United States Department of Labor
Employees' Compensation Appeals Board

A.J., Appellant	)	
	)	
and	)	**Docket No. 11-2119**
	)	**Issued: August 6, 2012**
DEPARTMENT OF VETERANS AFFAIRS, G.V. MONTGOMERY MEDICAL CENTER, Jackson, MS, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On September 21, 2011 appellant filed a timely appeal from the August 23, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his claim for a work-related injury. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 appellant met his burden proof to establish that he sustained an injury in the performance of duty on July 9, 2009.

FACTUAL HISTORY

On April 27, 2010 appellant, then a 51-year-old medical administration officer, filed a notice of traumatic injury claiming that on July 9, 2009 he sustained an injury in the performance

[1] 5 U.S.C. §§ 8101-8193.

of duty.[2] He stated that, while attending a director's meeting at 8:30 a.m., he experienced nausea and had an awkward feeling in his chest, neck and jaw. Appellant then lost consciousness and suffered a grand mal seizure. He indicated that his claimed condition might be related to "stress and long work hours."[3]

In a May 10, 2010 letter, OWCP requested that appellant submit additional factual and medical evidence in support of his claim. It asked him various questions regarding the claimed July 9, 2009 incident, including whether he fell to the floor and, if so, whether he struck an object on the way to the floor. Appellant submitted a description of his job duties as a medical administration officer, a position which required supervision of the employing establishment's intermediate supervisors and administrative officers of the day.

In a June 16, 2010 decision, OWCP denied appellant's claim that he sustained an injury in the performance of duty on July 9, 2009. It found that appellant had not established the fact of injury because the evidence of record did not support that the claimed "injury or event" occurred as he described.

On June 13, 2011 appellant disagreed with the June 16, 2010 decision and requested reconsideration. In support of his request, he submitted his responses to OWCP's request for additional information, several statements of coworkers who witnessed the July 9, 2009 incident and medical evidence, including progress notes from July 2009 through January 2010.

In a June 13, 2011 statement, appellant stated that on July 9, 2009 he was attending a meeting with the Medical Center Director and coworkers and suffered a grand mal seizure after verbally reporting the previous day's events. He indicated that just prior to the seizure he experienced chest pain, nausea, left arm pain and tightening sensation around his neck, throat and jaw. Appellant stated that his coworkers reported him that he slumped in his chair, went unconscious and then suffered the seizure, but that he did not fall from the chair. He described his work as a medical administration officer and indicated that for several days prior to July 9, 2009 he worked 12 to 14 hours per day "in order to keep up with the daily demands and service operation as a mid-level manager." Appellant stated that he had not fainted or had a seizure prior to July 9, 2009.

Appellant submitted several statements from coworkers which describe the July 9, 2009 event. The statements indicate that he was attending a meeting on July 9, 2009 when he lost consciousness and suffered a seizure while sitting in a chair. After the brief seizure ended, appellant was helped to the floor by his coworkers and medical assistance was summoned.[4] The July 9, 2009 event was witnessed by at least two physicians, including Dr. Kent A. Kirchner, a

[2] Appellant at times listed the claimed injury as occurring on July 10, 2009, but medical records indicate that the incident actually occurred on July 9, 2009.

[3] Appellant's immediate supervisor, Carolyn Tindall, stated that she had no first-hand knowledge of the July 9, 2009 incident.

[4] Two of the statements indicate that appellant fell to the floor, but these statements are not detailed in nature. The most detailed statements of record do not indicate that appellant fell to the floor or struck any object during the July 9, 2009 event.

Board-certified internist who was Chief of Staff at the employing establishment, and Dr. Paul Low, a Board-certified pulmonologist who was Deputy Chief of Staff.

