Vet.App. No. 19-1477

IN THE UNITED STATES COURT OF APPEALS
FOR VETERANS CLAIMS

CYNTHIA FRANKLIN
Appellant,

v.

ROBERT L. WILKIE
Secretary of Veterans Affairs,
Appellee.

ON APPEAL FROM THE
BOARD OF VETERANS' APPEALS

BRIEF OF APPELLEE SECRETARY OF VETERANS AFFAIRS

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BRIEF OF THE APPELLEE
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I. ISSUE PRESENTED

1. Whether the Court should vacate the portion of the January 11, 2019, Board of Veterans' Appeals' (Board) decision, which denied entitlement to an evaluation in excess of 50% for major depressive disorder, for accrued benefit purposes, because the Board failed to provide adequate reasons or bases and consider favorable evidence.

2. Whether the Court should affirm the remaining portions of the January 11, 2019, Board decision that are on appeal, which denied entitlement to (1) service connection for the cause of Mr. Christopher F. Franklin's (the Veteran) death and (2) a total disability rating based on individual unemployability (TDIU), for accrued benefit purposes, where the Board's findings are plausibly based on the evidence of record, adequate examinations, Department of Veterans Affairs (VA) statute current regulations, and case law, as well as an adequate statement of reasons or bases.

II. STATEMENT OF THE CASE

A. Jurisdictional Statement

The Court has jurisdiction over this appeal pursuant to 38 U.S.C. § 7252(a).

B. Nature of the Case

On January 11, 2019, the Board issued the decision on appeal, denying Mrs. Cynthia Franklin (Appellant) entitlement to (1) entitlement to service connection for the cause of the Veteran's death, (2) dependency and indemnity compensation benefits, (3) an evaluation in excess of 50% for major depressive disorder (MDD), for accrued benefit purposes, (4) an evaluation in excess of 10% for a left knee disability, for accrued benefit purposes, (5) an evaluation in excess of 10% for a right knee disability, for accrued benefit purposes, (6) service connection for a back disorder, for accrued benefit purposes, (7) service connection for a bilateral hip disorder, for accrued benefit purposes, (8) TDIU, for accrued benefit purposes, and (9) death pension benefits. [Record Before the Agency (R.) at 1-25].

Appellant does not challenge the Board's denial of (1) dependency and indemnity compensation benefits, (2) an evaluation in excess of 10% for a left knee disability, for accrued benefit purposes, (3) an evaluation in excess of 10% for a right knee disability, for accrued benefit purposes, (4) service connection for a back disorder, for accrued benefit purposes, (5) service connection for a bilateral hip disorder, for accrued benefit purposes, and (6) death pension benefits. She has thus abandoned the appeal of those six issues. *See Pederson v. McDonald,* 27

Vet.App. 276, 283 (2015) (en banc) (stating that "this Court, like other courts, will generally decline to exercise its authority to address an issue not raised by an appellant in his or her opening brief."); *Cacciola v. Gibson*, 27 Vet.App. 45, 47 (2014) (holding that when appellant expressly abandons an appealed issue or declines to present arguments as to that issue, appellant relinquishes the right to judicial review of that issue and the Court will not decide it); *Grivois v. Brown*, 6 Vet.App. 136, 138 (1994) (holding that issues or claims not argued on appeal are considered abandoned).

C. Statement of Facts and Procedural History

The Veteran served in the United States Army from May 20, 1986, to August 3, 1987. [R. at 288]. STRs document that the Veteran reported chest pain in June 1986. [R. at 269-73]. After ruling out any heart abnormalities, the Veteran was diagnosed with a muscular strain. *Id*. In January 1987, the Veteran was hospitalized after reporting he was "going to kill myself." [R. at 194-98]. STRs show that he was hospitalized for 16 days between January and February 1987 and diagnosed with major depression. [R. at 198]. The physician noted that at discharge "some improvement of this patient's depression has been noted. One can, however, expect in the future severe decompensation and depression with suicidal ideation and attempts, and one cannot see this patient functioning within the military service." [R. at 196]. Chief of inpatient psychiatry found that the Veteran's diagnosis constituted a disqualifying defect. [R. at 199-206].

Within a year of leaving service, the regional office (RO) granted the Veteran service connection for MDD at a 50% evaluation effective the day after his separation from service. [R. at 2889-90 (August 7, 1987, Application); 2880-83 (August 31, 1987, Rating Decision)]. The Veteran sought an increase for his evaluation for MDD and entitlement to TDIU in October 2001. [R. at 2738]. The RO denied his claims on February 14, 2003. [R. at 2537-41]. The Veteran did not appeal that decision within one year and it became final.

The Veteran again sought an increase in his evaluation for MDD and entitlement to TDIU nine years later in March 2012. [R. at 2522]. In an April 21, 2012, VA examination, the psychologist found that the Veteran had anxiety, impaired judgment and abstract thinking, difficulty establishing work and social relationships, and that he neglected his personal appearance and hygiene. [R. at 1800-01 (1794-1803)]. The examiner noted that while the Veteran did not endorse suicidal ideation, he "endorsed thinking about being dead more frequently than weekly." [R. at 1801-02]. The examiner stated that "there is no evidence that Veteran would be incapable of performing sedentary self-paced work given his mental condition…[the Veteran] thought he could handle some kinds of jobs, but could not do what he used to." [R. at 1802].

