

**United States Department of Labor  
Employees' Compensation Appeals Board**

_____	)	
<b>J.H., (widow of A.H.) Appellant</b>	)	
	)	
<b>and</b>	)	<b>Docket No. 18-1143</b>
	)	<b>Issued: December 23, 2019</b>
<b>DEPARTMENT OF THE ARMY, ARMY</b>	)	
<b>CORPS OF ENGINEERS, Grapevine, TX,</b>	)	
<b>Employer</b>	)	
_____	)	

*Appearances:*  
*Alan J. Shapiro, Esq., for the appellant<sup>1</sup>*  
*Office of Solicitor, for the Director*

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:  
CHRISTOPHER J. GODFREY, Chief Judge  
ALEC J. KOROMILAS, Alternate Judge  
VALERIE D. EVANS-HARRELL, Alternate Judge

**JURISDICTION**

On May 15, 2018 appellant, through counsel, filed a timely appeal from an April 5, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act<sup>2</sup> (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

---

<sup>1</sup> In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

<sup>2</sup> 5 U.S.C. § 8101 *et seq.*

## ISSUE

The issue is whether appellant has met her burden of proof to establish that the employee's death on April 21, 2016 was causally related to his accepted employment injury.

## FACTUAL HISTORY

On August 8, 2014 the employee, then a 58-year-old engineering technician, filed a traumatic injury claim (Form CA-1) alleging that on August 6, 2014 he injured his hips, arms, shoulders, and knees when he slipped and fell on loose rock while in the performance of duty. He did not stop work. OWCP accepted the claim for bilateral post-traumatic osteoarthritis of the knees, a right shoulder foreign body granuloma of the soft tissue, cervical sprain, lumbar sprain, bilateral knee sprains, bilateral sprains of the shoulder joint, and a right shoulder osteophyte.

The employee voluntarily retired from the employing establishment on September 1, 2014.

On May 29, 2015 Dr. Jack Thomas, an orthopedic surgeon, performed a right knee arthroscopy including a partial medial and lateral meniscectomy. On November 19, 2015 he performed a right shoulder arthroscopy with debridement of a torn labrum, an open subacromial decompression with acromioplasty and resection of the distal clavicle, and a repair of a supraspinatus tear.

Dr. James Albert Freer, Board-certified in emergency medicine, evaluated the employee at the emergency department on December 31, 2015 for a wound infection and possible septic arthritis following a November 2015 rotator cuff repair. On examination he found that appellant was "afebrile and tachycardic." Dr. Freer diagnosed septic arthritis and recommended surgery.

On January 1, 2016 Dr. Christopher Anthony Fernandez, Board-certified in internal medicine, diagnosed an infected surgical site and paroxysmal atrial flutter, noting that the employee had no prior symptoms of arrhythmia.

Dr. Aidin Esiam-Pour, a Board-certified orthopedic surgeon, on January 1, 2016, performed a right shoulder arthroscopy with extensive debridement to treat septic arthritis, a failed rotator cuff repair, and wound dehiscence.

On February 10, 2016 the employee telephoned OWCP and requested authorization for subsequent surgery. In a February 12, 2016 CA-110 form, he advised that he underwent emergency right shoulder surgery on January 1, 2016 due to an infection. OWCP informed the employee that it had expanded the acceptance of the claim to include the infection and further surgery.

In a report dated February 23, 2016, Dr. Ephraim Keng, an internist, noted that the employee had a history of an employment injury to his right shoulder with surgery in November 2015 and repeat shoulder surgery in January 2016 due to an infection. He diagnosed a continued infection with drainage.

On February 24, 2016 Dr. Jason Davis, a Board-certified orthopedic surgeon, performed a right shoulder resection arthroplasty, debridement and irrigation, an insertion of an antibiotic

spacer and bead, and a complex closure. He diagnosed right shoulder chronic sepsis and a retained foreign body after a failed rotator cuff repair.

An x-ray of the chest obtained on February 28, 2016 showed increased lower lung interstitial opacities and central pulmonary vasculature prominence relative to a February 23, 2016 x-ray.

The employee died on April 21, 2016.<sup>3</sup> An April 29, 2016 death certificate listed the cause of death as acute respiratory failure due to interstitial lung disease.

