Brosseau v. North Country Vending (March 13, 1996)

STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRIES

Myrna Brosseau	*)*	*File #: 84-6846*
	)	*By: Barbara H. Alsop*
v.	*)*	*Hearing Officer*
	)	*For: Mary S. Hooper*
North Country Vending)		*Commissioner*
	)	
	)	*Opinion #: 5-96WC*

Hearing held at Montpelier, Vermont, on November 27, 1995.
Record closed on December 8, 1995.

APPEARANCES

Robert R. Bent, Esq., for the claimant

ISSUE

Whether the claimant is entitled to additional permanency benefits since she signed a Form 22 in October of 1987.

THE CLAIM

1. Permanent total disability compensation pursuant to 21 V.S.A. §644.

2. Medical and hospital benefits pursuant to 21 V.S.A. §640.

3. Attorneys' fees and costs pursuant to 21 V.S.A. §678(a).

EXHIBITS

1. Joint Exhibit 1 Medical records notebook
2. Joint Exhibit 2 Deposition of Marcy E. Jones, D.C., dated October 6, 1995.

FINDINGS OF FACT

1. Judicial notice is taken of all prior proceedings in this matter, as well as all forms filed with the Department.

2. The evidence in this case is made up of three types: First, there is the

testimony of the claimant, and the deposition of Marcy E. Jones, D.C. Second,
there are the voluminous medical records introduced as Joint Exhibit 1. Third,
there are the Departmental filings and rulings, including a stipulation signed by the claimant and the decision of the Commissioner when the claimant later
tried to vacate the agreement. I will discuss these forms of evidence seriatim.

Testimonial Evidence

3. The claimant was the only live witness. She testified regarding her job with the employer North Country Vending, where her assignment was restocking,
filling and repairing vending machines. She also worked part-time for Ethan Allen in Orleans, performing janitorial tasks. In 1983, while lifting a box with four gallons of syrup in it and turning to place it on a cart, she felt something snap in her back.

4. The claimant denied any prior work related injury, and indicated that she continued to work for a few weeks after the injury. Then she noticed that her
leg was dragging, and she sought medical attention.

5. She later moved to Arizona, and in 1985 in Tucson, had surgery on her back. It was performed by Dr. Ronald Bernstein. Although initially painful after the surgery, she began to improve. Suddenly, after six weeks, she lost use of her arm, but that was later corrected by physical therapy. Then she began to worsen, and in December of 1985, had a severe falling out with her surgeon.

6. While in Arizona, the claimant took courses through Technology Plus and Pima Community College, where she was learning data entry skills. She was scheduled to take a course in medical terminology, with the expectation that she could work at home as a transcriptionist, and she could pace herself. She
also applied for SSDI during that period of time. She did not, however, find any work, and did not take the course in medical terminology as originally planned.

7. She returned to Vermont at some time in 1986, where she saw Dr. Farfan
and Dr. Frymoyer. She went to them because she was in a lot of pain and was

*frustrated, as Dr. Bernstein had, she claimed, promised that she would be 85%
better. She was told at this time that she had arachnoiditis.*

*8. In 1987, the claimant went to see Dr. Marcy Jones, a chiropractor. At that time, she was suffering lower back pain with occasional pain down her legs
and into her feet. She described the pain as sharp and shooting, or pins and needles, and occasionally burning in her legs. She testified that at that time she had no pain in her neck or upper back. She indicated that she was able to
type, and had rented a typewriter which she could use successfully.*

*9. The claimant described her condition in 1987 as follows: she could not sweep or mop, but could vacuum occasionally. She had a hard time making her
bed. She could occasionally go to the store, if someone else would carry the groceries. She had good and bad days, and the worse days were after seeing a
doctor or going to class. She was always very tired, in a lot of pain, and would have to lie down for about an hour every day.*

*10. The claimant testified that her pain is worse now than it was in 1987, specifically noting the following: the pain has gone up her back into the right side of her face and into her arms and hands. There are days when she cannot
dress herself, and she stays in bed all day long. She can only lift her left arm to shoulder height. She can vacuum only a small area at a time. The pounding and vibration of riding in a car bothers her. She will go shopping with her daughter on occasion, mainly just to get out of the house. The pain is much worse than in 1987, and she is bedridden once or twice every two to three weeks. She does not remember "it being so bad" in 1987. She has problems with concentration and with remembering things, and she believes this
is caused by having to fight pain all the time. She cannot now imagine doing any work, and considers the inability to work to be degrading.*

*11. She admits that she drove to the hearing from Bolton, having borrowed her
daughter's car. She also acknowledges that, when she applied for SSDI in 1987,
she stated that she could not work. She admitted that she had a pre-existing
depression, attributable to a messy divorce, for which she was treating at the
time of the work related injury. She also agreed that her doctors in 1987*

wanted her to go through the Back Center program, an intensive rehabilitation and behavioral modification program, and that she declined to accept it. She confirmed that she was aware that Dr. Frymoyer believed that she was totally and permanently disabled from any meaningful work.

