Lippard v. T. Copeland & Sons, Inc. (Feb 5, 1996)

STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRIES

Ronald D. Lippard	*)*	*File #: B-25324*
	)	
	)	*By: Barbara H. Alsop*
v.	*)*	*Hearing Officer*
	)	
	)	*For: Mary S. Hooper*
T. Copeland & Sons, Inc., et al.	*)*	*Commissioner*
	)	
	)	*Opinion #: 7-96WC*

Hearing held at Montpelier, Vermont, on December 18, 1995. Record closed on January 9, 1996.

APPEARANCES

Steven A. Adler, Esq., for the claimant
Christopher J. Whelton, Esq., for T. Copeland & Sons, Inc.
Thomas P. Simon, Esq., for Jenne Brothers
Jeffry W. White, Esq., for Montgomery Wire
Christopher J. McVeigh, Esq., for Vermont Tap and Die

ISSUE

1. Which, if any, of the employers is responsible for the claimant s workers compensation benefits?

2. To what benefits, if any, is the claimant entitled?

THE CLAIM

1. Temporary total disability compensation pursuant to 21 V.S.A. §642 from July of 1992, until the reaching of an end medical result.

2. Permanent partial disability compensation pursuant to 21 V.S.A. §648.

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

4. Vocational rehabilitation pursuant to 21 V.S.A. §641(b).

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

STIPULATIONS

1. The claimant has been a resident of New Hampshire from 1987 to the present.

2. Montgomery Wire is a New Hampshire company.

3. All of the claimant s work for Montgomery Wire was performed in the state of New Hampshire.

EXHIBITS

Joint Exhibit 1	*Medical Record Notebook*
Joint Exhibit 2	*Affidavit of Carlton Jenne*
Joint Exhibit 3	*Ronald Lippard Chronology*
Joint Exhibit 4	*Previous Employment Record*
Joint Exhibit 5	*Photographs of Scar*
Joint Exhibit 6	*Deposition of Kuhrt Wieneke, Jr., M.D.*
Joint Exhibit 7	*Deposition of Ronald A. Lippard, March 10, 1995 8.*
Joint Exhibit 8	*Letter to Department of Safety, February 10, 1993*
Joint Exhibit 9	*Letter from Lon W. Howard, M.D., December 12, 1989*
Joint Exhibit 10	*Curriculum Vitae of Seddon R. Savage, M.D.*

FINDINGS OF FACT

1. The above stipulations are accepted as true and the exhibits are admitted into evidence, with one exception. Included in Joint Exhibit 1 is an affidavit by George Lippard, the claimant s father, regarding the claimant s appointment with one of the physicians retained by the defendants. Objection has been made to the admission of the affidavit, and that objection is sustained. The claimant has not established the unavailability of the deponent, nor that the affidavit is anything more than a self-serving production of the claimant. Notice is taken of all forms filed with the Department in this case.

2. The claimant suffered a compensable injury on March 7, 1989, while working for the defendant T. Copeland & Sons

(hereafter Copeland), in Bradford, Vermont. The injury involved the forceful driving of a 2"x 4" of hardwood into the palm of his hand, propelling him backwards and off his feet. The claimant was at the time operating a table saw.

3. The claimant was initially treated on the date of the injury in the emergency room at Cottage Hospital in Waterville, N.H., where he complained of pain in the right shoulder, elbow and wrist joints, with numbness in his fingertips and painful motion of his fingers. It was originally diagnosed as a soft tissue injury, and he was released with instructions to rest for four days before returning to work.

4. The claimant next went to the Littleton Hospital on May 12, 1989, with continued difficulties with his right arm. He was referred to Dr. Parker Towle, (with whom he had previously treated for migraines) for nerve conduction studies, which were essentially normal. He then was sent to Dr. Lon W. Howard, an orthopedic surgeon. Dr. Howard opined that the claimant was suffering from a probable torn rotator cuff and subacromial bursitis, and planned a Neer acromioplasty.

5. On June 16, 1989, the claimant underwent surgery on his right shoulder, which was moderately successful. There was some pain and discomfort after the surgery, and many of his hand symptoms remained, but he was returned to work with lifting restrictions after about six weeks.

6. The claimant left Copeland and began to work for Montgomery Wire in July of 1989. His job there entailed maintenance machining, particularly remanufacturing worn parts. It was a job he could do without heavy lifting or repetitive or overhead lifting, and was within the work restrictions imposed on him by Dr. Howard. He had found that job on his own, and told a medical management specialist for Aetna, the insurer for Copeland, that the job there was more in line with his prior experience. He also told the specialist that he was a professional musician.

7. In July of 1989, the claimant also returned to see Dr. Towle for additional nerve conduction studies, referring specifically to the functioning of his thumb and index finger on his right hand. Although Dr. Towle found the median motor and sensory latencies at wrists and motor velocities to axilla to be normal, he did find some denervation/reinnervation of the Flexor Digitorum Profundis. He indicated that the damage was severe,

but that there might be some future improvement in the function of the two digits.