On October 14, 2016 appellant filed a claim for compensation by widow, widower, and/or children (Form CA-5) requesting survivor's benefits. Dr. Farhan A. Khan, Board-certified in internal medicine, completed the medical portion of the CA-5 form on August 9, 2016. He provided the history of injury as a rotator cuff repair that became infected and was treated with a washout and intravenous (IV) antibiotics. Dr. Khan diagnosed right shoulder osteomyelitis, acute hypoxic respiratory failure likely due to interstitial lung disease, and congestive heart failure. He indicated that the direct cause of death was "acute hypoxemia respiratory failure and heart failure secondary to cryptogenic organizing pneumonia with [a] previous history of ischemic cardiomyopathy with myocardial infarctions in the past." Dr. Khan indicated that he was treated for osteomyelitis of the shoulder and that while receiving treatment he experienced acute hypoxic respiratory failure that contributed to a myocardial infarction and death. He advised that different things could cause cryptogenic organizing pneumonia, including connective tissue disease, drugs, and other issues. Dr. Khan noted that the employee had a history of stable coronary artery disease, congestive heart failure, and chronic kidney disease.

By decision dated October 4, 2017, OWCP denied appellant's claim for survivor's benefits. It found that the medical evidence of record was insufficient to establish a causal relationship between the employee's death and his August 6, 2015 employment injury and resulting surgeries.

On October 12, 2017 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative.

OWCP thereafter received the first page of a provisional autopsy report, performed on April 21, 2016. The report provided the clinical history as the employee undergoing a right rotator cuff repair in November 2015 and a washout in January 2016 due to a subsequent infection. The employee received treatment with antibiotics and "subsequently had a second procedure include bone resection and placement of an antibiotic spacer." He was admitted to the hospital for a cough with shortness of breath, lower extremity edema, and fever. The report provided:

"[The employee's] past medical history includes coronary artery disease requiring two stents, ischemic cardiomyopathy, obstructive sleep apnea, atrial fibrillation,

---

<sup>3</sup> The employee, on March 3, 2016, filed a schedule award claim (Form CA-7). In support of his request, he submitted a December 10, 2015 impairment evaluation. By decision dated October 7, 2016, OWCP found that the employee had 12 percent permanent impairment of each lower extremity.

melanoma, and chronic kidney disease. He also has hypothyroidism possibly due to previous treatment for lymphoma.

“Imaging studies found ground-glass lung infiltrates and the differential diagnosis included infection disease, worsening congestive heart failure, and interstitial lung disease. Empiric steroid therapy was given, but [the employee’s] respiratory insufficiency proved to be irreversible. Ultimately, he experienced a cardio-respiratory arrest associated with acute respiratory failure.”

At the telephonic hearing, held on February 22, 2018, counsel asserted that the employee’s condition deteriorated after he experienced postsurgical complications of his authorized shoulder surgery. He noted that, subsequent to the employee’s November 2015 shoulder surgery, he traveled to see his son, Dr. Seth Hale, a cardiologist, who is Board-certified in internal medicine. The employee received treatment in the emergency department with antibiotics and subsequently had a second surgery in January 2016. At the hearing, Dr. Hale related that the hospital advised that his father had a staph infection and also atrial fibrillation, a new condition that was treated with medication including amiodarone. He advised that amiodarone caused the employee’s interstitial lung disease. Dr. Hale opined that the employee’s surgery, hospitalization, infection, and treatment with medication resulted in interstitial lung disease and death.

In a report dated February 25, 2018, Dr. Hale related that the employee had a history of ischemic cardiomyopathy, chronic obstructive pulmonary disease, obstructive sleep apnea, and arthritis requiring chronic steroid treatment. When the employee visited him in late December 2015, he had a shoulder infection and symptoms of sepsis. The hospital admitted him on December 21, 2015 for a staph infection of the shoulder and atrial fibrillation, which Dr. Hale indicated commonly resulted from infection and sepsis. He noted:

“[The employee] underwent a surgical washout on the day of his admission and was started on both IV vancomycin and amiodarone, which were continued at home until his subsequent hospitalization in April 2016, at which time he was diagnosed with interstitial lung disease. He succumbed to the disease on April 21, 2016.

“The cause of death was determined to be hypoxemic respiratory failure secondary to interstitial lung disease, or more specifically cryptogenic organizing pneumonia. Cryptogenic organizing pneumonia is a noninfectious inflammatory process that leads to a lack of oxygen and often to death. The majority of the data behind this refer to the prior name of cryptogenic organizing pneumonia, bronchiolitis obliterans. Amiodarone is a well-known agent that can trigger this disease.

“It is my opinion that [the employee’s] downward spiral and eventual death began with his postoperative infection. This surgery was necessary due to injuries he obtained during his fall that occurred while working for the [employing establishment]. The medications used to treat the complications arising from this infection has direct, proven causality of the disease process which resulted in his death and this is supported by current medical literature, as referenced below.”

