United States Department of Labor
Employees' Compensation Appeals Board

J.H., widow of D.H., Appellant **and** **DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Boulder City, NV, Employer**	**Docket No. 13-505** **Issued: May 8, 2014**

Appearances:
Toby Rubenstein, for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On January 2, 2013 appellant, through her representative, timely appealed the September 18, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether the employee's May 22, 2001 death was causally related to his federal employment.

[1] 5 U.S.C. §§ 8101-8193 (2006).

FACTUAL HISTORY

This case was previously before the Board.[2] The decedent-employee, a former supervisory mine safety and health inspector, passed away on May 22, 2001 at the age of 54. He suffered cardiac arrest while at home and was transported *via* ambulance to Boulder City Hospital emergency room where he was pronounced dead at 4:06 a.m. The death certificate identified cardiopulmonary arrest as the immediate cause of death.[3]

A June 15, 2001 heart pathology report identified the cause of death as cardiac arrest.[4] The report also revealed left ventricular hypertrophy and subendocardial fibrosis consistent with scarring secondary to a past myocardial infarction involving the posterior left ventricle. There was also evidence of severe coronary atherosclerosis. The right coronary artery was 90 percent occluded, the left anterior descending coronary artery was 80 percent occluded, and the left circumflex coronary artery was 60 percent occluded. There was no coronary thrombosis identified. Additionally, the aortic valve and conduit showed mild atherosclerosis.

Appellant claimed that job-related stress caused her husband's death. She subsequently alleged that the employing establishment failed to inform the decedent-employee of the results of a May 8, 1995 electrocardiogram (ECG) that was administered as part of an employing establishment sponsored periodic medical examination.

The decedent-employee had a lengthy smoking history and reportedly weighed in excess of 200 pounds at the time of death.[5] His primary care physician, Dr. Robert E. Kessler, a Board-certified family practitioner, advised that he last saw the decedent on April 13, 2001 and had never treated him for any heart-related problems.[6] He attributed the employee's death to an acute myocardial infarction and indicated that stress could have been a factor. Dr. Kessler was misinformed about the June 15, 2001 pathology findings and initially believed the decedent's coronary arteries were "fairly clear." After personally reviewing the pathology report, he acknowledged that the decedent-employee had very significant coronary atherosclerosis.

At appellant's request, Dr. Irwin Hoffman, a Board-certified internist with a subspecialty in cardiovascular disease, reviewed the decedent's medical records. In a March 24, 2004 report, Dr. Hoffman noted that the decedent had severe triple vessel coronary artery disease and an old myocardial infarction. Risk factors for developing progressive coronary atherosclerosis included

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[2] Docket Nos. 05-380 (issued October 3, 2005) and 06-2019 (issued March 13, 2007 and February 11, 2008).

[3] An autopsy was not performed.

[4] Appellant had donated her deceased husband's heart valves and associated tissue. The heart specimen analysis and pathology report was part of the organ donor process. Dr. Gregory S. Ray, a Board-certified pathologist, prepared the June 15, 2001 report.

[5] The emergency medical technician indicated that the decedent weighed approximately 100 kg (220 pounds). His latest fitness-for-duty examination in June 1999 noted a height of 5'9" and a weight of 192 pounds.

[6] Dr. Kessler signed the May 29, 2001 death certificate. He began treating the employee in January 1998.

cigarette smoking, mild dyslipidemia and job-related stress.[7] Dr. Hoffman indicated that job-related stress accelerated the decedent-employee's coronary atherosclerosis, making him increasingly likely to sustain coronary disease complications, such as the ventricular fibrillation episode that caused his death. Dr. Hoffman also stated that the failure to inform the decedent of the May 8, 1995 abnormal ECG findings allowed his disease to progress unchecked by medical intervention.[8]

The employing establishment submitted a May 8, 1995 authorization of disclosure of medical information that was signed by the decedent. A copy of all examination components from the May 1995 in-service evaluation were to be sent to the decedent's home address. He also authorized the release of medical information to the employing establishment.

The May 8, 1995 ECG computer printout noted a preliminary assessment of "borderline ECG" and "consider inferior ischemia." However, the examining physician, Dr. John P. Holland, Board-certified in occupational medicine, noted on the same computer printout that the results were "essentially normal" and the employee was "asymptomatic." The employing establishment provided copies of reports dated July 11 and August 15 to 16, 1995, which advised that the decedent-employee should consult with his private physician regarding the recent ECG results, as well as borderline cholesterol, LDL. The employing establishment represented that this information had been conveyed to the employee.

