UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 19-1477

CYNTHIA FRANKLIN

Appellant,
v.

ROBERT L. WILKIE,

SECRETARY OF VETERANS AFFAIRS,

Appellee.

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2. The Board provided an inadequate statement of reasons or bases for its decision that failed to explain why it rejected favorable evidence that showed Appellant was entitled to a rating, in excess of 50 percent for the service-connected MDD and only relied upon the April 2012 VA medical opinion.
3. The April and May 2016 VA medical opinions relied on by the Board to deny Appellant's service connection claim for the death of her late husband are inadequate.
4. Appellant's entitlement to TDIU, for accrued benefits purposes is inextricably intertwined with her entitlement to a higher schedular rating for the service-connected MDD, in excess of 50 percent.

II. STATEMENT OF THE CASE

Cynthia Franklin ("Appellant") seeks an award of DIC benefits based on her claim that her late-husband's death should be service connected because his service-connected bilateral patellofemoral syndrome and Major Depressive Disorder ("MDD") contributed, and aided and lent assistance, to his immediate cause of death from cardiovascular disease. The crux of Appellant's case for DIC benefits is that there are conflicting medical opinions

contained in the record addressing this matter. *See* Record Before the Agency at 11 (hereinafter "R. at xx.").

VA secured medical opinions from two VA examiners who found that there was no connection between the service-connected MDD or bilateral patellofemoral syndrome and his death, due to cardiovascular disease. R. at 11, 155-57, 151-52. Conversely, Appellant submitted a positive private medical opinion from Dr. H.S. that favorably determined that it is as least as likely as not the deceased Veteran's service-connected MDD contributed both substantially and materially to his cause of death from cardiovascular disease because the MDD aided in the development of and permanently aggravated his non-service-connected hypertension and cardiovascular disease. R. at 35. Despite Dr. H.S.'s statement that he reviewed the claims file, the Board determined the private opinion was "not persuasive" compared to the "great weight" it afforded the adverse VA medical opinions, because he failed to cite any specific evidence from the claims file that demonstrated the claimed connection between the Veteran's psychiatric disability and cardiovascular disease. However, the Board's decision to rely on VA's adverse medical evidence is erroneous, because the Board's statement of reasons or bases to support its finding the VA medical opinions were adequate and persuasive is inadequate. While asserting these opinions were adequate and persuasive, the Board ignored the fact that both VA examiners applied an improperly high evidentiary standard to evaluate and deny Appellant's service connection claim for her late husband's death.

Additionally, Appellant is also seeking entitlement to a rating, in excess of 50 percent for the service-connected MDD and TDIU, for accrued benefits purposes. These claims remained on appeal at the time of the Veteran's death.

The Veteran, Christopher Franklin, ("Veteran") honorably served with the United States Army from May 20, 1986 to August 3, 1987. R. at 288. While on active duty, the Veteran became profoundly depressed and expressed thoughts of suicide. R. at 194-98, 223. He was medically separated from the Army on August 3, 1987, applied for, and the Department of Veterans Affairs ("VA") granted the Veteran's claim for MDD, due to significant pre-enlistment and in-service psychiatric hospitalizations and in-service diagnoses of profound depression and suicidal ideation. R. at 2883, 2886, 2889-90, 3249-51, 3254-60, 3340-41. The Veteran's MDD was evaluated at 50 percent, effective August 4, 1987, the left knee impairment received a noncompensable rating, effective August 1987. R. at 2881-83.

Prior to his death, the Veteran submitted a supplemental claim in March 2012 for an increased rating for the service-connected knee and the MDD, stating "depression/anxiety due to unemployability". R. at 2522.[1] The evidence of record shows the Veteran had been unemployed since 2001. R. at 710, 1361, 1796, 2105, 2189, 2552,

[1] The Veteran's Supplemental Claim sought an increased rating for the service-connected left knee and service connection for a back and bilateral hip disorder. Appellant is not appealing the Board's denial of her entitlement to an increased rating, in excess of 10 percent for the bilateral patellofemoral knee syndrome or service connection claims for a back or hip disorder, for accrued benefits purposes.

Shortly thereafter, on April 21, 2012, VA provided a psychological evaluation to the Veteran to determine whether his MDD had increased in severity. R. at 1794-1802. Depression; anxiety; panic attacks; impaired judgment; impaired abstract thinking; difficulty in establishing and maintaining effective work and social relationships; neglect of personal appearance and hygiene; and thoughts of being dead "more frequently than weekly" were documented. R. at 1801-02, 1794-1802. "Depressed mood most of day nearly every day" and a "loss of pleasure" with most activities was reported. R. at 1796. Although, the examiner attributed all of the Veteran's occupational and social impairment to the MDD, examiner believed his impairment was mild due to transient symptoms, which decreased work efficiency and ability to perform occupational tasks only during periods of significant stress. R. at 1797-98.

In July 19, 2012, the Louisville, Kentucky Regional Office ("RO") denied the Veteran's claim for increased rating, in excess of 50 percent for the service-connected MDD, but granted his claim for patellofemoral syndrome, right knee and increased the left knee to 10 percent. R. at 635-37. Unemployability was also denied, because the total combined disability rating equaled 60 percent and did not satisfy the percentage requirement. R. at 635-37.

The Veteran died from cardiovascular disease on July 30, 2012. R. at 594. At the time of his death, the Veteran was service-connected MDD, evaluated at 50 percent and patellofemoral syndrome, left knee, evaluated at 10 percent; and patellofemoral syndrome, right knee, evaluated at 10 percent. His combined rating was 60 percent, effective March 6, 2012. R. at 635-37.