In a July 19, 2012, rating decision, the RO denied an evaluation in excess of 50% for MDD and entitlement to TDIU, among other claims. [R. at 621-37, 639-44]. On July 30, 2012, the Veteran passed away from cardiovascular disease. [R. at 594]. Appellant notified VA of the Veteran's passing, and applied for

compensation benefits, to include accrued benefits and service connection for the cause of the Veteran's death. [R. at 586-94 (August 26, 2013, Application), 607-608 (December 11, 2012, Report of Death)]. The RO denied entitlement to service connection for the cause of death and accrued benefits, among other claims, in a December 5, 2013, rating decision. [R. at 549-53]. Appellant appealed that decision. [R. at 300-02 (August 15, 2014, Notice of Disagreement)].

VA then provided two medical opinions that addressed the relationship between the Veteran's service-connected disabilities and his cause of death. The April 7, 2016, examiner found that:

> [n]either patellofemoral pain syndrome nor major depressive disorder are known to influence the onset, or progression of cardiovascular disease… the only treatment he was receiving for a service[-]related condition that has any influence on heart disease is taking NSAIDs for his patellofemoral pain. The risk from NSAIDS is small enough that it is much less likely as not to have caused or contributed to his development of CAD. None of his service[-]related conditions nor the medications used to treat them would have had any effect on his ability to resist the effects of CAD.

[R. at 156 (155-57)]. The examiner documented that the Veteran's STRs noted chest pain in service, but found that the notation was not cardiac related; instead, it was tenderness in the ribs and bicipital tendon, diagnosed as "muscular strain." [R. at 156-57]. The examiner found that "given that no heart related symptoms were noted at the time of discharge, it is highly unlikely that the chest pain was [misdiagnosed because] heart disease is progressive and therefore should have caused symptoms through the remainder of his military career." [R. at 156]. The examiner listed a portion of the Veteran's cardiac history including a history of

tobacco use, diabetes mellitus with neuropathies, obesity, and coronary artery disease (CAD). *Id*.

The May 26, 2016, examiner found that the Veteran's MDD less likely than not contributed to his death from cardiovascular disease. [R. at 151-52]. She noted that

> [w]hile depression and other mental health concerns can co-occur and are thought to have a bidirectional influence with physical conditions, existing research has not been able to determine that mental health conditions including depression have a casual connection with physical conditions like cardiovascular disease. In part, there is the potential for unaccounted variables that lead to the shared development/predisposition of these disorders.

[R. at 152]. The examiner cited to a National Institute of Mental Health publication on chronic illnesses and mental health as support for her opinion. *Id*.

Subsequently, the RO issued the statement of the case, and Appellant submitted her substantive appeal. [R. at 86-150 (June 15, 2016, Statement of the Case); 84-85 (June 21, 2016, Substantive Appeal)]. Appellant submitted a private opinion dated July 19, 2017. [R. at 35-57]. The physician opined that "it is as likely as not the veteran's service[-]connected major depressive disorder aided in the development of and permanently aggravated his hypertension and cardiovascular disease. It is also my opinion the veteran's hypertension aggravated his chronic kidney disease and coronary artery disease." [R. at 35]. The physician stated that depression causes:

> overactive nerve activity, dysfunctional immune response, and activation of the hormone system that controls blood pressure. Just think of how your own heart races when you are scared or angry. This

> veteran had that type of stress on his heart daily and this problem continuously since the service. For many years, physicians have referred to stress as "the silent killer." The relationship between stress, such as this veteran's depressive disorder, and hypertension is undisputed. Depression stimulates the heart[]rate but this type of stimulation is not healthy like the type of simulation a person receives when they exercise. This constant long-term stress damages the heart. Stress increases blood pressure by increasing the heart rate and constricting blood vessels.
>
> Research has shown anxiety and depression are predictive of later incidence of hypertension and prescription treatment for hypertension. A recent study found the incidence rate of hypertension was higher in persons with high or immediate depressive symptoms scores than in persons with low depressive symptoms scores.

[R. at 35-36]. The physician noted that "depression is common in patients with coronary artery disease" and "[t]he data is consistent in supporting that depression is a risk factor for both the development and worsening of coronary artery disease." [R. at 36]. The physician cited to studies that found "anxiety and depression are predictive of later incidence of hypertension," [R. at 37 (37-43)], "depression is unquestionably associated with cardiovascular disease…. [y]et it is important to remember that what has been demonstrated is an association and not causality," [R. at 49 (44-53)].

On January 11, 2019, the Board issued the decision, denying entitlement to service connection for cause of death, an evaluation in excess of 50% for MDD, for accrued purposes, and TDIU, for accrued purposes, among other claims. [R. at 1-25]. Appellant timely appealed only those portions of the Board decision on March 4, 2019.

