

FACTUAL HISTORY

In 1986 the Office accepted that the employee, then a 42-year-old staff nurse, sustained generalized anxiety disorder, irritable bowel syndrome, atrophic gastritis, psychogenic gastrointestinal disease and hypoglycemia due to anxiety.² It paid her compensation for total disability beginning April 19, 1986. At the time of her death on April 21, 2008, the employee received compensation at the three-quarters augmented rate paid to claimants with dependents as she supported her disabled adult daughter.

On March 30, 2009 appellant, the employee's daughter, filed a claim for death benefits on behalf of her disabled, adult sister, for whom she had general power of attorney.³ She listed the cause of the employee's death as hypoglycemia.

A May 28, 2009 death certificate indicated that the cause of death was pending investigation. A supplementary medical certification accompanying the death certificate listed the cause of death as hypertensive atherosclerotic cardiovascular disease.

By letter dated April 29, 2009, the Office advised appellant's representative that it had denied the employee's claim that she sustained hypertension due to factors of her federal employment. It noted that the death certificate listed hypertensive atherosclerotic cardiovascular disease as the cause of death. The Office requested additional medical information, including a copy of the autopsy and a reasoned medical opinion relating the accepted conditions to the employee's death.

On May 21, 2009 appellant requested that Dr. David G. Litaker, a Board-certified internist, review the evidence and address whether the employee's hypoglycemia and generalized anxiety disorder caused or contributed to her death. In a May 28, 2009 report, Dr. Litaker advised that he had not examined the employee. He reviewed the medical evidence and the results of laboratory tests from the Veterans Affairs Medical Center (VAMC). Dr. Litaker noted there was no mention of an anxiety disorder or a diagnosis of atherosclerotic cardiovascular disease in 2007 and 2008 medical reports from the VAMC. He determined that a May 14, 2002 echocardiogram showed findings "consistent with the diagnoses of hypertension of long-standing diastolic heart failure and the immediate cause of death listed on the supplementary medical certification." Dr. Litaker listed the medical and psychiatric diagnoses that "may have contributed to [the employee's death]" as diabetes with unspecified complications, hyperlipidemia, morbid obesity, unspecified diastolic heart failure, hypertension, borderline personality disorder and chronic, generalized anxiety. He stated, "The severity of [the

² The Office determined that the employee had established as compensable work factors that she had to prioritize the needs of patients and worked in a ward that was understaffed.

³ The record contains a portion of a decision by the Social Security Administration finding appellant's sister disabled on and after July 22, 1999 through at least April 24, 2000.

employee's] generalized anxiety disorder cannot be clearly ascertained, given the absence of documentation on its evaluation or treatment by VA medical providers." Dr. Litaker related:

"Hypoglycemia, resulting from use of medications used to treat diabetes mellitus may have resulted in tachycardia and increased myocardial oxygen demand. Chronic anxiety in the absence of an acute exacerbation may have contributed to reduced heart rate variability, a risk factor for cardiovascular morbidity and mortality. An acute exacerbation of anxiety, if present prior to death, may have resulted in tachycardia and increased myocardial oxygen demand. In instances in which myocardial oxygen demand is increased but myocardial oxygen supply is limited due to atherosclerosis, myocardial infarction may ensue. It is also likely, based on concerns raised in the medical record, that inconsistent dietary intake, inconsistent use of diabetes and hypertension-related medications, or changes made to the complex medical regimen by the [employee] may have increased the probability of hypoglycemia and/or death from underlying, undiagnosed cardiovascular disease."

In an undated report received July 6, 2009, Kenneth Felker, Ph.D., a clinical psychologist, related that he treated the employee from 1988 until he retired in December 2005. He advised that the employee showed symptoms of generalized anxiety disorder throughout her therapy and opined that her "medical diagnoses, in my opinion, were exacerbated by her anxiety." Dr. Felker noted that the employee had difficulty accepting her separation from the employing establishment. He stated, "Though it is always difficult to assign a simple causation to a death, it is my opinion that [the employee's] medical conditions were aggravated by her chronically-elevated anxiety and these medical conditions led to her death." Dr. Felker indicated that he was unable to address her condition from January 2006 onwards.

By decision dated July 15, 2009, the Office denied appellant's claim for death benefits. It found that the medical evidence was insufficient to establish that the employee's accepted work injury caused or contributed to her death.

On July 23, 2009 appellant, through her attorney, requested an oral hearing held on December 9, 2009. She noted that her sister received disability benefits from the Social Security Administration. The hearing representative indicated that he would confirm that the Office had accepted the employee's daughter as a dependent. Counsel contended that the death certificate listed diabetes as a secondary cause of death, which was equivalent to the accepted condition of hypoglycemia. He noted that progress reports indicated that the employee received treatment for hypoglycemia prior to her death.

On October 19, 2009 counsel questioned whether the Office had accepted the employee's daughter, for whom appellant had power of attorney, as a dependent. He further noted that the death certificate finding diabetes as a cause of death created a presumption that the death was due to diabetes, which he equated to hypoglycemia.

In a report dated April 22, 2008, received by the Office on December 8, 2009, a coroner determined that the cause of death was hypertensive atherosclerotic cardiovascular disease with another condition as diabetes mellitus.