12. The claimant has no recollection of meeting with the Deputy Commissioner, nor of any discussions with anyone at the Department with regard to the Form 22 that she signed. She agreed that she was represented by counsel at all times through the proceedings in 1987 that led up to the Commissioner's acceptance of the Form 22 and the stipulation attached to it.

13. She testified that she is now treated by Dr. Klikunas only, and that she has had physical therapy lately. She had been advised not to undergo therapy by Dr. Hadjipavlou, one of her Arizona doctors, but that she participated in it after she returned to Vermont. She tries to walk a mile a day. She testified that at the time she signed the Form 22, her treating doctor was Dr. Loes, in Arizona.

14. Dr. Marcy Jones testified by deposition. He had not, at the time of the deposition, reviewed his records in the case, nor had he seen the claimant since 1987. He last spoke with the claimant in 1988, and is unaware of any treatment that she received since that time.

15. Dr. Jones testified that, although the impairment from which the claimant was suffering in 1987 was not severe, her disability was. He reported at the time that she was 100% disabled from 90% of the job market, and that her work capacity was measured by the limitations she had in terms of sitting, standing and walking, with minimal lifting. He thought at that time that she could work about twenty hours a week in a job that was closely tailored to her limits, and the only one that he could think of was as a salesperson in a not very busy jewelry store, with an understanding employer. He considered her to be extremely disabled, notwithstanding his finding that, under the guidance of the AMA Guides to the Evaluation of Permanent Impairment, her impairment was either

26.5% or 34% of the lumbar spine and 8% of each lower extremity.

16. Dr. Jones also testified that he had spoken with the claimant on a few occasions after his examination of her. The last time was when she called him from Arizona, seeking his advice about further care for her injury. He referred her to Dr. J.M. Mazion, a chiropractor of note, according to Dr. Jones.

17. Dr. Jones also testified that it was probable that the claimant's condition would deteriorate as a result of her arachnoiditis, a condition that can spread or cause other mechanical problems due to compensatory behaviors. He indicated that he took this factor into consideration in making his impairment rating.

Medical Evidence

18. The claimant has seen a number of health care professionals because of her injury. The medical records exhibit, Joint Exhibit 1, contains records from at least 24 doctors, chiropractors and physical therapists, as well as vocational rehabilitation consultants.

19. The claimant in 1983 at the time of the injury initially saw Dr. George Linton, who noted that she described "severe back pain, for the most part right sided radiating to her right buttock and right hip." He also noted that she had had somewhat similar back pain several years previously, which had resolved after a hysterectomy. He also noted that she was being treated for depression, with some difficulty with insomnia.

20. The claimant was then admitted in December of 1983 to the Mary Hitchcock Memorial Hospital, where her neurological examination was normal, and where it was noted that she had "somewhat atypical lumbar back pain with right groin radiation and no real radicular symptoms." She was followed at that facility by Dr. Quentin J. Durward, who last saw her on January 28, 1985, when he noted that she considered herself to have improved about 75%. He determined that "it has become more obvious that, in fact, major psychogenic factors are involved

in this lady's pain syndrome, and I think a lot of it is psychosomatic." He opined that she would greatly benefit from behavioral modification techniques.

21. All of the doctors who saw the claimant in Vermont and New Hampshire prior to her relocation to Arizona in early 1985 determined that her case did not warrant surgical intervention, as there was no evidence of a surgically correctable lesion. In fact, Dr. Richard Gagnon, who saw her for a second opinion and attempted to give her an injection of a local anesthetic, observed some hysterical behavior, and concluded that she had "a very atypical pain pattern and she appears to have chronic pain due to nonorganic causes." A number of health care providers indicated that the claimant would benefit from an in-patient behavioral modification program, focusing on her pain behaviors and the non-organic bases for her chronic pain.