III. SUMMARY OF THE ARGUMENT

The Court should vacate the portion of the Board's decision that denied an evaluation in excess of 50% for MDD for accrued purposes, because the Board failed to provide adequate reasons or bases and address all favorable evidence of record. However, the Court should affirm the remaining portions of the Board's decision that denied entitlement to service connection for cause of the Veteran's death and TDIU for accrued purposes, because the Board provided an adequate statement of reasons or bases and relied on adequate VA examinations.

IV. ARGUMENT

A. The Board Failed to Consider All Favorable Evidence in Determining the Appropriate Evaluation for MDD

In her brief, Appellant argues that the Board failed to consider favorable evidence, which may demonstrate that an evaluation in excess of 50% for MDD could be warranted, stating generally that there is evidence outside of the April 2012 VA examination that supports a rating in excess of 50%. *Appellant's Brief* (App. Br.) at 20-22. The Secretary agrees that remand is appropriate because the Board failed to consider all favorable evidence of record, specifically evidence demonstrating suicidal ideation and indications of violent behavior. *See Caluza v. Brown*, 7 Vet. App. 498, 510-11 (1995), *aff'd per curiam*, 78 F. 3d 604 (Fed. Cir. 1996).

The record shows that the Veteran was hospitalized in service with suicidal ideation. [R. at 194 (194-97)]. Upon discharge, it was noted that "one can,

however, expect in the future severe decompensation and depression with suicidal ideation and attempts…" [R. at 196]. Similarly, VA treatment records document that the Veteran had thoughts about taking his life. [R. at 646 (645-48) (July 2012 VA Treatment Records)]. In the April 2012 VA examination, the examiner noted that "although he denied suicidal ideation, Veteran endorsed thinking about being dead more frequently than weekly." [R. at 1801-02]. The Board failed to address any evidence of suicidal ideation in the decision. [R. at 14-16].

Additionally, the record shows that the Veteran reported "having anger that is 'frightening' at times, and noted concern that he would 'snap' on someone (due to rapidly escalating rage," [R. at 545 (544-47) (July 26, 2012, VA Treatment Record)], and that he had previously "punched an individual in the mouth," [R. at 3864]. The Board failed to discuss this evidence, which may demonstrate unprovoked irritability and indications of violent behavior.

As evidence of suicidal ideation and indications of violent behavior may allow for a higher evaluation and were not discussed by the Board, the Secretary concedes that remand is warranted for the issue of an increased evaluation for MDD for accrued purposes for the Board to provide adequate reasons or bases.

B. TDIU Is Not Intertwined with an Increased Evaluation for MDD

Appellant argues that the issue of TDIU is inextricably intertwined with the schedular rating for MDD. App. Br. at 26-29. She is incorrect. Two claims are inextricably intertwined only where the Court finds that they are so "intimately connected" that they must be adjudicated together. *See Smith v. Gober,* 236 F.3d

1370, 1373 (Fed. Cir. 2001); *Harris v. Derwinski*, 1 Vet.App. 180, 183 (1991) (if one decision on one issue would have a significant impact on another and in turn render any review by the Court meaningless and a waste of judicial resources, the two claims are considered inextricably intertwined).

In this case, the issue of TDIU is not inextricably intertwined with an increased rating for MDD. First, the standard governing the appropriate evaluation for MDD compared to whether a TDIU rating is warranted are demonstrably different. The regulation relevant to MDD, 38 C.F.R. § 4.130, uses the level of occupational and social impairment suffered by the veteran due to his mental health symptomatology to determine the appropriate evaluation. *See* 38 C.F.R. § 4.130. TDIU is considered under 38 C.F.R. § 4.16 and awarded only where a veteran's service-connected disabilities, alone, are severe enough to prevent the veteran from obtaining or maintaining a substantially gainful occupation. 38 C.F.R. § 4.16. Thus, simply because a veteran may be entitled to an increased rating does not necessarily follow that they would be entitled to TDIU. As such, Appellant cannot show that the Veteran's MDD and TDIU claims are inextricably intertwined.

Second, the facts specific to this case show that TDIU is not intertwined with the evaluation for MDD. In the April 21, 2012, examination, the Veteran reported that "[h]e appeared surprised when asked if there were any employment whatsoever he felt he could manage. He said yes, he thought he could handle some kinds of jobs, but could not do what he used to." [R. at 1802]. The examiner similarly found that "there is no evidence that [the] Veteran would be incapable of

performing sedentary self-paced work given his mental condition." [R. at 1802]. The April 2012 examiner's finding that "all occupational and social impairment identified…is attributed to [MDD]" does not alter the fact that both the examiner and the Veteran reported that MDD did not prevent him from obtaining employment, let alone substantially gainful employment. App. Br. at 28; [R. at 1798].

