United States Department of Labor
Employees' Compensation Appeals Board

JANET COMBS, claiming as widow of SIDNEY COMBS, Appellant	)	**Docket No. 04-741**
	)	**Issued: October 20, 2004**
and	)	
DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Barbourville, KY, Employer	)	

Appearances:
Janet Combs, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On January 20, 2004 appellant, the deceased employees' spouse, filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated November 25, 2003 which denied appellant's claim for death benefits on the grounds that the medical evidence did not establish that the employee's death was causally related to his federal employment. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue on appeal is whether appellant has met her burden of proof in establishing that the employee's death was causally related to his federal employment.

FACTUAL HISTORY

On July 19, 1978 the employee, then a 48-year-old coal mine inspector, filed a claim alleging that he developed pneumoconiosis in the performance of duty. The Office accepted the employee's claim for minor acceleration of emphysema, bronchitis and pneumoconiosis.[1] The employee stopped work on June 26, 1978 and was placed on the periodic rolls and received wage-loss compensation until his date of death on May 9, 2003.[2]

After the employee filed his claim, the Office, in the course of developing the claim, referred the employee to several second opinion physicians.

On January 27, 1981 the employee filed a claim for a schedule award. In a decision dated June 27, 1983, the Office granted appellant a 15 percent permanent impairment of both lungs. The period of the award was June 28, 1982 to May 21, 1983.

The employee continued to submit reports from his treating physician, Dr. Mitchell Wicker, Jr., a Board-certified internist, which supported total disability due to his work-related conditions of minor acceleration of emphysema, bronchitis and pneumoconiosis.

On June 23, 2003 appellant submitted a claim for compensation by widow, Form CA-5, alleging that her husband's May 9, 2003 death was causally related to his employment. In support of her claim, appellant submitted a death certificate signed by Dr. Wicker who noted the immediate cause of death as ischemic cardiomyopathy and coronary artery disease. He noted that the time of death was 12:30 a.m. and that no autopsy was performed.

Appellant also submitted medical records from a hospital admission from January 17 to 31, 2003 which noted that the employee presented with a history of increasing shortness of breath. The employee was diagnosed with severe aortic stenosis and aortic insufficiency, severe tricuspid regurgitation, pulmonary hypertension, renal failure, chronic obstructive pulmonary disease, past history of cholelithiasis, history of jaundice, bilateral pulmonary infiltrates, history of gastrointestinal bleeding, history of subdural hematoma and severe two vessel coronary artery disease. The employee underwent a triple coronary artery bypass and an aortic valve replacement and was discharged in satisfactory condition. Included was a pulmonary function report dated January 20, 2003 which revealed a small airway obstruction and possible severe restrictive ventilatory defect which may have been due to less than maximal effort.

Also submitted were medical records from a hospital admission from February 19 to May 9, 2003, where Dr. Wicker noted in a death summary dated July 8, 2003, that the employee presented with diuresis, evaluation for shortness of breath and an ulcer on the sacrum. During

[1] The record reveals that the employee filed the following claims for compensation benefits due to work-related injuries: a claim for black lung disease which was accepted by the Office, file number 50-0009753; a claim for hearing loss which was accepted by the Office and later closed, file number A50-12083; and a claim for a knee and back injury, file number A50-19240. File number 50-0009753 was consolidated with the present claim by appellant file number 112016733.

[2] The record reveals that the employee died on May 9, 2003 and the immediate cause of death was listed as ischemic cardiomyopathy and coronary artery disease.

