U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GARY F. VOET and U.S. POSTAL SERVICE,
POST OFFICE, Mason City, IA

Docket No. 98-1175; Submitted on the Record;
Issued May 23, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant met his burden of proof to establish that he sustained a recurrence of disability on November 2, 1994 causally related to his December 27, 1993 employment injury.

On December 27, 1993 appellant, then a 43-year-old letter carrier, sustained an employment-related cervical strain when his employing establishment vehicle was hit from behind.[1] He missed intermittent periods from work and returned to full duty on March 3, 1994. On June 24, 1995 appellant filed a claim, alleging that he sustained a recurrence of disability on November 2, 1994 when he stopped work. In an accompanying statement, he advised that he had been under continuous care since the December 27, 1993 injury and noted that on November 2, 1994 he had a seizure, which he contended was the result of a closed head injury sustained in the December 1993 accident. Appellant noted that he had received electroshock therapy for depression and was currently hospitalized. By letter dated August 4, 1995, the Office of Workers' Compensation Programs advised appellant of the information needed to support his claim and, following further development, in a November 29, 1995 decision, denied the claim on the grounds that the evidence of record failed to establish that the claimed recurrence was causally related to the December 27, 1993 employment injury. In the attached memorandum, the Office stated that the medical evidence appeared to contain various histories of injury and did not contain an unequivocal opinion, which discussed the etiology of appellant's seizures and was thus not rationalized.[2] On November 14, 1996 appellant, through counsel, requested reconsideration and submitted additional evidence. By decision dated February 19, 1997, the Office denied modification of the prior decision. The instant appeal follows.

[1] On his CA-1 claim form submitted on the date of injury, appellant stated that he sustained a bump on the back of the head, headache, sore neck and right wrist and a stiff back.

[2] The Office noted that appellant suffered from alcoholism and cited an April 3, 1995 note from Dr. Thomas Wilson and therapy notes that referred to a reinjury that may have resulted from drinking while driving.

The medical record in the instant case is extensive and contains numerous reports dating from the December 27, 1993 employment injury. In a report dated December 28, 1993, Dr. Samuel R. Hunt, a Board-certified family practitioner, noted findings on examination and diagnosed cervical strain. Cervical spine x-ray was normal. Appellant was referred to Dr. John Tagett, a surgeon, who returned him to full duty without restrictions on March 1, 1994. Dr. Steven H. Septer, an internist, submitted a September 29, 1994 report in which he advised that appellant had continued to have pain and restriction and diagnosed soft tissue injury of the upper back with probable ligamentous and muscle and tendon damage. A discharge summary dated November 4, 1994 indicated that appellant was hospitalized from November 2 to 4, 1994 after suffering seizures. Magnetic resonance imaging (MRI) scan of the head demonstrated a small lucency in the left frontal area, which "may suggest an old small hemorrhage or angioma." Discharge diagnoses included status post motor vehicle accident about one year ago with chronic neck and back pain, history of chronic alcohol use and recurrent seizures, etiology unclear -- "could be related to multiple medications and the use of alcohol."

In a November 11, 1994 report, Dr. Septer advised:

> "I have again examined [appellant] regarding his thoracic back pain, which is a result of his motor vehicle accident on December 27, 1993, while delivering mail. He was recently hospitalized ... with seizures. It is my medical opinion that the seizures are probably related to the same motor vehicle accident of December 27, 1993, resulting in an area of hemorrhage in the left frontal lobe resulting in his recent seizures."

Appellant was hospitalized numerous times in 1995 for major depression and suicidality and underwent approximately 20 electroconvulsive treatments (ECT).[3] He was evaluated by a number of physicians who were consistent in their history of the motor vehicle accident in December 1993, followed by seizures in November 1994. In a February 28, 1995 report, Dr. Ed Loon Chua, a psychiatrist, advised that, since the 1993 motor vehicle accident, appellant's health had deteriorated because of continued pain and that he had become depressed as a result.