On July 31, 2012, Appellant notified the VA about the Veteran's death. R. at 608. Appellant submitted an informal claim for Dependency and Indemnity Compensation benefits ("DIC") on December 4, 2012. R. at 607. A formal application for DIC and Accrued Benefits was submitted on August 26, 2013. R. at 586-93. On December 5, 2013, the RO denied her claim for DIC and accrued benefits. R. at 550-53. Shortly thereafter, she initiated her appeal. R. at 300-01.

On April 7, 2016, VA obtained a medical opinion to determine whether the Veteran's death was related to his active duty service or the service-connected bilateral patellofemoral syndrome and/or MDD. R. at 155-57. Although, the Veteran received in-service treatment for sharp left-sided chest pain that radiated into the left arm, accompanied with nausea and vomiting, the examiner opined, it was "highly unlikely" that his death was linked to his in-service treatment for complaints of chest pain. R. at 156. The examiner did not believe the Veteran's chest pain was a misdiagnosed cardiac condition, because in his opinion, heart disease is a progressive condition; a cardiac diagnosis was not made; and additional symptoms would have been exhibited during the remainder of his military career, and at discharge. R. at 156. Because of which, the examiner did not believe the Veteran's service treatment records revealed any diagnosis/treatment that would have contributed to his death.

Notably, the examiner believed the Veteran's medical history contained several risk factors for developing CAD, including his use of NSAIDs to treat the service-connected bilateral patellofemoral pain syndrome. However, despite this known, potential risk,

examiner felt the risk "is small enough that it is much less likely as not to have caused or contributed to the Veteran's development of CAD. R. at 156.

VA obtained a second opinion on May 26, 2016, that similarly determined it was less likely as not that the service-connected MDD contributed to the Veteran's death from cardiovascular disease. R. at 152. Despite the examiner's acknowledgment of the existence of a "bidirectional influence" with depression and physical conditions. R. at 152. The examiner did not believe the Veteran's MDD had a causal connection with cardiovascular disease. R. at 152. Notably, the medical study cited to within the examiner's rationale from the National Institute of Mental Health, Health & Education Publication: Chronic Illness & Mental Health acknowledged "[p]eople with depression have an increased risk of cardiovascular disease . . . ." ("NIMH") R. at 152.

Shortly thereafter, on June 15, 2016, the RO issued a Statement of the Case that continued to deny Appellant's claim for the Veteran's cause of death, as well as her entitlement to DIC, and accrued benefits. R. at 86-150. On June 21, 2016, Appellant perfected her appeal to the Board. R. at 85.

In August 2017, Appellant's prior attorney submitted a positive nexus opinion from a private physician, Dr. H.S., supported by scientific research that suggested the Veteran's MDD "aided in the development of and permanently aggravated [the Veteran's] hypertension and cardiovascular disease. R. at 35-57. Dr. H.S. further opined that the Veteran developed hypertension because of the service-connected MDD, which in turn aggravated his cardiovascular disease R. at 35-36.

On January 11, 2019, the Board denied Appellant's appeal for service connection for the cause of the Veteran's death, entitlement to DIC, entitlement to a rating, in excess of 50 percent for MDD, for accrued benefit purpose, and entitlement to TDIU, for accrued benefits purposes. R. at 6-23. Appellant appealed the denial of these claims to this Court. *See* Notice of Appeal (March 4, 2019).

III. SUMMARY OF THE ARGUMENT

The Court should vacate and remand the January 11, 2019 Board Decision on the ground that the Board's decision did not fulfill its requirement to provide an adequate statement of reasons or bases when denying Appellant's appeal for service connection for the cause of the Veteran's death or entitlement to DIC benefits; entitlement to a rating, in excess of 50 percent for MDD, for accrued benefits purposes; and TDIU, for accrued benefits purposes. Specifically, the Board ignored positive evidence that substantiated Appellant's claim that the service-connected MDD substantially and materially contributed and/or aided in the development of cardiovascular disease, when it failed to discuss favorable treatment records that showed the deceased Veteran suffered from severe MDD-related symptoms that plagued him until his death in July 2012.

Next, the Board offered an inadequate explanation about why it rejected Dr. H.S.'s favorable July 2017 nexus opinion and only relied upon the two unfavorable and inadequate VA medical opinions form April and May 2016.

The Board relied, in part on the April 2016 examiner's unfavorable opinion that concluded that the risk associated with the Veteran's use of NSAIDs to treat the service-connected bilateral patellofemoral syndrome is "so small" that it is much less likely as not

to have caused or contributed to his development of CAD. With regard to the Veteran's in-service treatment for left sided radiating chest pain, the examiner negatively opined that it was "highly unlikely" that the chest pain was misdiagnosed cardiovascular disease, because there was no in-service diagnosis of this condition, nor were there any further heart-related symptoms noted during the remainder of his military career or at discharge. As a result, the factual findings by the April 2016 examiner that the Veteran's cause of death is "less likely" related to his service due to a lack of symptoms or diagnoses during service is flawed and inadequate as a matter of law. The Veteran's STRs show complaints of, and treatment for, heart-related symptoms. Moreover, the examiner failed to give any meaningful attention to the fact that the Veteran had a significant familial history for heart disease. Whether the Veteran received the same diagnosis while in service is irrelevant, as VA regulations expressly provide for a grant of service connection for conditions diagnosed after separation of service.

The Board also relied, in part on the May 2016 examiner's unfavorable opinion that concluded the service-connected MDD, less likely as not contributed to the Veteran's death from cardiovascular disease, despite the existence of a bidirectional influence between depression and cardiovascular disease, as suggested by the NIMH. As a result, the factual findings by the May 2016 examiner that the Veteran's cause of death is "less likely" related to his service due to a lack of symptoms or diagnoses during service is flawed and inadequate as a matter of law.