Further, the April 2012 examiner considered and discussed what the Board will consider on remand: suicidal ideation and violent tendencies. [R. at 1800-02]. The Board's findings reiterated what the record demonstrated: "the Veteran himself did not attribute his unemployment to [MDD]." [R. at 22]. These findings have a plausible basis in the record. *Gilbert v. Derwinski*, 1 Vet.App. 49, 52-53 (1990) (finding of fact is not clearly erroneous if there is a plausible basis for it in the record).

Finally, the Board's findings were plausibly based on the evidence of record. The Board discussed the Veteran's limitations caused by his MDD and knee disabilities, but found that his "service-connected disabilities were not so severe as to preclude gainful employment." [R. at 22]; App. Br. at 27-28. Thus, the Board already made the determination that TDIU is not inextricably intertwined with MDD. The Secretary does not discount the fact that the Veteran's employment and earning capacity were impaired by his MDD and his knee disabilities, as Appellant notes is evident from the record. App. Br. at 27-28. However, the Veteran's disability ratings represent, as far as can practicably be determined, the average

impairment in earning capacity in civilian occupations, resulting from such diseases and injuries and their residual conditions. 38 C.F.R. § 4.1; *see Van Hoose v. Brown*, 4 Vet.App. 361, 363 (1993) ("A high rating in itself is a recognition that the impairment makes it difficult to obtain and keep employment").

Moreover, demonstrating additional occupational impairment for the purposes of seeking an increased rating for MDD and preclusion from substantially gainful employment for purposes of establishing entitlement to TDIU are different standards. *Compare* 38 C.F.R. § 4.130, 38 C.F.R. § 4.16(a). The record illustrates—and the Board plausibly determined—that the Veteran's ability to work falls within the former (impaired), not the latter (precluded). No amount of Appellant's revisionist weighing of the evidence demonstrates that the Board erred in this finding. App. Br. at 27-28; *see Deloach v. Shinseki*, 704 F.3d 1370, 1380 (Fed. Cir. 2013); *Owens v. Brown,* 7 Vet.App. 429, 433 (1995). ("It is the responsibility of the BVA, not this Court, to assess the credibility and weight to be given to evidence"). Appellant has not established clear error committed by the Board or demonstrated that the Board provided an inadequate statement of reasons or bases for finding that TDIU was not warranted. *Hilkert v. West*, 12 Vet.App. 145, 151 (1999) (en banc).

To the extent Appellant cites to unpublished opinions to argue that TDIU was "reasonably raised" by the record, that is not in question in this case. App. Br. at 29 *citing Penso v. Shulkin,* No. 17-0058, 2017 U.S. Vet. App. Claims LEXIS 1852, at *4 (Dec. 28, 2017); *Swann v. Shulkin,* No. 16-2689, 2017 U.S. Vet. App.

Claims LEXIS 1614, at *11 (Nov. 2, 2017). In both cases, the Court determined that the Board had erred in failing to adjudicate the raised issue of TDIU. In this case, the Board clearly found TDIU raised by the record and adjudicated the claim. [R. at 21-22]. Appellant fails to demonstrate the necessity of these citations to nonprecedential decision in violation of U.S. Vet.App. Rule 30(a), particularly when there exists clear precedent that she cites to in her own brief. *Rice v. Shinseki*, 22 Vet.App. 447, (2009); App. Br. at 26.

Again, the Secretary acknowledges that the Veteran was impaired by his MDD, but his schedular evaluation will reflect the occupational and social impairment he suffers as a result of his MDD symptomatology. However, the evidence shows that the Veteran was not prevented from obtaining or maintaining substantially gainful employment by his MDD and knee disabilities. [R. at 1794-1803]. Taking this evidence into account, the Board plausibly found that TDIU was not warranted. [R. at 21-22]. Appellant's argument that TDIU is always and essentially intertwined with an increased evaluation is not supported by any law and fails to account for the relevant facts of this case. As Appellant simply asks the Court to reweigh the evidence already considered by the Board, her argument is not persuasive.

C. The April and May 2016 VA Examinations Were Adequate

Appellant argues that the May 2016 VA examination is inadequate because the examiner cited to a study which, in Appellant's reading, contains evidence that demonstrates that the May 2016 examiner's rationale is inadequate. App. Br. at

14. Whether a medical examination is adequate is a factual determination subject to review under the deferential clearly erroneous standard. *Nolen v. Gober*, 14 Vet.App. 183, 184 (2000). An adequate medical opinion must be based upon a consideration of the relevant evidence and must provide the Board with a foundation sufficient enough to evaluate the probative worth of that opinion. *See Ardison v. Brown*, 6 Vet.App. 405, 407 (1994). This requires the examiner to not only render a clear conclusion on the relevant medical question but to support that conclusion "with an analysis that the Board can consider and weigh against contrary opinions." *Stefl v. Nicholson,* 21 Vet.App. 120, 124 (2007) (holding that "a mere conclusion by a medical doctor is insufficient to allow the Board to make an informed decision as to what weight to assign to the doctor's opinion"); *see Nieves-Rodriguez v. Peake,* 22 Vet.App. 295, 301 (2008) (examiner must provide "not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two").