Dr. Thomas Wilson, a neurologist, provided a March 30, 1995 report in which he noted that appellant had one seizure in November 1994 and two in December 1994. He noted appellant's history of depression and that he suffered from post ECT memory loss. An electroencephalography (EEG) was interpreted by Dr. Wilson as diffusely slowed, consistent with a post ECT recording. Dr. Wilson opined that the EEG did not reveal evidence of a right focal lesion or epileptiform process. In an April 3, 1995 report, he noted that a neuroradiologist, Dr. Mark Myers, had reviewed appellant's head MRI and noted the left frontal polar area of subcortical change, consistent with a localized small area of hemosiderin pigment from past trauma. Dr. Wilson noted that an interview with appellant was difficult due to past ECT and advised that there was a possible discrepancy regarding appellant's alcohol use in the year prior to his seizures. He described a history of a single episode of seizures in November 1994 and opined that the MRI record was consistent with appellant having sustained a head injury at some

[3] The record indicates that he was hospitalized from January 10 to February 16, February 22 to March 19, March 26 to April 13, May 11 to 15, June 12 to 16 and August 14 to September 8, 1995.

time in the past and concluded that it was unlikely that it was due to the December 1993 employment injury "although we cannot rule out that possibility."

In reports dated June 17 and 20, 1995, respectively, Drs. Susan Schultz and Gerald Clancy, Board-certified psychiatrists, diagnosed major depressive disorder due to closed head injury. By report dated June 21, 1995, Dr. Ernest M. Found, a Board-certified orthopedic surgeon, described the December 1993 work injury and diagnosed chronic thoracic and cervical pain syndrome, likely muscular in origin. Dr. M. Paul Strottman, who is Board-certified in internal medicine and rheumatology, provided a consultation report dated June 22, 1995 and diagnosed myofascial pain of the neck and thoracic paraspinals and shoulder girdle muscles.

Dr. Gerard P. Clancy, a Board-certified psychiatrist, who is an assistant professor at the University of Iowa, provided deposition testimony on November 4, 1996. He advised that he had treated appellant both as an inpatient and an outpatient and opined that appellant's type of motor vehicle accident can cause a traumatic brain injury. Dr. Clancy noted the November 1994 MRI findings and described the mechanics of what happens inside the skull during an accident such as appellant's. He testified that it was not surprising that appellant's injury was "silent," that with a left frontal bleed you commonly see only pain, poor memory and depression, which was consistent with appellant's complaints at the time of the motor vehicle accident. Dr. Clancy stated that the time lapse between the motor vehicle accident and appellant's seizures was not significant because seizures can occur months later. Appellant's alcohol use was discussed and Dr. Clancy opined that it was not enough to induce seizure activity, even in combination with appellant's medication. He concluded that the most likely cause of appellant's seizures was scar formation after a traumatic brain injury. Dr. Clancy advised that ECT impairs memory, especially in patients with a traumatic brain injury. He noted that neuropsychological testing of appellant revealed marked cognitive impairments and explained that his attempted suicide was consistent with a left frontal traumatic brain injury. Dr. Clancy diagnosed severe depression, which was very difficult to treat, noting that appellant could not work due to impairment of cognitive functions and severe depression and had a poor prognosis. He opined that both the seizure disorder and psychological disorder were the direct result of a traumatic brain injury sustained in the motor vehicle accident of December 27, 1993. Dr. Clancy advised that he was still treating appellant and concluded that appellant's seizure disorder was permanent.

Dr. Ronald M. Larsen, who is Board-certified in psychiatry and neurology, provided deposition testimony on November 5, 1996. He stated that he had treated appellant and reviewed medical records, including the November 1994 MRI and advised that the history of the motor vehicle accident and appellant's symptomatology were consistent with a brain injury, advising that such an injury can progress over time. Dr. Larsen testified that one could have a normal computerized tomography (CT) at the time of injury and later demonstrate an abnormal MRI. He opined that it was consistent to believe appellant's seizures were caused by brain trauma sustained in the motor vehicle accident and not caused by appellant's alcohol intake. Dr. Larsen noted that ECT can cause forgetfulness and opined that appellant's depression was related to the history of brain trauma and subsequent seizure disorder. He concluded that the most telling evidence of this was appellant's neuropsychological testing, which showed impairments of verbal memory, attention, psychomotor speed, depression consistent with a closed head injury and postconcussive symptoms.

Joseph Barrash, Ph.D., a research scientist at the University of Iowa, also provided deposition testimony on November 6, 1996. He stated that he is a specialist in neuropsychology and brain behavior relationships and that he saw and tested appellant on June 21, 1995. Dr. Barrash testified regarding appellant's deficiencies, noting deficits in attention and concentration with a mild defect in active verbal fluency. He noted that some areas of appellant's cognitive functioning were lower in 1996 than in 1995. Dr. Barrash noted that appellant's pain impacted on his disability and depression and concluded that he had suffered a traumatic brain injury.

