United States Department of Labor
Employees' Compensation Appeals Board

P.P., Appellant	)	
and	)	**Docket No. 07-845**
	)	**Issued: September 4, 2007**
DEPARTMENT OF DEFENSE, OFFICE OF THE INSPECTOR GENERAL, Arlington, VA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 6, 2007 appellant filed an appeal of a March 1, 2006 decision of the Office of Workers' Compensation Programs denying his occupational disease claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the appeal.

ISSUE

The issue is whether appellant has established that he sustained a stroke while in the performance of duty.

FACTUAL HISTORY

On October 13, 2004 appellant, a 54-year-old criminal investigator, filed an occupational disease claim alleging that on October 5, 2004 he sustained an aortic aneurism and stroke as a result of stressful conditions of employment. On October 14, 2004 the employing establishment confirmed that appellant suffered a stroke at a job fair and was incapacitated and unable to assist in the collection of documentation necessary to support his claim.

By letter dated March 21, 2005, the Office notified appellant that the evidence submitted was insufficient to establish his claim. The Office advised appellant to provide details as to employment-related events or conditions believed to have caused or contributed to his illness, as well as a medical report containing a diagnosis, treatment history, results of tests and examinations and an opinion with medical reasons on the cause of his diagnosed conditions.

Appellant submitted a job description for the position of criminal investigator; a June 21, 1985 application for employment; and a March 14, 2005 notification of personnel action "time-off" award. In an undated statement, he alleged that the work he performed involving the events of September 11, 2001 and subsequent cases and assignments caused him continued and heightened levels of stress that exacerbated his hypertension, ultimately culminating in a dissected aorta and two strokes. Appellant identified numerous employment factors he believed to be responsible for his conditions:

> 1. Required to execute arrests and search warrants, often under hostile or dangerous situations and to perform or oversee undercover operations, often involving targets of felonious activities.
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> 2. Position required long periods of overtime on a weekly basis, as well as abrupt changes to his daily schedule. For example, following September 11, 2001, appellant was assigned to the investigation of terrorist attacks in New York City, which included a search for human remains at Ground Zero. He was extremely anxious, due to safety concerns surrounding contamination at the site. Moreover, his 12- to 14-hour day schedule significantly impacted appellant's time with his family.
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> 3. The magnitude and importance of appellant's work weighed heavily on his mind and, by its very nature, was acutely stressful.
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> 4. As the office's technical agent since 1986, appellant was responsible for proper procurement of security and maintenance of all technical and surveillance equipment. He was acutely aware that his failure to field technical equipment could result in loss of critical evidence and appellant experienced great stress preceding the execution of cover-up operations.
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> 5. Appellant was the main presenter of integrity/fraud awareness briefings and often received short notice for such presentations. He was stressed about arriving and being set up on time so that he could make a professional presentation.
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> 6. As a firearms instructor, Appellant was extremely concerned for the safety of his fellow agents, as well as his own liability.
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> 7. As a senior agent, appellant carried a large caseload (12 cases simultaneously), consisting of many multi-million dollar complex frauds allegedly committed by some of the largest defense contractors in the state. He routinely testified before federal grand juries presenting complex and detailed investigative results. The nature of the work was both "chronically and acutely stressful" and often overwhelming.

8. Appellant stated that the rigors of juggling his duties became overwhelming, culminating at the law enforcement fair on October 5, 2004 when he suffered a stroke caused by his dissected aorta.

In an undated statement, appellant's immediate supervisor, James Murawski, stated that appellant's description of his job responsibilities, including general and collateral duties was accurate. As his coworker since 1984 and supervisor since 1997, Mr. Murawski stated that over a period of time, he had observed a growing level of stress in appellant when conducting his duties, which may have been exacerbated in the aftermath of September 11, 2001. He noted that appellant carried a "significant, heavy, complex caseload."

