United States Department of Labor
Employees' Compensation Appeals Board

T.O., Appellant **and** **DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Oberlin, OH, Employer**	)))))))))	**Docket No. 07-1442** **Issued: April 17, 2008**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 27, 2007 appellant filed a timely appeal from the decision of the Office of Workers' Compensation Programs dated March 7, 2007 terminating his medical and compensation benefits. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the Office properly terminated appellant's wage-loss compensation and medical benefits.

FACTUAL HISTORY

This case has been before this Board before. The law and the facts of this case as set forth in the Board's prior decision are hereby incorporated by reference.[1] The facts relevant to the current appeal are set forth below.

On December 17, 1975 appellant, then a 39-year-old air traffic control specialist, filed a claim for a stomach disorder and nervous tension which he attributed to stress and strain of his air traffic control duties over the previous 17¾ years. He was assigned to a light-duty position on July 13, 1976 but was reinstated to his air traffic controller position on May 27, 1984. On June 10, 1987 appellant retired and filed a recurrence of disability claim which was accepted by the Office, and he began receiving compensation benefits for total disability. His claim was accepted for moderate, chronic anxiety reaction, anxiety disorder depression and duodenal ulcer.

By letter dated January 14, 2004, the Office requested that appellant submit updated medical information. In response, appellant submitted a January 26, 2004 report wherein Dr. Robert G. Fawcett, appellant's treating Board-certified psychiatrist, indicated that he last saw appellant on June 18, 2003 for a follow-up on his generalized anxiety disorder. Dr. Fawcett noted that appellant was taking lorazepam and that his anxiety was generally under control for the activities of retirement. He noted that appellant does have difficulties if he attempts to reduce his dose. Dr. Fawcett noted that appellant's anxiety disorder has been continuous since working as an air traffic controller in 1975, noting that it worsened when he attempted to return to work in the 1980s. Finally, he noted that the "lorazepam appears to keep some of his generalized anxiety at bay, but he has still not reverted to the baseline level of functioning prior to 1975." In a February 13, 2004 work capacity evaluation form, Dr. Fawcett indicated that appellant is not competent to work eight hours a day, noting that he is 67 years old and has not worked regularly since 1984. He noted that appellant's anxiety symptoms worsened in the past when he attempted to return to work.

By letter dated March 31, 2004, the Office referred appellant to Dr. Krishan K. Batra, a Board-certified psychiatrist, for a second opinion. In an opinion dated March 19, 2004, Dr. Batra concluded that appellant was totally dysfunctional due to chronic anxiety state, depression, associated psychosomatic reactivities and a poorly managed psychiatric condition. She also noted cognitive disturbances in the form of attention and concentration diminution, which could be aggravated under stressful circumstances. Dr. Batra noted that, as alertness and proficiency required in his previous job is compromised, it would be unsafe for appellant to work as an air traffic controller. However, she further concluded that in her professional judgment that not having been on antidepressant medication, not attending Alcoholics Anonymous (AA) meetings and continuing to drink on a daily basis along with benzodiazepines is not related to his job performance in 1975 or 1987 nor is it the fault of the employing establishment. Dr. Batra concluded that appellant's suffering and incapacities do not have any relationship to his position with the employing establishment or to the gastric upsets which took place in the 70's or 80's. She recommended treatment with antidepressants, gradual reduction of benzodiazepines, AA

[1] Docket No. 95-2613 (issued March 2, 1998) (the Board reversed the Office's decision reducing appellant's compensation benefits as it found that the Office had not met its burden of proof).

meetings and psychotherapy before returning to an alternate job, but noted that he will never be able to go back to the air controller's job.

In a report dated May 12, 2005, Dr. Fawcett commented on Dr. Batra's report, indicating that he was "not in complete agreement with Dr. Batra's conclusions." He noted that it was not rational to conclude in the 1970s and 1980s that appellant's generalized anxiety disorder was causally related to his previous work, that it has continued through all these years, and suddenly in 2004 the etiology is no longer related to his job. Dr. Fawcett did not believe that appellant's current drinking rose to the level of alcohol abuse. He also saw no evidence that he was engaged in any prescription benzodiazepine abuse. Dr. Fawcett noted that, if appellant did reduce his lorazepam, significant symptoms of anxiety do recur. He noted that, although appellant might benefit from some changes in his pharmacologic regimen, cessation of drinking or psychotherapy, he was skeptical that appellant could return to full-time work. Dr. Fawcett also noted that the demands of retraining for him at age 68 may be beyond reasonable expectation. He concluded:

> "Again, in summary, [appellant] apparently functioned well during his [m]ilitary service and for many years as an air traffic controller until around 1977 when he had a forced medical retirement because of his anxiety. He did return to work as an air traffic controller but, again, retired with anxiety problems around 1987. The chronology of his anxiety problems in leaving work suggests a relationship, which was judged to be a causal relationship at the time between his work and his anxiety related in its onset and continuity to his original work situation.