Consequently, the Court should vacate and remand the Board's January 11, 2019 decision on the ground that the medical opinions it relied upon were based on an

inadequate medical opinion that failed to take all record evidence favorable to the Appellant and applied an improperly high evidentiary standard in violation of the benefit of the doubt rule.

The Court should also vacate and remand the Board's decision denying Appellant a rating, in excess of 50 percent for MDD, because the Board failed to discuss favorable treatment records that substantiated the Veteran's psychiatric history included symptoms described under the 100 percent disability rating criteria (intermittent inability to perform activities of daily living, maintenance of minimal personal hygiene, and persistent danger of hurting himself). The Veteran also complained of MDD-related symptoms, described under the 70 percent disability rating criteria (suicidal ideation, near continuous panic attacks and depression, impaired impulse control, difficulty in adapting to stressful circumstances, and an inability to establish and maintain effective relationships). None of this evidence was discussed by the Board who only relied upon the symptoms identified by the April 2012 VA examiner, as it pertained to his occupational and social impairment, which the examiner opined was mild due to transient symptoms that decreased his work efficiency and his ability to perform occupational tasks only during periods of significant stress.

Consequently, the Court should vacate and remand the Board's decision denying Appellant's entitlement to a rating, in excess of 50 percent for the MDD, because the Board provided an inadequate explanation when it relied on the April 2012 VA medical opinion, but the medical evidence, when considered in its entirety, more nearly approximated the maximum disability rating of 100 percent.

Finally, the standard for determining whether the issue of entitlement to TDIU is reasonably raised in the context of an increased rating claim is whether the record contained cogent evidence of unemployability. Indeed, Appellant's late husband was unable to engage or maintain substantially gainful employment because of the service-connected bilateral patellofemoral syndrome and/or the service-connected MDD. Thus, should the Court decided to vacate and remand Appellant's appeal, her entitlement to TDIU, for accrued benefits purposes is interstricably intertwined with any decision to assign a schedular rating, in excess of 50 percent for the MDD.

IV. STANDARD OF REVIEW

This Court has jurisdiction to review the Board's decision pursuant to 38 U.S.C. § 7252(a), which invests the Court with the "power to affirm, modify, or reverse [the Board's] decision, or to remand the matter as appropriate." The Court's power extends to reviewing a decision of the Board to ensure that all relevant provisions of law have been properly applied. *Horowitz v. Brown*, 5 Vet. App. 217, 233 (1993). A Board decision that the Court finds is "not in accordance with law" will be set aside. 38 U.S.C. § 7261(a)(3); *Horowitz*, 5 Vet. App. at 223; *Brown v. Brown*, 5 Vet. App. 413, 422 (1993). With respect to the standard of review used by the Court to review a Board decision for errors of law, it conducts its review of such legal issues without deference to the Board's reasoning. 38 U.S.C. § 7261(a)(1); *Butts v. Brown*, 5 Vet. App. 532 (1993) (en banc).

V. ARGUMENT

1. The Board provided an inadequate statement of reasons or bases for its decision that relied upon two unfavorable VA medical opinions and failed to consider positive evidence favorable to Appellant's service connection claim for the cause of death of her late husband from cardiovascular disease.

Pursuant to 38 U.S.C. § 7104(d)(1), a decision of the Board shall include a written statement of the Board's findings and conclusions, and the reasons or bases for those findings and conclusions, on all material issues of fact and law presented on the record. *Gilbert v. Derwinski*, 1 Vet. App. 49, 56 (1990). The Board's statement of reasons or bases must explain the Board's reasons for discounting favorable evidence, *Thompson v. Gober*, 14 Vet. App. 187, 188 (2000), discuss all issues raised by the claimant or the evidence of record, *Robinson v. Peake*, 21 Vet. App. 545, 552 (2008), and discuss all provisions of law and regulation where they are made "potentially applicable through the assertions and issues raised in the record." *Schafrath v. Derwinski*, 1 Vet. App. 589 (1991).

In order to comply with this requirement, the Board must analyze the credibility and probative value of the evidence, account for the evidence it finds persuasive or unpersuasive, and provide the reasons for its rejection of any material evidence favorable to the claimant. *Kahana v. Shinseki*, 24 Vet. App. 428, 433 (2011). While the Board is not required to discuss all of the evidence of record, it must explain its rejection of favorable evidence. *Dela Cruz v. Principi*, 15 Vet. App. 143, 149 (2001); *Thompson*, 14 Vet. App. at 188 (the Board must provide an adequate statement of reasons or bases "for its rejection of any material evidence favorable to the claimant."). In light of this statutory requirement "[i]t is not enough for the Board to merely summarize what a physician stated without

actually discussing why the Board did or did not find that statement persuasive." *Lathan v. Brown*, 7 Vet. App. 359, 367 (1995).

In the present case, the Board's decision does not provide an adequate statement for the reasons or bases for its finding that the April and May 2016 VA medical opinions were "products of reliable principles and methods reliably applied to sufficient facts or data." R. at 11. A cursory analysis of both medical opinions show neither. Thus, the Board erred when it evaded its statutory responsibility by merely adopting VA's medical opinions as its own, whereas here, the Board failed to discuss all the various positive evidence that appears to support the Veteran's service-connected disabilities contributed "substantially or materially" to his death and/or aided or lent assistance to the production of his death. R. 10-12; 38 C.F.R. § 3.312. Accordingly, it is necessary to set the Board's decision aside and remand the matter for re-adjudication consistent with the "reasons and bases" requirements of 38 U.S.C. § 7104(d); *Gilbert v. Derwinski*, 1 Vet. App. at 57 ("A bare conclusory statement without both supporting analysis and explanation is neither helpful to the veteran, nor 'clear enough to permit effective judicial review,' nor in compliance with statutory requirements."); *Gabrielson v. Brown*, 7 Vet. App. 36, 40 (1994).