By decision dated May 5, 2005, the Office denied appellant's claim. The Office accepted that the claimed events occurred, but found that there was no medical evidence containing a diagnosis which could be connected to the established event. On May 17, 2005 appellant requested an oral hearing.

Appellant submitted numerous medical documents from Riverview Medical Center and Jersey Shore University Medical Center and test results, including: triage notes and emergency room records dated October 5, 2004; an October 5, 2004 consent for administration of thrombocytic therapy for acute ischemic stroke, signed by appellant's wife; a cumulative summary reflecting that appellant was admitted to the Riverview Medical Center on October 5, 2004 for treatment of a pulmonary embolism; and a discharge summary from Jersey Shore University Medical Center reflecting that appellant was admitted on October 6, 2004 with a diagnosis of aortic dissection, hypertension and hyperlipidemia, underwent repair of an aortic dissection and was discharged on October 19, 2004. He submitted October 5 and 6, 2004 reports of x-rays; electrocardiograms (EKG); computerized tomography (CT) scans of the head, brain and chest; blood chemistry profiles; echocardiograms; and magnetic resonance imaging (MRI) scans of the upper shoulder.

In a report dated October 5, 2004, Dr. Rafiya Khakoo, a treating physician, diagnosed a possible right posterior cerebral artery stroke causing left arm weakness and headache related to the stroke. He stated that, while at a work-related convention on that date, appellant began to experience a severe headache and confusion with dysarthria and slurring of speech, followed by weakness in the left upper extremity and numbness in the left arm. His past medical history was significant for hypertension.

Appellant submitted reports from Dr. Joseph Clemente, a Board-certified internist. On October 6, 2004 Dr. Clemente recommended immediate surgery to repair an aortic dissection. He indicated that a CT scan revealed proximal aortic dissection with involvement of the right and left carotid artery. Dr. Clemente noted a history of hypertension. Results of an echocardiogram performed that day revealed dissection of the aortic root and aortic arch; moderately dilated aortic arch; and moderate aortic insufficiency. On April 14, 2005 he indicated that appellant's symptoms related to his previous stroke and repair of the aortic valve had significantly improved. In a letter dated May 13, 2005, Dr. Clemente stated that appellant had a history of hypertension and that, in the past, had significant stress during work which may

have elevated his blood pressure at times. He also stated that "this may have contributed somewhat to his aortic dissection."

In an October 6, 2004 report, Dr. Drew Greeley, a Board-certified thoracic surgeon, indicated that appellant had presented to Riverview Medical Center on October 5, 2004 with slurred speech. An echocardiogram revealed aortic insufficiency. A CT scan of the chest demonstrated Type 1 aortic dissection. On physical examination, appellant exhibited a diminished right radial pulse, obvious left visual defect and left arm paresthesia. Dr. Greeley diagnosed acute Type 1 aortic dissection with obvious malperfusion of the carotid artery and recommended immediate repair. He noted that appellant's medical history was significant for hypertension. In an accompanying attending physician's report, Dr. Greeley stated that appellant's symptoms began on October 5, 2004. The record contains an October 6, 2004 operative report describing surgery performed on that date by Dr. Greeley to replace the ascending aorta with resuspension of the aortic valve. On November 11, 2004 Dr. Greeley reported that appellant had presented with a stroke and had dissection that extended up both carotid arteries. He underwent repair of his aortic dissection on October 6, 2004. Postoperatively, appellant suffered a left hemispheric cerebral vascular accident and had acute arterial occlusion of the right lower extremity. He underwent an embolectomy for this condition. Dr. Greeley indicated that appellant's conditions seemed to be "resolving quite well from the stroke he suffered preoperatively."