In a letter dated March 25, 2006, the Office asked Dr. Fawcett to respond to various questions concerning appellant. In a report dated June 23, 2006, he indicated that appellant has generalized anxiety disorder, with symptoms generally controlled with the use of lorazepam. Dr. Fawcett noted that appellant was sleeping adequately, eating well and not exhibiting any panic attacks. He stated that appellant's prognosis for return to work was poor. Dr. Fawcett noted that appellant was 70 years old and would not realistically be able to relearn some of the current modalities involved in functioning as an air traffic controller. He noted that appellant appeared to deteriorate from stress of the workplace with increased anxiety and he fatigues very easily in attempting to do work around the house. Dr. Fawcett believed that appellant's disability was a permanent condition. He did not believe that it was realistic to think appellant was going to be reemployed as an air traffic controller or in a similar position given his age and general health status.

By letter dated June 23, 2006, the Office referred appellant to Dr. Gillian Karatinos, a Board-certified psychiatrist, for an impartial medical examination to resolve the conflict between Dr. Fawcett and Dr. Batra with regard to appellant's continuing disability due to his accepted work conditions. In a medical report dated July 4, 2006, Dr. Karatinos reviewed appellant's medical records and conducted an examination. She diagnosed: benzodiazepine (lorazepam) dependence, possible alcohol abuse or alcohol-related disorder and anxiety disorder treated for 14 years by lorazepam. Dr. Karatinos noted chronic duodenal ulcer/dyspepsia, and high blood pressure for 14 years controlled on medication. She also noted prostate cancer treated in 2004 or 2005. Dr. Karatinos listed his stressors as loss of interest in high school, large family of origin, history of divorce, job stress and chronic alcohol use. She noted that combining benzodiazepine

and alcohol shows poor insight because both of these decrease memory and attention and can actually be fatal if enough of each one is taken at the same time. However, Dr. Karatinos noted that this may be, to some extent, the fault of his physicians, as appellant did not appear to be at all concerned or even aware that the alcohol and lorazepam were a problem. She indicated that because of the alcohol and lorazepam that appellant could not work at anything at this time. Dr. Karatinos also noted that he was 70 years old and that as he gets older, the lorazepam will be more of a problem as it decreases reflexes, or interferes with sleep and causes memory loss. Finally, she noted that he might not be able to function without the lorazepam or with another less addictive antianxiety medication. Dr. Karatinos recommended a biopsy with regard to appellant's stomach pain. She then concluded:

> "I believe it is unlikely that [appellant's] current mental status is related to the mental status at the time of his beginning Workers' Compensation due to work-related anxiety in 1979. He certainly presents very calmly today and does not seem concerned when I tell him that I do not find him to have any current symptoms of [p]sychiatric [d]isorders outside of the heavy use of alcohol and lorazepam."

In answer to questions propounded by the Office, Dr. Karatinos indicated that appellant did not have any current anxiety reaction or depression. She noted that, with regard to his duodenal ulcer, there were no studies to show that it existed since 1986. Dr. Karatinos noted that most ulcers respond to H2-blockers or acid pump inhibitors over a period of 3 to 12 months and resolve. She noted that appellant had ongoing dyspepsia, but that this might not be related to an ulcer; she noted that a gastroenterologic work-up was mandatory at this time. Dr. Karatinos indicated that it was possible that appellant was experiencing abdominal pain due to irritable bowel or recurrent gastritis from the use of smoking and alcohol. She concluded that appellant was not suffering from anxiety reaction, depression and probably not from duodenal ulcer, although he did claim to have dyspepsia. Dr. Karatinos noted that appellant does not meet the criteria now for either generalized anxiety disorder or panic disorder, possibly because of his long-term treatment with lorazepam. She noted that panic disorder is a lifetime relapsing, recurrent disorder in two-thirds of the cases. Dr. Karatinos noted that this diagnosis could link current symptoms with initial work-related onset in the 1970's by causing permanent neurotransmitter changes in the limbic system. She further noted that the diagnosis of generalized anxiety disorder cannot be made when the patient is chronically using alcohol. Dr. Karatinos noted that the diagnosis of generalized anxiety disorder and/or panic disorder may be present, which would be the closest that one could get officially to regarding anxiety retrospectively. She noted that it was difficult to say whether appellant continued to require lorazepam as he never has been off it, noting that, "although he may have some underlying anxiety that is resolved by the use of lorazepam, he does not manifest the anxiety while on the lorazepam." Dr. Karatinos questioned whether appellant ever had depression, noting that she did not find it in any of his medical reports. She stated that she believed that appellant's condition had reverted to its baseline level since the December 17, 1975 incident and has improved and resolved completely since then, with occasional brief recurrences due to stress. Dr. Karatinos noted that appellant "is not capable of working due to alcohol use, lorazepam dependence, age and physical problems such as renal disease and prostate cancer. Appellant is not disabled by anxiety, depression, or ulcer." Dr. Karatinos noted that, because of the fact that he is using lorazepam combined with moderate continuous alcohol use, it is doubtful that he can return to

productive and gainful employment, especially at the age of 70, when it is normal to expect a decrease in physical prowess and memory, further decreased by lorazepam and alcohol. She concluded that the current optimal treatment of chronic anxiety is not chronic benzodiazepine use and noted that the recommended treatment is an antidepressant which is not addictive.