22. In March of 1985, the claimant underwent a lumbar laminectomy and discectomy in Arizona, performed by Dr. Ronald A. Bernstein. His report of operation contains the following language: "The patient is a 41 year old white female who is admitted for treatment of lumbosacral pain which developed approximately 18 months ago with acute onset low back pain radiating down the right side. She was worked up and did not have surgical procedure in spite of the fact that her myelogram was positive. Approximately one week prior to admission she developed left sided sciatica as well and was noted to have positive straight leg raising as well as cross straight leg raising." This is the first medical record to note the positive leg raising tests. It is unclear what the source was for Dr. Bernstein's conclusion that the myelogram was positive, as there is no evidence before me that it was in fact positive and later reports have commented on Dr. Bernstein's apparent lack of appropriate information prior to the surgery.

23. Dr. Bernstein saw the claimant in follow-up after the surgery, and found "very little objective findings." He determined, two weeks following surgery, that the claimant was not doing as well as was to be expected, and attributed this to a "chronic suffering syndrome" and the possibility that her symptoms were not caused by a "true pathologic entity." He also noted that "[s]he has been on antipsychotic medication for some time and her boyfriend states that she has in the past discussed suicide intentions and now is severely

incapacitated. I have great difficulty correlating her symptoms with her physical findings and with the surgical findings." A week later, he found that the return of her "suffering syndrome" was caused in part by her home situation, including problems with her boyfriend. She was referred to Dr. Robert Crago, a psychologist involved with the care of pain patients. However,
she did not see Dr. Crago until December of 1990.

24. From May through October of 1985, Dr. Bernstein saw the claimant on a number of occasions, commenting throughout on the exceptional recovery the
claimant was making from her surgery. He approved her return to work, a goal
she avidly sought, with a few restrictions and with at least one consultation with a vocational rehabilitation counselor in Arizona.

25. In December of 1985, the claimant again saw Dr. Bernstein, now denying
with apparent hostility that she had ever received any improvement from the surgical intervention in March, in spite of the documentary evidence to the contrary. On neurological examination, Dr. Bernstein could find no significant
deficit, although there was a "diminished Achille's [sic] tendon reflex on the L side which is of long standing nature." He found that "[i]n summary, I feel that Ms. Brousseau [sic] has gotten an excellent result as far as the neurologic deficit that she demonstrated prior to the surgery. Her only complaint at this time is subjective though she has no evidence of objective findings to support this. I suspect as I did on several occasions following her surgery that she has a significant "suffering" syndrome which is influenced
by other considerations. She was also quite concerned that she only received
a 10% disability from Workmens' Comp. at this time." He again recommended a
pain clinic referral. Further letters in his file that were included in Joint Exhibit 1 reiterated these findings.

26. At various times in 1985 and thereafter, the claimant returned to Vermont
and received services from physicians in this area. For example, in the summer
of 1985, she went through a course of physical therapy at the request of Dr. Linton for tendinitis of the biceps and causalgia, attributed at the time to her period of bed rest apparently after the surgery.

27. In 1986, the claimant was treated by Dr. H.F. Farfan in Quebec, and also Dr. John W. Frymoyer, at University Orthopedics in Burlington. Dr. Frymoyer determined that with the definitive diagnosis of arachnoiditis, the claimant was at an end medical result. He believed that she had a permanent and total impairment of her lumbar spine as a result of the condition, and indicated that this reflected the "natural history" of arachnoiditis. He indicated that the only reasonable alternative for treatment for the claimant was attendance at the New England Back Center, as representing the "only alternative potential for her reaching some level of improved function and possible employability."

28. The claimant went to the Back Center, where she was evaluated by Dr. Rowland G. Hazard in February of 1987. Without recourse to her medical record, he recorded her history as reported by the claimant. It is not consistent in some respects with other reports admitted into evidence. Based on the reported history and a quantitative functional evaluation, Dr. Hazard determined that her admission to the program would be appropriate and warranted, although there was a substantial risk that she would not be able to complete the program because of psychological factors, including depression and a very poor self-image.

