

Appellant submitted several medical reports concerning treatment on December 2, 2007 for cough, fever and cold symptoms.¹

In a report dated December 3, 2007, Dr. E. Noyes, Board-certified in emergency medicine, reported treating appellant following a diagnosis of fever, sinusitis and possible urinary tract infection. He reported that three of four blood cultures were positive for staphylococcus and that additional cultures were pending. Dr. Noyes diagnosed appellant with bacteremia of unclear source. In a subsequent report, also dated December 3, 2007, he reported that, based upon an MRI scan of appellant's lower extremities, he suspected myositis in appellant's right vastus lateralis with a very small intramuscular abscess.

Appellant submitted a December 3, 2007 report in which Dr. Lisa M. Ivanjaack, internist, reported that physical examination revealed right thigh myalgia without any obvious injury and evidence of diffuse isolated muscle myositis on an MRI scan. She reported that neurological examination of appellant's right thigh revealed appellant was not able to lift his right leg, secondary to pain. Dr. Ivanjaack reported that three out of four blood cultures performed on December 2, 2007 were positive for staphylococcus. She noted the presence of small fluid collection that could have been a hematoma or an abscess, but ruled out necrotizing myositis.

In December 4, 2007 report, Dr. Alice B. Josafat, a Board-certified diagnostic radiologist, reported that an MRI scan of appellant's lower extremity revealed an irregular shaped hypointense area, a small abscess, within the mid-aspect of the right vastus lateralis. She noted that appellant presented with: back pain; right leg pain with right thigh pain and tenderness; bacteremia; and fevers. Dr. Josafat diagnosed appellant with suspected myositis in the right vastus lateralis with a very small intramuscular abscess. In another report, also dated December 4, 2007, she reported that appellant pulled a muscle getting up "a couple days ago."

In a December 5, 2007 report, Dr. William F. Ehni, a Board-certified internist, diagnosed appellant with MRSA right leg pyomyositis. He reported that blood cultures were repeated and that they were positive for staphylococcus aureus. Dr. Ehni noted that appellant did not appear to have another primary source and, therefore, doubted that appellant had MRSA sinusitis.

Appellant submitted a December 6, 2007 report, signed by Dr. Ben H. Harmon, Board-certified diagnostic radiologist, who reported that an MRI scan of appellant's right thigh with and without contrast revealed the presence of an intramuscular cystic fluid collection that could

¹ Appellant submitted several duty status reports (Form CA-17) all of which bore a physician's signature that was illegible. In a CA-17 dated December 17, 2007, a physician noted clinical findings of "tender, swollen right leg and fever." The physician asserted that this diagnosis was due to injury and that appellant had no other disabling conditions. In a subsequent CA-17, this physician stated clinical findings consisting of a pulled muscle and right thigh infection with MRSA. The physician proffered a diagnosis of MRSA infection. In another CA-17 dated January 10, 2008, this physician reported clinical findings consisting of a pulled muscle resulting in infection and surgery. This physician diagnosed appellant with a right thigh infection.

These reports are insufficient to establish appellant's burden of proof because, as they bore an illegible signature, their authors cannot be identified as a physician. *Vickey C. Randall*, 51 ECAB 357 (2000); *Merton J. Sills*, 39 ECAB 572 (1988) (Reports not signed by a physician lack probative value). Therefore, the Board finds that as these reports lack proper identification and, therefore, they do not constitute they do not constitute probative medical evidence sufficient to establish appellant's burden of proof.

represent a focal area of necrosis or abscess. He reported that the right vastus lateralis muscle was diffusely abnormal. Dr. Harmon noted that some edema fluid separated the distal rectus femoris muscle from the vastus lateralis and vastus medialis musculature.

Appellant submitted² a December 7, 2007 report signed by Dr. Steven D. MacFarlane, a Board-certified surgeon, who reported that appellant had a muscle strain in his right leg and then became ill with sepsis and was found to have a groin abscess in the right vastus lateralis. Dr. MacFarlane proffered a preoperative diagnosis of right thigh vastus lateralis deep muscle abscess. He operated on appellant, creating an incision and drained the deep muscle abscess. Dr. MacFarlane reported that appellant had about 20 milliliters of nonfoul smelling, thick, purulent abscess. He reported that this fluid was irrigated nicely.

By report dated December 7, 2007, Dr. Charles P. Daly, Board-certified diagnostic radiologist, reported that ultrasound guided perc drainage revealed multiloculated collection in the right vastus lateralis muscle. He noted that, following aspiration, a moderate amount of residual loculated fluid was visible. Dr. Daly's impression was that multiloculated collection at the right vastus lateralis muscle was consistent with an abscess and that only a partial aspiration was possible due to the loculated nature of the collection. In a subsequent report dated December 7, 2007, he noted that an appropriate skin entry site had been identified.