On January 30, 2007 the Office issued a proposed notice of termination of compensation and medical benefits. The Office proposed terminating all benefits because the evidence established no remaining psychiatric and physical residual causally related to appellant's employment.

By letter dated February 20, 2007, appellant responded to the proposed termination of benefits by indicating that he disagreed with the proposed action, noting disagreements with characterizations of his alcohol use.

By decision dated March 7, 2007, the Office terminated appellant's medical and compensation benefits.

LEGAL PRECEDENT

Once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation benefits.[2] The Office may not terminate compensation without establishing that disability ceased or that it was no longer related to the employment.[3] The Office's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[4] The right to medical benefits for an accepted condition is not limited to the period of entitlement to disability. To terminate authorization for medical treatment, the Office must establish that a claimant no longer has residuals of an employment-related condition, which require further medical treatment.[5]

The Act provides that, if there is a disagreement between a physician making an examination for the United States and the physician of the employee, the Secretary must appoint a third physician to make an examination.[6] Likewise, the implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office must appoint a third physician to make an examination. This is called a referee examination and the Office is required to select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[7] It is well established that, when a

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[2] *Jorge E. Stotmayor*, 52 ECAB 105, 106 (2000).

[3] *Mary A. Lowe*¸52 ECAB 223, 224 (2001).

[4] *Gewin C. Hawkins*, 52 ECAB 242, 243 (2001).

[5] *Mary A. Lowe*, *supra* note 3.

[6] 5 U.S.C. §§ 8101-8193, 8123(a).

[7] 20 C.F.R. § 10.321.

case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on proper factual and medical background, must be given special weight.[8]

ANALYSIS

The Board finds that the Office did not meet its burden of proof in terminating appellant's wage-loss compensation and medical compensation. The Office accepted appellant's claim for moderate chronic anxiety reaction, anxiety disorder, depression and duodenal ulcer. The Office accepted both the initial occurrence in 1975 and the recurrence in 1987. In 2004 a conflict arose between appellant's treating psychiatrist, Dr. Fawcett, and the second opinion psychiatrist, Dr. Batra, with regard to whether appellant was still suffering from residuals of his work-related injury. Accordingly, the Office referred appellant to Dr. Karatinos to resolve the conflict.

The Board finds that the opinion of Dr. Karatinos is not sufficient to terminate appellant's compensation. Initially, the Board notes that she does not conclude that appellant's disability has ceased. In fact, Dr. Karatinos notes that appellant is not capable of working. However, she attributes this inability to work to alcohol use, lorazepam dependence, age and physical problems such as renal disease and prostate cancer. Dr. Karatinos contended that the anxiety disorder from the 1970s does not currently manifest itself with any symptomatology and that this may be because the lorazepam keeps the symptoms controlled. She later states, "[A]lthough [appellant] may have some underlying anxiety that is resolved by the use of the lorazepam, he does not manifest the anxiety while on the lorazepam." Dr. Karatinos admitted that appellant may not be able to function without the lorazepam or even with another less addictive antianxiety medication. She later noted that appellant may not meet the criteria for generalized anxiety disorder or panic disorder at the present time because of his long-term treatment with lorazepam. Dr. Karatinos also admitted that appellant's diagnosis of generalized anxiety disorder could link appellant's current symptoms with initial work-related onset by causing permanent neurotransmitter changes in the limbic system. She indicated that appellant is 70 years old and that as he gets older, lorazepam will cause further problems such as interfering with his sleep and memory loss. If appellant is currently disabled due to the use, or possible abuse, of lorazepam, and the lorazepam was prescribed to treat his work-related anxiety disorder, then it cannot be said that he does not have disability resulting from his work-accepted injury. Furthermore, if he still needs medication to treat anxiety, he may still have a medical condition related to his employment. Also her statement that appellant does not appear to be suffering from a psychiatric disorder conflicts with her later comments that appellant has a problem with alcohol and lorazepam. Finally, as Dr. Karatinos is a psychiatrist and does not specialize in stomach disorders, it is significant that she noted that a gastroenterologic work-up was mandatory.

Accordingly, the Board finds that the Office did not meet its burden of proof when it relied on the opinion of Dr. Karatinos to find that appellant had no remaining disability related to his employment disability.

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[8] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

CONCLUSION

The Board finds that the Office improperly terminated appellant's wage-loss compensation and medical benefits.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 7, 2007 is reversed.

Issued: April 17, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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