8. In November, the claimant returned again to Dr. Towle with continued reports of difficulties with his fingers, and he was referred to Dr. James M. Murphy at the Hitchcock Clinic. Although Dr. Murphy found some evidence of inconsistencies in the claimant s report of symptoms, he did suggest that the claimant was a suitable subject for nerve decompression. He referred the claimant to Dr. Daniel Wing, who urged an attempt at nonsurgical care for a period of time. When conservative approaches were unavailing, the claimant underwent, on March 7, 1990, an operation for anterior interosseous nerve syndrome. The surgery was at the level of the elbow, and produced a pronounced zig-zag scar on the interior of the right forearm.

9. Prior to the operation, the claimant returned to the Dartmouth-Hitchcock Medical Center where he attempted to obtain a refill of a percocet prescription given him by Dr. Murphy. He was seen by Dr. John Gorczyca, who declined, after a discussion about the addictive properties of percocet, to give him the prescription and instead gave him a prescription for Tylenol #3.

10. After the decompression of the anterior interosseous nerve, the claimant had a good recovery to the point that he was on May 1, 1990, nearly 100% improved from his preoperative condition. He was released to full duties at work, with no restrictions.

11. The claimant testified that, although he felt fairly good after the 1990 surgery, he always had some difficulties with his right arm. In the spring of 1991, he returned to Dr. Murphy with complaints relating to his right bicep. Dr. Murphy noted on March 26 that the onset of the bicep symptoms had been approximately two weeks earlier. By the end of April, the injury was diagnosed as an obvious rupture of the long head of the biceps. Dr. Murphy indicated that [a]t this point in time, no further workup is necessary. I doubt that he will have any functional deficit as a result of this. The people that rupture the long head oftentimes lose about 20% of their power of strength and flexion, but this, I doubt, will cause him to be in any way disabled at work. He can use the arm as tolerated. There are no restrictions on him at this time. No surgical intervention is necessary. The patient is reassured, and I would see him back on an as-needed basis.

12. The claimant did not seek additional medical attention for

his right arm for another two years. During that period of time, the claimant continued to suffer occasionally from migraine headaches, a problem that had plagued him for many years and predated his injury at Copeland. During that period of time, the claimant left Montgomery Wire to work at Jenne Brothers Machine Shop. The claimant worked for Jenne from May to August of 1991, when he was laid off because of lack of work. The claimant testified that his right arm was slowing him down, and he could not work fast enough, and hinted that this was the true reason for his layoff. The claimant never reported any work injury while at Jenne, although he was working with lathes, grinders and other machines, and was doing some light to medium lifting. There is no evidence in the record to support the claimant s claim that his right arm was causing him difficulty at that time.

13. After the claimant was laid off, he remained unemployed until May of 1992. He testified that he was actively looking for work during that period of time, and that he collected unemployment compensation during that period. In May of 1992, the claimant accepted a position with Vermont Tap and Die, where his duties involved sharpening taps. He testified that he told them about the problems with his arm, but that no accommodations were made for his disability. He felt a general weakness in his hand, and he had difficulty keeping up with his work. He was released after two months for not meeting the job requirements and for attitude problems with long time employees. The claimant has not worked since he left Tap and Die. He denied any specific injury at Tap and Die.

14. In January of 1993, the claimant met with personnel at the New Hampshire Department of Education Vocational Rehabilitation program in Berlin, N.H. Based on reports filed by that organization, it appears that the claimant was involved in both professional Celtic harping and wood sculpting using a compound wedge technique. The claimant denied at hearing that he had ever played the harp professionally, although the report is clear that the claimant stated that he could earn $15.00 an hour working professionally as a musician, and that he had earned money playing in the past. At the hearing, the claimant said that, to perform the harp professionally, he would have to practice 10 to 15 hours a week. The claimant also reported to the counselor that he was involved in designing machines and working in friends shops to develop prototypes. The claimant indicated to the counselor that he had explored ways to make money from his various enterprises, and was interested in

starting his own business. The claimant s attorney, at Dr. Savage s deposition, confirmed that the claimant had a business card with the picture of a harp on it. However, one of these cards was not requested nor produced in evidence.

15. The claimant had been receiving treatment for severe migraine headaches at least since 1987. In connection with this condition, the claimant received therapy at White Mountain Mental Health and Developmental Services. The claimant s first treatment was on referral from Dr. Towle, when he appeared at the emergency room of the Littleton Hospital with a migraine headache and suicidal feelings. The claimant was apparently overusing certain medications that had been prescribed by Dr. Towle, and this was a matter of some concern. His crisis at that time was precipitated at least in part by the regular occurrence of migraines triggered by his then unemployment.

16. In 1991, Dr. Towle again referred the claimant to White Mountain Mental Health and Developmental Services because of his overuse of prescribed medications for his migraines. He once again was suffering from anxiety attacks because of his unemployment, as he had in 1987, with severe headaches. He confirmed at that time that he was working professionally as a harpist. He indicated that he intended to return to active sculpting. He entered group therapy, where his expressed interest was to deal with the pain of his migraines.