In July 9, 2009 reports, Dr. Kirchner stated that appellant was admitted following onset of a grand mal seizure on July 9, 2009.[5] Appellant was sitting in a chair when he noted chest pain, shortness of breath and pain radiating down his left arm. He then lost consciousness and was eased to the floor where he had a tonic-clonic seizure which lasted for 90 seconds. The seizure included shaking of the extremities and foaming of the mouth. Dr. Kirchner indicated that appellant's history was significant for primary aldosteronism, hypertension, sleep apnea, dyslipidemia and degenerative joint disease.[6] Although appellant had some cardiac risk factors and family history, including his father sustaining a heart attack at age 40, he had no real history of significant cardiac disease. Dr. Kirchner noted that appellant's mother had a history of epilepsy starting at age 50, but appellant had no history of seizure disorder and the July 9, 2009 event was his first seizure. He stated, "This could well be arrhythmic episode triggered by chest pain."

In a July 17, 2009 report, Dr. Kirchner repeated his prior recitation of appellant's medical history and the circumstances of the July 9, 2009 event. He diagnosed generalized tonic-clonic seizure and indicated that appellant should have follow-up consideration by a neurologist for cardiac and brain testing.

In an August 13, 2009 report, Dr. Ethel Rose, an attending Board-certified neurologist, provided a description of the July 9, 2009 event and indicated that appellant had a history of hypertension, primary aldosteronism, dyslipidemia and obstructive sleep apnea.

In a September 18, 2009 report, Dr. Rose stated that on July 9, 2009 appellant had a single brief generalized seizure lasting 90 seconds. She indicated that she did not know if appellant would have further seizures or epilepsy, noting that he might not ever have another seizure. Appellant was expected to do well in the long run and he was "not having any cognitive problems or disabilities nor is he expected to have any." Dr. Rose stated that the treatment plan for appellant was to stay on seizure medications for the time being and possibly as long as two years. If he had no further seizures he could go for a trial without seizure medications but if he had recurrent seizures he would need to stay on medications. The treatment plan also included not driving until free of seizures for one year, showering instead of bathing, no operating heavy machinery and no climbing in high places until the course of appellant's disorder could be ascertained. Dr. Rose stated that appellant's mother had epilepsy and his father had a history of coronary artery disease. Appellant's previous medical history included hypertension, sleep apnea and primary aldosteronism. She indicated that an August 2009 magnetic resonance imaging (MRI) scan test, August 2009 electrocardiogram (EKG) and July 2009 cardiac heart catherization were normal. Dr. Rose noted that appellant was functioning quite effectively in his job and continuing his physical activity program.

[5] Several of the July 9, 2009 reports were cosigned by other attending physicians.

[6] Primary aldosteronism is characterized by the overproduction of the hormone aldosterone and dyslipidemia occurs when there is an abnormal amount of lipids in the blood.

In a January 21, 2010 report, Dr. Rose indicated that appellant had a seizure on July 9, 2009 during a meeting at work. Appellant had chest pains and breathing problems prior to suffering the seizure. Dr. Rose also reported that on another occasion in July 2009 appellant had a "second spell" lasting five minutes which consisted of not being able to speak well, his jaw getting "tired" and not being able to think clearly. He diagnosed "presumed or possible seizure or at least [loss of consciousness] for a few minutes" and indicated that neither reported incident was "typical."

In an August 23, 2001 decision, OWCP affirmed its June 13, 2011 decision but modified it to reflect that appellant had established a work factor because he was attending a meeting at work when he sustained a grand mal seizure on July 9, 2009. It further found that he had not met his burden to submit rationalized medical evidence relating a diagnosed condition to the established work factors.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of her claim including the fact that the individual is an "employee of the United States" within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[7] The medical evidence required to establish a causal relationship between a claimed period of disability and an employment injury is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the compensable 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 supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[8]

It is a well-settled principle of workers' compensation law, and the Board has so held, that an injury resulting from an idiopathic fall -- where a personal, nonoccupational pathology causes an employee to collapse and to suffer injury upon striking the immediate supporting surface and there is no intervention or contribution by any hazard or special condition of employment -- is not within the coverage of FECA. Such an injury does not arise out of a risk connected with the employment and, therefore, it is not compensable.[9] The question of causal relationship in such cases is a medical one, and must be resolved by medical evidence.[10] However, as the Board has made equally clear, the fact that the case of a particular fall cannot be

[7] *J.F.*, Docket No. 09-1061 (issued November 17, 2009).