The May 2016 examiner stated that "while depression and other mental health concerns can co-occur and are thought to have a bidirectional influence with physical conditions, 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 152 (emphasis added)]. The examiner considered and cited to an online article. *Id*. The online article cited by Appellant from the National Institute of Mental Health states that "[p]eople with depression have an increased risk of cardiovascular disease," adding the caveat

that "[o]ngoing research is also exploring whether physiological changes seen in depression may play a role in increasing the risk of physical illness" and "[i]t is not yet clear whether these changes, seen in depression, raise the risk of other medical illness."[1]

Based on this article, the examiner's finding has a plausible basis in the record and Appellant's suggestion that the medical evidence suggests otherwise is not persuasive. [R. at 152]; *Acevedo v. Shinseki*, 25 Vet.App. 286, 293 (2012) ("[T]here is no reasons or bases requirement imposed on [medical] examiners"). More importantly, the examiner's conclusion was not based on this article alone, but included the specific facts of this case, showing the Veteran was a tobacco and alcohol user, and the general finding that "existing research has not been able to determine that mental health conditions… have a causal connection with physical conditions like cardiovascular disease." *Id*.; *see Reonal v. Brown*, 5 Vet.App. 458 (1993). As the May 2016 examination "sufficiently inform[ed] the Board of a medical expert's judgment on a medical question and the essential rationale for that opinion," the May 2016 examination is adequate. *Monzingo v. Shinseki*, 26 Vet.App. 97, 106 (2012).

The May 2016 examiner was able to find that the Veteran's cause of death was less likely than not related to his depression based on her review of the

1. NAT. INST. OF MENTAL HEALTH, *Chronic Illness & Mental Health*, (last visited January 16, 2020), https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health/index.shtml.

evidence and the record and she appropriately provided her opinion. *See Jones v. Shinseki*, 23 Vet.App. 382, 388 (2010) (finding that if "the physician is able to state that a link between a disability and an in-service injury or disease is 'less likely than not,' … he or she can and should give that opinion; there is no need to eliminate all lesser probabilities or ascertain greater probabilities."); *compare Wise v. Shinseki*, 26 Vet.App. 517, 532 (2014) (finding where a medical professional "admits that he or she lacks the expertise necessary to provide the opinion requested…the opinion itself…prevents the presumption of competence from attaching).

Indeed, Appellant is simply seeking for this Court to reweigh the medical evidence put before the May 2016 examiner and reach a different result. Appellant does not demonstrate that such a result is necessary based on the evidence and fails to provide any medical rationale that would support her conclusion. Her suggestion that the examination is inadequate because she reads the medical literature a particular way is an unhelpful insight given her lack of expertise, and thus, cannot be a basis for finding the May 2016 examination inadequate. *See Kern v. Brown,* 4 Vet.App. 350 (1993) (noting that "appellant's attorney is not qualified to provide an explanation of the significance of the clinical evidence"); *Hyder v. Derwinski*, 1 Vet.App. 221, 225 (1991) ("Lay hypothesizing, particularly in the absence of any supporting medical authority, serves no constructive purpose and cannot be considered by this Court."). Overall, the May 2016 examiner

reviewed the relevant evidence and plausibly determined that the Veteran's depression less likely than not contributed to his cardiovascular disease.

Appellant also argues that the April 2016 examination is inadequate because she believes the examiner impermissibly required the existence of "identical in-service and post-service diagnoses" for a heart condition, and therefore, Appellant's cardiovascular disease is related to service. App. Br. at 23-24. Again, Appellant's argument is entirely based on her own medical assertion that the Veteran's chest pain in service related to his fatal cardiovascular disease. App. Br. at 24; *Kern,* 4 Vet.App. at 350; *Hyder*, 1 Vet.App. at 225. Nothing in the April 2016 examination suggests that the examiner required STRs to show a specific heart symptom to make his determination. [R. at 155-57]. Rather, the April 2016 examiner directly addressed Appellant's contention, stating that STRs show that the Veteran's chest pain in service was not cardiac related, but simply a muscle strain, and that he had no heart related symptoms at the time of his discharge. [R. at 156]. Review of STRs from June 1986 shows that the Veteran reported left sided chest pain, tenderness in the ribs and bicipital tendon, and was diagnosed with muscular strain. [R. at 157, 269-73]. An electrocardiogram conducted in June 1986 revealed "normal" results. [R. at 273]. The evidence of record is consistent with the examiner's medical opinion. Appellant's contention that STRs "showed the presence of…heart/vascular-related symptoms during service" is based on nothing but her own unsubstantiated medical opinion.

Appellant argues that the examiner's opinion contained "a misunderstanding of law." App. Br. at 24. But there is no indication, and Appellant does not provide any specifics, that the April 2016 examiner made any legal findings. Further, examiners are not permitted to make any legal determinations. *Sizemore v. Principi*, 18 Vet.App. 264, 275 (2004) (explaining that, when an examiner makes factual findings and legal determinations, a new medical examination may be necessary to "remove whatever taint there may be from [the examiner's] overreaching"). Because the examiner did not make a legal finding and Appellant cites to nothing beyond a bare assertion, this argument is unpersuasive.