Appellant submitted a November 22, 2004 report from Dr. John B. Maggio, a Board-certified internist, who reviewed his medical history, indicating that he had undergone surgery for acute proximal aortic dissection, complicated by a cerebral vascular accident. He was stable until October 23, 2004 when he developed acute arterial insufficiency of the right leg, along with numbness and weakness of the right upper extremity. Appellant then underwent embolectomy with repair and dissection of the right femoral artery. Examination revealed no ischemia. Blood pressure was 132/84. Neck examination demonstrated equal carotid pulsations bilaterally. Chest examination showed clear lung fields bilaterally. Cardiac examination demonstrated S1 and S2 with a negative rhythm and II -- III/VI systolic murmur. Electrocardiogram demonstrated sinus rhythm at 92 beats with normal PR and mildly prolonged QRS intervals. He provided an impression of status postaortic dissection and valve repair; hypertension; hyperlipidemia; peripheral and cerebral vascular disease; and mild aortic insufficiency on echocardiogram. In a January 22, 2005 perfusion imaging report, Dr. Maggio noted no LV chamber dilation; a fixed moderate apical defect; and mildly impaired gated LVEF. In a February 28, 2005 report of a routine follow-up examination, he reiterated the impressions provided on November 22, 2004 but did not address the cause of appellant's conditions.

Appellant submitted a January 21, 2005 report from Dr. Barry M. Schanza, a treating physician, who examined him on January 5, 2005. Noting that he sustained a stroke and underwent aortic valve and repair surgery in October 2004, Dr. Schanza stated that appellant had a blind spot and had episodes of seeing gray spots. He opined that appellant's visual field loss was most likely due to the stroke. Other intermittent problems were more likely due to vascular insufficiency.

Appellant submitted reports from Dr. Ian Molk, a Board-certified internist. On March 4, 2005 Dr. Molk provided a history of appellant's condition, indicating that he sustained a left-sided stroke and underwent a repair of the aortic valve and replacement of the ascending aorta. Subsequently, appellant suffered a right-sided stroke, felt to be embolic in nature which was followed by an embolectomy and surgical repair of the right iliac region. Dr. Molk stated that appellant had suffered from hypertension for many years. On September 9, 2005 Dr. Molk indicated that appellant had been experiencing episodes of mild lower chest discomfort. An EKG showed no evidence of ischemia and demonstrated normal sinus rhythm. A cardiolite revealed no reversible ischemia and minimally impaired LV systolic function. Due to his valve and ascending aortic repair, Dr. Molk recommended against a significant amount of isometric exercise.

Other medical evidence of record includes a December 16, 2004 "Holter Report Summary;" reports of echocardiograms dated October 25, 2004 and April 14, 2005; an April 19, 2005 report from Dr. Steven E. Hodes reflecting the results of an April 5, 2005 upper endoscopy; an April 28, 2005 attending physician's report signed by Dr. Kenneth Steiner, a treating physician, reflecting a diagnosis of "aortic aneurism/stroke;" and an undated attending physician's report signed by Dr. Stuart Hochron, a Board-certified internist, containing a diagnosis of dissecting thoracic aneurism.

At the December 13, 2005 hearing, appellant's representative confirmed that the issue in the case was whether appellant had suffered a stroke causally related to factors of his employment. He reiterated that his regular duties as a special agent at the time of the incident were extremely stressful. Appellant recounted the events leading up to his stroke, noting that he had been required to attend a job fair on short notice on the date of the incident. He stated, "I remember tripping and falling or just falling. What caused it, I don't know."

By letter dated January 16, 2006, appellant's representative indicated that he was submitting reports from Drs. Molk and Clemente supporting appellant's position that work factors contributed to his conditions. In a letter dated May 13, 2005, Dr. Clemente stated that appellant had significant stress during work which "probably" elevated his blood pressure at times. He noted that "it is well established that hypertension is a significant contributory factor for aortic dissection." On January 11, 2006 Dr. Molk stated that appellant who had a history of hypertension, underwent surgery for ascending aortic dissection. He noted that "stresses on the job can certainly aggravate hypertension and hypertension itself can be a cause of aortic dissection." Dr. Molk stated that it was "certainly a reasonable possibility that the hypertension, which was aggravated by the stress of the job, contributed to the aortic dissection, which required ascending aorta replacement in October 2004."