[8] *See E.J.*, Docket No. 09-1481 (issued February 19, 2010).

[9] *G.B.*, Docket No. 10-2155 (issued June 1, 2011); *Amrit P. Kaur*, 40 ECAB 848, 853 (1989); *Robert J. Choate*, 39 ECAB 103, 106 (1987).

[10] *John D. Williams*, 37 ECAB 238, 240 (1985); *Rudolph Golz*, 33 ECAB 129, 133 (1981).

ascertained, or that the reason it occurred cannot be explained does not establish that it was due to an idiopathic condition. This follows from the general rule that an injury occurring on the industrial premises during working hours is compensable unless the injury is established to be within an exception to the general rule.[11] If the record does not establish that the particular fall was due to an idiopathic condition, it must be considered as merely an unexplained fall, one which is distinguishable from a fall in which it is definitely established that a physical condition preexisted the fall and caused the fall.[12]

ANALYSIS

Appellant has claimed that he sustained an employment injury when he suffered an apparent grand mal seizure while attending a staff meeting on July 9, 2009. The Board finds that he established work factors, in the form of carrying out his duties on July 9, 2009. Appellant was attending a meeting with the Medical Center Director and coworkers and had presented a verbal report just prior to suffering the apparent seizure.

The Board notes that application of the idiopathic fall analysis described above is not appropriate in the present case because, although appellant did lose consciousness during the July 9, 2009 event, he did not fall and suffer injury upon striking an immediate supporting surface when he suffered his apparent seizure on that date.[13] Rather, appellant slumped in his chair and lost consciousness without falling from the chair. After he suffered convulsions for 90 seconds, his coworkers eased him down to the floor, without striking any surface and summoned medical assistance. Therefore, the primary question before the Board is whether appellant submitted rationalized medical evidence showing that he sustained a medical condition on July 9, 2009 due to work factors, including the act of attending and participating in a meeting on July 9, 2009.[14]

Although it appears that appellant suffered a seizure on July 9, 2009, none of the physicians of record related the apparent seizure to his work duties or conditions. Dr. Kirchner, a Board-certified internist, who was Chief of Staff at the employing establishment, and Dr. Rose, an attending neurologist, did not provide any clear opinion on the cause of the July 9, 2009 event. He suggested that a cardiac condition might have played a role but he provided no indication that appellant had a work-related cardiac condition.[15] Both Dr. Kirchner and Dr. Rose made note of appellant's history of aldosteronism, hypertension, sleep apnea and dyslipidemia, but neither physician provided a clear opinion that these conditions were work related or that they contributed to the July 9, 2009 event.[16] The record does not contain a rationalized medical

[11] *Emelda C. Arpin*, 40 ECAB 787, 789 (1989); *Judy Bryant*, 40 ECAB 207, 213 (1988).

[12] *M.M.*, Docket No. 08-1510 (issued November 25, 2008); *see Martha G. List (Joseph G. List)*, 26 ECAB 200, 204-05 (1974).

[13] *See supra* note 9.

[14] *See supra* notes 7 and 8.

[15] In a July 9, 2009 report, Dr. Kirchner stated, "This could well be arrhythmic episode triggered by chest pain."

[16] Both physicians also noted that appellant's mother had a history of epilepsy.

report indicating that appellant sustained a specific medical condition on July 9, 2009 which was related to accepted work factors.

For these reasons, appellant has not shown that he sustained an injury in the performance of duty on July 9, 2009.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained an injury in the performance of duty on July 9, 2009.

ORDER

IT IS HEREBY ORDERED THAT the August 23, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 6, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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