17. The claimant then began to treat in 1992 at the Dartmouth-Hitchcock Medical Center for his headaches. On December 12, 1992, he reported an increase in his headache frequency due to the stress of a flopped sculpture exhibition. The failure was apparently caused by the inability to mail the notice of the exhibition, which had been printed on cards too small to comply with postal regulations. This confirms the vocational rehabilitation report that the claimant was actively pursuing his sculpting avocation prior to his consultation with the counselor.

18. On January 11, 1993, the claimant was in a car accident in which his car collided with a large truck. The claimant s driver side was hit by the driver s side of the truck on a snow covered road. The claimant wrote to the Department of Safety for the state of New Hampshire to complain that the accident caused him serious financial loss as well as triggered migraine headaches, which finally were under control. "I may have to be hospitalized if the current treatment can t bring them back

under control. He also in that letter contested the findings of the investigating officer, in an apparent effort to magnify the fault of the other party, even though the officer indicated that fault could not be assigned because of the snowy conditions and the narrowness of the road. The claimant testified that his wife had written the letter. He did not, however, indicate whether or not his wife had been a witness to the accident.

19. During the same period of time, the claimant was treating with Claudia Zayfert, M.A., on an outpatient basis for psychotherapy regarding his headaches. Her notes confirmed that he suffered an increase in his migraine headaches after the motor vehicle accident. She also noted that his headaches occurred predictably after stressful interpersonal interactions. In February of 1993, she noted that he was making progress in marketing some of his projects, with resulting decreases in his headaches and his use of medications.

20. On March 11, 1993, Ms. Zayfert noted that the claimant was claiming that he was suicidal, and she attributed his increased distress to the fact that his unemployment benefits had expired. Her notes contain the following statement: Pt views options as either obtaining narcotics through legitimate means, or not, entering hospital for pain control, or suicide. When pressed, however, he described this a low probability [sic] and readily agreed to plan.

21. The claimant was admitted on March 15, 1993, to the Neurology Service at Mary Hitchcock Memorial Hospital for a neurological and later psychological course of treatment. He was diagnosed with "schizo-effective [sic] disorder, provisional, schizotypal personality disorder, provisional, migraine headaches, opiod [sic] dependence, and benzodiazepine dependence." Aside from the treatment discussion, the report of this hospitalization was significant for the following language: The patient s wife was able to express much frustration and anger she had at the medical institution for contributing to the patient s overuse of medications. However, it became quite apparent to her and to the staff that the patient was doing some degree of "doctor shopping" and soliciting multiple prescriptions from physicians who were not coordinating with each other. The patient and his family heard our recommendations that he receive only coordinated care and that he not look to medicines as an answer to his problems.

22. On April 1, 1993, the claimant saw Dr. Murphy again,

complaining of significant weakness of his hand and discomfort about the shoulder and arm region. The claimant told Dr. Murphy that he thought the problems with his arm precluded him from woodworking and metal work, although it does not appear that the claimant told Dr. Murphy that the work he had been doing was of an artistic or creative nature. The findings were of good range of motion, some generalized weakness throughout the right upper extremity, and symmetrical reflexes. The sensory examination was normal with the exception of slight dullness in the median nerve distribution. Dr. Murphy found that it would be reasonable to assume that he will be unable to perform the duties previously expected of him and that Vocational Rehabilitation and support would be appropriate. Dr. Murphy was clearly unaware that the claimant had been involved with a vocational rehabilitation counselor only a few months previously, and he made no reference to the claimant s psychiatric admission.

23. On August 26, 1993, the claimant returned to the New Hampshire vocational rehabilitation office. He told his counselor that his March hospitalization had been due to migraine headaches and did not apparently refer to the substantial psychological nature of his treatment at that time. The claimant told the counselor that his doctors were now recommending retraining. However, he also stated that he was possibly going to have a show of his artwork in North Carolina, and also, possibly, a one-man show in Florida. He also indicated contact with a friend in Franconia with a machine shop and computer hardware, and the possibility of employment there.

24. Dr. Murphy next saw the claimant on September 16, 1993. He made additional findings, specifically involving abnormal desensitization distribution and tremulous activity. Dr. Murphy noted that the claimant was unable to play his harp in several performances. Many of Dr. Murphy s findings were later analyzed by Dr. Kuhrt Wieneke as suggestive of symptom magnification. Based on Dr. Murphy s findings at that appointment, he referred the claimant to the Pain Clinic.