Appellant also argues that the Veteran had a familial history for heart disease and that the examiner "glossed over the fact." App. Br. at 25. Not only is it unclear how the Veteran's familial predisposition for a particular disease would show that his cardiovascular disease was related to service, her argument also seeks to have the Court reevaluate evidence that the April 2016 examiner already discussed. [R. at 157 (noting that the Veteran's father died at age 54 from CAD)]. Again, Appellant is merely disagreeing with the medical examiner's conclusion, but she does not have the medical training or expertise to do so.

Finally, Appellant argues that the examiners "applied an improperly high evidentiary standard," but provides no factual argument to support her proposition. App. Br. at 26. Both the April and May 2016 examiners provided their opinions in terms of "less likely than not." [R. at 152, 156]; *Hilkert*, 12 Vet.App. at 151; *Woehlaert v. Nicholson,* 21 Vet.App. 456, 463 (2007) ("The Court has consistently

held that it will not address issues or arguments that counsel fails to adequately develop in his or her opening brief"). As the examiner provided the Board with the opinion adequately supported by rationale, the April and May 2016 examinations and opinions were adequate for adjudication purposes. *Monzingo*, 26 Vet.App. at 106.

D. The Board Provided Adequate Reasons or Bases in Finding that the Veteran's Cause of Death Was Not Related to His Service or Service-Connected Disabilities

Appellant argues that the Board failed to consider all favorable evidence of record and further erred by finding the April and May 2016 VA opinions more probative than the July 2017 private opinion. App. Br. at 11-20. Unlike Appellant's characterization of the Board's decision, the Board discussed all favorable evidence of record and provided sufficient discussion that enabled Appellant to understand why it found the April and May 2016 opinions more probative than the July 2017 opinion. *Gilbert*, 1 Vet.App. at 57.

Appellant argues that the Board failed to discuss "all the various positive evidence that appears to support" her claim for service connection for cause of the Veteran's death. App. Br. at 12. To demonstrate her point, Appellant lists bullet point citations to VA treatment records and opinions. App. Br. at 16-18. A review of this list demonstrates that the citations are 1) evidence considered by the Board, 2) evidence irrelevant to the question on appeal, or 3) evidence that is not favorable to her claim. App. Br. at 16-18. The Board considered the favorable evidence of record and Appellant fails to demonstrate prejudicial error in the Board's decision.

See Mayfield v. Nicholson, 19 Vet.App. 103, 129 (2005) (where judicial review is not hindered by deficiency of reasons or bases, a remand for reasons or bases error would be of no benefit to the appellant and would therefore serve no useful purpose); *Caluza*, 7 Vet. App. at 510-11

First, Appellant cites to evidence the Board discussed, including the positive July 19, 2017, opinion, arguing first that the Board failed to consider this opinion, but then that the Board erred by not affording the 2017 opinion more probative weight. App. Br. at 16-18; [R. at 35-57]. From the decision, it is clear that the Board discussed the positive opinion, finding the opinion was not persuasive to the question of whether the Veteran's depression contributed to his death from cardiovascular disease because the physician failed to cite to "any specific evidence from the record demonstrating the claimed connection between the Veteran's psychiatric disability and cardiovascular disease" and further that "the medical articles submitted with the opinion specifically note the absence of evidence establishing a causal relationship." [R. at 11-12].

A review of the July 2017 private opinion confirms the Board's finding: the physician noted an association between depression and cardiovascular disease but did not provide specific rationale for *causation* between the two. The July 2017 physician stated that the medical "literature states depression is common in patients with coronary artery disease. The data is consistent in supporting that depression is a *risk factor* for both the development and worsening of coronary artery disease. The *association* of hypertension and coronary artery disease is

also well established." [R. at 36 (*emphasis* added)]. Parsing the July 2017 physician's language carefully, the physician positively indicated that depression and cardiovascular disease were concurrent, but even conceded that there is no evidence, in the record or in literature, that supports a conclusion that the Veteran's depression "contributed both substantially and materially" to his cause of death. *Id*.

The articles attached to the July 2017 opinion confirm the Board's skepticism. They note that while an association between depression and heart problems has been documented in medical literature, causation between the two conditions has not been demonstrated. [R. at 44 ("patients with depression in the period immediately following a myocardial infraction were 3.5 times more likely to die than nondepressed patients. The basis of this association remains speculative."); 48 ("although there is no question that depression is associated with both developing cardiovascular disease and death, there are a number of issues that remain to be clarified."); 49 ("it is important to remember that what has been demonstrated is an association and not causality.")].[2]

The Board's conclusion that the July 2017 physician's rationale and the submitted articles did not support the physician's conclusion and "do not demonstrate the existence of a causal relationship between depression and cardiovascular disease" is a plausible interpretation of the evidence. [R. at 12];

2. *Also available at* Alexander H. Glassman & Peter A. Sharpiro, *Depression and the Course of Coronary Artery Disease*, 155 AM. J. OF PSYCHIATRY 4, 4-11 (1998).

see Gilbert, 1 Vet.App. at 52-53 (finding of fact is not clearly erroneous if there is a plausible basis for it in the record); *D'Aries v. Peake*, 22 Vet.App. 97, 107 (2008) (it is within the purview of the Board to evaluate the medical evidence and favor one medical opinion over another). The Board does not commit an error simply because it favors the opinion of one competent medical expert over that of another. *See Owens,* 7 Vet.App. at 433. Moreover, because the Board provided adequate reasons or bases for rejecting the July 2017 opinion in favor of the April and May 2016 opinions, Appellant's argument is unpersuasive.