The employing establishment also submitted a May 12, 2004 report from Dr. Barbara J. Connors, Board-certified in both internal medicine and occupational medicine, who reviewed the decedent-employee's medical records, as well as Dr. Hoffman's March 24, 2004 report. She disagreed with Dr. Hoffman's interpretation of the May 1995 ECG results, and instead concurred with Dr. Holland's finding that this study was essentially normal. With respect to job-related stress having played a role in the employee's death, Dr. Connors noted that during his June 24, 1999 in-service examination, the employee denied depression, excessive worry and nervous trouble of any sort.

In a September 15, 2004 report, Dr. Hoffman expressed disagreement with Dr. Connors' opinion. He also noted that the decedent-employee reported depression or excessive worry during his May 8, 1995 in-service examination, which Dr. Hoffman found responsible for the employee's then-elevated cholesterol. In a March 31, 2006 report, Dr. Hoffman reiterated both his finding that the employee's death was job related, as well as his challenge to Dr. Connors' opinion.

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[7] Dr. Hoffman noted the decedent-employee could not accomplish his job without working nights and weekends. He also noted the decedent received personal and legal threats as a result of a mine investigation. OWCP accepted as compensable the factor that the decedent worked prolonged hours and that he had been threatened regarding the Rattlesnake Pit mine investigation.

[8] Dr. Hoffman interpreted the May 1995 ECG as demonstrating abnormalities diagnostic of an inferior wall myocardial infarction. A preemployment ECG from September 1991 was reportedly normal.

The last time the case was on appeal, the Board set aside OWCP's August 15 and March 14, 2006 decisions and remanded the survivor's claim for further medical development.[9] The Board initially found a conflict in medical opinion between Dr. Connors and Dr. Hoffman based on the mistaken belief that OWCP had referred the record to Dr. Connors. On petition for reconsideration before the Board, the Director of OWCP noted that the employing establishment secured Dr. Connors' May 12, 2004 report, not OWCP. As such, there was no conflict in medical opinion. Rather than remand for an impartial medical evaluation, OWCP requested that the case be referred for a second opinion evaluation. Accordingly, by order dated February 11, 2008, the Board modified its March 13, 2007 decision, and remanded the case to OWCP for referral to a Board-certified cardiologist for a second opinion evaluation.[10]

Since the case was last on appeal, OWCP prepared a July 1, 2008 statement of accepted facts and then amended it three times, most recently on October 5, 2011. Additionally, it has referred the case record for three second opinion evaluations and two impartial medical evaluations (IME). Appellant's claim has been consistently denied by OWCP, and the Branch of Hearings and Review has remanded the case on several occasions for further development.

By decision dated September 20, 2011, the hearing representative found a conflict in medical opinion between Dr. Hoffman and Dr. Raye L. Bellinger, a Board-certified cardiologist and OWCP-referral physician. In a December 16, 2010 report, Dr. Bellinger indicated that there was insufficient evidence to conclude that any factor(s) of employment caused, precipitated or contributed to the employee's May 22, 2001 death due to myocardial infarction. In reports dated January 22 and February 15, 2011, Dr. Hoffman disagreed with Dr. Bellinger, particularly his finding of death due to myocardial infarction. He indicated that death threats the decedent-employee received caused stress, which more than likely precipitated his fatal arrhythmia.

In a report dated October 23, 2011, Dr. Anjum Ismail, a Board-certified internist and IME, indicated that there was no evidence the employee died of an acute fatal myocardial infarction.[11] He explained that there was no acute myocardial damage or coronary thrombosis noted in the heart pathology report, but there was evidence of chronic coronary artery disease with previous myocardial damage and scar involving the posterior wall of the left ventricle. Dr. Ismail indicated that the most likely cause of death was a fatal ventricular arrhythmia due to electrical instability of damaged myocardium. He then proceeded to address the question of what triggered the arrhythmia. Dr. Ismail explained that factors of having a stressful job, working long hours, being involved in a job-related investigation in April 2000, and receiving threatening calls "can all exacerbate a cardiac condition." However, these factors alone did not cause the underlying chronic coronary artery disease. Dr. Ismail indicated that the decedent's 40-year smoking history, his elevated cholesterol and gender (male) were all important risk factors in the development of coronary artery disease. He also discussed the prevalence of sudden cardiac death in the U.S. and identified risk factors, such as chronic smoking and left

[9] The Board had earlier found that the decedent-employee's regular job duties of investigating fatalities and carrying out his supervisory duties, including investigating those employees he supervised, were also compensable.