By decision dated April 5, 2018, OWCP's hearing representative affirmed the October 4, 2017. She found that Dr. Hale had not adequately explained how the employee's infection after surgery contributed or caused his death, noting that medical articles were of no evidentiary value. The hearing representative further noted that Dr. Khan had indicated that cryptogenic organizing pneumonia could result from multiple factors.

### **LEGAL PRECEDENT**

The United States shall pay compensation for the death of an employee resulting from personal injury sustained while in the performance of duty.<sup>4</sup> An appellant has the burden of proof to establish by the weight of the reliable, probative, and substantial evidence that the employee's death was causally related to his federal employment. This burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based on a proper factual and medical background.<sup>5</sup> The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale.<sup>6</sup> The mere showing that an employee was receiving disability compensation at the time of death does not establish that the employee's death was causally related to his federal employment.<sup>7</sup>

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While it is appellant's burden of proof to establish the claim, OWCP shares responsibility in the development of the evidence.<sup>8</sup> It has the obligation to see that justice is done.<sup>9</sup>

### **ANALYSIS**

The Board finds that the case is not in posture for decision regarding whether the employee's death resulted from his accepted August 6, 2014 employment injury.

OWCP accepted the employee's claim for bilateral post-traumatic osteoarthritis of the knees, a right shoulder foreign body granuloma of the soft tissue, cervical sprain, lumbar sprain, bilateral knee sprains, bilateral sprains of the shoulder joint, and a right shoulder osteophyte. On November 19, 2015 the employee underwent a right shoulder debridement of a torn labrum and open subacromial decompression with acromioplasty and resection of the distal clavicle, and a repair of a supraspinatus tear.

In a December 31, 2015 report, Dr. Freer related that the employee had symptoms of septic arthritis following a November 2015 right rotator cuff repair. He noted that he was afebrile with

---

<sup>4</sup> 5 U.S.C. § 8102(a).

<sup>5</sup> *Viola Stanko (Charles Stanko)*, 56 ECAB 436 (2005).

<sup>6</sup> *L.R. (E.R.)*, 58 ECAB 369 (2007); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

<sup>7</sup> *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139 (2001).

<sup>8</sup> *C.W.*, Docket No. 19-0231 (issued July 15, 2019); *D.G.*, Docket No. 15-0702 (issued August 27, 2015); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

<sup>9</sup> *Id.*

tachycardia. On January 1, 2016 Dr. Fernandez diagnosed an infected surgical site and paroxysmal atrial flutter. He indicated that the employee related no prior history of arrhythmia. On January 1, 2016 the employee underwent a right shoulder arthroscopy with extensive debridement to treat septic arthritis, a failed rotator cuff repair, and wound dehiscence.

Dr. Keng evaluated the employee on February 23, 2016 and recommended additional shoulder surgery to treat an infection with drainage. On February 24, 2016 Dr. Davis performed a right shoulder resection arthroplasty, debridement and irrigation, insertion of an antibiotic spacer, and a complex closure. He diagnosed chronic sepsis of the right shoulder and a retained foreign body after a failed rotator cuff repair.

The employee died on April 21, 2016. The death certificate provided the cause of death as acute respiratory failure due to interstitial lung disease. In a Form CA-5, Dr. Khan diagnosed right shoulder osteomyelitis, acute hypoxic respiratory failure likely due to interstitial lung disease, and congestive heart failure. He provided the cause of death as respiratory and heart failure due to cryptogenic organizing pneumonia and a history of myocardial infarctions. Dr. Khan advised that there were varied causes of cryptogenic organizing pneumonia.

At the hearing, Dr. Hale related that the employee developed an infection subsequent to his shoulder surgery in November 2015. He sought treatment in the emergency department for a staph infection and atrial fibrillation, a new condition. The hospital treated the atrial fibrillation with amiodarone, which Dr. Hale asserted caused interstitial lung disease. Dr. Hale attributed the employee's death to his surgery, subsequent infection, and treatment with medication that resulted in interstitial lung disease.

In February 2018, OWCP informed the employee that it had expanded the acceptance of the claim to include the additional conditions of infection and further surgery.