In a December 7, 2007 report, Dr. Ivanjaack reported that ultrasound revealed multiloculated fluid collection in the right thigh consistent with an abscess and that a needles aspiration would be performed. In a subsequent report, also dated December 7, 2007, he reported that ultrasound revealed a multiloculated collection in the right vastus lateralis muscle and that aspiration of the fluid revealed only a moderate residual amount remained.

By letter dated March 10, 2008, the Office notified appellant that his claim had originally been accepted as a simple, uncontroverted case which resulted in minimal or no time loss from work. It reported that since appellant's medical bills now exceeded \$1,500.00 it had to formally adjudicate his claim. The Office notified appellant that the evidence received in support of his claim was insufficient and requested appellant submit additional evidence.

Appellant submitted no additional evidence in support of his claim and by decision dated April 9, 2008 the Office denied appellant's claim because the evidence of record was insufficient to establish that he sustained an injury in the performance of duty.

Appellant disagreed with the Office's April 9, 2008 decision and, through counsel, requested an oral hearing.

² The Board notes that appellant submitted several medical reports signed by individuals who are registered nurses and an individual who is a physicians' assistant. Registered nurses and physicians' assistants are not "physicians" as defined by the Act and, consequently, their reports and opinions are of no probative value. *Roy L. Humphrey*, 57 ECAB 238 (2005); *see* 5 U.S.C. § 8101(2) (defining the term "physician"); *see also Charley V.B. Harley*, 2 ECAB 208 (1949) (the Board held that medical opinion, in general, can only be given by a qualified physician). As these reports were not prepared by "physicians," as defined by the Act, they are of no probative value.

Appellant submitted a personal note dated April 1, 2008, clarifying that he was not claiming that he got infected with the MRSA virus on the job. He stated that his employment injury was a pulled muscle. Appellant asserted that he was claiming that when he pulled his muscle, it got infected with an abscess when his blood went to repair the pulled muscle. This, he alleged, required him to have surgery. Appellant asserted that, if he had not pulled a muscle, he would not have needed surgery and antibiotics would have cured his MRSA.

Appellant also submitted duplicate copies of medical reports already of record.

A hearing was conducted on August 11, 2008. Appellant testified that he went to the hospital because he was sick, had a fever and was concerned it was the flu. The emergency room doctors performed blood tests. The next day, November 26, 2007, appellant reported that he pulled a muscle while unloading pallets at the Kirkland station. He told his supervisor but chose not to seek medical attention because he believed that icing it and using heat treatments would solve the problem. The following day, appellant concluded that the pain in his thigh was more than just a pulled muscle and sought medical attention. He stated that his right leg was noticeably swollen and that the physicians he saw performed multiple tests. Appellant also stated that he has no prior exposure to or with MRSA. He did report, however, that he sustained a similar injury five or six years ago while unloading containers of mail off a truck.

Appellant testified that he received a telephone call from the emergency room informing him that he had MRSA and needed to come in for examination and treatment. He testified that Dr. Ehni told him that the pulled muscle was probably produced when his MRSA infected blood tried to repair the muscle in his right leg and instead formed an abscess. Appellant testified that once his physicians diagnosed him with MRSA they largely ignored his pulled muscle condition, focusing their efforts on getting him on antibiotics to treat MRSA.

Claimant's attorney argued that an accident had occurred at work, appellant reported it and significant complications resulted that were identified in the emergency room.

The record was held open for 30 days following the hearing for submission of additional evidence.

By decision dated October 24, 2008, the hearing representative affirmed the Office's April 9, 2008 decision.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act³ has the burden of proof to establish the essential elements of his claim by the weight of the evidence,⁴ including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment

³ 5 U.S.C. §§ 8101-8193.

⁴ *J.P.*, 59 ECAB ____ (Docket No. 07-1159, issued November 15, 2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

injury.⁵ As part of his burden, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background showing causal relationship.⁶ The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion.⁷

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether the fact of injury has been established. There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place and in the manner alleged.⁸ Second, the employee must submit evidence, in the form of medical evidence, to establish that the employment incident caused a personal injury.⁹

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.¹⁰

ANALYSIS

The Board accepts that appellant was lifting pallets at the Kirkland station on November 26, 2007. It is his burden to establish, through production of rationalized medical opinion evidence, that his pulled right thigh muscle and MRSA infection are causally related to this identified employment incident.