The April 2016 medical opinion is only that, an opinion; however, rather than discuss all the various positive evidence contained in the record, the Board relied on the examiner's unfavorable opinion that concluded that the Veteran's service-connected MDD and patellofemoral syndrome (to include the effects of prescribed medications), less likely as not contributed to his death. R. at 156. The examiner opined that neither of these conditions caused the debilitating effects or impaired the Veteran's health to an extent

rendering him materially less capable of resisting the effects of other diseases causing death. R. at 156. The examiner further opined that neither disability is known to influence the onset or progression of cardiovascular disease. R. at 156.

Notably, the examiner acknowledged the Veteran's use of NSAIDs to treat the service-connected bilateral patellofemoral syndrome might influence the development of heart disease. R. at 156. However, because the risk is "small", the examiner negatively opined that the Veteran's use of NSAIDs did not cause or contribute to the development of CAD. R. at 156; *Wise v. Shinseki*, 25 Vet. App. 517, 531 (2014) (emphasizing, "Congress has not mandated that a medical principle have reached the level of scientific consensus to support a claim for VA benefits."); *Jones v. Shinseki,* 23 Vet. App. 382, 388 n.1 (2010) (citing *Hodges v. Sec'y of Dep't. of Health and Human Servs.*, 9 F.3d 958, 961-63 (Fed. Cir. 1993) (pointing out, "the legal standard of evidentiary preponderance is not to be confused with the clinical standard of medical certainty.").

After reciting the evidence, the Board described the examiner's opinion as follows:

> "The April 2016 examiner opined that the Veteran's left and right knee disabilities less likely as not contributed to his death[,]" because "patellofemoral pain syndrome is not known to influence the onset or progression of cardiovascular disease and that the Veteran had multiple non-service-connected risk factors for development of cardiovascular disease."

R. at 11.

The Board failed to adequately describe the examiner's opinion since it is silent with regard to his admission that acknowledged the existence of an influential cause and effect relationship between the Veteran's lengthy use of NSAIDs and heart disease. R. at 11; *Gabrielson v. Brown,* 7 Vet. App. at 40 (noting, "[i]n an adversarial proceeding, a medical

opinion would have been subject to cross-examination on its factual underpinnings and its expert conclusions."); *Wise v. Shinseki*, 25 Vet. App. at 532 (noting, "the Board, when evaluating evidence, cannot demand a level of acceptance in the scientific community greater than the level of proof required by the benefit of the doubt rule). The Board's decision is also silent regarding the Veteran's treatment while on active duty for sharp left sided chest pains that radiated into his left arm or that his familial history was significant for heart disease. R. at 10-12; *Moody v. Wilkie*, 30 Vet. App. 329, 339 (2018) ("the Board must explain why it rejects relevant evidence favorable to the claimant.").

The Board also relied on the May 2016 VA Examiner's unfavorable opinion that also concluded that it was less likely as not that the Veterans' service-connected MDD contributed to his death, because "[w]hile depression and other mental health concerns can co-occur and are thought to have a bidirectional influence with physical conditions . . . there is the potential for unaccounted variables that could lead to the shared development/predisposition of these disorders." R. at 152. However, according to publication cited in support of her negative opinion, "[p]eople with depression have an increased risk of [developing] cardiovascular disease." R. at 152. *See* NAT. INST. OF MENTAL HEALTH, *Chronic Illness & Mental Health*, https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/index.shtml; *see also Jones v. Shinseki*, 23 Vet. App. at 388 n.1 (clarifying that "the data may support statistical analysis, whereby although the data may not establish a causal relationship to a medical certainty [which means 95% confidence level, they may nonetheless meet the more-likely-than-not standard of the law.") (internal citation omitted).

The Board described the examiner's opinion as follows:

> "The May 2016 examiner opined that the Veteran's service-connected psychiatric disability less likely as not contributed to his death from cardiovascular disease." The examiner noted that existing research has not been able to determine that mental health conditions, including depression, have a causal connection with physical conditions like cardiovascular disease."

R. at 11.

The Board failed to adequately explain its analysis of the probative value of the evidence submitted by, and on behalf of, Appellant in support of her claim, which conflicted with the "benefit of the doubt" rule. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant." *See* 38 U.S.C. § 5107(b); 38 C.F.R. § 3.102. When the Board "incorrectly [applies] the law [or fails] to provide an adequate statement of reasons or bases for its determinations . . . a remand is the appropriate remedy." *Tucker v. West*, 11 Vet. App. 369, 374 (1998). "This 'unique' standard of proof is lower than any other in contemporary American jurisprudence. . . ." *Wise v. Shinseki*, 25 Vet. App. at 530 (emphasizing, that "[i]mposing a higher standard [when the evidence is in approximate balance] would be counter to the benefit of the doubt rule."). The evidence before the board indeed, tended to show an approximate balance of positive and negative evidence. However, rather than weigh all the evidence, the Board relied upon VA's two unfavorable medical opinions in reaching its denial to not service connect the Veteran's cause of death.