25. The claimant was seen by Dr. Seddon R. Savage, the director of the outpatient pain clinic at Dartmouth-Hitchcock on October 25, 1993. Dr. Savage took a history from the claimant that was in part inaccurate, in that she believed that his injury occurred in 1990, with the subsequent median nerve decompression surgery in 1991, when in fact the years of these occurrences were 1989 and 1990 respectively. She indicated that he was pain

free for a period of a year or two before the onset of new symptoms of a similar nature in March of 1993. She indicated in her initial notes that [h]e describes himself as an artist who made his living as a fine machinist designing and making fine tools. On his own time he has been a sculptor and a musician. He plays the harp and a variety of clarinets and guitars. He has been unable to perform his chosen vocation or enjoy his art and music. His right arm at this time is essentially useless to him, he says. He at times things [sic] of suicide and often goes to bed hoping he will not wake up. She made certain positive findings, including suggestions of a reflex sympathetic response, although she noted that he had full passive range of motion of the right wrist and fingers, with some discomfort noted. Many of her tests were limited by the claimant s complaints of pain. She opined the possibility of recurrent distal nerve entrapment related to scarring. Symptoms were somewhat global and not limited to the distribution of the median nerve.

26. On November 16, 1993, Dr. Savage, after seeing the claimant, made the following note: Previous to several weeks ago, he was taking three Percocet a day on a regular basis. He reports that this provided him with excellent relief of pain and allowed him to use his right arm almost equivalently to his left arm. He was sleeping better at that time as well. He reports no difficulty taking medications as prescribed. He has received his medications in the past from one doctor at a time only, though he sequentially saw a number of different doctors at the recommendation of each doctor. He reports no past history of substance abuse. This note is in direct contradiction of the reports of the psychiatric unit at Dartmouth-Hitchcock, which documented doctor shopping and abuse of prescription medications as recently as six months prior to this consultation. Based on Dr. Savage s consultation with the claimant, the doctor planned a course of opioids on an intermittent basis.

27. Dr. Savage next saw the claimant on December 3, 1993, when he reported some relief from the reintroduction of percocet, but recited new symptoms. Based on those symptoms, the doctor again suggested the use of stronger opioids, but deferred a decision until the receipt of nerve conduction studies on the claimant s median nerve.

28. Dr. Lawrence R. Jenkyn performed a nerve conduction study of the claimant s right median nerve on December 15, 1993, with

the conclusion that the findings were consistent with entrapment of right median nerve in the carpal tunnel, or carpal tunnel syndrome.

29. Although Dr. Savage reported in her deposition that she saw the claimant on January 28, 1994 and various dates thereafter, there are no further records admitted into evidence of Dr. Savage s visits with the claimant, other than letters to the claimant s attorney or physical therapy referrals, until the doctor s permanency examination in May of 1995. It appears that the claimant s treatment and drug therapy was thereafter monitored by Dr. Richard Plotkin, a psychiatrist who began to treat the claimant at the White Mountain Mental Health & Developmental Services, where he had been treated before, on August 18, 1993. Dr. Plotkin noted in his intake summary the claimant s history of significant medication abuse problems in the past. He also found the claimant to be suffering from a major depression. His assessment was that [a]s in the past, the patient seems to be experiencing depressive symptomology in response to a lack of employment and resultant lowering of his self-esteem and feeling a lack of control over his life. In the past he has responded well to support and development of insight into his defenses. The only note of significant past medical history is of the migraine headaches. No reference is made to the injury at Copeland.

30. The claimant takes daily doses of a long acting opioid referred to as MS Contin. He had called Dr. Savage s office on May 27, 1994, requesting an increase in his dosage of morphine as the pain in his arm was damn near intolerable and her records seem to reflect that his dosage was later increased. The claimant continued to take the medication through the date of the hearing, although he indicated at the hearing that it did not affect his ability to testify.

31. The claimant was seen by John M. Peterson, D.O., Kuhrt Wieneke, M.D., and Sheldon Weiner, M.D., at the request of Aetna Insurance Company, the insurer for Copeland. Dr. Peterson noted that the claimant was a poor historian and needed to be cued to answer many of the questions asked. The claimant did not report to Dr. Peterson his apparent complete recovery after the interosseous nerve decompression, and was vague about the treatment he was receiving. Dr. Peterson adopted Dr. Savage s opinion of the work-relatedness of the carpal tunnel syndrome and the reflex sympathetic dystrophy, both of which were confirmed by Dr. Peterson. It was his opinion that the reflex

sympathetic dystrophy was the dominant problem.

32. Dr. Savage testified at the hearing with regard to her diagnosis and treatment of the claimant, as well as the permanency evaluation that she performed. She was only available to testify for a very limited period of time, and it is not clear whether that limitation resulted in a decreased questioning of the doctor by the various attorneys. The doctor had previously been deposed and her deposition was admitted into evidence as part of the medical records notebook, Joint Exhibit 1.

33. Dr. Savage testified that the claimant suffered from two different kinds of neuropathic pain, the medial nerve entrapment and reflex sympathetic pain. She opined that the original injury resulted in irritation of the median nerve at two levels, the elbow and the wrist, and that the elbow injury was initially more severe. However, over time, the damage to the wrist became symptomatic and resulted in the current diagnosis of carpal tunnel syndrome. She admitted that she was not a neurologist, and would defer to such a specialist in describing the actual mechanics of the injury. She assumed that there was scarring that developed over the intervening years, and that led to the current problem. She could not say whether surgery would be effective to relieve the current symptoms because of the lengthy period between the original trauma, the onset of symptoms and the present.