By decision dated March 1, 2006, an Office hearing representative affirmed the Office's May 5, 2005 decision on the grounds that the medical evidence failed to establish that appellant's diagnosed conditions were causally related to his accepted employment factors.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[1] has the burden of establishing the essential elements of his claim, including the fact that an injury was sustained in the performance of duty as alleged[2] and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[3]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or conditions for which compensation is claimed; (2) a factual statement identifying the employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[4] The medical evidence required to establish a causal relationship, generally, is rationalized medical opinion evidence, *i.e*., medical evidence presenting a physician's well-reasoned opinion on how the established factor of employment caused or contributed to the claimant's diagnosed conditions. To be of probative value, 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 supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5] An award of compensation may not be based on appellant's belief of causal relationship. Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish a causal relationship.[6]

ANALYSIS

Appellant alleged that his regular-work duties and responsibilities as a criminal investigator exacerbated his hypertension, thereby contributing to his stroke. Stress-inducing activities identified included execution of arrests and search warrants; being subjected to long periods of overtime and abrupt changes to his daily schedule following the September 11, 2001 terrorist attacks in New York City, which included a search for human remains at Ground Zero;

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[1] 5 U.S.C. §§ 8101-8193.

[2] *Joseph W. Kripp,* 55 ECAB 121 (2003); *see also Leon Thomas*, 52 ECAB 202, 203 (2001). "When an employee claims that he sustained injury in the performance of duty he must submit sufficient evidence to establish that he experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. He must also establish that such event, incident or exposure caused an injury." *See also* 5 U.S.C. § 8101(5) ("injury" defined); 20 C.F.R. § 10.5(q) and (ee) (2002) ("Occupational disease or Illness" and "Traumatic injury" defined).

[3] *Dennis M. Mascarenas*, 49 ECAB 215, 217 (1997).

[4] *Michael R. Shaffer,* 55 ECAB 386 (2004). *See also Solomon Polen*, 51 ECAB 341, 343 (2000).

[5] *Leslie C. Moore,* 52 ECAB 132, 134 (2000*)*; *see also Ern Reynolds*, 45 ECAB 690, 695 (1994).

[6] *Phillip L. Barnes*, 55 ECAB 426 (2004); *see also Dennis M. Mascarenas*, *supra* note 3 at 218.

procurement of security and maintenance of all technical and surveillance equipment; presentation of integrity/fraud awareness briefings on short notice; presenting firearms instruction to his fellow agents; carrying a large and complex caseload; and routinely testifying before federal grand juries presenting complex and detailed investigative results. Appellant's supervisor supported the accuracy of appellant's description of his job responsibilities, indicating that as his coworker since 1984 and supervisor since 1997, he had observed a growing level of stress in appellant when conducting his duties which may have been exacerbated in the aftermath of September 11, 2001. The supervisor noted that appellant carried a "significant, heavy, complex caseload." In denying appellant's claim, the Office accepted that the events claimed by appellant occurred as alleged. The Board finds that appellant has identified compensable factors of employment with regard to his regular employment duties.[7]

Appellant's burden of proof, however, is not discharged by the fact that he has established employment factors which may give rise to a compensable disability under the Act. To establish his occupational disease claim, appellant must also submit rationalized medical evidence establishing that his claimed conditions were causally related to the accepted employment factors.[8] The Board finds that the medical evidence of record fails to establish that appellant's aortic aneurysm or stroke were caused by the accepted compensable employment factors.