29. Within three months of her appointment with Dr. Hazard, the claimant was also evaluated by Dr. Marcy Jones, whose findings have been related above, and Dr. Philip E. Gates. Dr. Gates confirmed that the claimant would benefit from the Back Center, and indicated that "[i]t may well be that following that she may be determined to have a permanent total impairment, or it may well be that she will have a lesser degree of impairment." He concluded that "...from some of the notes which suggest that she has a poor pain tolerance and that there are some abnormal findings on her psychological testing, ...there probably is not a strong likelihood of marked improvement. Nevertheless, my approach would certainly to [sic] be to send her through the rehabilitation program in the hope that she will be able to be returned to some form of employment such that she may contribute to our society."

30. After Dr. Gates' report, the next series of medical records offered in this case commence in 1988, when the claimant went to see Dr. J.M. Mazion in Arizona, on referral from Dr. Marcy Jones. He treated her for a period of several months, and confirmed Dr. Jones' permanency evaluation and the unlikelihood of any substantial improvement.

31. In 1989, the claimant returned to Vermont again for a short period of time, and was treated briefly by Dr. Thomas Turek, a chiropractor, who made no findings of note. She was also evaluated by Dr. Kuhrt Wieneke, Jr., at the request of the insurer. Dr. Wieneke performed a permanency evaluation based on the AMA Guides, and found that the claimant was suffering from a 22% permanent partial impairment to the lumbosacral spine and a 4% permanent partial impairment to each lower extremity.

32. From 1990 until 1994, the bulk of the claimant's treatment apparently occurred in Arizona. The reports from that period included in Joint Exhibit 1 include those of Dr. B. Robert Crago, a psychologist specializing in biofeedback and pain management techniques, Dr. William J. Brooks, a specialist in biomechanics and orthopedic surgery, and Dr. Michael W. Loes, board certified in disability and chemical dependency evaluation and treatment. Dr. Crago did extensive psychological testing of the claimant and found that she had a number of clinically significant problems, including anxiety, depression, hypersensitivity, obsessive rumination and social alienation, poor ego strength and a tendency towards co-dependency. It does not appear that Dr. Crago was aware of the claimant's prior psychiatric problems, as referenced by Dr. Linton and Dr. Bernstein. Over the course of his treatment of the claimant, Dr. Crago noted improvement in her condition, although she suffered some difficulties around the time of a proposed settlement of her workers' compensation case.

33. Dr. Brooks treated the claimant with myofascial releases and stretching techniques over a period of several months, concurrently with Dr. Crago's treatments. In a letter to her lawyer in November of 1991, Dr. Brooks indicated that the claimant was making progress with the "psychosocial ramifications of her pain" although there was no success to report in obtaining

sustained relief from the pain she was suffering.

34. In December of 1991, the claimant began to treat with Dr. Loes for acupuncture and other pain management techniques, on the referral of Dr. Brooks. After the acupuncture failed within weeks, other treatments were attempted, including narcotics. None did more than provide temporary relief of her symptoms.

35. The claimant returned once again to Vermont, and was seen again by Dr. Wieneke in August of 1992. His physical findings were identical to the findings that he made in 1989. He made a number of disparaging comments about the nature of the treatments the claimant had received in Arizona, which, as expected, resulted in a spirited response from Dr. Loes, who in particular contested Dr. Wieneke's negative finding on straight leg raises. Dr. Wieneke confirmed his previous permanency rating.

36. Dr. Loes in April of 1993 performed a permanency evaluation of the claimant. He conceded throughout the evaluation that he did not have access to more than a few of the claimant's records, those mainly from Arizona, and that his source for her prior history was from the claimant. He found that the claimant had a spinal permanent partial impairment of 39% and a psychiatric impairment of 35%. The basis for the latter rating was his finding, later reported to the claimant's attorney, that "[i]t is clear she has an adjustment disorder secondary to chronic pain involving the four ratable areas of psychiatric impairment: activities of daily living, social functioning, concentration and adaptation. It is clear she has at least a mild to moderate impairment in this area." The spine impairment was based on findings in the cervical, thoracic and lumbar areas of the spine, the first time any doctor had made findings in areas other than the lumbar spine.

37. In 1994, the claimant returned to Vermont, where she has been living up to the time of the hearing. She is now treating with Dr. Marvin Klikunas, who is managing her various medications. He has also referred her back to The Spine Institute, the renamed Back Center. She was again seen on July 26, 1994, by Dr. Hazard, who confirmed Dr. Wieneke's negative straight leg raise test. He noted "[d]iffuse pattern of pain with a major complaint of lower back pain without clear evidence for a surgically correctable cause. It may well be that

her evident arachnoiditis changes our cause of some of her pain. After a long discussion today of her recovery goals, I think that a brief intervention with instruction in mechanical self care through two visits of physical therapy would be most appropriate. I think that management of her medication should be managed through Dr. Klikunas, the relevant issue here medication-wise is really with her antidepressant." She was given the physical therapy instruction as recommended, and returned later with continuing complaints. Dr. Hazard's last record indicates that he referred her for chronic pain group therapy in October of 1994. There is no record that she actually participated in such therapy.