34. The doctor based her opinion on the relationship between the trauma at Copeland and the current diagnosis on the nature of the trauma and the lack of any reported intervening injury, as well as the similarity of his current complaints to his original complaints. She indicated that the original injury would cause a weakness that would develop over time into the current problem. She conceded that other work that he did might have contributed to his current condition, but that the original cause was the work related injury of April 1989. She was not aware of any particular events that led up to the claimant s report of the onset of pain in the spring of 1993, and was not aware of any particular activity that occurred prior to that period of time. While she remained firm in her testimony that the original injury was sufficient or likely to cause his current condition, she could not state that other activities did not accelerate or exacerbate his original injury. The doctor,

in her deposition, testified that she would defer to orthopedists and neurologists on the actual mechanics of the injury.

35. Dr. Savage testified both at the hearing and at her deposition that there was a possibility that an individual with a substance abuse problem would misrepresent pain or other problems in an effort to obtain medication. However, even if that were the case in the past with the claimant, it was her belief that the objective signs of his current condition were sufficient to cause the level of pain that he was reporting to her, and that she did not question that he was actually in pain at this time. This testimony is credible, as there is ample evidence that the claimant is now suffering from carpal tunnel syndrome.

36. Dr. Savage performed a permanency evaluation on the claimant on May 15, 1995. She stated that [p]ermanency evaluation based on today s physical examination as well as longitudinal observation and knowledge of Mr. Lippard and his pain syndrome was performed today and is calculated on an attached sheet. Total permanency based on pain and dysfunction in the right upper extremity is 53 percent of the right upper extremity which translated to 32 percent of the whole person. This is based on limited functional range of motion at the level of the shoulder and wrist and on sensory changes consistent with median nerve entrapment and associated causalgia, and a small contribution from previous observed muscular fasciculations likely related to the sympathetically maintained component of his pain. Any psychological changes related to his pain and disability have not been calculated in. Her calculation was based on a 14% loss of range of motion in the shoulder, a 10% loss of range of motion in the wrist and a 40% sensory and motor loss in the median nerve. It is not clear if she included any amount for the prior surgeries on the shoulder and the elbow.

37. At her deposition, the doctor was cross-examined extensively about the bases for her calculations. She indicated that she relied more on the sensory deprivations than the range of motion because of the difficulty in performing range of motion evaluations in a person with a serious pain problem. She could not, under questioning, replicate the calculations by which she reached her permanency evaluation. She could, on the other hand, hypothesize a number of ways to support the number

she reached.

38. Dr. Savage s background is as an anesthesiologist, with a specialty in pain and symptom management. She also has an interest in problems with addictions and the use of opioids in the treatment of pain. She has substantial teaching and research experience in these fields and has published a number of articles in these and related fields.

39. The claimant also presented the deposition of Dr. Richard Plotkin as part of Joint Exhibit 1. Dr. Plotkin, as noted above, has treated the claimant for his psychological problems in a number of settings. He first saw the claimant during the inpatient period at Dartmouth-Hitchcock in the spring of 1993 when the problems with the migraine headaches and substance abuse had reached a crisis of sorts. Thereafter, he treated the claimant in the practice at the White Mountain Mental Health and Developmental Services, and finally he was his physician when he returned to the outpatient practice of the Department of Psychiatry at Dartmouth-Hitchcock Medical Center. In all, the contact between the two spanned a period slightly longer than two years. During all of this period, Dr. Plotkin was in his four year residency in psychiatry, which was completed in June of 1995, around the time that Dr. Plotkin finished his treatment of the claimant.

40. The earliest records that Dr. Plotkin reviewed of the claimant s psychiatric course were the ones from 1987 at White Mountain. He also obtained some of the claimant s past history from the claimant. He found that there was a strong biological component to the claimant s depression, in that there was family history of depressive illness and the claimant s recurrent bouts with the disease suggested a genetic component. He also noted that the claimant s history of migraine headaches and the concomitant use of strong, addicting medications probably also had a biological component. Additionally, he testified that the claimant had had two traumatic conditions in his childhood, an emotionally abusive mother and a seriously traumatic burning incident, that contributed to his underlying psychological difficulties. Finally, he had a schizotypal personality disorder, which was said to be a complex condition involving eccentricity, grandiosity, fantasy and magical thinking as a defensive mechanism.

41. Dr. Plotkin indicated that when the claimant was admitted to the hospital in the spring of 1993, his pain and his addiction problem were so severe that he could not function or care for himself in the outside world. When the doctor last saw the claimant in June of 1995, he was functioning fairly well, given the underlying biological and historical psychiatric illnesses from which he was suffering.