Appellant continued to receive medical treatment for his seizure disorder and depression. In a report dated February 26, 1996, Julie Suhr, Ph.D., advised that neuropsychological evaluation continued to be consistent with a closed head injury/postconcussive syndrome, with likely exacerbation of cognitive symptoms related to severe depression. In a July 9, 1996 report, Dr. Mark E. Dyken, who is Board-certified in psychiatry and neurology, described the history of injury and appellant's past medical history of frontal lobe injury with seizure disorder and depression. He noted that appellant had suffered a seizure on June 29 and July 1, 1996 appellant had suffered seizures and was admitted to the hospital for one day.

The employing establishment provided statements dated August 9 and 15, 1995 in which Dave Walswick, supervisor, customer services, Hugh E. Strong and James A. Havig described the events of November 2, 1994 when appellant became sick at work and was taken to the hospital by ambulance.

The Board finds that this case is not in posture for decision.

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 recurrence of the disabling condition for which compensation is sought is causally related to the accepted employment injury.[4] This burden includes the necessity of furnishing evidence from a qualified physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury and supports that conclusion with sound medical reasoning.[5] Causal relationship is a medical issue,[6] and the medical evidence required to establish a causal relationship is rationalized medical evidence. Rationalized medical evidence is medical evidence, which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be

[4] *Kevin J. McGrath*, 42 ECAB 109 (1990); *John E. Blount*, 30 ECAB 1374 (1974).

[5] *Frances B. Evans*, 32 ECAB 60 (1980).

[6] *Mary J. Briggs*, 37 ECAB 578 (1986).

supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[7]

It is an accepted principle of workers' compensation law and the Board has so recognized, that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause.[8] As is noted by Professor Larson in his treatise: "[O]nce the work-connected character of any injury, has been established the subsequent progression of the condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause."[9]

Initially, the Board notes that the evidence of record is insufficient to establish that appellant continues to be disabled due to an orthopedic condition. To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such a causal relationship.[10] While Dr. Septer advised in 1994 that appellant continued to have thoracic pain from the December 1993 employment injury and Dr. Chua advised that appellant had become depressed as a result of the pain, they did not indicate that appellant was disabled, therefore. Likewise, Drs. Found and Strottman diagnosed continuing pain and/or myofascial pain syndrome. Their reports, however, do not contain an opinion regarding the cause of this condition.

The Board, nonetheless, finds that, regarding appellant's seizure disorder and depression, applying the principles noted above, the deposition testimony of Drs. Larsen, Clancy and Barrash constitutes sufficient evidence in support of appellant's claim to require further development by the Office as the doctors consistently opine that the 1993 employment injury led to these conditions. Although their reports are insufficient to discharge appellant's burden of establishing that his condition and disability on or after November 2, 1994 were causally related to the December 27, 1993 employment injury, the reports constitute sufficient evidence in support of appellant's claim to require further development of the record by the Office.[11]

It is well established that proceedings under the Federal Employees' Compensation Act[12] are not adversarial in nature[13] and, while the claimant has the burden to establish entitlement to

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[7] *Gary L. Fowler*, 45 ECAB 365 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[8] Larson, *The Law of Workmen's Compensation* § 13.00. *See also Stuart K. Stanton*, 40 ECAB 859 (1989); *Charles J. Jenkins*, 40 ECAB 362 (1988).

[9] *Id*. at § 13.11(a).

[10] *See* 20 C.F.R. § 10.110(a); *Kathryn Haggerty*, 45 ECAB 383 (1994).

[11] *See John J. Carlone*, 41 ECAB 354 (1989).

[12] 5 U.S.C. §§ 8101-8193.

[13] *See, e.g., Walter A. Fundinger, Jr.*, 37 ECAB 200 (1985).

compensation, the Office shares responsibility in the development of the evidence.[14] Only in rare instances where the evidence indicates that no additional information could possibly overcome one or more defects in the claim is it proper for the Office to deny a case without further development.[15] On remand the Office should compile a statement of accepted facts and refer appellant, together with the complete case record and questions to be answered, to appropriate Board-certified specialists for a detailed opinion on the relationship of appellant's condition and the December 27, 1993 employment injury and any period of disability therefrom. After such development as the Office deems necessary, a *de novo* decision shall be issued.

The decision of the Office of Workers' Compensation Programs dated February 19, 1997 is hereby vacated and the case is remanded to the Office for proceedings consistent with this opinion.

Dated, Washington, D.C.
May 23, 2000

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member

[14] *See Dorothy L. Sidwell*, 36 ECAB 699 (1985).

[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.800.5c (April 1993).