The positive evidence that substantiated the Veteran's service-connected disabilities and/or his active duty service contributed to his death consisted of the following:

- Lengthy prescription history for using high dosages of NSAIDs to treat the Veteran's bilateral knee pain. R. at 157, 215, 219, 227-28, 280, 1018, 1735, 1885, 1868, 1894, 1216, 1262, 2050, 2592, 2607, 2696, 2704. The record before the board showed the Veteran used NSAIDs while on active duty until his death.
- Lengthy history of multiple MDD-related panic attacks and "intense" stress that consisted of apprehension, SOB, tremors, sweating, heart palpitations, and tachycardia. R. at 1279, 2544, 2567, 2637-38, 2640, 3681.
- Anxiety attack disorder that "complicated the Veteran's aortic bi-femoral bypass surgical procedure." R. at 1514.
- Lengthy history of MDD-related anxiety. R. at 545, 646, 700, 1360, 1514, 2231, 2593, 2631, 2796, 3676.
- Chest pain and discomfort associated with panic attacks and when "stressed out". R. at 3036, 3676.
- History of explosive anger issues related to MDD. R. at 545, 2812-14.
- Lengthy history of uncontrolled hypertension. R. at 2553, 2565, 2593, 2667, 2799.
- Positive nexus opinion from Dr. H.S. that opined that the MDD "contributed both substantially and materially to the veteran's cause of death." R. 35-57. Dr. H.S., found that the Veteran's MDD aided in the development of and permanently aggravated his non-service-connected hypertension, which in

turn caused him to develop cardiovascular disease. R. at 35-36. Indeed, Dr. H.S. supported his conclusions with competent scientific literature that linked anxiety and depression to hypertension and cardiovascular disease. R. at 37-57; *Stefl v. Nicholson*, 21 Vet. App. 120, 124 (2007); *see also McLendon v. Nicholson*, 20 Vet. App. 79, 83 (2006) (observing that the third prong of § 3.159(c)(4)(i), which requires that evidence of record indicate that the claimed disability or symptoms may be associated with another service connected-disability, "establishes a *low threshold*.") (bolding omitted); *Locklear v. Nicholson*, 20 Vet. App. 410, 419 (2006).

- In-service treatment for left-sided chest pain, radiating into the left arm, with nausea and vomiting; diaphoresis; and dyspnea pain. R. at 273. The Veteran described this pain as "sharp" lasting between 5 and 15 minutes, made worse with movement. R. at 273. Notably, the Veteran had been experiencing this sharp and radiating pain approximately 8 to 10 times for approximately two days. R. at 273. At the time of the in-service evaluation, tenderness was elicited at the sixth rib on the Veteran's left side. R. at 273. Shoulder pain was also reported. R. at 269.
- In-service treatment for dizziness/vertigo. R. at 262.
- Post-service medical records show a history of heart attacks that presented with radiating pain into the Veteran's shoulder and neck. R. at 2268-70.

- Post-service medical records that show the Veteran's heart disease presented with identical in-service symptoms to include chest pain, left shoulder numbness, shortness of breath, nausea, and diaphoresis. R. at 2299.

With respect to the private nexus opinion, the Board concluded the opinion was "not persuasive" because the doctor "fails to cite [sic] any specific evidence from the record demonstrating the claimed connection between the Veteran's psychiatric disability and cardiovascular disease." R. at 11. The Board's rejection of the expert's private positive opinion, due to his alleged failure to review the record is flawed. R. at 11. As this Court has indicated previously, "the claims file is not a magical or talismanic set of documents, but rather a tool to assist VA examiners to become more familiar with the facts necessary to form an expert opinion to assist the adjudicator in making a decision on a claim." *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, 301, 303 (2008) ("This Court . . . has not required VA medical examiners to perform complete review of the entire file claims file or state that they have done so in every instance."); *Gardin v. Shinseki*, 613 F.3d 1374, 1378-79 (Fed. Cir. 2010) (holding that the Court violated its precedent by approving the Board's reasoning that a private physician opinion was not probative because he did not review the claims file).

The Board's stated reasons and bases also mischaracterized the favorable medical studies included by Dr. H.S. to support his opinion. R. at 12; *see* 38 U.S.C. § 5107(b); 38 C.F.R. § 3.102. Contrary to the information selected by the Board, these studies indeed, suggested:

- "Anxiety and depression are predictive of later incidence of hypertension and prescription treatment for hypertension. R. at 37.[2] In fact, "the incidence rate of hypertension was higher in persons with high or intermediate anxiety scores than in persons with low anxiety symptom scores." R. at 40-41. Additionally, "the incidence rate of hypertension was higher in person who had high depression symptom scores than in persons who had low symptoms scores." R. at 41.
- "Nine out of ten studies found an increased mortality from cardiovascular disease among depressed patients." R. 44.[3] "In the United States, men without any prior history of angina or myocardial infarction who had higher levels of depression were more likely to experience a first infarction . . ." R. at 46. Indeed, the studies included in the medical article concluded, "depression is *unquestionably* associated with cardiovascular disease." R. at 49. (emphasis added).
- "There are important pathophysiologic links between atrial hypertension and [coronary heart disease (CHD)], which might explain the pathogenesis of CHD when hypertension is present." R. at 54.[4]

[2] Bruce Jones, et al., *Are Symptoms of Anxiety and Depression Risk Factors for Hypertension?* R. at 37-43.
[3] Alexander Glassman & Peter Schapiro, *Depression and the Course of Coronary Artery Disease* R. at 44-53.
[4] E. Escobar, *Hypertension and coronary heart disease* R. at 54-57.

Consequently, Appellant's case should be remanded. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89-90 (1992) ("A remand is required where the BVA fails to provide an adequate statement of the 'reasons or bases' for its findings and conclusions, with respect to both the merits and the 'benefit of the doubt' under 38 U.S.C. § 5107(b)."); *Hicks v. Brown*, 8 Vet. App. 417, 422 (1995) (emphasizing that remand is the appropriate remedy where the Board has failed to provide an adequate statement of reasons or bases for its determinations); *Kay v. Principi*, 16 Vet. App. 529, 532 (2002) (an inadequate statement necessitates remand for further adjudication).