42. Dr. Plotkin opined that the one strong correlation in all of the periods of the claimant s greatest periods of disability was his unemployment. He concluded that the greatest stressor in the claimant s life was his inability, at any given time, to work. Dr. Plotkin was not, apparently, aware of the fact that the claimant had had approximately 17 jobs in about 20 years, a fact that the claimant reported to one of his vocational rehabilitation counselors. In any event, since at the time Dr. Plotkin treated the claimant, from 1993 to 1995, the claimant was claiming that his unemployment was due to his allegedly work related injury, the doctor opined that there was a correlation between the injury and the extent of the claimant s disability in a psychological sense. In effect, he found that work was very therapeutic for the claimant, and the inability to work caused a substantial decompensation of the claimant s coping mechanisms. He indicated that it was his current understanding that the claimant is now productively if not gainfully employed in a home lapidary business, where he finishes semi-precious stones and sets them up in interesting ways. He is, as a result, substantially improved, more so than the doctor would have expected, and has reached an equilibrium. He anticipates the necessity for supportive psychological maintenance and medicine review, but no current need for therapeutic involvement.

43. Based on his reviews of the second and third editions of the AMA Guides to the Evaluation of Permanent Impairment, Dr. Plotkin assessed the claimant s psychological impairment as 25%. Of that, he estimated that half of the impairment was attributable to the prior underlying conditions, specifically the schizotypal personality, depression and substance abuse, and half was attributable to the depression and decompensation attributable to the unemployment and chronic pain caused by the work injury. He found that the claimant was suffering additional impairment and stress over and above his preexisting condition which would not have been present absent the work injury.

44. Dr. Kuhrt Wieneke testified by deposition in this case. Dr. Wieneke examined the claimant on March 22, 1995, at the request of Aetna. He found that the claimant was uncooperative in the physical examination, and exhibited signs of symptom magnification. Dr. Wieneke opined that the claimant did not engage in symptom magnification until some time far removed from the injury. He specifically referenced the reports of Nancy Cousino, a physical therapist, and Dr. Murphy, who both indicated within the year following the interosseous nerve decompression that the claimant was symptom free, with the exception of some weakness in his index finger, and was in fact pleased with the course of his recovery. Dr. Wieneke also found it significant that the claimant was working during this period of time at medium duty jobs, as they would be likely to cause problems, if he were to have them. Dr. Wieneke also found that the rupture of the long head of the bicep was not causally related to the 1989 injury.

45. In the physical examination, Dr. Wieneke managed to establish that the claimant had passive full and normal range of motion in his shoulders, elbows, wrists and hands. He also noted that the complaints of pain did not fit a dermatomal or peripheral nerve pattern. Nor were any of the classic tests for carpal tunnel syndrome present, notwithstanding the positive nerve conduction study performed by Dr. Jenkyn. None of the signs of a reflex sympathetic dystrophy, including abnormal sweat and hair patterns, was present.

46. Dr. Wieneke also reviewed Dr. Savage s report of her impairment rating, as well as those pages of her deposition in which Attorney Barbara Blackman, then appearing for Aetna, questioned Dr. Savage. He indicated that her failure to produce the objective findings which she had used regarding median nerve sensory and motor impairment was problematic. Further, her report of the ranges of motion in the claimant s right shoulder and wrist were markedly inconsistent with the ranges of motion he had found in those areas just two months earlier. He further contests her failure to include the surgery on the shoulder in her evaluation of the shoulder impairment, a flaw he considers fatal. Finally, he challenges her conclusions with regard to the sensory and motor losses in the median nerve. Her discussion of the global pain that the claimant claimed to suffer in his right arm was not applicable to the median nerve, since global pain in the arm would include many nerve trunks, not just the median nerve. Moreover, her analysis, with her inability to assign the deficits she found to motor or to

sensory deprivation, implied that she could not use Table 15 of the AMA Guides to the Evaluation of Permanent Impairment. Table 15 is the applicable table in this case that shows the maximum upper extremity impairments due to the combined sensory and motor deficits on the major peripheral nerves. For all of these reasons, Dr. Wieneke determined that Dr. Savage s permanency evaluation was not supportable under the terms of the AMA Guides.

47. Dr. Wieneke performed a permanency evaluation based on his findings of normal range of motion in the shoulder, elbow and wrist, and the inconsistent complaints of pain. He factored in the surgeries that the claimant underwent, and specifically excluded any permanency for the carpal tunnel syndrome. He found that the claimant had suffered a 5% permanent impairment for the shoulder surgery and a 7% permanent impairment of the right elbow because of the interosseous nerve decompression surgery. Dr. Wieneke found no permanency attributable to the ruptured long head of the biceps, in part because of the remoteness of the injury from the date of the work injury, and in part because there is no permanency attributable to the injury, which Dr. Wieneke characterized as being mainly cosmetic. As Dr. Wieneke testified, there are two heads to the biceps, and the short head is the more important one. A rupture of the long head might result in a painful condition of several weeks duration, with a bulging of the muscle, but that the bulge and pain will both resolve spontaneously with minimal if any loss of function.