his hospital stay the employee suffered a cardiac arrest and was intubated and placed on mechanical ventilation. Dr. Wicker noted that the employee's congestive heart failure was secondary to ischemic heart disease and organ failure. He diagnosed congestive heart failure, septicemia, pulmonary collapse with acute respiratory failure, decubitus ulcers, ventricular fibrillation, atrial fibrillation, shock, malnutrition, aspiration pneumonia, staphylococcus aureus pneumonia, seizure disorder and hypertensive heart disease. During his final hospital admission the employee underwent the following procedures: insertion of endotracheal tube with mechanical ventilation, permanent tracheostomy, percutaneous endoscopic gastrostomy tube placement, central line placement, excision and wound debridement, multiple bronchoscopies and cardioverter defibrillator implantation. In a July 30, 2003 report, Dr. Wicker advised that the specific cause of death was multiple organ failure syndrome. He advised that the employee's death was accelerated by the fact that he had underlying lung disease which was partially causative of his lung failure. Dr. Wicker noted that it was "reasonable but not provable that this could have began the cascade towards the multi-organ failure syndrome" which caused the employee's death. He noted that the employee developed staphylococcus aureus infections which generally occurred in individuals who have a lowered immune response and fibrotic lung disease.

On September 8, 2003 the Office referred the entire case record and statement of accepted facts to an Office medical adviser for evaluation and determination as to whether the employee's May 9, 2003 death was causally related to his accepted work-related conditions. In a report dated September 14, 2003, the Office medical adviser noted that in the hospitalizations from October 2002 to May 2003 the employee was never diagnosed with the accepted conditions of bronchitis or emphysema. He advised that due to generalized atherosclerosis the employee developed kidney failure and required dialysis for several years before his health began to deteriorate in October 2002. The physician advised that the employee's heart failure was due to his diagnosed condition of artherosclerosis which affected the coronary arteries. The medical adviser noted that the employee's heart failure could not be easily or aggressively managed due to his renal function failure. He therefore opined that the employee's death was not caused, aggravated, accelerative or precipitated by the accepted conditions.

On September 22, 2003 the Office determined that a conflict of medical opinion had been established between Dr. Wicker, appellant's treating physician, who indicated that the employee's death was causally related to his employment and, Dr. Daniel D. Zimmerman, a Board-certified internist and Office medical adviser, who determined that the employee's death was not causally related to his employment.

To resolve the conflict, the Office referred the employee's medical records, a statement of accepted facts and a list of specific questions pursuant to section 8123(a) of the Federal Employees' Compensation Act to a referee physician, Dr. David G. Hof, a Board-certified internist with a subspecialty in pulmonary medicine.

In a report dated October 28, 2003, Dr. Hof indicated that he reviewed the records provided to him and noted a history of the employee's work-related injury. He noted that the employee had trivial pneumoconiosis and that the pulmonary difficulties he experienced were related to his long history of cigarette smoking, hyper-responsive airway problems and

nonspecific dust exposure. Dr. Hof also noted reviewing medical evidence indicating that the employee had "very little" coal dust lung disease. He indicated that there was nothing in his clinical course that could be substantiated from 1970 to the 1990's which would even remotely parallel a progressive pneumoconiosis course. Dr. Hof reviewed the medical reports from Dr. Wicker, specifically focusing on those from November 1990 to April 2000, and noted that the chest examinations revealed good distribution of ventilation, clear lungs and no wheezing, rhonchi or rales. He noted that these normal reports and a lack of worsening of the findings on the x-ray's were not compatible with pneumoconiosis. Dr. Hof opined that there was no way accelerated pneumoconiosis and bronchitis contributed to the employees general demise, rather he believed it was the result of peripheral vascular disease, coronary artery disease and aortic valvular disease. Dr. Hof also indicated that the employee's pulmonary hypertension was not the result of pneumoconiosis but rather it was due to his severe aortic insufficiency and chronic severe heart failure. He further opined that the employee's severe peripheral vascular disease highly contributed to his multi-organ failure. Dr. Hof also determined that the staphylococcal sepsis was not the result of underlying lung disease, but he attributed this condition to the employee's overall severe medical condition of chronic vascular overload, pulmonary vascular congestion, pleural effusions and his malnutrition from his chronic illness that started in the fall of 2002.

