

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of IRVING WINTER and DEPARTMENT OF DEFENSE  
Columbus, OH

*Docket No. 02-526; Submitted on the Record;  
Issued November 13, 2002*

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DECISION and ORDER

Before ALEC J. KOROMILAS, WILLIE T.C. THOMAS,  
MICHAEL E. GROOM

The issue is whether appellant established that he sustained new employment injury or a recurrence of disability on September 8, 1999 causally related to his October 28, 1991 accepted injury.

On November 8, 1991 appellant, then a 58-year-old contract administrator, filed a traumatic injury claim alleging that on October 28, 1991 he sustained a heart attack in the performance of duty. On December 12, 1991 the Office of Workers' Compensation Programs accepted appellant's claim for an acute myocardial infarction.<sup>1</sup>

On September 26, 1999 appellant filed a notice of recurrence alleging that, on September 8, 1999, he had a recurrence of his October 28, 1991 employment injury.<sup>2</sup>

On November 1, 1999 an Office medical adviser indicated that appellant's underlying coronary artery disease predated the myocardial infarction of October 28, 1991 by at least 12 years. He explained that it was a progressive disease that produced increasing disability over the course of the years and there was no evidence that the disease was caused by appellant's employment. He stated that the myocardial infarction of October 28, 1991, was a self-limiting event, which produced a permanent loss of a certain portion of the heart muscle. The Office medical adviser explained that the recurrent ventricular tachycardia was a complication of coronary artery disease and not the myocardial infarction of October 28, 1991.

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<sup>1</sup> The record reflects that appellant stopped work on the date of the injury and returned to light duty on January 27, 1992. The Office also authorized bypass surgery on April 12, 1995 when appellant stopped work and returned to full duty on July 17, 1995. The record also reflects that appellant had a history of prior myocardial infarction and angina. Additionally, the Office authorized a cardiac rehabilitation program on September 11, 1998.

<sup>2</sup> Appellant alleged that his myocardial infarction of September 8, 1999 was related to the October 28, 1991 injury. The record reflects that appellant returned to work on July 17, 2000.

By letter dated November 3, 1999, the Office advised appellant of the medical evidence needed to establish his recurrence claim.

In a response received by the Office on November 5, 1999 appellant noted that, “on September 8, 1999, I passed out in my office, I was treated by the rescue squad and rushed to the hospital. I needed surgery to put a defibrillator into my chest because I had a near-death experience. The [physician] put in an Implantable Defibrillator (ICD). The [physician] said this was necessary, because of scar tissue in my heart from the heart attack that I had in 1991, for which I am already on workmen’s compensation.” In a second response received on November 15, 1999, appellant stated: “In the last two to three years because of downsizing in the [D]efense [L]ogistic [A]gency, the pressure and the amount of work in my office has increased tremendously. My caseload increased little by little until it became intolerable. I had been going home at night exhausted. Other people in the office began to feel pressured too. As a result of the pressure one of them became very ill. The day I collapsed and the week before I was exhausted a good deal of the time I was in the office from overload of work.”

On April 6, 2000 the Office determined that appellant was alleging both a new occupational injury and a recurrence of disability and undertook development of both issues.

In a report dated December 7, 1999, Dr. Lou-Anne M. Beauregard, Board-certified in internal medicine, stated that appellant: “suffered a cardiac arrest at his desk at Fort Monmouth at the end of August, 1999.” Dr. Beauregard stated that, “I believe that his cardiac arrest was caused by an episode of ventricular tachycardia arising from the border zone of the aneurysm that developed as a result of the heart attack that he suffered on October 28, 1991.” She noted further that: “[t]he ventricular tachycardia was followed by a ventricular fibrillation, in which he was found by the paramedics and successfully resuscitated. He did not suffer a heart attack during this cardiac arrest and this is a common scenario for sudden cardiac death in patients with coronary artery disease and left ventricular aneurysms.” Dr. Beauregard explained that, prior to the 1991 infarct, appellant did not have a definable aneurysm and there were no documented arrhythmias. She noted that it could take months to years for ventricular tachycardia to occur following an index heart attack and opined that it was her opinion that the sequence of events that led to appellant’s cardiac arrest was related to appellant’s heart attack of October 28, 1991.