The Board finds that the evidence of record does not establish appellant's claim that he sustained a pulled muscle in the performance of duty. While appellant alleged that he sustained a pulled right thigh muscle on November 26, 2007, the record reflects that he did not seek

⁵ *G.T.*, 59 ECAB ___ (Docket No. 07-1345, issued April 11, 2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

⁶ *G.T.*, *supra* note 5; *Nancy G. O'Meara*, 12 ECAB 67, 71 (1960).

⁷ *Jennifer Atkerson*, 55 ECAB 317, 319 (2004); *Naomi A. Lilly*, 10 ECAB 560, 573 (1959).

⁸ *Bonnie A. Contreras*, 57 ECAB 364, 367 (2006); *Edward C. Lawrence*, 19 ECAB 442, 445 (1968).

⁹ *T.H.*, 59 ECAB ___ (Docket No. 07-2300, issued March 7, 2008); *John J. Carlone*, 41 ECAB 354, 356-57 (1989).

¹⁰ *I.J.*, 59 ECAB ___ (Docket No. 07-2362, issued March 11, 2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

immediate medical attention. The medical evidence of record also demonstrates that neither he nor his physicians pursued diagnosis or treatment of a pulled right thigh muscle.

During the hearing, while appellant testified that he sustained a pulled right thigh muscle and that Dr. Ehni told him that the pulled muscle was probably produced when his MRSA infected blood tried to repair the muscle in his right leg and instead formed an abscess, the medical reports and notes of record do not contain such an opinion. An award of compensation may not be based on surmise, conjecture, speculation, or upon appellant's own belief that there is a causal relationship between his claimed condition and his employment.¹¹ The Board has held that an appellant's subjective symptoms and self-serving declaration do not constitute sufficiently substantive evidence such that satisfy appellant's burden of proof.¹² The record reflects that appellant is not a physician and therefore his interpretation of the causal relationship between his alleged pulled right thigh muscle and the identified employment incident is of no probative value. As there is no probative medical evidence of record concerning this issue, appellant has not established that he sustained a pulled right thigh muscle in the performance of duty on November 26, 2007.

The deficiency with the remainder of appellant's claim is that the medical opinion evidence does not establish a causal relationship between what happened at work on November 26, 2007 and appellant's diagnosed medical condition: an MRSA infection. The issue is whether the medical evidence establishes that he sustained an MRSA infection causally related to his federal employment. The determination of whether an employment incident caused an injury is generally established by medical evidence.¹³

Appellant submitted reports from Drs. Daly, Ehni, Harmon, Ivanjaack, Josafat, MacFarlane and Noyes. While these reports established that appellant had an MRSA infection in his right thigh for which he had surgery on December 7, 2007, taken as a group, these reports are of limited probative value as none of them proffered an opinion on the causal relationship between a diagnosed medical condition and the employment incident.

The Board has consistently held that medical reports lacking an opinion on causal relationship are of little probative value,¹⁴ and the mere fact that a condition manifests itself or worsens during a period of employment¹⁵ or that work activities produce symptoms revelatory of an underlying condition¹⁶ does not raise an inference of causal relationship between a claimed

¹¹ *D.D.*, 57 ECAB 734 (2006); *Patricia J. Glenn*, 53 ECAB 159 (2001).

¹² *Edgar G. Maiscott*, 4 ECAB 558 (1952) (holding appellant's self-serving declarations do not, in the opinion of the Board, constitute evidence of a sufficiently substantial nature).

¹³ *Lois E. Culver* (Clair L. Culver), 53 ECAB 412 (2002).

¹⁴ See *Mary E. Marshall*, 56 ECAB 420 (2005) (medical reports that do not contain rationale on causal relationship have little probative value). See also *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001).

¹⁵ *E.A.*, 58 ECAB ____ (Docket No. 07-1145, issued September 7, 2007); *Albert C. Haygard*, 11 ECAB 393, 395 (1960).

¹⁶ *D.E.*, 58 ECAB ____ (Docket No. 07-27, issued April 6, 2007); *Fabian Nelson*, 12 ECAB 155,157 (1960).

condition and employment factors. As none of these physicians' medical reports contained a medical opinion on causal relationship they are of little probative value and appellant has not met his burden.

In order to establish entitlement, a claimant must provide a physician's opinion that is based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant. Because appellant did not submit a reasoned medical opinion explaining how the November 26, 2007 employment incident caused his MRSA infection, he did not establish the critical element of causal relationship.¹⁷

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained a pulled muscle and an MRSA infection causally related to his federal employment on November 26, 2007.

ORDER

IT IS HEREBY ORDERED THAT the October 24, 2008 decision of the Office of Workers' Compensation Programs' Branch of Hearings and Review is affirmed.

Issued: August 5, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

¹⁷ See *John W. Montoya*, 54 ECAB 306 (2003).