[10] The Board's prior decisions are incorporated herein by reference.

[11] Dr. Ismail is also Board-certified in the subspecialties of cardiovascular disease and interventional cardiology.

ventricular hypertrophy. Dr. Ismail further noted that coronary artery disease and scarred myocardium are sufficient to provoke ventricular tachyarrhythmia causing sudden cardiac death. He explained that the decedent had a scar on the posterior wall of this heart, which was evidence of a prior myocardial infarction.[12]

Dr. Ismail found that the decedent-employee suffered sudden cardiac death from most likely a fatal ventricular arrhythmia rather than an acute fatal myocardial infarction. The arrhythmia occurred because of underlying coronary disease. Dr. Ismail further explained that the decedent developed coronary artery disease because of multiple risk factors. In response to the question of whether job-related stress could have aggravated the decedent's coronary artery disease, Dr. Ismail stated "It remains a possibility."

In a supplemental report dated January 2, 2012, Dr. Ismail discussed the difference between ventricular tachycardia (VT) due to acute ischemia versus VT due to structural heart disease (myocardial scar). He reiterated that the most likely cause of the employee's death was fatal ventricular arrhythmia due to electrical instability surrounding the previous myocardial damage and scar involving the posterior wall of his left ventricle, as noted on the pathology report.

By decision dated March 15, 2012, OWCP denied appellant's claim based on the IME's opinion. It subsequently denied modification in a September 18, 2012 decision.[13]

LEGAL PRECEDENT

FECA provides for the payment of compensation for the disability or death of an employee resulting from personal injury sustained while in the performance of duty.[14] Appellant has the burden of proving by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to his or her employment.[15] This burden includes the necessity of furnishing rationalized medical opinion evidence demonstrating a causal relationship.[16] The physician's opinion must be based on a complete factual and medical background, must be expressed in terms of a reasonable degree of medical certainty, and must be

[12] Dr. Ismail noted the results of particular study which revealed that as many as half of myocardial infarctions may be clinically silent and unrecognized by patients. He also provided statistical data on U.S. deaths due to cardiovascular disease, including the number of annual deaths due to coronary heart disease.

[13] Appellant's representative questioned whether OWCP's September 18, 2012 decision was a non-merit denial of reconsideration or a merit view denying modification. The Board acknowledges that the notice of decision is internally inconsistent. OWCP stated that a "merit review was undertaken," but later concluded that the new evidence submitted was insufficient to "warrant a merit review of the prior decision." Despite the contradictions in the body of the decision, the September 18, 2012 cover page indicated that OWCP had "not modified [its] prior decision," but had evaluated the evidence submitted and "reviewed the merits of [appellant's] case." Based on this latter representation, the Board will exercise jurisdiction over the merits of the claim.

[14] 5 U.S.C. §§ 8102(a) and 8133.

[15] *L.R.*, 58 ECAB 369, 375 (2007).

[16] *Id.*

supported by medical rationale explaining the relationship between the employee's death and his or her previous employment.[17]

If there is disagreement between an OWCP-designated physician and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[18] For a conflict to arise the opposing physicians' viewpoints must be of "virtually equal weight and rationale."[19] Where OWCP has referred the case to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well reasoned and based upon a proper factual background, must be given special weight.[20]

ANALYSIS

Appellant's representative argued that the employing establishment was liable for the employee's May 22, 2001 death because of its failure to disclose to him the abnormal results of his May 8, 1995 ECG. The purported failure to disclose this information allegedly caused a deleterious effect on the course of the employee's cardiac condition.

Coverage for the deleterious effects of employer-provided medical services is limited to "employees who are voluntary participants in the employer's sponsored health service program...."[21] Deleterious effects of employer-provided medical services may be unavoidable or may occur because of error or agency failure to report examination results to the employee or to the employee's physician in time to alter the course of a disease.[22] They may also result from an act such as inadvertently administering the wrong drug, or failure to inform an employee of positive test results.[23] Following appropriate development, all cases of this type should be referred to a district medical adviser for an opinion on whether the condition claimed was causally related to the agency medical service or was adversely affected by the failure to promptly alert the employee or the employee's physician.[24]

Dr. Hoffman surmised that had the decedent-employee been provided information regarding the May 8, 1995 ECG results, his life would have been prolonged. First, there is a difference of opinion regarding the interpretation of the May 8, 1995 ECG results. While Dr. Hoffman believed the results were indicative of a prior myocardial infarction, Dr. Holland, who reviewed the study in conjunction with his 1995 examination of the employee, interpreted the ECG findings as essentially normal and noted that the employee was asymptomatic at the

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[17] *Id.*

[18] 5 U.S.C. § 8123(a); *see* 20 C.F.R. § 10.321 (2012); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[19] *Darlene R. Kennedy*, 57 ECAB 414, 416 (2006).