Appellant also argues that the Board's finding that the 2017 physician failed to "review the record is flawed." App. Br. at 18. While an examiner does not need to review all evidence in the claims file and further does not need to provide reasons or bases for their opinion, an opinion is only as probative as the factual background on which it is based. *Compare Acevedo*, 25 Vet.App. at 293; *with Reonal*, 5 Vet.App. at 458. In this case, the Board determined that the 2017 examiner failed to cite to any specific evidence that would have shown that the Veteran's depression caused or contributed to his cardiovascular disease and death. [R. at 11]. The Board's statement is true: the 2017 private physician noted a long history of depression, that the Veteran smoked and used alcohol, and that there were indications his cardiovascular disease may have familial ties. [R. at 35-36]. But there is nothing in the evidence discussed by the 2017 physician that would show the Veteran's depression caused or contributed to his cardiovascular

disease. Appellant fails to identify any evidence that would. *Hilkert*, 12 Vet.App. at 151.

In truth, Appellant requests that the Court reweigh the probative value of the July 2017 private opinion. App. Br. at 18-19. Appellant's argument is not persuasive because the Board reviewed the opinion and plausibly determined that it was not probative to the question on appeal. *Washington v. Nicholson*, 19 Vet.App. 362, 368 (2005) (it is the responsibility of the Board to assess the probative weight of the evidence).

Appellant next argues that the Board failed to discuss the Veteran's use of NSAIDs to treat his knee pain, stating that this evidence was favorable because the April 2016 examiner found that NSAIDs had an influence on heart disease. App. Br. at 13, 16; [R. at 156]. This was not favorable evidence that the Board had to discuss. The April 2016 examiner discounted the effect of NSAIDs on the Veteran's heart disease, specifically finding that "the risk from NSAIDs is small enough that it is much less likely as not to have caused or contributed to his development of CAD. None of his service-related conditions nor the medications used to treat them would have had *any effect* on his ability to resist the effects of his CAD." *Id*. (*emphasis* added). Appellant argues that because the April 2016 examiner did a complete and thorough review of the evidence and considered all possible avenues that service-connected disabilities could have contributed to his cardiovascular disease, the Board was required to parrot the same evidence, even though the examiner found there was no evidence that NSAIDs contributed to his

cardiovascular disease. Her argument mistakes the roles of the Board and examiners and misunderstands the law; it is unpersuasive. *Moore v. Nicholson*, 21 Vet.App. 211, 218 (2007) ("The medical examiner provides a disability evaluation and the rating specialist interprets medical reports in order to match the rating with the disability."), *rev'd on other grounds sub nom Moore v. Shinseki*, 555 F. 3d 1369 (Fed. Cir. 2009); *Wray v. Brown,* 7 Vet.App. 488, 493 (1995) (finding the Board's failure to discuss medical opinions which "did not provide any further scientific evidence probative of the theory advanced by the appellant" did not render inadequate its statement of reasons or bases and was not error); *see Gonzalez v. West,* 218 F.3d 1378, 1380-81 (Fed. Cir. 2000) (Board does not have to discuss each piece of evidence it considers when deciding a claim).

Appellant also cites to records that note the Veteran's panic attacks caused stress, which in her opinion, contributed to his cardiovascular disease and therefore constituted favorable evidence the Board was required to discuss. App. Br. at 16. This evidence does not demonstrate a relationship between his depression and cardiovascular symptoms, but merely documents that he suffered from depression and cardiovascular disease at the same time. The May 2016 examiner reviewed the Veteran's treatment records and determined that there was no evidence that the Veteran's depression and his symptoms caused or contributed to his cardiovascular disease. [R. at 151-52].