On December 23, 2009 Dr. Alan E. Kravitz, a Board-certified internist, reviewed the medical evidence of record and autopsy report. He expressed amazement that the employee used “oral agents for diabetes II along with beta blockers....” Dr. Kravitz related that, while hypertensive cardiovascular disease with cardiomegaly may “be a cause of death, the combination of oral hypoglycemics and beta blockers is one that more likely than not in [the employee] caused interactions. The record [is] unclear, in part stating that [she] was taking labetalol and later stating that [she] is allergic to atenolol and metoprolol.” Dr. Kravitz concluded, “It is my opinion that the combination of drugs as stated above played a role in her death by causing hypoglycemia blunted by the beta blockers. This would substantially accelerate the allowed medical condition.”

By decision dated February 24, 2010, the Office hearing representative affirmed the July 15, 2009 decision. She found that the Office paid compensation to the employee at a dependent rate for her adult, disabled daughter. The hearing representative determined that the medical evidence was insufficient to show that the accepted hypoglycemia resulting from anxiety caused or contributed to the employee’s death.

LEGAL PRECEDENT

The United States shall pay compensation for the death of an employee resulting from personal injury sustained while in the performance of duty.⁴ An 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 federal employment. This burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based on a proper factual and medical background.⁵ The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale.⁶ The mere showing that an employee was receiving compensation for total disability at the time of death does not establish that the employee’s death was causally related to his or her federal employment.⁷

ANALYSIS

The Office accepted that the employee sustained generalized anxiety disorder, irritable colon, atrophic gastritis, psychogenic gastrointestinal disease and hypoglycemia due to employment-related anxiety. The employee died on April 21, 2008. The Office determined that the employee’s adult disabled daughter, for whom appellant has general power of attorney, qualified to apply for death benefits under the Federal Employees’ Compensation Act.⁸ In order

⁴ 5 U.S.C. § 8102(a).

⁵ *Viola Stanko (Charles Stanko)*, 56 ECAB 436 (2005).

⁶ *L.R. (E.R.)*, 58 ECAB 369 (2007); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

⁷ *Susanne W. Underwood, (Randall L. Underwood)*, 53 ECAB 139 (2001).

⁸ Section 8133 of the Act provides for compensation for the death of an employee in the performance of duty for surviving spouses and children. 5 U.S.C. § 8133. The Act provides that a child is “one who at the time of death of the employee is under 18 years of age or over that age and incapable of self-support, and includes stepchildren, adopted children and posthumous children, but does not include married children.” 5 U.S.C. § 8101(9).

to establish entitlement to death benefits, appellant must submit rationalized medical evidence showing that the employee's death was causally related to her accepted employment injury.⁹

On May 28, 2009 Dr. Litaker noted that the medical reports and test results he reviewed from the VAMC did not indicate that the employee received treatment for anxiety or cardiovascular disease. He found that diabetes, hyperlipidemia, morbid obesity, diastolic heart failure, hypertension, borderline personality disorder and chronic, generalized anxiety "may have contributed" to the death of the employee. Dr. Litaker could not comment on the seriousness of the employee's anxiety disorder as there were no records from the VAMC addressing the condition. He asserted that medications for diabetes may have caused hypoglycemia and tachycardia and that acute anxiety "may have contributed to reduced heart rate variability, a risk factor for cardiovascular morbidity and mortality." Dr. Litaker's opinion that hypoglycemia and anxiety may have contributed to the employee's death is speculative in nature and thus of diminished probative value.¹⁰ Further, he did not relate the anxiety to the employee's accepted work injury over 20 years prior. Consequently, Dr. Litaker's report is insufficient to meet appellant's burden of proof.

On July 6, 2009 Dr. Felker discussed his treatment of the employee for continued symptoms of generalized anxiety disorder from 1988 until 2005. He opined that her anxiety exacerbated her coexisting medical conditions which resulted in her death. Dr. Felker, however, also asserted that he was not able to comment on the employee's condition after January 2006, and consequently his opinion on her death in 2008 is of diminished probative value. Further, he did not provide any rationale for his causation finding. A mere conclusion regarding causal relationship without supporting medical rationale is of little probative value.¹¹

On December 23, 2009 Dr. Kravitz questioned the employee's use of beta blockers and oral medications for diabetes. He noted that, while the cause of death was hypertensive cardiovascular disease with cardiomegaly, the use of oral hypoglycemics and beta blockers accelerated her condition "by causing hypoglycemia blunted by the beta blockers." Dr. Kravitz did not attribute the employee's death to the accepted condition of anxiety-related hypoglycemia but instead to medication used for diabetes taken in conjunction with beta blockers. Consequently, his opinion is insufficient to meet appellant's burden of proof. Further, Dr. Kravitz did not bolster his opinion that the employee died in part from an interaction of medication with any objective findings.

On March 14, 2008 a coroner determined that the employee died from hypertensive atherosclerotic cardiovascular disease with another condition as diabetes mellitus. The Office did not accept diabetes as an accepted condition but rather anxiety-related hypoglycemia. Appellant has not submitted a medical report from a physician who provides an accurate history of the employee's work injury, addresses the cause of death on April 21, 2008 and explains with

⁹ *Jacqueline Brasch (Ronald Brasch)*, *supra* note 6.

¹⁰ *Rickey S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal; the opinion should be expressed in terms of a reasonable degree of medical certainty).

¹¹ *T.M.*, 60 ECAB ___ (Docket No. 08-975, issued February 6, 2009).

sound medical reasoning how the injury contributed to the death. Consequently, she has not met her burden of proof.¹²

CONCLUSION

The Board finds that the employee's death is not causally related to her accepted employment injury.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 24, 2010 is affirmed.

Issued: February 14, 2011
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

¹² *Jacqueline Brasch (Ronald Brasch)*, *supra* note 6.