38. The final record submitted is the claimant's file with regard to her claim for Social Security Disability Insurance benefits, which were awarded on August 26, 1987. As the standards for such an award are materially different from those applied in the workers' compensation context, the information is not germane, except for the fact that the claimant did start receiving benefits as a result of the award.

Departmental Records

39. The claimant signed a Form 22 with an attached Stipulation which was accepted by the Department only after the claimant met with the then Deputy Commissioner and urged him to accept the agreement. It was accepted on January 6, 1988. Pursuant to that agreement, the claimant received permanency benefits based on a permanent partial impairment to her spine of 26.5% and to each lower extremity of 8%. The claimant, by the terms of the stipulation, waived her request to enroll in the New England Back Center program, and agreed not to renew her claim for this service.

40. Thereafter, the claimant sought to reopen her case, specifically the settlement agreement, raising a number of questions, including the level of permanency to which she was entitled. The findings in Opinion 2-89, Myrna Brosseau v. North Country Vending, are incorporated by reference herein. All of Dr. Frymoyer's, Dr. Farfan's and Dr. Gates' material was admitted into

evidence at that proceeding, as was Dr. Wieneke's first report of February 2, 1989, and Dr. Bernstein's letter of October 18, 1985. Based on all of those records and the claimant's testimony, the Commissioner found that the claimant had failed to present any evidence that her condition had changed since she signed the Form 22.

41. The claimant at the prior hearing advanced the "theory that defendant had breached the agreement and therefore claimant should be allowed to reopen the matter." Since there was no breach, she was not allowed to reopen it. But the clear import of this conclusion was that the claimant was, at that time, trying to increase the amount of permanency she received.

CONCLUSIONS OF LAW

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. Goodwin v. Fairbanks, Morse Co., 123 Vt. 161 (1963). The claimant must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. Egbert v. The Book Press, 144 Vt. 367 (1984).

2. There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the inference from the facts proved must be the more probable hypothesis. Burton v. Holden & Martin Lumber Co., 112 Vt. 17 (1941). Where the causal connection between an accident and an injury is obscure, and a lay-person would have no well grounded opinion as to causation, expert medical testimony is necessary. Lapan v. Berno's Inc., 137 Vt. 393 (1979).

3. An approved Form 22 is binding on the parties unless there is a change in circumstances or the Commissioner lacked jurisdiction. 21 V.S.A. §668. An award is conclusive with regard to the issues raised absent a showing of fraud. 21 V.S.A. §669. Therefore, the issue in this case is whether the claimant has established by credible evidence that there is a change in circumstances since

the issuance of the decision in Opinion No.2-89, since as of the date of that decision, there had been no change in her condition sufficient to warrant a change in the terms of the Form 22.

4. The claimant's testimony with regard to her pain is not accepted. First, the claimant has not proved credible in the main on issues of either treatment or history. Specifically, her failure to recall a meeting with the deputy commissioner and the inconsistency of her reports to Dr. Bernstein are very troublesome. Secondly, the medical records are replete with references to unsupported complaints and inconsistent findings, which suggest that the claimant is not a credible witness on the issue of pain. As a result of this conclusion, the only basis for a finding in the claimant's favor would be in medical evidence establishing the necessary change. This decision is hampered both by the incomplete medical records offered and the lack of any live or deposition testimony about the claimant's current condition. Specifically, the failure to call the doctor upon whose opinion the claimant is relying, Dr. Loes, precludes a meaningful analysis of his decisions.

5. I find that the claimant has failed to meet her burden of proof as to a change in her condition sufficient to warrant a revision of the terms of the Form 22 and the attached stipulation. Separating the issue into the physical and the psychiatric components allows the more careful elucidation of the reasoning.