In a February 25, 2018 report, Dr. Hale discussed the employee's history of ischemic cardiomyopathy, chronic obstructive pulmonary disease, obstructive sleep apnea, and arthritis requiring treatment with steroids. He related that in December 2015 the hospital found that he had a staph infection and atrial fibrillation. Dr. Hale reasoned that atrial fibrillation often resulted from infection and sepsis. The employee received treatment at the hospital with intravenous medication, including amiodarone, which he continued taking until his diagnosis in April 2016 of interstitial lung disease, or cryptogenic organizing pneumonia. Dr. Hale noted that cryptogenic organizing pneumonia was an inflammatory rather than infectious process that commonly resulted in death. He explained that amiodarone was known to trigger cryptogenic organizing pneumonia. Dr. Hale opined that the employee's infection after his shoulder surgery necessitated by the work injury and the subsequent treatment of the infection and resulting complications caused his death.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.<sup>10</sup> The Board finds that Dr. Hale provided a clear opinion that the employee's condition deteriorated subsequent to his authorized right shoulder surgery in November 2015 and that the medication

---

<sup>10</sup> See *supra* note 8; *John J. Carlone*, 41 ECAB 354 (1989).

used to treat complications of his condition resulted in his death. His opinion is supportive of the claim, based on an accurate history of injury, and unequivocal. Dr. Hale did not, however, provide sufficient rationale to meet appellant's burden of proof. In particular, he did not explain how the staph infection caused the atrial fibrillation that required amiodarone or the mechanism through which the amiodarone caused the cryptogenic organizing pneumonia. Though Dr. Hale's opinion is insufficiently rationalized to meet appellant's burden of proof, it raises an undisputed inference of causal relationship sufficient to require further development by OWCP.<sup>11</sup> Accordingly, the Board will remand the case to OWCP for further development of the medical evidence.<sup>12</sup> On remand OWCP shall create and provide a statement of accepted facts and the medical evidence of record to an appropriate Board-certified physician. The chosen physician shall provide a rationalized opinion as to whether the employee's death is causally related to the accepted employment injury and resultant treatment. If the physician opines that the employee's death is not causally related, he or she must explain with rationale how or why their findings differ from that of Dr. Hale. Following this and any other further development as deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim.

### CONCLUSION

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

---

<sup>11</sup> See *H.S.*, Docket No. 15-0904 (issued July 29, 2015); *J.W., T.W., and R.E.*, Docket No. 11-0597 (issued December 9, 2011).

<sup>12</sup> The claim should be administered based upon the procedures applicable to death claims. See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Initial Processing*, Chapter 2.700.5 (August 1994).

**ORDER**

**IT IS HEREBY ORDERED THAT** the April 5, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: December 23, 2019  
Washington, DC

Christopher J. Godfrey, Chief Judge  
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge  
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge, dissenting

The majority opinion finds that, although the February 25, 2018 medical report/letter of Dr. Seth Hale, a cardiologist, who is Board-certified in internal medicine, was insufficient to meet appellant's burden of proof to establish her claim, it was sufficient to require the Office of Workers' Compensation Programs to further develop the medical evidence. I respectfully disagree.

I confine my disagreement not with the substance of Dr. Hale's report, but with the fact that he was the physician-son of the deceased employee. I have no reason to believe that Dr. Hale is anything, but an experienced and skilled physician in his field; however, the fact that he is offering his observations and opinion on his father's cause of death, I find to be outside the acceptable level of probative medical opinion. I base my opinion not only on my view of issues regarding objectivity and impartially, but also based on medical ethics codes from both the past and present.

Physicians have long been discouraged from providing medical care for their own family members. Percival's Medical Ethics, published in 1803, argued for the separation of professional and personal identities in the care of family members. More contemporaneously, the more recent American Medical Association (A.M.A.) guidelines from the Council on Ethical and Judicial Affairs, state: "physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the

physician is the patient, the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered." These principles are also referenced in the A.M.A., Code of Medical Ethics Opinion 1.2.1.

In this case, Dr. Hale's examinations, observations, and opinion are being relied upon for his judgement relative to the causal relationship of his father's fall and a chain of events that led to his unfortunate death. In his February 25, 2018 medical report/letter, he gives a brief history of his father's injury, subsequent treatment, his examining observations, and opined:

"It is my opinion that my father's downward spiral and eventual death began with his postoperative infection. This surgery was necessary due to the injuries he obtained during his fall that occurred while working for the United States Army Corp of Engineers. The medications used to treat the complications, arising from this infection have a direct, proven causality of the disease process which resulted in his death."

It is clear that long-standing medical guidelines discourage involvement in the medical care of immediate family members. The record does not reflect the extent to which Dr. Hale provided treatment to his father; however, he certainly was involved to the degree that he was knowledgeable of his father's condition relative to his examination and observations, as well as his history of treatment to form an opinion on causal relationship. His findings and opinion, although well-intentioned, cannot be divorced from his relationship to the subject of his report, his father. There is nothing that would prohibit appellant from obtaining an opinion from an objective physician who is not personally involved with the decedent.

I recognize that the majority is remanding the matter for further development by OWCP; however, the opinion being used to do so still remains a medical opinion regarding observations and causation directly from an immediate family member which I would not accept as a legally competent and probative opinion given the close familial relationship. As such, I would affirm.

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