Medical evidence of record includes an October 5, 2004 report from Dr. Khakoo who diagnosed a possible right posterior cerebral artery stroke causing left arm weakness and headache. He stated that, while at a work-related convention on that date, appellant began to experience a severe headache and confusion with dysarthria and slurring of speech, followed by weakness in the left upper extremity and numbness in the left arm. Dr. Khakoo noted a medical history significant for hypertension. He did not provide a definite diagnosis or an opinion on the cause of appellant's conditions. The Board has long held that medical evidence which does not offer any opinion regarding the cause of an employee's conditions is of limited probative value on the issue of causal relationship.[9]

On October 6, 2004 Dr. Greeley diagnosed acute Type 1 aortic dissection with obvious malperfusion of the carotid artery and recommended immediate repair which he performed on that date. He noted that appellant's medical history was significant for hypertension. On November 11, 2004 Dr. Greeley reported that appellant had presented with a stroke and aortic dissection that extended up both carotid arteries. After undergoing repair of appellant's aortic dissection on October 6, 2004 appellant suffered a left hemispheric cerebral vascular accident and had acute arterial occlusion of the right lower extremity. He underwent an embolectomy for this condition. Dr. Greeley indicated that appellant's conditions seemed to be "resolving quite

[7] *See Penelope C. Owens*, 54 ECAB 684 (2003) (where a claimed disability results from an employee's emotional reaction to the performance of his or her regular or specially assigned duties or to an imposed employment requirement, the disability comes within the coverage of the Act.) *See also Lillian Cutler*, 28 ECAB 125 (1976).

[8] *William P. George*, 43 ECAB 1159, 1168 (1992).

[9] *Willie M. Miller*, 53 ECAB 697 (2002). *See also Michael E. Smith*, 50 ECAB 313 (1999).

well from the stroke he suffered preoperatively." However, he did not provide an opinion on the cause of his diagnosed conditions. Therefore, his reports are of limited probative value.[10]

Reports from Dr. Maggio are similarly deficient. On November 22, 2004 he reviewed appellant's medical history, indicating that appellant had undergone surgery for acute proximal aortic dissection, complicated by a cerebral vascular accident. Noting that appellant was stable until October 23, 2004 when he developed acute arterial insufficiency of the right leg, along with numbness and weakness of the right upper extremity, Dr. Maggio reported that appellant underwent embolectomy with repair and dissection of the right femoral artery. Examination revealed no ischemia. Blood pressure was 132/84. Neck examination demonstrated equal carotid pulsations bilaterally. Chest examination showed clear lung fields bilaterally. Cardiac examination demonstrated S1 and S2 with a negative rhythm and II -- III/VI systolic murmur. An EMG demonstrated sinus rhythm at 92 beats with normal PR and mildly prolonged QRS intervals. Dr. Maggio provided impressions of status postaortic dissection and valve repair; hypertension; hyperlipidemia; peripheral and cerebral vascular disease; and mild aortic insufficiency on echocardiogram. In a January 22, 2005 perfusion imaging report, he noted no LV chamber dilation; a fixed moderate apical defect; and mildly impaired gated LVEF. In a February 28, 2005 report, Dr. Maggio reiterated the impressions provided on November 22, 2004. As none of his reports addressed the cause of appellant's conditions they are of diminished probative value and are insufficient to establish appellant's claim.

On January 21, 2005 Dr. Schanza reported that appellant had a blind spot and had episodes of seeing gray spots. He opined that appellant's visual field loss was most likely due to the stroke and that other intermittent problems were more likely due to vascular insufficiency. While Dr. Schanza expressed an opinion as to the cause of appellant's visual field loss, he did not address the cause of appellant's stroke which is at issue in this case. Accordingly, his report does not support appellant's claim.