To prove the May 2016 examiner wrong and make her point, Appellant cites to a September 2005 record that notes the Veteran's aortic bifemoral bypass

surgery was complicated by "anxiety attacks (? ICU Psychosis) and pneumonia." App. Br. at 16; [R. at 1513-14]. There is nothing in this evidence to show that the Veteran's anxiety caused him to undergo a bypass surgery. The evidence merely demonstrates his pneumonia and anxiety were concurrent with his heart condition and made a complex surgery even more difficult. Further, the evidence demonstrates that the Veteran had tachycardia and depression-related panic attacks at the same time, but the VA physician noted that the Veteran could "easily distinguish between cardiac and panic chest discomfort" and that his stress from his psychological symptoms was separate from the stress felt from his cardiac symptoms. App. Br. at 16; [R. at 3036]. The existence of these symptoms at the same time is not evidence of causation between the two disabilities, and Appellant's lay hypothesizing otherwise is not only incompetent, but it also contradicts the medical evidence she seeks to use to support her claim. [R. at 44-53 (noting that causation between depression and cardiovascular disease has not been demonstrated by any reviewed study); 152 (finding that the Veteran's depression less likely than not contributed to his cardiovascular disease)]; *see Allin v. Brown*, 6 Vet.App. 207, 214 (1994) (holding medical examiners have broad discretion in making medical judgments); *Zimick v. West*, 11 Vet.App. 45, 48 (1998) (finding the exercise of a medical examiner's discretion is generally not subject to appellate review).

Furthermore, some of Appellant's citations are not relevant to the question of whether the Veteran's death from cardiovascular disease related to his service-

connected depression. She cites to a treatment record documenting a "[l]engthy history of MDD-related anxiety," the Veteran's difficulty with anger, notations of dizziness, and the Veteran's history of heart attacks. App. Br. at 17. At best, this evidence shows what the Board already knew: the Veteran suffered from depression and heart problems at the same time. But the existence of two independent disabilities at the same time does not demonstrate correlation or causation. This evidence was reviewed by the May 2016 examiner, [R. at 151], who found that it was less likely than not that the Veteran's service-connected depression contributed to his death. [R. at 152]. There is nothing from this evidence that would advance Appellant's argument that his depression contributed to his death from cardiovascular disease. *See Newhouse v. Nicholson*, 497 F.3d 1298, 1302 (Fed. Cir. 2007) (Board must only discuss that evidence which is relevant to the issues on appeal). Her citations again simply request the Court to reweigh the evidence of record already considered by the Board. *See Deloach*, 704 F.3d at 1380; *see also Buchanan v. Nicholson*, 451 F.3d 1331, 1336-37 (Fed. Cir. 2006) (holding that determinations of probative value are "completely within the Board's discretion to weigh the evidence").

Appellant further argues that the Board failed to discuss his "chest pain" reported in service, App. Br. at 14, but very plainly, the Board noted that Appellant had "chest pain in June 1986 which resolved with no diagnosis of a heart disorder." [R. at 10]. The Board found that there was no evidence of a diagnosis for cardiovascular disease until many years after service and "appellant does not

argue the contrary." *Id*. The April 2016 examiner found that this evidence of chest pain in service was a muscular strain and not a heart problem, reasoning that STRs ultimately ruled out any heart problem, [R. at 157, 269-73], and that "heart disease is progressive and therefore should have caused symptoms through the remainder of his military career." [R. at 156]. Without evidence that these complaints in service related to his cardiovascular disease, the examiner and the Board found that these reported chest pains in service did not show that his cause of death related to service. [R. at 10]. There is no basis for Appellant's suggestion that the Board failed to consider this evidence or that it showed that the Veteran's death was related to service.

Appellant also avers that the Board did not provide adequate reasons or bases for finding the April and May 2016 examinations were adequate. App. Br. at 12. As stated above, the examinations considered the relevant facts of the case and provided opinions as to the outstanding medical questions that were supported by adequate rationale. [R. at 151-52, 155-57]; *Monzingo*, 26 Vet.App. at 105. The Board specifically found that the April and May 2016 examinations were afforded more probative weight than the private July 2017 opinion. [R. at 11]. The Board stated that the July 2017 opinion was not persuasive because the physician did not provide any citations to specific evidence from the Veteran's case and further failed to provide sufficient rationale for his opinion. [R. at 11-12]. As such, the Board's finding that the VA examinations of record were more probative than the July 2017 opinion is supported by an adequate statement of reasons or bases and

permitted Appellant to understand the basis for its decision. *See Gilbert*, 1 Vet.App. at 52; *Owens,* 7 Vet.App. at 433 (Board may properly favor one medical opinion over another).

Appellant finally states that the Board failed to review the evidence with the benefit of the doubt rule. App. Br. at 15. The Board found that the preponderance of the evidence weighed against a finding that any service-connected disability caused or contributed to the Veteran's death. [R. at 10-12]. Under 38 U.S.C. § 5107, "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 C.F.R. § 3.102. In this case, the Board found the preponderance of the evidence was against Appellant's claim, and therefore, that doctrine is not applicable. [R. at 10-12]; *see Schoolman v. West*, 12 Vet.App. 307, 311 (1999) (Where the preponderance of the evidence is against an appellant's claims, the benefit of the doubt does not apply).

V. CONCLUSION

WHEREFORE, in light of the foregoing, the Court should vacate the January 11, 2019, Board decision, only insofar as the Secretary has conceded the Board provided inadequate reasons or bases for the issue of entitlement to an evaluation in excess of 50% for MDD. The Secretary respectfully requests that the Court affirm the remaining portions of the Board's decision.

Respectfully submitted,

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