U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LARUE DAVIS, claiming as widow of JOHN W. DAVIS and DEPARTMENT OF THE NAVY, NAVAL CONSTRUCTION BATTALION CENTER, Gulfport, MS

Docket No. 97-2827; Submitted on the Record;
Issued August 4, 1999

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
BRADLEY T. KNOTT

The issue is whether the employee's death was causally related to his June 16, 1971 employment injury.

On June 16, 1971 the employee, then a 50-year-old planning officer, sustained a heart attack which he attributed to his federal employment. The Office of Workers' Compensation Programs accepted his claim for a myocardial infarction and he received appropriate benefits for total disability. The employee died on February 11, 1995 and appellant, his widow, filed a claim for survivor's benefits contending that the employee's death was causally related to his accepted injury.

By decision dated July 28, 1995, the Office denied appellant's claim on the grounds that the evidence was insufficient to establish that the employee died due to his accepted employment injury. By decision dated December 11, 1995, the Office denied modification of its prior decision.

In a letter dated October 29, 1996, appellant, through her attorney, requested reconsideration and submitted additional medical evidence. The Office determined that the evidence submitted by appellant created a conflict in medical opinion regarding whether the employee's employment injury caused his death and thus referred the case record to an impartial medical examiner.

By decision dated June 17, 1997, the Office found that the evidence submitted did not warrant modification of its prior decision. The Office found that the opinion of Dr. Lawrence J. Kanter, a Board-certified internist and impartial medical specialist, constituted the weight of the evidence and established that the employee's death was not causally related to his 1971 myocardial infarction.

The Board has duly reviewed the case record and finds that appellant has not established that the employee's death was causally related to his June 16, 1971 employment injury.

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 federal employment. This burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based upon a proper factual and medical background.[1]

In the present case, appellant contended that the death of the employee on February 11, 1995 was causally related to his employment-related injury of June 16, 1971, which was accepted by the Office for a myocardial infarction. In support of her claim, appellant submitted a report dated May 30, 1995 from Dr. Edmund H. Crane, Jr., an internist, in which he discussed the employee's history of hypertension, myocardial infarction in 1971, transient ischemic attacks and coronary artery disease. Dr. Crane stated that prior to his death the employee entered the hospital following a stroke and developed fatal pneumonia. The physician attributed the stroke to either a mural thrombi or carotid artery disease.

In a report dated August 7, 1995, Dr. Crane related that a mural thrombus can develop after an acute myocardial infarction which can cause an embolic infarction in the brain. He stated:

> "[I]f the myocardial infarction had not occurred, the mural thrombus would not have occurred and the source of emboli to the brain, with his ultimate multiple strokes and cerebral infarctions leading to his death. An autopsy was not done, which is the only way that this could be proven to be true. However, current medical knowledge and information would support such a scenario."

In a report dated September 27, 1996, Dr. Crane related that appellant developed coronary artery disease in 1971 which ended with his death and opined:

> "It seems to me that if one accepts the responsibility for compensability of an illness or disease state, one must then accept the responsibility of the processes that flow from this state in years to come, no matter how far removed in time but still remaining the process of original disease. It is the cardiovascular disease that caused the myocardial infarction. It is the cardiovascular disease that led to the mural thrombi with embolization to his brain resulting in his death. This diagnosis is based upon rationale, probative and substantial evidence."

Appellant further submitted a report dated August 20, 1996 from Dr. Michael R. Lewis, a Board-certified internist, who opined:

> "[The employee] has had a congestive cardiomyopathy related to myocardial infarction in 1971 and was suffering from respiratory insufficiency due to acute congestive heart failure. It is my opinion that [the employee's] cardiomyopathy

[1] *See Kathy Marshall (Dennis Marshall)*, 45 ECAB 827 (1994); *Rose P. Stagner (Roland C. Stagner)*, 44 ECAB 806 (1993).

was due to his myocardial infarction in 1971. It was also my opinion that the cerebrovascular accident was an embolic event brought on by a mural thrombus with subsequent cerebral embolization following onset of atrial fibrillation. It is the presence of his myocardial infarction in 1971 and associated cardiomyopathy that placed [him] at risk for a cerebrovascular accident and subsequent death following the onset of atrial fibrillation."

In a report dated January 9, 1997, Dr. Lawrence Geeslin, an Office medical adviser, indicated that he agreed with Dr. Crane that coronary artery disease ultimately led to the employee's death but noted the Office had accepted only the 1971 myocardial infarction as related to employment. Dr. Geeslin found that "the cardiomyopathy noted by Dr. Lewis was a consequence of the coronary artery disease which proceeded independently and was not caused directly by the myocardial infarction of 1971." The Office medical adviser referred to his prior December 8, 1995 opinion in which he opined that the cause of death was not the 1971 accepted employment injury.

The Office properly determined that a conflict in medical opinion existed between Drs. Lewis and Crane, for appellant and Dr. Geeslin, an Office medical adviser.[2] The Office referred the case record to Dr. Kanter for review and an opinion on whether the employee's 1971 myocardial infarction contributed to his death.

In a report dated April 25, 1997, Dr. Kanter provided a thorough review of the employee's medical history and treatment following the 1971 myocardial infarction. He stated:

"In 1980, nine years after his myocardial infarction, he had good myocardial wall motion with an ejection fraction of 60 percent, indicative of good ventricular function. Clearly this was not a cardiomyopathic heart nine years after his myocardial infarction. He had multiple episodes of recurrent chest pain throughout the 1980s and subsequent strokes which began in 1977. This was all due to his severe hypertension, coronary artery disease and cerebrovascular disease. In January 1995 he presented with atrial fibrillation, a rhythm which had not been commented upon earlier. At that time he was found by echocardiography to have an ejection fraction of 20 percent. He had evidence of bilateral strokes, respiratory failure and he subsequently died a respiratory death.

"This man's pathology was, in my opinion, initiated by his severe hypertension. The myocardial infarction in 1971 was an isolated event which left him with modest myocardial dysfunction. The severe hypertension which persisted caused progressive deterioration of his heart function and recurrent cerebrovascular accidents."

Dr. Kanter concluded that the 1971 myocardial infarction did not cause or hasten the employee's death and provided as rationale for his opinion the fact that the employee did not have documented cardiomyopathy until 24 years later.

[2] *See* 5 U.S.C. § 8123(a).

The Board has held that where opposing medical reports of virtually equal weight and rationale exist and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist is entitled to special weight if sufficiently rationalized and based upon a proper factual background.[3] The Board finds that the weight of medical opinion evidence in this case is represented by the report of Dr. Kanter, who provided a well-reasoned medical opinion in support of his finding that the employee's death was not causally related to his accepted myocardial infarction. Dr. Kanter provided a proper analysis of the factual and medical history and findings upon a review of the case record, including the results of diagnostic testing over the years, reached conclusions regarding the employee's condition which comported with this analysis and supported his opinion with medical rationale.[4] Thus, his opinion is entitled to special weight and establishes that the employee's death was not caused by the accepted employment injury.

The decision of the Office of Workers' Compensation Programs dated June 17, 1997 is hereby affirmed.

Dated, Washington, D.C.
August 4, 1999

Michael J. Walsh
Chairman

David S. Gerson
Member

Bradley T. Knott
Alternate Member

[3] *See Nancy Lackner (Jack D. Lackner*), 44 ECAB 840 (1992).

[4] *See Melvina Jackson*, 38 ECAB 443 (1987).