2. The Board provided an inadequate statement of reasons or bases for its decision that failed to explain why it rejected favorable evidence the showed Appellant was entitled to a rating, in excess of 50 percent for the service-connected MDD, for accrued benefits purposes and only relied upon the April 2012 VA medical opinion.

As discussed above, the Board's statement of reasons or bases must explain the Board's reasons for discounting favorable evidence. *Thompson v. Gober*, 14 Vet. App. at 188; *Kahana v. Shinseki*, 24 Vet. App. at 433; *Dela Cruz v. Principi*, 15 Vet. App. at 149. Here, the Board found that the Appellant was not entitled to a rating, in excess of 50 percent for the service-connected MDD, for accrued benefits purposes. R. at 14-16. In reaching its decision, it appears that the Board relied only upon the April 2012 VA medical opinion and ignored important evidence that substantiated Appellant's entitlement to a higher rating. *See* 38 U.S.C. § 7104(a); *see also Maurhan v. Principi*, 16 Vet. App. 436 (2002) (emphasizing that the symptoms listed in VA's General Rating Formula for Mental Disorders were not meant to be an exhaustive list or to be requirements, but were meant to

serve as examples of the type and degree of symptoms or their effects that would justify a particular rating); *Gabrielson v. Brown*, 7 Vet. App. at 40.

At the time of his death, the Veteran's MDD was rated at 50 percent disabling. *See* 38 C.F.R. § 4.130 (Diagnostic Code 9434). However, the Veteran's medical records contained MDD-related symptoms described under the 100 percent disability rating criteria: *gross impairment in thought processes or communication* R. at 544-47, 3183, 3835 (reporting explosive anger); *grossly inappropriate behavior* R. at 3181-83, 3864, 3866 (reporting two DUIs causing the Veteran' license to be revoked; history of violence); *intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene* R. at 2663, 2673, 2679, 3059, 3075 (noting rotting/decaying teeth); *persistent danger of hurting self or others* (R. at 3037-38, 3835) (noting working 70+ work weeks despite having serious heart condition and homicidal ideation). *See* § 4.130.

Symptoms described within the 70 percent disability rating criteria, were also present: *suicidal ideation* R. at 194, 1796-97, 2358, 2452-54, 2544-45, 2638, 2641-42, 2768, 2881-83, 2935-37, 2962-63, 3000, 3037-38, 3251, 3255, 3677-78, 3809, 3835 (noting lengthy history of SI); *near-continuous panic or depression affecting the ability to function independently, appropriately and effectively* R. at 2768, 2962-63, 3033, 3037-38, 3674, 3676, 3681, 2935) (noting history of consistent panic and depression); *impaired impulse control, such as unprovoked irritability with periods of violence* R. at 544-47, 3183, 3835 (reporting explosive anger and irritability). *See* § 4.130. Indeed, this evidence contradicts the Board's finding that Appellant was not entitled to a rating higher than 50 percent.

Nevertheless, the Board determined that the totality of the evidence failed to show that the symptoms of the Veteran's psychiatric disability produced occupational and social impairment with deficiencies in most areas, because at the time of the April 2012 VA examination, the Veteran did not display symptoms such as suicidal ideation; obsessional rituals which interfered with routine activities; impaired speech; near continuous panic or depression affecting ability to function independently, appropriately, and effectively; impaired impulse control; spatial disorientation; difficulty in adapting to stressful circumstances; or an inability to establish and maintain effective relationships. R. at 15. However, the Board's statement of reasons or bases is inadequate. *See Dennis v. Nicholson*, 21 Vet. App. 18, 22 (2007) (holding that merely listing the evidence is not an adequate statement of reasons and bases for the Board's conclusion). Moreover, the Board did not explain how the Veteran's lengthy psychiatric history as described above did not warrant granting Appellant a higher rating—regardless of whether the Veteran exhibited these symptoms at the time of the April 2012 examination. *See generally McClain v. Nicholson*, 21 Vet. App. 319, 320-23 (2007) (emphasizing that VA cannot deny a claim for lack of evidence showing a current disability as long as the evidence shows that a disability existed at some point during the pendency of the claim, and service connection may be granted even if the disability resolves prior to claim's adjudication); *see generally Romanowsky v. Shinseki*, 26 Vet. App. 289, 293-94 (2013).

Remand is warranted for the Board to properly apply the law and to provide an adequate statement of reasons and bases regarding the severity of the deceased Veteran's service-connected MDD.

3. The April and May 2016 VA medical opinions relied on by the Board to deny Appellant's service connection claim for the death of her late husband are inadequate.

In addition, while the VA is not required to provide a medical examination in all cases, once it "undertakes the effort to provide an examination when developing a service-connection claim . . . [it] must provide an adequate one." *See Barr v. Nicholson*, 21 Vet. App. 303, 311 (2007); *see also Davies v. Nicholson*, 21 Vet. App. 46, 51-52 (2007). In order to be adequate, "a medical examination report must contain not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two." *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, 301, 304 (2008) (adding that "[i]t is the factually accurate, fully articulated, sound reasoning for the conclusion . . . that contributes probative value to a medical opinion . . . ."). When an examination lacks supporting rationale or is inconsistent with the evidence of record, the VA should return that examination report for clarification or explain why it is not necessary to do so in light of the conflicting evidence of record. *See Vazquez-Flores v. Peake*, 22 Vet. App. 37, 50 (2008), *vacated on other grounds sub nom, Vazquez-Flores v. Shinseki*, 580 F.3d 1270 (Fed. Cir. 2009).