[20] *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

[21] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Performance of Duty*, Chapter 2.804.19b (March 1994).

[22] *Id.* at Chapter 2.804.19d.

[23] *Id.*

[24] *Id.* at Chapter 2.804.19e.

time. Also, Dr. Connors disagreed with Dr. Hoffman's interpretation of the May 8, 1995 ECG results. Second, the record does not demonstrate that the employing establishment failed to disclose the May 1995 in-service examination findings and test results to the employee. According to the release signed by the employee, this information was to be mailed to his home address. Also, the employing establishment prepared contemporaneous reports disclosing the May 1995 ECG findings, as well as information regarding the employee's borderline cholesterol results. Whether or not he personally received this information is unclear, and unfortunately, the decedent-employee is unavailable to shed light on the issue. The fact that appellant and Dr. Kessler were previously unaware of the May 1995 test results is not proof that the employing establishment failed to timely disclose the information to the decedent-employee.[25] Apart from Dr. Hoffman's speculation, there is no proof that the employee's May 22, 2001 death was adversely affected by the employing establishment's purported failure to promptly alert him of the May 1995 examination results.

Appellant's representative also invoked the human instincts doctrine as a basis for liability. However, her reliance on this doctrine is misplaced. An employer has the duty to make reasonable efforts to procure medical aid or other means of relief for an employee who becomes ill or injured on the job, and as a result is helpless to provide for his own care.[26] A failure to satisfy this duty -- the human instincts doctrine -- may be sufficient to establish a causal connection between an employee's condition and the employment if it is shown that the employer's failure contributed to the claimed condition.[27] The decedent employee was off-duty and at home just prior to his death at 4:06 a.m. on May 22, 2001. Consequently, the human instincts doctrine is inapplicable.

Notwithstanding the above-noted findings, the question of whether the employee's death was employment related is not in posture for decision. Dr. Ismail, the IME, did not adequately resolve the issue of whether job-related stress contributed to the decedent-employee's coronary artery disease. In his October 23, 2011 report, Dr. Ismail stated "It remains a possibility." Earlier in his report, the IME noted that the factors of having a stressful job, working long hours, being involved in a job-related investigation in April 2000, and receiving threatening calls "can all exacerbate a cardiac condition." He did not definitively state whether the decedent-employee's job duties exacerbated his cardiac condition. The IME merely noted that it remains a possibility. Thus, the question remains as to whether the accepted compensable employment factors contributed to the employee's May 22, 2001 cardiac arrest.

The IME's report must actually fulfill the purpose for which it was intended; it must resolve the conflict in medical opinion.[28] OWCP should ensure that the IME's report is comprehensive, clear and definite and that it is based on current information and supported by

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[25] Moreover, Dr. Kessler did not begin to treat the employee until approximately two-and-a-half years later.

[26] *J.W.*, Docket No. 11-1655 (issued May 18, 2012); *Joseph J. Rotelli,* 40 ECAB 987, 992 (1989).

[27] *J.W.*, *id.*

[28] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing & Evaluating Medical Evidence*, Chapter 2.810.11d(2) (September 2010).

substantial medical reasoning, as well as a review of the case file.[29] If the referee specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues or conflict, OWCP is obliged to seek clarification from the IME.[30] Because of the above-noted defect in Dr. Ismail's opinion, the Board finds the case is not in posture for decision. Accordingly, OWCP's September 18, 2012 decision shall be set aside and the case remanded for further development.

If Dr. Ismail is either unwilling or unable to provide the necessary clarification, then OWCP should refer appellant to another IME.[31] After OWCP has developed the case record consistent with the Board's directive, a *de novo* decision shall be issued.

CONCLUSION

The case is not in posture for decision.

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[29] *Id.*

[30] *Id.* at Chapter 2.810.11e.

[31] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the September 18, 2012 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further action consistent with this decision of the Board.

Issued: May 8, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board