed, and oxygen was not administered.

Lab studies performed on that date revealed nothing of significance. In particular, the test for carbon monoxide in the employee's blood was normal. The medical report indicated that any suspicion that the employee's dizziness may have been caused by diminished blood flow to the brain was low. By 10:02 a.m., the employee's dizziness and nausea had improved, but she reported that she still felt foggy. Dr. Lauro's notes in the hospital records state that the fire department's investigation did not reveal any noxious chemicals. He testified that the most notable symptoms of an inhalation injury are shortness of breath, upper airway irritation, and possibly pain. The employee did not voice any of these complaints while in the emergency room.

Dr. Lauro agreed that the warm temperature in the room may have caused the employee's dizziness and vomiting. The doctor testified that there was nothing in the employee's medical presentation, physical examination, or testing that would lead him to conclude that this event caused her bronchiectasis. The employee was discharged at 10:51 a.m. At the time of her discharge, the employee's vital signs were reassuring, her gait was steady, the dizziness had improved, and she was able to tolerate liquids without any nausea.

On cross-examination, Dr. Lauro agreed that it was reasonable to presume that something in the breakroom caused all three (3) women to feel ill at the same time. He acknowledged that the employee may have felt warm because she was nauseous, not because of the room's temperature; he noted, however, that a person can become nauseous from feeling warm. Dr. Lauro also agreed that it is unlikely that three (3) women would become ill just because the room was warm. The doctor's notes reflect that one of the co-workers in the breakroom with the employee also reported that the room felt warm. When pressed on whether the women became ill due to something they inhaled, Dr. Lauro responded, "I don't know what they would have

inhaled that would have made them all sick that we couldn't detect." Er's Ex. B, Dep. of Joseph Lauro, M.D., 20:11-13. He further testified that the theory that the women inhaled something in the breakroom that caused a sudden onset of symptoms is "not an unreasonable assumption. I wouldn't say most likely." *Id.* at 22:8-9. Dr. Lauro acknowledged that some respiratory irritants do not produce immediate symptoms.

On redirect examination, Dr. Lauro identified infection, immune disorders, cystic fibrosis, asthma, COPD, and reactive airway diseases as the most common causes of bronchiectasis. Although he is not a pulmonary expert, Dr. Lauro stated that it was his understanding that toxin inhalation is low on the list of known causes of the disease. In addition, he asserted that there was no "identifiable toxin that caused the constellation of physical exam findings" that he found during his examination of the employee. *Id.* at 29:2-3.

Dr. Rocha, the employee's primary care physician who practices internal medicine, testified that he has been caring for the employee since 1993. Among other conditions, Dr. Rocha treated the employee for recurrent sinusitis (since 2006) as well as bronchial difficulties, chronic obstructive pulmonary disease (COPD), and asthma. At the employee's annual physical on August 11, 2015, she complained of headache, fever, dizziness, and anxiety/stress. She did not have any respiratory symptoms. At the next visit on September 21, 2015, the doctor indicated that the employee complained of a cough with dark green sputum, headache, shortness of breath, and body aches. She was diagnosed with sinusitis, right-sided bronchitis, headaches, and possible bronchial pneumonia. Dr. Rocha treated the employee with medications similar to those he had prescribed for her sinusitis on previous occasions. The employee was taken out of work for four (4) days due to her breathing and sinusitis symptoms.

Three (3) weeks later, on October 8, 2015, the employee still had a cough with acute bronchitis, which Dr. Rocha believed was caused by a bacterial infection. In November and December 2015, the employee continued to treat with Dr. Rocha for sinus pressure, wheezing and cough. He diagnosed the employee with an exacerbation of COPD-asthma caused by sinusitis and bacterial infection and referred the employee to a pulmonologist for a consultation. Dr. Rocha continued to treat the employee for worsening symptoms of what he diagnosed as sinusitis, asthma, and COPD, through December of 2016. By then he had deferred to Dr. Blundin, a pulmonologist, for the treatment of these problems.

At the employee's annual physical on March 21, 2017, she continued to complain of breathing difficulties, which had been diagnosed by the pulmonologist as bronchiectasis. Dr. Rocha testified that until he learned of that diagnosis, he had believed that the employee's symptoms were caused by sinusitis which developed into upper respiratory infections. Dr. Rocha also testified that the employee's blood work revealed an IgG subclass 2 deficiency which causes a diminished immune response to infection. Therefore, the employee has a more difficult time fighting off infections.