48. Dr. Sheldon Weiner, a psychiatrist who is currently the director of the General Psychiatry Clinic at the University of Vermont, Department of Psychiatry, evaluated the claimant at the request of Aetna. He also reviewed, prior to his testimony at the hearing, the depositions of the claimant, taken October 18, 1995, and Dr. Plotkin. He interviewed the claimant for two hours on November 16, 1995, and had the claimant take three tests in his office. In the first test, a test for organic brain defect, the claimant scored a 30 out of a possible score of 30, indicating the absence of any organic brain defect. On the Beck Depression Inventory, where scores above 20 would equate with clinical depression, the claimant scored only a 4. On the Brief Psychiatric Rating Scale, a test designed to allow hospital personnel to make an assessment whether a psychiatric intervention is necessary, the claimant had a remarkably low score, with a mild-to-moderate score in only four out of 24 categories. Based on these tests and his discussions with the

claimant, Dr. Weiner determined that the claimant was not suffering from a clinical depression on November 16, 1995.

49. Based on his evaluation of the claimant, Dr. Weiner found nothing to preclude the claimant from holding a job for any psychiatric reason as of the date of the evaluation. He indicated that he would not, in any event, try to characterize any impairment based on a percentage. He stated that the AMA Guides do not currently authorize such a rating, and that the current edition of the Guides does not assign any impairment percentage for any psychiatric problem, but rather instructs the practitioner to evaluate the disability against the backdrop of work. Based on that instruction, Dr. Weiner found no impairment. However, he also testified that he has taken the position that psychiatry is too imprecise a science to allow for numerical classifications. Hence, he found Dr. Plotkin s rating to be imprecise and unreliable.

50. Dr. Weiner also testified to some of the comments made by the claimant during the evaluation. In particular, the claimant expressed the caution to never believe your own bullshit. He also told the doctor that his claims of suicide attempts had just been bullshit to get medication.

51. Dr. Weiner had briefly been in charge of a pain clinic at the University of Vermont, during which time he had had ample opportunity to watch the behaviors of people in chronic pain. He did not witness any pain behaviors in the claimant during the examination, and the only evidence of an injury was the splint that the claimant wore on his right wrist. He testified that he had no opinion about the physical injury, although he noted that people who suffered from chronic pain tended to be fidgety, which the claimant was not. Also, after years of chronic pain, there is usually some psychological effect, and he did not observe any such effect in the claimant.

52. The claimant clearly suffered a compensable injury in 1989 when he was working for Copeland. Had the case been properly adjusted thereafter, it is likely that this hearing would not have been necessary. Specifically, I find that the claimant was at an end medical result from the original injury as of May 1, 1990, when his treating doctor found that he was nearly 100% recovered, and he was released to work with no restrictions. At that time, the claimant was gainfully employed at Montgomery Wire, where he remained for another year. I find that the claimant reported his substantially improved condition to a

number of caregivers, who confirmed that he had reached a level of maximum medical improvement. His permanency at that time, given the apparent lack of residual problems, was consistent with those percentages assessed by Dr. Wieneke, and he was entitled to permanency benefits at that time in the amount of 12% of the upper extremity, or an award of 25.8 weeks.

53. The case thereafter becomes problematical, as the claimant alleges continuing pain and difficulties with his right upper extremity that finally led to his termination of employment from Vermont Tap and Die. His testimony is not supported by any independent evidence in this regard. In fact, during the period between his lay-off from Jenne Brothers until his employment by Tap and Die, the claimant collected unemployment benefits, as he did again after he left Tap and Die, which suggests that he believed he was willing and able to work. In fact, the claimant sought no medical attention for his right arm after the bicep problem in 1991 until the spring of 1993 after a substantial psychiatric admission to a hospital. In spite of numerous contacts with mental health providers and with the same neurologist who had performed some of the nerve conduction studies with regard to the elbow surgery, there is no evidence that the claimant ever complained of pain in his arm for a period of two years.

54. In the meantime, the claimant was receiving attention for his migraine headaches and psychiatric problems during the period from 1990 through 1993. Specifically, he related his problems with migraines to his lack of employment. This was a continuing trend that had commenced years before his work injury, and cannot be said to be related to his work injury. It is compelling that at no time during this period did he address pain in his arm with this therapists, and in fact regularly reported that he was a professional Celtic harper and a sculptor, activities that he now denies that he could engage in because of his difficulties with his arm. I find that the claimant never became unemployed because he was unable to work due to his arm injury. Therefore, none of the migraines can be attributed to his work injury and the concomitant abuse of medications is also without causal connection to the work injury. Where the claimant had throughout his history a spotty employment record, with periods of unemployment that triggered both psychological and headache problems, there is no basis for determining that his problems in 1993 were not continuations of the same history, rather than a product of the injury in 1989.

55. The claimant s treatment at the Mary Hitchcock Memorial Hospital in March of 1993 was necessitated by his intractable migraine headaches and his abuse of medications. He was at that time suffering from a severe psychological disturbance. While in the hospital, he was seen about his arm by Dr. Murphy who made minimal findings of deficits as seen in Finding #22. The claimant had good range of motion throughout his right upper extremity, with minor weakness and dullness over the median nerve. The claimant had been actively involved in sculpting and harping for the two years prior to this appointment, and it is clear that Dr. Murphy was not apprised of this activity or of the claimant s work history in the intervening period.

