U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NANCY JUNE ADAMS, claiming as widow of HAROLD G. ADAMS, M.D.
and DEPARTMENT OF VETERANS AFFAIRS, MEDICAL CENTER,
Bay Pines, Fla.

Docket No. 95-1834; Submitted on the Record;
Issued January 12, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether the employee's death on December 4, 1992 was causally related to his accepted employment-related condition.

On September 27, 1993 appellant filed a claim for survivor benefits following the death of her husband on December 4, 1992. A copy of the death certificate showed the main causes of death were congestive heart failure and atherosclerotic heart disease, with a contributory cause of gastric illness.

Three years prior to the employee's death, the Office of Workers' Compensation Programs had accepted a claim filed by the employee for an emotional condition and gastrointestinal bleeding. The employee, a physician at the employing establishment since February 1984, served as Chief of Admissions from August 1985 until the date he stopped work on November 8, 1989. During the time of his employment, the employee was diagnosed with obstructive pulmonary disease, congestive heart failure, and coronary artery disease with resulting bypass surgery, as well as adult-onset of diabetes mellitus for which he used insulin.[1] The employee cited to several factors of employment which he felt aggravated his underlying conditions, and caused gastrointestinal bleeding. The primary factor pertained to an investigation begun in December 1987 and a reprimand which followed, charging him for failure to take reasonable precautionary measures in admitting, or at least personally examining, a patient who

[1] The employee indicated in statements he submitted with his claim, that he had a 45-year history of smoking, to which he attributed obstructive pulmonary disease and pneumonia he sustained in August 1985. The record also demonstrates alcohol abuse. He stopped smoking and drinking after either the initial hospitalization in August 1985, or the second hospitalization in October 1985, when he was treated for congestive heart failure and diagnosed with coronary artery disease. He underwent the quadruple bypass surgery in March 1987.

died a day after being treated at the employing establishment.[2] The employee-related episodes of congestive heart failure and gastrointestinal bleeding he suffered in February and in April 1988 due to the stress from the pending reprimand. He also claimed an employment-related aggravation of his underlying coronary artery disease. The employee was off work for approximately nine weeks during the spring of 1988 and beginning in June 1988 he resumed part-time work.

Dr. Byron W. Goldberg, a psychiatrist, and Dr. Joseph H. Rosin, an internist, supported a relationship between the disciplinary action taken and the episodes of gastrointestinal bleeding, and provided a history of recurrent gastrointestinal bleeding associated with the appeal of the reprimand which appellant had filed.[3] An Office medical adviser negated a causal relationship between the gastrointestinal bleeding and the stress from work, based on the endoscopic showing of varices. Dr. James A. Fesler, a Board-certified psychiatrist and Office referral physician, noted in the summer of 1989, the effect of stress on the employee in neglecting to care for his underlying physical conditions, which resulted in the gastrointestinal bleeding. Dr. Fesler negated a permanent aggravation and indicated that the condition should resolve in time. Based on Dr. Fesler's evaluation and opinion, the Office accepted on November 3, 1989, the claim for adjustment disorder with mixed anxiety features and depression, as well as the gastrointestinal bleeding.

The employee stopped work on November 8, 1989 and submitted reports by Dr. Rosin who indicated that the employee could not return to work at the employing establishment, even in another position, because of the gastrointestinal bleeding. The Office placed the employee on the periodic rolls for wage-loss compensation and referred him to Dr. Elliot M. Livstone, a Board-certified internist and gastroenterologist, who correlated the bleeding episodes with the failure to take Carafate, and recommended that the employee not return to work.

The record indicates that the employee filed for disability retirement, which was approved on January 28, 1991. He was hospitalized again in December 1991 for acute upper gastrointestinal bleeding, at which time it was suggested that he undergo surgery. Dr. Alexander Balko, a Board-certified surgeon, who diagnosed recurrent variceal bleeding due to cirrhosis of the liver, performed surgery in January 1992, which consisted of a portal-caval shunt.