On October 6, 2004 Dr. Clemente recommended immediate surgery to repair an aortic dissection. On April 14, 2005 he indicated that appellant's symptoms related to his previous stroke and repair of the aortic valve had significantly improved. In a letter dated May 13, 2005, Dr. Clemente stated that appellant had a history of hypertension and "during his work in the past, had significant stress during work which may have elevated his blood pressure at times." He also stated that "this may have contributed somewhat to his aortic dissection." In another letter dated May 13, 2005, Dr. Clemente stated that appellant had significant stress during work which "probably" elevated his blood pressure at times. He noted that "it is well established that hypertension is a significant contributory factor for aortic dissection." Dr. Clemente's reports dated October 6, 2004 and April 14, 2005 do not contain an opinion as to the cause of appellant's diagnosed conditions and, therefore, lack probative value in that regard. His May 13, 2005 letters are also insufficient to establish appellant's claim. Although Dr. Clemente purports to express an opinion as to a causal relationship between appellant's diagnosed aortic dissection and factors of his employment, his opinion is speculative at best. Moreover, he has not provided a rationalized explanation as to how appellant's employment activities caused or contributed to his diagnosed conditions. The Board has long held that a medical opinion not fortified by

[10] *Id.*

medical rationale is of diminished probative value.[11] Dr. Clemente's general statement that "hypertension is a significant contributory factor for aortic dissection" is insufficient to explain how appellant's stroke was physiologically related to the accepted employment conditions.

Dr. Molk's reports are also insufficient to establish appellant's claim. On March 4, 2005 he provided a history of appellant's conditions, indicating that he sustained a left-sided stroke and underwent a repair of the aortic valve and replacement of the ascending aorta. Subsequently, appellant suffered a right-sided stroke, felt to be embolic in nature which was followed by an embolectomy and surgical repair of the right iliac region. Dr. Molk stated that appellant had suffered from hypertension for many years. On September 9, 2005 he indicated that appellant had been experiencing episodes of mild lower chest discomfort. An EKG showed no evidence of ischemia and demonstrated normal sinus rhythm. A cardiolite revealed no reversible ischemia and minimally impaired LV systolic function. Due to his valve and ascending aortic repair, Dr. Molk recommended against a significant amount of isometric exercise. As neither report contained an opinion as to the cause of appellant's stroke they are of limited probative value. On January 11, 2006 Dr. Molk stated that appellant who had a history of hypertension, underwent surgery for ascending aortic dissection. He noted that "stresses on the job can certainly aggravate hypertension and hypertension itself can be a cause of aortic dissection." Dr. Molk stated that it was "certainly a reasonable possibility that the hypertension, which was aggravated by the stress of the job contributed to the aortic dissection which required ascending aorta replacement in October 2004." His hypothesis was not expressed to a reasonable degree of medical certainty, but rather, was equivocal in nature. Moreover, although Dr. Molk stated generally that hypertension caused by job-related stress can cause an aortic dissection, he failed to explain how, in this specific case, conditions of appellant's employment aggravated his hypertension and physiologically how that hypertension caused his stroke. Therefore, his report is of diminished probative value.

The Board notes that the remaining medical evidence of record does not contain an opinion as to the cause of appellant's diagnosed conditions. Accordingly, it is of diminished probative value and does not support appellant's claim.

The Office advised appellant that it was his responsibility to provide a comprehensive medical report which included a description of his symptoms, test results, diagnosis, treatment history and the doctor's opinion with medical reasons as to the cause of his conditions. Appellant failed to do so. As there is no probative, rationalized medical evidence explaining how appellant's aortic aneurysm or stroke were caused or aggravated by his employment, he has not met his burden of proof in establishing that he sustained an occupational disease in the performance of duty causally related to factors of employment.

CONCLUSION

The Board finds that appellant has failed to submit rationalized medical evidence establishing that his aortic aneurysm or stroke was caused by the accepted employment factors. Therefore, he has failed to satisfy his burden of proof in this case.

[11] *See Brenda L. DuBuque*, 55 ECAB 667 (2004); *see also David L. Scott*, 55 ECAB 330 (2004); *Willa M. Frazier*, 55 ECAB 379 (2004).

ORDER

IT IS HEREBY ORDERED THAT the March 1, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 4, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board