The April and May 2016 VA medical opinions are inadequate to form the basis of the Board's denial, because the April 2016 examiner premised his unfavorable medical opinion on a mistaken requirement for the existence of identical in-service and post-service diagnoses for the Veteran's heart condition when there is no such requirement. *See* 38 C.F.R. § 3.303; *Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. 2009). Moreover, both

examiners applied an improperly high evidentiary standard that disregarded the benefit of the doubt rule. *See* § 5107(b); § 3.102; *Wise v. Shinseki*, 25 Vet. App. at 532.

A medical examination is adequate "where it is based upon consideration of the veteran's prior medical history and examinations and also describes the disability, if any, in sufficient detail so that the Board's 'evaluation of the claimed disability will be a fully informed one.'" *See Stefl v. Nicholson*, 21 Vet. App. at 123 (quoting *Ardison v. Brown*, 6 Vet. App. 405, 407 (1994)); *see also Nieves-Rodriguez*, 22 Vet. App. at 304 (noting, "most of the probative value of an opinion comes from its reasoning"). Although examination reports are not subject to reasons or bases requirements, an adequate examination must "sufficiently inform the Board of a medical expert's judgment on a medical question and the essential rationale for that opinion." *See Monzingo v. Shinseki*, 26 Vet. App. 97, 105 (2012); *Acevedo v. Shinseki*, 25 Vet. App. 286, 293 (2012) ("an adequate medical report must rest on correct facts and reasoned medical judgement so as to inform the Board on a medical question and facilitate the Board's consideration and weighing of the report . . . .").

The April 2016 medical opinion is inadequate as the examiner clearly predicated his opinion on a misunderstanding of the law, due to the examiners failure to discuss relevant evidence that tended to show Appellant's in-service symptoms have persisted since separating from service. *See Davidson v. Shinseki*, 581 F.3d at 1313. Indeed, Appellant's STRs showed the presence of complaints of, and treatment for heart/vascular-related symptoms during service, even if lacking in diagnoses:

- In-service treatment for left-sided chest pain, radiating into the left arm, with nausea and vomiting; sweating; and dyspnea pain. R. at 273. The Veteran described this pain as "sharp" lasting between 5 and 15 minutes, made worse with movement. R. at 273. Notably, the Veteran had been experiencing this sharp and radiating pain approximately 8 to 10 times during the last two days. R. at 273. At the time of the in-service evaluation, tenderness was elicited at the sixth rib (located at or near the aorta) on the Veteran's left side. R. at 273.
- In-service treatment for dizziness. R. at 262.

Indeed, the Veteran's familial history was significant for heart disease; yet, the examiner glossed over the fact that both his mother and his father had positive medical histories for heart disease or that his father died at age 54 of CAD. R. at 157. Similarly, the Veteran was diagnosed with CAD by the time he was 30 years old and died at the age of 47. R. at 594, 2670. VA's regulations expressly provide for a grant of service connection for conditions that are diagnosed after separation of service. *See* 38 C.F.R. § 3.303(d); *Combee v. Brown*, 34 F.3d 1039, 1042 (Fed. Cir. 1994) ("[p]roof if direct service connection thus entails proof that exposure during service caused the malady that appears many years later"); *Cosman v. Principi*, 3 Vet. App. 503, 506 (1990) ("even though a veteran may not have had a particular condition diagnosed in service, or for many years afterwards, service connection can still be established"). The fact that the Appellant did not receive the same diagnosis in service as the post-service cardiovascular disease diagnoses is irrelevant to the question of whether his heart condition is related to the symptoms that he very clearly experienced while on active duty. *See* 38 C.F.R. § 3.303(b). Indeed, the

Veteran experienced identical post-service heart/vascular-related symptoms. *See* Section I, *infra*; *see Davidson v. Shinseki*, 581 F.3d at 1313. Moreover, both examiners applied an improperly high evidentiary standard when they determined that the Veteran's service-connected disabilities did not contribute to his cause of death from cardiovascular disease. *See* Section I, *infra*; *see* § 5107(b); § 3.102; *Wise v. Shinseki*, 25 Vet. App. at 532.

Without an adequate examination, the Board lacked the evidence necessary to adjudicate Appellant's claim. *See Bowling v. Principi*, 5 Vet. App. 1, 12 (2001); 38 C.F.R. § 3.159(c)(4) (holding that a medical examination or opinion is necessary if the information and evidence of record does not contain sufficient competent medical evidence to decide the claim). As a result, the Board clearly erred by relying upon medical opinions that had no probative value, and remand is required to obtain an adequate examination report. *Stegall v. West*, 11 Vet. App. 268, 270-71 (1998); *Hayes v. Brown*, 9 Vet. App. 67, 73 (1996); *Hicks v. Brown*, 8 Vet. App. at 422 (concluding inadequate medical examinations frustrate judicial review).

4. Appellant's entitlement to TDIU, for accrued benefits purposes is inextricably intertwined with her entitlement to a higher schedular rating for the service-connected MDD, in excess of 50 percent.

The Board denied Appellant's entitlement to TDIU because it found that Appellant did not satisfy the percentage requirement of 38 C.F.R. § 4.16(a). R. at 21. As such, Appellant's entitlement to TDIU, for accrued benefits purposes is inextricably intertwined with any decision to assign a schedular rating, in excess of 50 percent for the deceased Veteran's service-connected MDD. *See Rice v. Shinseki*, 22 Vet. App. 447 (2009).