The Physical Impairment

6. The evidence on the physical impairment is lengthy but imprecise. However, in looking at the evidence available at the time the claimant signed the Form 22 and at the time of the hearing, it is not clear that theclaimant's current impairment, even as rated by her physician, is any greater than it was in 1988 or 1989. At the time of the signing of the Agreement, there were three impairment ratings of the claimant which were the subject of the compromise. Dr. Wieneke found a 22% impairment of the lumbar spine and a 4% impairment of each lower extremity, which would result in an award of 89.8 weeks of compensation. Dr. Jones found initially a 26.5% impairment of the lumbar spine and an 8% impairment of each lower extremity, resulting in an award of 121.85 weeks. Dr. Jones later amended his rating to 34% of the lumbar spine, with the

same lower extremity impairment, resulting in an award of 146.6 weeks. Finally, Dr. Loes found in 1993, under a different and more recent edition of the AMA Guides to the Evaluation of Permanent Impairment, a 39% impairment to the spine, resulting in an award of 128.7 weeks. Dr. Loes' figure is substantially lower than Dr. Jones' second figure, the one undoubtedly compromised by the claimant when she settled her case prior to hearing in 1987.

Even assuming that Dr. Frymoyer's and Dr. Gates' opinions of permanent total impairment were not considered seriously at the time, the claimant negotiated from a position higher than Dr. Loes' in reaching the accepted figure. She cannot now be heard to claim that her election to accept a lesser amount gives her the right to the additional 5.85 weeks that represents the difference between the compromise and Dr. Loes' determination.

7. Moreover, the evidence of the medical records supports this conclusion. First, it is significant that Dr. Wieneke's findings both before the agreement and after the agreement, as late as 1992, were identical. Secondly, Dr. Hazard also had the opportunity to examine the claimant both before and after the agreement, and could find no mechanical basis for her claims of pain. He confirmed Dr. Wieneke's negative straight leg raises, and apparently found that factor significant. Virtually all of the doctors who saw the claimant prior to the agreement reported exquisite and debilitating pain, with minimal organic basis other than the arachnoiditis. Because of the number of practitioners the claimant has seen, there is no other physician whose records reflect that he treated her both before and after the agreement. Dr. Loes' report of the claimant's condition is based on the Arizona records alone, along with her report of her history. As has already been noted, the claimant is not a good or reliable historian with regard to her medical history.

The Psychological Impairment

8. In order to establish entitlement to the psychologic impairment as assessed by Dr. Loes, the claimant must prove the causal connection between the impairment that she is claiming and the compensable injury. This the claimant has not done.

9. The very first medical record in this case establishes that the claimant had a pre-existing psychological condition. Therefore, the evidence must establish that the injury at work aggravated or accelerated that pre-existing condition, or that the claimant is suffering from a different condition specifically caused by the work injury, in order to prevail. The very sparse psychological evidence does not support either theory.

10. Dr. Linton referenced the pre-existing condition. Dr. Bernstein referenced treatment by anti-psychotic medications for an unrelated psychologic problem. He also suggested that she treat with Dr. Crago as early as 1985. Neither of these pieces of evidence was addressed by the claimant in her case.
Nor was Dr. Crago apparently aware of either of the prior treatments. His psychological evaluation was premised on the theory that the claimant's problems began with and arose out of the work injury, in spite of evidence that the claimant had a complex of problems, as found above in Finding #32. This begs the question. Dr. Loes in his permanency letter dated April 1, 1993 conceded that he lacked her prior medical records. There is simply no evidence from which I can find that the claimant's pre-existing psychological condition was in any way exacerbated by the work injury, or that a different complex of problems occurred as a result of that injury.

11. Each party makes a number of legal arguments in support of its positions in this case. Most of them do not need to be addressed in light of the decision being reached on the facts of this case. However, the claimant argues that the defendant has made an "admission" that the claimant is permanently totally disabled, based on some of the defendant's statements in pleadings before the hearing in this case. Statements taken out of context may, indeed, appear to admit certain points now disputed. However, it is clear that the defendant's arguments were based on the position that the claimant, at the time of the signing of the Form 22 and the prior hearing, had evidence available to her which would have supported a finding of permanent total disability, if believed by the Commissioner. The defendant's choice of words in arguing alternative theories of the case may have been improved upon, but the theory

was clear to the hearing officer at the time of the filing, and will not now be held against the employer.

ORDER

THEREFORE, based on the foregoing findings of fact and conclusions of law, it is hereby ORDERED that Myrna Brosseau's claims for further permanency benefits be and hereby is DENIED.

DATED at Montpelier, Vermont, this 13th day of March 1996.

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Mary S. Hooper
Commissioner