Dr. Blundin, a board-certified pulmonologist, testified that he first saw the employee on October 19, 2016. On that date, the employee did not mention the work incident of July 2015. After a physical examination, the doctor thought the employee's complaints were caused by an airways related process, along with sinus issues. Pending further testing, he did not have a firm diagnosis, but his assessment was dyspnea, meaning shortness of breath. Dr. Blundin ordered bloodwork, the results of which indicated that the employee had an ongoing infection or inflammation as well as an IgG subclass 2 deficiency. The employee also underwent an echocardiogram, a CT scan, and pulmonary function tests. The results of these tests showed a

mild to moderate obstructive lung disease with a marked reduction in small airways and small reduction in diffusion capacity. Two (2) weeks later, on November 2, 2016, the employee continued to complain of cough with sputum, chills, shortness of breath, and wheezing. Dr. Blundin adjusted the employee's medications and subsequently performed a bronchoscopy, during which he removed plugs of mucus from her airways.

On February 22, 2017, the employee complained that her symptoms were worse. On that date Dr. Blundin diagnosed the employee with bronchiectasis: a dilation of the airway which can lead to secretions, bleeding, chronic cough, and sputum production. The employee was taken out of work due to the combination of asthma and bronchiectasis symptoms. Since that date, Dr. Blundin has treated the employee with medication, a special vest that oscillates to improve mucus clearance, and several bronchoscopies. Dr. Blundin also referred the employee to a hematologist to treat her low IgG levels.

Dr. Blundin wrote a letter dated November 7, 2017 in which he concluded that it was more likely than not that the July 30, 2015 incident at work caused the employee's respiratory symptoms. In the letter, the doctor noted that the employee stated her symptoms began shortly after the incident at work when she and a couple of co-workers got sick, and she had shortness of breath and nausea and was administered oxygen in the emergency room. In forming his opinion, Dr. Blundin also stated in the letter that the employee did not have a history of respiratory issues and has had severe, persistent respiratory symptoms since the incident.

Dr. Blundin testified that infection is the most common cause of bronchiectasis. Other causes include immunodeficiencies, aspiration or reflux, cystic fibrosis, or ciliary dyskinesia; it can also be idiopathic. Dr. Blundin agreed that he "would assume" that bronchiectasis could also possibly be caused by the inhalation of a toxic substance such as noxious fumes that injure the

airways. Ee's Ex. 10, Dep. of Michael Blundin, M.D., 34:15. Dr. Blundin then listed various causes of asthma such as smoking, allergies, and inhaled irritants. When asked directly, Dr. Blundin replied that there are reports that inhaling noxious substances can lead to asthma.

Dr. Blundin testified that the employee first told him of the July 30, 2015 Miriam Hospital event on March 17, 2017. The employee informed him that there was construction around the endoscopy unit at the time of the incident, and that she became short of breath. Dr. Blundin explained that this information was shared as part of a conversation exploring possible causes of the development of the employee's lung disease.

Dr. Blundin stated that he "can't help but think" that the July 30, 2015 incident at Miriam Hospital and the employee's lung issues are "temporally related." *Id.* at 39:1-7. In response to a lengthy, detailed, hypothetical question on causation, Dr. Blundin opined that "there is a reasonable thought" that the hospital incident "contributed" to the employee's respiratory symptoms. *Id.* at 45:11-14. When asked if that was his opinion to a probability, the doctor responded that he thought so. In providing the basis for his opinion, Dr. Blundin explained that there was a "lot of uncertainty in medicine" and that the employee's illness "could be related" to the July 30, 2015 event. *Id.* at 46:5, 15. At a later point in his deposition, Dr. Blundin testified, "whether [the hospital incident] was the cause or was the inciting event, I can't help but link the two in my head." *Id.* at 47:21-23.

On cross-examination, Dr. Blundin admitted that his opinions expressed during direct examination were based on the history he received from the employee and that any defects in that history could affect his ultimate opinion regarding causal relationship. The doctor admitted that the employee told him that, right after the incident, she was short of breath, and she received oxygen in the emergency room. The doctor also agreed that the employee denied any specific

exposure to toxins or to chemicals at her first appointment. He conceded that he did not know what made the three (3) women ill and that the cause may have been inhalation of a non-toxic substance.

Dr. Blundin acknowledged that he had initially indicated that the employee's incapacity was work-related on forms provided by the Department of Labor and Training to assist her in obtaining TDI benefits, but he crossed out those responses to indicate that her symptoms were due to illness. This occurred in both March and November of 2017. He could not recall why he made those changes to the two (2) documents. The doctor also agreed that other than what was told to him by the employee, he has seen no documentation or evidence to suggest that the employee was exposed to a toxic substance on July 30, 2015.