On April 26, 2000 the Office referred the case file to an Office medical adviser, who explained in a May 3, 2000, response that Dr. Beauregard did not take into account the preexisting progressive coronary artery disease. The medical adviser indicated that the fact of progression was attested to by the need for the coronary bypass surgery in 1995, four years after the accepted myocardial infarction. He explained that the ventricular aneurysm was present since at least 1994 on catheterization.

By letter dated July 11, 2000, appellant explained that he was not claiming a new occupational disease, but a recurrence of disability and enclosed the December 7, 1999 report, from Dr. Beauregard.

In the July 26, 2000 report, Dr. Beauregard explained that she did not discuss the involvement of the appellant’s job stresses, if any, in precipitating his cardiac arrest. Dr. Beauregard explained that, if someone had a myocardial infarction, there would be a

localized scar which could produce a reentrant circuit within the ventricular myocardium leading to ventricular tachycardia. She opined that it was well established that ventricular tachycardia might develop at any point after an infarction and was not limited to a specific time frame. Dr. Beauregard explained that what triggered an onset of ventricular tachycardia or fibrillation on a given day was complex and might involve myocardial ischemia, high catecholamine levels, as in stress, or electrolyte abnormalities. She further noted that the consultant provided by the Office was not a cardiac electrophysiologist. Dr. Beauregard indicated that his perspective on the sequence of events reflected that, “[w]hile the underlying coronary disease is a factor in the general likelihood of arrhythmias, it is the scar from his 1991 infarction that is most likely to have created a substrate for cardiac arrhythmias. If there is no other documented infarction or scar, then it is probable that ventricular mapping during an electrophysiology study might localize the site of origin of his tachycardia to the site of his 1991 infarction. A formal electrophysiologic study with such mapping was not undertaken in this case. The reason for this was that, for his problem, *i.e.*, cardiac arrest, the only effective long-term therapy is an automatic defibrillator. If this is the best treatment option, the electrophysiology study is superfluous.” She stated further that: “[t]his patient was under the care of my partner, Dr. Ted Gutowski, at the time of both his bypass surgery and prior to the cardiac arrest. He may well have more information regarding the issues raised by Dr. Duggan regarding the chronicity of [appellant’s] problems. I suggest that we get him involved in this appeal.”

In a July 27, 2000 report, Dr. Beauregard opined that she thought that a report could be prepared that might support appellant’s case, however, it would probably take five to six hours to prepare, including references from the medical literature. She explained that, unfortunately, in appellant’s situation there was no cut-and-dry answer. Dr. Beauregard offered that:

“[o]ne could argue that if he had primary ventricular fibrillation that this was due to chronic coronary disease dating back to 1970. If one argues that ventricular tachycardia preceded the ventricular fibrillation (which is what I believe because of some ventricular tachycardia in the hospital and because of a relative lack of anoxic brain injury) then this was due to the aneurysm that developed from the heart attack in 1991. In either case, I need to bring all three volumes of his chart home and make multiple copies of records so that we can respond carefully and this will take me some time. If you want to answer the government of the issue of mental stress or job stress preceding the event, you need to get a report from my partner. [Appellant] and I discussed that he was stressed at work but it did not strike me that he was inordinately or acutely stressed prior to this event and I will provide, in my report, studies examining the role of stress in producing cardiac arrest.”

By decision dated December 8, 2000, the Office denied the claim finding that appellant failed to establish fact of injury.

By decision dated December 14, 2000, the Office denied appellant’s claim for recurrence of disability, finding that he failed to submit rationalized medical evidence sufficient to establish

that the claimed condition or disability as of September 8, 1999, was caused or aggravated by the accepted October 28, 1991 employment injury.<sup>3</sup>

By letters dated December 13 and 18, 2000, appellant, through his representative, requested a hearing. The hearing was held on May 15, 2001.