A "claim to TDIU benefits is not a free-standing claim that must be pled with specificity; it is implicitly raised whenever a pro se veteran, who presents cogent evidence of unemployability, seeks to obtain a higher disability rating." *Comer v. Peake*, 552 F.3d 1362, 1368-69 (Fed. Cir. 2009). Therefore, the standard for determining whether the issue of entitlement to TDIU is reasonably raised in the context of an increased rating claim is whether the record contains "cogent evidence of unemployability." *See id*.; *AB v. Brown*, 6 Vet. App. 35, 38 (1993) (when a claimant files a claim for an increased rating, it is presumed that the claimant is seeking the highest rating possible"). The Court has not yet defined "cogent evidence of unemployability." However, the word "cogent" is defined as convincing, pertinent or relevant. *See* MERRIAM-WEBSTER DICTIONARY, *Cogent*, https://www.merriam-webster.com/dictionary/cogent (last visited Oct. 12, 2019). One Federal Circuit decision describes this standard to mean '"persuasive and pervasive' evidence of unemployability." *Rivera v. Shinseki*, 654 F.3d 1377 (Fed. Cir. 2011); *but see*, *Porter v. Shinseki*, No. 13-1163, 2014 U.S. App. Vet. Claims LEXIS 833, at *7 (May 15, 2014 (suggesting that even "[e]vidence that arguably demonstrates that a service-connected condition causes unemployability" meets the "low threshold" of cogent evidence).

At the time of his death, the Veteran's service-connected disabilities were sufficiently severe to prevent him from engaging in substantially gainful employment. *See Hatlestad v. Brown*, 5 Vet. App. 524, 529 (1993). With respect to the MDD, the November 2002 VA examiner opined that the Veteran's unemployability was related, in part to his MDD. R. at 2935-37. Indeed, the Veteran reported that he quit working in 2001 due to a "great deal of stress". Additionally, the Veteran reported that he "won't drive because it 'it

depends on different things such as anger/anxiety issues, can't deal with traffic."' R. at 700. The Veteran remained unemployed at the time of the April 2012 VA examination. Likewise, the examiner believed that "[a]ll occupational and social impairment identified at this time is attributable to [MDD]." R. at 1798. Additionally, the Veteran reported issues with his memory, stating he forgot how to operate a piece of equipment on his boat. R. at 2186-88. Lastly, the Veteran was found to be moderately limited with his ability to understand, carry out, remember detailed instructions, or maintain attention or concentration for extended periods. R. at 2151, 2153. Regarding the bilateral patellofemoral syndrome, a separate VA examiner who evaluated the Veteran's patellofemoral pain syndrome agreed that there was functional loss and/or functional impairment associated with the service-connected bilateral knee condition, which "impacted his ability to work". R. at 3608, 3614. At the time of the examination, the Veteran's knees exhibited less movement than normal, pain on movement that disturbed locomotion and interfered with sitting, standing, and weight bearing. R. at 3608. It was also noted that the Veteran regularly used a cane for ambulation and was unable to carry more than a few pounds. R. at 2145, 3613. Regardless, whether the Veteran was unable to secure or follow a substantially gainful occupation due to the aggregate impact of all of the Veteran's service-connected disabilities is a factual rather than a medical question. *See Geib v. Shinseki*, 733 F.3d 1350, 1354 (Fed. Cir. 2013).

The Court's memorandum decisions, although non-precedential, give a sense of the range of evidence that the Board should consider "cogent evidence of unemployability." There are no precedential decisions clearly interpreting the phrase cogent evidence, and so

these cases are noted for the persuasive value of their reasoning. *See* U.S. Vet. App. R.30(a). For example, evidence of a veteran's "emotional lability" combined with evidence the veteran had not worked during the period on appeal and was fired "after only 1 week of working for a church" was cogent evidence sufficient to raise an implicit claim for TDIU. *Penso v. Shulkin*, No. 17-0058, 2017 U.S. Vet. App. Claims LEXIS 1852, at *4 (Dec. 28, 2017). When the Board denied TDIU due to service-connected PTSD because evidence in the record demonstrated the veteran was unemployable due to non-service-connected back and neck conditions, the Board clearly erred because it "conflate[d] whether TDIU was reasonably raised by the record with whether the appellant established entitlement to the benefit. *Swann v. Shulkin*, No. 16-2689, 2017 U.S. App. Vet. Claims LEXIS 1614, at *11 (Nov. 2, 2017).

In light of the above arguments, if the Court remands the Board's decision to cure the errors that denied Appellant a higher schedular rating for the service-connected MDD, the Board's analysis for entitlement to TDIU may also change. Not merely as it relates to the rating levels described under 38 C.F.R. § 4.130, but also as it relates to the Board's substantive decision as to whether or not the Veteran's service-connected MDD and/or patellofemoral pain syndrome rendered him unable to maintain or participate in substantially gainful activity. For the reasons set forth above, the Board's reasons or bases statement is inadequate; thus, remand is warranted. *See* 38 C.F.R. § 4.16.

VI. CONCLUSION AND STATEMENT OF RELIEF SOUGHT

Accordingly, the Board's decision denying Appellant's entitlement to service connection for the cause of her late husband's death from cardiovascular disease,

entitlement to rating, in excess of 50 percent for the service-connected MDD, for accrued benefits purposes, and entitlement to TDIU, for accrued benefits purposes. When adjudicating Appellant's appeal, the Board (1) failed to apply the benefit of the doubt rule; (2) failed to provide adequate reasons or bases for its denials; and (3) relied on two inadequate VA medical opinions. As a result, the Court should vacate the Board's decision denying these claims, and grant Appellant's claims or, alternatively, remand the claims with instruction to provide an adequate medical examination and an adequate statement of reasons or bases.

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