Dr. Blundin agreed that toxic exposure is low on the list of possible causes of bronchiectasis. Recurrent respiratory infections and immune deficiency are more likely causes of the disease. Dr. Blundin acknowledged that, because idiopathic development is "up at the top of the list" of causes of bronchiectasis, the employee's condition could be unrelated to the July 30, 2015 incident. *Id.* at 83: 7-9. The employee had a history of at least two (2) prior bouts of pneumonia, which alone can cause bronchiectasis. She also had repeated respiratory infections and an immune deficiency. For these reasons, and because bronchiectasis can be idiopathically induced, Dr. Blundin agreed that the employee fit the characteristics of an individual who may have developed this condition independent of any possible incident at Miriam Hospital on July 30, 2015.

At the conclusion of his deposition, on redirect examination, Dr. Blundin was questioned further regarding his causation opinion. He replied that he "just can't help but still find a possible link" between the July 30, 2015 incident and the employee's respiratory problems. *Id.*

at 93:10-11. Dr. Blundin further stated that, if the two (2) co-workers also became acutely ill at the same time as the employee, there was probably a causal connection between an inhaled noxious substance and the development of her airway disease.

In her comprehensive forty-one (41) page written decision, the trial judge carefully reviewed the testimony of the employee as well as that of David Britland. She presented a detailed analysis of the depositions and medical records of Drs. Lauro, Rocha, and Blundin. The judge included all the additional exhibits in her review, such as the records of the Providence Fire Department, the employee's application for employment at Bayside Endoscopy, the affidavit and medical reports of Dr. McRae's office, the records of the Department of Labor and Training, and the listing of construction activities at Miriam Hospital.

Following the recitation of the evidence, the trial judge found that the employee had failed to meet her burden of proof necessary to demonstrate that her incapacity was caused by the July 30, 2015 incident at the hospital. In support of this conclusion, the judge cited the fact that the employee displayed no breathing or lung symptoms in the emergency room, the fact that the fire department found no noxious fumes in their testing, and the fact that evidence demonstrated that construction in the endoscopy area had been completed more than a year before the event on July 30, 2015.

The trial judge acknowledged that Dr. Blundin stated that he thought the subject incident probably contributed to the employee's ongoing respiratory symptoms. The judge noted, however, that the doctor's belief was largely based upon what he described as the employee's rather "benign" medical history prior to the episode at work. Trial Dec. at 37. The trial judge then noted that when Dr. Blundin initially formulated his opinion, he had not seen the employee's medical records regarding her extensive treatment with Dr. Rocha. Furthermore, he

had never reviewed the employee's July 30, 2015 emergency room record, he did not have her co-workers' July 30, 2015 emergency room records, and he did not have the results of the fire department's air quality testing. The trial judge also referenced Dr. Blundin's testimony that he had no independent knowledge or documentation of anything unusual that may have been present in the air of the breakroom on the morning in question.

The trial judge noted Dr. Lauro's testimony that the results of the employee's bloodwork in the emergency room were normal and that the employee did not exhibit symptoms that indicated an inhalation injury. Dr. Lauro also testified that bronchiectasis is usually caused by infections and immune deficiencies. Dr. Lauro found nothing on the date of the incident to suggest any toxin entered the employee's airway system. No evidence was presented to the court that any unusual chemical was present in the breakroom on July 30, 2015, to cause the employee's symptoms.

In her analysis of Dr. Blundin's testimony, the trial judge mentioned his comments that, among the many causes of bronchiectasis, toxic exposure is among the least common triggers for the disease, especially when compared to an idiopathic etiology or a history of repeated infections. Furthermore, the judge referred to Dr. Blundin's testimony that although people develop asthma and bronchiectasis for many reasons, he "just can't help but still find a possible link between the two of them," meaning the incident at work and the employee's condition; however, the doctor acknowledged that the issue of causation is a "tough question" and that a "lot of linking. . .goes on in medicine" to determine causation. Ee's Ex. 10, 93:10-13.

The trial judge concluded by expressing her concern that Dr. Blundin's causation opinion was only based on a process of elimination, while at the same time he acknowledged the numerous more common causes for the development of this disease. The trial judge found that

the significant qualifications in the doctor's opinion rendered his testimony not persuasive, when viewed in its entirety. For these many reasons, the judge concluded that the employee had failed to meet her burden of proof for this essential element in her case and therefore denied her original petition. From this decision and decree, the employee filed a timely appeal.