During the hearing, appellant denied that he had had a history of angina in 1970, but confirmed that he had a prior heart attack in 1979 and open heart surgery in 1980.

By letter dated May 29, 2001, appellant's representative submitted a May 23, 2001 report from Dr. Gutowski, Board-certified in internal medicine. He stated:

“[Appellant] did indeed experience ventricular tachycardia requiring defibrillation and eventually the insertion of an automatic implantable cardioverter defibrillator. Clearly, ventricular tachycardia is a sequela of a scarred myocardium secondary to the myocardial infarction which he experienced in 1991.”

Dr. Gutowski explained that, with regard to when appellant first experienced any symptoms related to coronary disease, he noted that appellant's first awareness of his heart condition did not occur until his first heart attack in December 1979. Dr. Gutowski opined that he did not believe that appellant was aware of or had a prior heart condition, prior to December 1979.

By decision dated July 27, 2001, the Office hearing representative affirmed the decisions of December 8 and 14, 2000.<sup>4</sup>

The Board finds that appellant has not met his burden of proof in establishing that he sustained a new employment injury or a recurrence of disability on September 8, 1999 causally related to his accepted employment injury of October 28, 1991.

An individual who claims a recurrence of disability due to an accepted employment-related injury has the burden of establishing by the weight of the substantial, reliable and probative evidence that the disability for which compensation is claimed is causally related to the accepted injury.<sup>5</sup> This burden includes the necessity of furnishing medical evidence from a physician who, on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to employment factors and supports that conclusion with sound medical reasoning.<sup>6</sup> An award of compensation may not be

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<sup>3</sup> The record reflects that, by letter of same date, the Office advised appellant that his claim had been doubled under File No. 030169895.

<sup>4</sup> The Office hearing representative addressed the claim as a recurrence and also addressed fact of injury.

<sup>5</sup> *Lourdes Davila*, 45 ECAB 139 (1993); *Dominic M. DeScala*, 37 ECAB 369, 372 (1986); *Bobby Melton*, 33 ECAB 1305, 1308-09 (1982).

<sup>6</sup> *See Nicolea Bruso*, 33 ECAB 1138, 1140 (1982).

made on the basis of surmise, conjecture or speculation or on appellant's unsupported belief of causal relation.<sup>7</sup>

In this case, the Office accepted that appellant sustained a myocardial infarction in the performance of duty on October 28, 1991; the Office paid appropriate compensation and appellant returned to full duty on July 17, 1995. He subsequently sustained a second heart-related injury and filed a notice of recurrence of disability commencing September 8, 1999. The Office requested that appellant provide medical evidence that would establish a causal relationship between his current condition and his accepted disability. Appellant did not submit any medical evidence that his present condition was causally related to his October 28, 1991 employment injury. For example, appellant did not submit a medical report, in which his treating physician explained why his claimed continuing condition would be related to the October 28, 1991 accepted injury.

Appellant submitted reports from Dr. Beauregard. In her December 7, 1999 report, Dr. Beauregard indicated that she believed that appellant's cardiac arrest was caused by an episode of ventricular tachycardia arising from the border zone of the aneurysm that developed as a result of the heart attack that he suffered on October 28, 1991. Dr. Beauregard explained that, prior to the 1991 infarct, appellant did not have a definable aneurysm and there were no documented arrhythmias and stated that it was her opinion that the sequence of events that led to appellant's cardiac arrest was related to appellant's heart attack of October 28, 1991. The record reflects that appellant himself confirmed that he had a history of heart attacks as far back as 1979 and Dr. Gutowski, also confirmed that appellant had a heart attack back in 1979. However, Dr. Beauregard did not provide any rationale for her conclusion that appellant's condition was related to the accepted employment injury of October 28, 1991. Moreover, Dr. Beauregard's reports were based on an incomplete and inaccurate history of injury as she never referenced or referred to any of appellant's previous injuries or explained why or how appellant's condition was or was not affected by them. The Board had held that medical reports not containing rationale on causal relationship are entitled to little probative value.<sup>8</sup> Additionally, medical reports based on an incomplete or inaccurate history are also entitled to little probative value.<sup>9</sup>