In a decision dated November 25, 2003, the Office denied appellant's claim for death benefits. The Office noted that the weight of the medical evidence rested with the opinion of the impartial medical specialist, Dr. Hof. The Office rejected appellant's claim on the basis that she failed to establish that the employee's death was causally related to his employment.

LEGAL PRECEDENT

The Act provides that the United States shall pay compensation for disability or death of an employee resulting from personal injury sustained while in the performance of duty.[3] An award of compensation in a survivor's claim may not be based on surmise, conjecture or speculation or on appellant's belief that the employee's death was caused, precipitated or aggravated by the employment.[4] A claimant 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 employment. The burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based on a complete factual and medical background. The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale.[5]

An employee receiving compensation for total disability at the time of death does not establish that his death was causally related to conditions resulting from the employment injury.[6]

[3] 5 U.S.C. § 8102(a).

[4] *Sharon Yonak (Nicholas Yonak)*, 49 ECAB 250, 254 (1997).

[5] *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[6] *Elinor Bacorn*, 46 ECAB 857 (1995); *see Joan Leveton*, 34 ECAB 1368 (1983).

The mere fact that a disease manifests itself during a period of employment does not raise an inference that there was a causal relationship between the two. Neither the fact that the disease was diagnosed during such employment nor appellant's opinion that an injury accepted by the Office ultimately caused the employee's death is sufficient to establish the required causal relationship.[7]

ANALYSIS

In the present case, the Office properly declared that there was a conflict in the medical evidence regarding whether the employee's death was causally related to his employment. Dr. Wicker, the employee's treating physician, believed that the employee's death was causally related to his employment and specifically noted that the employee's demise was accelerated by the fact that he had underlying work-related lung disease which was partially causative of his lung failure. On the other hand, an Office medical adviser found that the employee's death was not related to his employment rather it was due to the generalized atherosclerosis which caused kidney failure and ultimately heart failure affecting the coronary arteries. As there was an unresolved conflict in the medical evidence, the Office properly referred the employee's medical record to Dr. Hof, a Board-certified internist and pulmonary specialist, for an impartial medical examination review and report.[8]

In situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[9] The Board has carefully reviewed the opinion of Dr. Hof and finds that it has sufficient probative value, regarding the relevant issue in the present case, to be accorded such special weight.

In his October 28, 2003 report, Dr. Hof provided a thorough review of the medical evidence. Dr. Hof opined that accepted employment conditions did not contribute to the employee's death. Instead, he believed it was the result of peripheral vascular disease, coronary artery disease and aortic valvular disease. Dr. Hof noted that the employee had an extensive history of cigarette smoking and that the medical evidence indicated that the employee had "very little" coal dust lung disease. He further opined that the diagnosed condition of pulmonary hypertension was not the result of pneumoconiosis but rather was due to the employee's severe aortic insufficiency and chronic severe heart failure which contributed to his dyspnea on exertion. Dr. Hof advised that the employee's severe peripheral vascular disease highly contributed to his multi-organ failure. He noted that the diagnosed condition of staphylococcal sepsis was not the result of the employee's underlying work-related lung disease, but was due to his overall severe medical condition of chronic vascular overload, pulmonary vascular

[7] *Martha A. Whitson*, 43 ECAB 1176 (1992).

[8] Section 8123(a) of the Act states that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination. 5 U.S.C. § 8123(a).

[9] *Jack R. Smith*, 41 ECAB 691 (1990); *James P. Roberts*, 31 ECAB 1010 (1980).

congestion, pleural effusions and malnutrition from his chronic illness that started in the fall of 2002. Dr. Hof reviewed the complete medical record and found no basis on which to attribute the employee's death to his employment-related conditions and he provided rationale, based on his comprehensive review of the medical record, to support his opinion on causal relationship. As Dr. Hof's report is based on an accurate factual background and is well rationalized, it is entitled to special weight and establishes that the employee's death was not caused or aggravated by his accepted condition.

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof in establishing that her husband's death was causally related to his employment.

ORDER

IT IS HEREBY ORDERED THAT the November 25, 2003 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 20, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member