In reviewing the decision of the trial judge, we must bear in mind that the trial judge's determination that the employee failed to meet her burden of proof is a finding of fact, which shall not be overturned unless it is demonstrated that the trial judge was clearly erroneous. R.I. Gen. Laws § 28-35-28(b); *see Diocese of Providence v. Vaz,* 679 A.2d 879, 881 (R.I. 1996). In applying this deferential standard of review, the appellate panel may not engage in its own de novo review of the evidence without first finding that the trial judge was clearly wrong or overlooked or misconceived material evidence. *Blecha v. Wells Fargo Guard-Company Serv.,* 610 A.2d 98, 102 (R.I. 1992). Following a careful review of the record and the decision of the trial judge, we conclude that trial court's findings are not clearly erroneous, and we therefore deny the employee's claim of appeal.

The employee put forth two (2) Reasons of Appeal, each essentially arguing that the trial judge erred by not accepting the causation opinion of Dr. Blundin. Initially, the employee cites *Hughes v. Saco Casting Co.,* 443 A.2d 1264 (R.I. 1982), contending that the trial court was required to accept Dr. Blundin's "uncontradicted" opinion as it contained no inherent improbabilities or contradictions that alone, or in combination with other circumstances, tended to contradict it.

The condition precedent to this assertion is acceptance of the belief that Dr. Blundin's opinion was, in fact, uncontradicted. This is hardly the case. Dr. Lauro stated that, if the employee had suffered some type of inhalation injury, she would have immediately reported

symptoms of shortness of breath, upper airway irritation, and/or difficulty breathing. The employee did not report any of these complaints in the emergency room. Dr. Lauro testified that there was nothing in the employee's presentation, physical examination, or test results that would lead him to believe that the July 30, 2015 incident caused her bronchiectasis.

Looking at Dr. Blundin's testimony in the light most favorable to the employee, his causation opinion barely reaches the reasonable degree of medical certainty required for an expert's opinion to be considered competent and probative. Citing the "uncertainty in medicine," Dr. Blundin used expressions such as "could be related" and "possible link" when responding to questions about this vital issue. While the employee correctly states that Dr. Blundin did not change his opinion during cross-examination, the testimony elicited did cast significant doubt upon what weight, if any, the court should give that opinion. For example, when Dr. Blundin offered an opinion about the cause of the employee's breathing problems in the November 7, 2017 letter, he did not have access to the employee's medical records from Dr. Rocha or the Miriam Hospital emergency room. At the time Dr. Blundin wrote the letter, he believed the employee both complained of shortness of breath and received oxygen in the emergency room on the date of the incident.

Furthermore, Dr. Blundin conceded that something nontoxic could have made the women sick, and he admitted that he did not know what made them feel ill. On two (2) occasions, Dr. Blundin signed TDI forms indicating that the employee's medical problem was not work-related. Most importantly, he agreed that toxic exposure is at the bottom of the spectrum of possible causes of bronchiectasis, as opposed to an idiopathic cause, which would be at the top of that list. Finally, Dr. Blundin conceded that this disease is more prevalent in patients with prior

pneumonia, an immune deficiency, or a history of repeat infections. The employee had all three conditions independent of the July 30, 2015 incident.

In *Hughes*, the Rhode Island Supreme Court indicated that the trial judge could not "arbitrarily" reject uncontradicted testimony; however, an expert's opinion may be disregarded on the basis of credibility when the trial court explains the reasons for rejecting that testimony. 443 A.2d at 1266. The employee's appeal relies on three (3) Appellate Division decisions as support to argue that a trial judge who fails to accept the uncontradicted opinion of a medical expert should be overruled.[1] On close examination, these decisions do not support the employee's argument because the reasoning in those cases is distinguishable from the instant matter.

In *Elizabeth VanAmersfoort v. Roger Williams General Hospital*, W.C.C. No. 1993-07063 (App. Div. 1996), and *Martin Henao v. NEPTCO Inc.*, W.C.C. No. 2008-03224 (App. Div. 2011), the trial judge's decision was overturned because the finder of fact failed to provide the rationale for declining to accept the opinion of the expert. The Appellate Division reversed the trial judge in *Cecilia Harper v. Caldor, Inc.*, W.C.C. No. 1998-03787 (App. Div. 2000), only after determining that the judge applied an incorrect legal standard in rejecting the medical expert's opinions; thus, the judge's stated basis for not following the expert opinion was clearly wrong. As detailed above, the trial judge in the present matter provided ample reasons for her decision. The trial judge did not arbitrarily reject the weak causation opinion expressed by Dr. Blundin.