In her July 26, 2000 report, Dr. Beauregard explained that she did not discuss the involvement of appellant's job stresses, if any, in precipitating his cardiac arrest. She also explained that, if someone had a myocardial infarction, there would be a localized scar, which could produce a reentrant circuit within the ventricular myocardium leading to ventricular tachycardia and that it was well established that ventricular tachycardia might develop at any point after an infarction and was not limited to a specific time frame. Further, she explained that the onset of ventricular tachycardia or fibrillation on a given day was complex and might involve myocardial ischemia, high catecholamine levels, as in stress, or electrolyte abnormalities. The

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<sup>7</sup> *Ausberto Guzman*, 25 ECAB 362 (1974).

<sup>8</sup> *See John Watkins*, 47 ECAB 597, 602 (1996); *William C. Thomas*, 45 ECAB 591, 594 (1994).

<sup>9</sup> *See James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little probative value because the history was both inaccurate and incomplete). *See generally Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).

doctor offered that the underlying coronary disease was a factor in the general likelihood of arrhythmias, however, it was her opinion that the scar from appellant's 1991 infarction most likely created a substrate for cardiac arrhythmias. Dr. Beauregard went on to explain that if there was no other documented infarction or scar, then it was probable that ventricular mapping during an electrophysiology study might localize the site of origin of his tachycardia to the site of his 1991 infarction. However, she did not explain why she did not consider how she determined that the scar was related to the 1991 infarction as opposed to being related to appellant's previous episodes of cardiac incidents dating back to the 80's and earlier. She deferred to her partner, Dr. Gutowski, indicating that he might have more information regarding the issues and appellant's problems. Her opinion was also speculative, incomplete and did not contain any rationale on causal relationship.<sup>10</sup> The Board has held that an opinion, which is speculative in nature, has limited probative value in determining the issue of causal relationship.<sup>11</sup>

In her July 27, 2000 report, Dr. Beauregard opined that she thought that a report could be prepared that might support appellant's case, however, it would probably take five to six hours to prepare, including references from the medical literature. Dr. Beauregard explained that, unfortunately, in appellant's situation there was no cut-and-dry answer.<sup>12</sup> She again deferred to her partner and failed to provide an accurate rationalized medical opinion.

Dr. Gutowski, in his report dated May 23, 2002, noted appellant's history of the prior myocardial infarction in 1979, however, he provided no medical rationale for finding that it was the heart attack in 1991 that precipitated the ventricular tachycardia in September 1999, as opposed to his previous nonwork-related conditions. He also noted that the claimant's first awareness of a heart condition did not occur until his first heart attack in December 1979, however, in an earlier report dated November 2, 1990, Dr. Gutowski noted that the claimant had an onset of angina in 1970 as "being mainly exertional, shortness of breath." In light of the lack of rationale and incomplete or inaccurate history, this report is also entitled to little probative value.

Accordingly, the Board finds that appellant has not met his burden of proof in this case as he has not submitted a reasoned medical report that concluded that the disabling condition was causally related to employment factors supported by sound medical reasoning.<sup>13</sup>

The July 27, 2001 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC  
November 13, 2002

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<sup>10</sup> *Id.*

<sup>11</sup> *Arthur P. Vliet*, 31 ECAB 366 (1979).

<sup>12</sup> *Id.*

<sup>13</sup> *See Nicolea Brusco*, 33 ECAB 1138, 1140 (1982).

Alec J. Koromilas  
Member

Willie T.C. Thomas  
Alternate Member

Michael E. Groom  
Alternate Member