In July 1992 the Office received a report from Dr. Jeffrey H. Kuch, a Board-certified internist and family practitioner associated with the employing establishment, who reviewed the employee's medical records and cited to the continued episodic bleeding in the employee's

[2] The patient in question had been admitted to the employing establishment for two days prior to the treatment on October 16, 1987, when it was determined by three staff members, including the employee, that admission was not necessary. The patient died the following day. During the investigation, the employee waived his right to counsel being present, based on his assurances that the investigation was for fact finding purposes. He indicated in his claim that he felt his rights had been violated, in that he first learned of the issuance of a reprimand through the newspaper. The employee appealed the reprimand and on August 11, 1989, it was decided that the reprimand would be expunged from his record, based on the lack of due process rights afforded to the employee.

[3] While the reports indicated that appellant suffered from congestive heart failure in February and April 1988, the physicians did not relate this specific condition or the condition of coronary artery disease, to the disciplinary action.

history. He stated that while the initial bleeding in February 1988 was probably work related, the episodes of continued bleeding were due to "congestive gastrophy," as caused by portal hypertension from cirrhosis. Dr. Kuch noted that on endoscopy, the lesions of "congestive gastropathy" looked like small ulcerations. He noted that the cirrhosis was due to alcohol abuse with a contributory effect from cigarette smoking.

In August 1992, the Office referred the employee to Dr. Robert Turkel, a Board-certified internist and cardiologist, who stated that the employee could not work due to his hepatic problems and portal hypertension. He noted that since the employee was not working at that time, there was no further work-related aggravation to gastrointestinal bleeding.

The employee was treated in the emergency room on November 9, 1992 for dehydration associated with his physical illness. He was later admitted to the hospital on November 21, 1992. A discharge report dated December 4, 1992 indicates that the employee's physical health was deteriorating and that he was at the near-end stage of his cardiomyopathy. Prior to being transferred to hospice care, as indicated on the discharge report, the employee died that evening at 6:15 p.m. No autopsy was performed. The death certificate listed as primary causes of death, congestive heart failure with a noted occurrence during the prior weeks, with atherosclerotic disease present for years. Gastric ulcers was listed as another significant condition contributing to death.

In response to appellant's request for death benefits, the Office advised appellant by letter dated March 4, 1993 that she was required to submit medical evidence establishing that her husband's death was caused or materially hastened by the accepted employment-related conditions.

Appellant submitted a form report dated October 5, 1993, from Dr. Rosin, who noted that his treatment was from October 1985 until December 1992, and that the employee died of congestive heart failure and ischemic cardiomyopathy. He noted with a check mark that the death was not related to the gastrointestinal bleeding secondary to work-related stress. Appellant also submitted an October 29, 1993 form report by Dr. Goldberg, who noted treatment dates of April 1988 until December 1992 and indicated with a check mark that the death was due to work-related stress. Dr. Goldberg stated that the "[s]evere and disabling anxiety and depression associated with work-related stressors instigated gastric and duodenal stress ulcers which resulted in recurrent gastrointestinal bleeding leading to severe, profound anemia, which along with COPD caused undue stress on an already compromised heart resulting in congestive heart failure."

The Office referred a statement of accepted facts and the medical evidence to an Office medical adviser, who negated a causal relationship between the death and the accepted employment-related conditions. In addition, the Office submitted the evidence to Dr. Jawahar L. Mehta, a Board-certified internist and cardiologist. In a March 7, 1994 report, Dr. Mehta reviewed the employee's medical history and stated his opinion that the accepted employment-related conditions aggravated the employee's underlying conditions but did not cause or contribute to his death. Dr. Mehta addressed the cardiac condition by noting that the coronary artery disease "was a result of a strong family history of vascular disease, insulin-dependent diabetes, obesity, and years of heavy smoking." He indicated that while stress can play a role in

increasing arrhythmias, patients with congestive heart failure often experience frequent arrhythmic episodes, and that "repetitive episodes of [gastrointestinal] GI bleeding and resulting anemia could also result in worsening of arrhythmias." Dr. Mehta addressed the episodic gastrointestinal bleeding by noting that the bleeding episodes continued well after the stressful events abated and the patient was no longer employed, and that it was "highly unlikely that the extensive GI and hepatic condition would improve once he was not exposed to the stress state." In response to a request for clarification from the Office, Dr. Mehta stated the following in a March 28, 1994 report:

> "1. I believe that the patient's extensive history of drinking and smoking were the basis of his [gastrointestinal] GI and hepatic disorder. The stressful situation precipitated the acute episodes of GI bleeding. Were the stressful situation by itself the *cause* of his GI bleeding, relief of this stress would have resulted in amelioration of his disease. The fact that his GI and hepatic conditions continued to deteriorate implies that the pathologic basis of his ailment related to his drinking and improperly taking prescribed medications.
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> "2. I do not believe that the stress of his job *caused* his GI and hepatic conditions or coronary artery disease. However, the stress probably aggravated the preexisting GI disease. It is possible that he drank *heavily* after the stress of reprimand, which resulted in GI ulceration and bleeding. I do not think the stress of his job caused him to have diabetes, obesity or [coronary artery disease] CAD which were preexisting conditions." (Emphasis in the original.)

By decision dated April 15, 1994, the Office denied appellant's claim for death benefits on the grounds that there was no causal relationship between the employee's death and his accepted employment-related aggravation of gastrointestinal bleeding and his accepted emotional condition claim.[4]

The Board finds that the employee's death on December 4, 1992 was not causally related to his accepted employment-related condition.

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 employment. This burden includes the necessity of furnishing rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship.[5]

In this case, appellant submitted two form reports from physicians of her husband's, prior to his death on December 4, 1992. Dr. Rosin, an internist who had treated the employee for congestive heart failure and coronary artery disease since October 1985 and recently for gastrointestinal bleeding, negated a causal relationship between the death of the employee and

[4] The Office referred to Dr. Mehta as a referral physician selected to resolve a conflict between the Office medical adviser and Dr. Goldberg.

[5] *Bertha J. Soule* (*Ralph G. Soule*), 48 ECAB ___ (Docket No. 95-251, issued January 21, 1997); *Kathy Marshall (Dennis Marshall)*, 45 ECAB 827 (1994).

his employment-related stress. In his earlier reports between November 1989 when the employee stopped work and December 1992 when the employee died, he correlated continued work stress with continued episodes of gastrointestinal bleeding, which the Office had accepted as an employment-related condition. While the death certificate indicated that a contributory cause of death was the gastric ulcer condition, Dr. Rosin's final report does not support a causal relationship between the gastric ulcer and bleeding and his death. Instead, he attributed the cause of death to the employee's cardiac condition, which was not an accepted employment condition based on the lack of medical evidence to establish an employment-related aggravation to the employee's underlying cardiac condition.

Dr. Goldberg, a Board-certified psychiatrist, opined that the death was related to the employment based on the recurrent gastrointestinal bleeding, which lead to anemia and coronary obstructive pulmonary disease, causing undue stress on an already compromised heart condition. Dr. Goldberg, however, did not address the failure of the employee to use his medication properly, which was documented in the medical records as a primary cause of the gastrointestinal bleeding, nor did Dr. Goldberg address the continued bleeding following the date he stopped work in November 1989.

Dr. Turkel, a Board-certified internist and cardiologist, who examined the employee a few months prior to his death, felt that the cause of the employee's disability from work was his hepatic condition and portal hypertension. He reviewed the evidence and indicated his opinion that the work-related aggravation of gastrointestinal bleeding had ceased. Dr. Mehta, a Board-certified internist and cardiologist, who reviewed the employee's medical records and work history after his death, addressed all of the risk factors of cardiac problems, including an extensive family history of cardiac conditions. While he acknowledged that stress plays a role in aggravating the acute gastrointestinal bleeding, he noted that continued deterioration of the employee's gastrointestinal and hepatic conditions evidenced a lack of employment relatedness, and noted the effect of improper use of medications. Dr. Mehta negated a causal relationship between the employee's underlying cardiac condition and his employment-related stress.

In contrast, the report from Dr. Goldberg who is not a specialist in cardiology, did not contain a full history of the employee's cardiac risk factors and address the continued deterioration of the hepatic and gastrointestinal condition during a period of time the employee was not working or under employment stress. The Board finds therefore that the weight of the medical evidence rests with the opinions of the cardiologists who found a lack of permanent aggravation on the employee's underlying condition from the employment-related gastrointestinal bleeding.

The decision of the Office of Workers' Compensation Programs dated April 15, 1994 is hereby affirmed.

Dated, Washington, D.C.
January 12, 1998

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member