[1] The employee cites the following cases: *Martin Henao v. NEPTCO Inc.*, W.C.C. No. 2008-03224 (App. Div. 2011); *Cecilia Harper v. Caldor, Inc.*, W.C.C. No. 1998-03787 (App. Div. 2000); *Elizabeth VanAmersfoort v. Roger Williams Gen. Hosp.*, W.C.C. No. 1993-07063 (App. Div. 1996).

The employee's second reason of appeal is similar to the initial reason of appeal in that it states that the trial judge misconceived, misconstrued, and overlooked the "uncontradicted" expert testimony of Dr. Blundin. In support of her argument the employee claims that the trial judge "erred in requiring the employee to show 'something specific' that she inhaled" as a necessary part of her proof. Ee's Mem. to Appellate Division at 2. The trial judge indicated that one of several reasons that she questioned the strength of Dr. Blundin's opinion was his inability to identify something "specific" to which the employee was exposed. Trial Dec. at 40. The employee analogizes this comment to previous Appellate Division decisions that she believes stand for the proposition that the trial judge committed reversible error by rejecting Dr. Blundin's opinion because he failed to specify exactly what toxin the employee inhaled that caused her condition.[2]

In *Maria Costantino v. Providence Ambulatory Health Care,* W.C.C. No. 1987-8000 (App. Div. 1990), the Appellate Division reversed a trial court decision that denied an employee's petition alleging incapacity due to a workplace allergy. In *Costantino,* the employee only experienced the allergic reaction at the workplace, and her symptoms would subside when she left work. The appellate panel ruled that the uncontradicted testimony of the employee's physician need not identify the specific allergen involved in a situation where there was little question that the employee's disability was due to workplace exposure.

In contrast, not only was Dr. Blundin's opinion contradicted by Dr. Lauro, but both doctors indicated that there were many possible causes for the employee's incapacitating airways disease. Furthermore, while in *Costantino* the evidence clearly indicated that something present

[2] The employee cites *Donna Brown v. Microfibres, Inc.*, W.C.C. No. 1996-06508 (App. Div. 2000); *Dora Keating v. State of Rhode Island,* W.C.C. No. 1994-05813 (App. Div. 2000); *Maria Costantino v. Prov. Ambulatory Health Care,* W.C.C. No. 1987-8000 (App. Div. 1990).

at the workplace was the cause of the employee's work injury, here, no causative substance of any type was ever proven to be present in the breakroom.

In *Dora Keating v. State of Rhode Island*, W.C.C. No. 1994-05813 (App. Div. 2000), the Appellate Division affirmed the trial court finding of apportioned causation in which the specific environmental workplace exposure that triggered the incapacity was never identified. Without significant analysis of the issue, the appellate panel merely applied the extremely deferential standard mandated by Rhode Island General Laws § 28-35-28(b) to determine that the causation finding of the trial judge was supported by the evidence presented. In *Donna Brown v. Microfibres, Inc.*, W.C.C. No. 1996-06508 (App. Div. 2000), the appellate panel does not refer to or discuss the issue of whether there is a need to identify a specific causative agent. In the present matter, it was perfectly appropriate for the trial judge to mention the lack of an identified substance as one of the reasons for her determination that causation was not sufficiently proven.

The employee next asserts that the trial judge misconceived or overlooked Dr. Lauro's acknowledgement that some respiratory irritants may not cause immediate damage but may affect the lungs and airways over time. The employee believes that this testimony may explain why she did not display breathing difficulty while in the emergency room on the date of the incident. While factually accurate, the argument ignores that the trial judge found that the employee neither sufficiently established that any substance possibly inhaled in the breakroom was toxic, nor that her bronchiectasis was caused by inhaled noxious fumes.

Consistent with the deferential standard of review of the Appellate Division we find the trial judge was not clearly wrong in denying the employee's original petition and we, therefore, deny and dismiss the employee's appeal and affirm the decision and decree of the trial judge.

In accordance with Rule 2.20 of the Rules of Practice of the Workers' Compensation Court, a final decree, a proposed version of which is enclosed, shall be entered on July 27, 2022.

Feeney, J. and Conte, J., concur.

ENTER:

/s/ Olsson, J.

/s/ Feeney, J.

/s/ Conte, J.