56. On or about December 16 ,1994, a contract hearing officer in this matter, not the officer who heard the case, issued an Interim Order to Copeland and Aetna to pay temporary total disability benefits to the claimant from July 1992, and ongoing during the pendency of this hearing.

57. The claimant has produced evidence of his attorney s costs in representing him in the amount of $3,798.06. He has also presented evidence that his attorney spent alternatively 180.7 hours or 216.8 hours in preparation of his case.

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. 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). 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).

3. I find that the claimant has not established that his current disability and injury is compensable under the statute.

I am troubled by the claimant s attempt to prove causation of what is effectively a neurological or orthopedic injury with an anesthesiologist whose expertise is in the treatment of pain and the therapeutic use of opioids. The issue in this case is not whether the claimant is suffering from pain at the current time but whether there is a sufficient causal nexus between the compensable injury of 1989 and the carpal tunnel syndrome that arose in 1993.

4. The claimant must establish both that the injury complained of arose out of his employment and that it occurred in the course of his employment, Miller v. International Business Machines Corp., 161 Vt. 21 (1993). I find that the claimant was not suffering from carpal tunnel syndrome at any time that he was working for any of the employers represented in this hearing, and that he developed the carpal tunnel syndrome at some later time. Since the claimant has been less than forthcoming and truthful about his activities in that later period, and since none of the treating physicians who did not testify seem to have been aware of the extent of his activities either in his last three jobs or after his last job, I cannot find that any opinion expressed by any of those physicians is sufficiently factually supported to be accepted.

5. Dr. Savage did not consider the activities of the claimant after the original injury because it was her opinion that the initial cause of the injury was the trauma of 1989. She misapprehended the standard applied by the Department in these cases. In all cases involving either an aggravation/recurrence claim or an intervening cause claim, the question is not whether the original injury was involved in the later claim, but whether there is an intervening cause of sufficient magnitude to break the chain of compensability. When Dr. Savage testified that there may or may not have been additional contributing factors, and that there was a good possibility that intervening work was contributory, she has begged the question. However, she did not examine those issues, assuming that her particular expertise would have allowed her to do so, because of her belief that the initial cause was the work injury at Copeland.

6. Dr. Wieneke, whose expertise is orthopedics, and who was not given any information about the claimant s activities after his employment at Vermont Tap and Die, still found that the combination of the additional medium duty work and the period of time between the near 100% recovery and the onset of new symptoms was sufficient to break the link of causation. This

opinion conforms with the Department s prior decision in Jaquish v. Bechtel Construction Company, Opinion No. 30-92WC, where the factors to be considered were enumerated: (1) the length of time the claimant s condition was stable, (2) whether the claimant actively treated prior to the second injury, and (3) the extent of the treatment and its proximity in time to the second injury. Where the claimant was found to be nearly 100% recovered after the elbow surgery as of May of 1990, with normal nerve conduction studies in his wrist in 1989, and did not treat for any injury to the median nerve again until April of 1993, and worked for some of that period of time in machine shops, I cannot find that the connection between the 1989 injury and the carpal tunnel syndrome has been established.

7. This is not a case where the issue is that of intervening cause or an activity of daily living. See, e.g., Verchereau v. Meals on Wheels, Opinion No. 20-88WC, or Correll v. Burlington Office Equipment, Opinion No. 64-94WC. I find that the claimant was actively engaged in self employment during the period after he left Vermont Tap and Die. Specifically, I find that he was a sculptor with a variety of exhibitions and shows, he was a Celtic harpist with a number of performances, and that he was exploring the possibility of working in machine shops in the area to design new equipment. He had a business card, which is certainly some evidence of self employment. The employment which he pursued involved repetitive use of his hands, as he conceded at the hearing. Carpal tunnel syndrome is frequently caused by repetitive use. The failure of the parties to address this issue with Dr. Wieneke is particularly troublesome where the evidence of the professional harping and sculpting is apparent throughout the psychiatric record, a record not shared with Dr. Wieneke. Self employment, particularly one involving repetitive use of the hands, may easily be an aggravating factor if not a primary cause of the syndrome. The fact of employment takes the issue out of the intervening cause class of cases and places it squarely in the aggravation/recurrence class of cases.

8. I find that the claimant s self employment was of a sufficiently potentially aggravating nature as to break the link of causation with the 1989 injury and any of the intervening employments.

9. The claimant has raised the issue that questioning of his witness Dr. Savage by the hearing officer was inappropriate in this case. He alleges that the hearing officer misstated facts

and stated that the claimant had lied to Dr. Weiner and another doctor. He alleges that the purpose of the examination was to get an expert witness to change her opinion. The claimant produced a transcript that purports to be a transcript of the exchange. Without addressing the accuracy of the transcript or the parenthetical comments contained in it, it must be said that the transcript does not support the claimant s position. First, it is clear that the hearing officer never asserted that the claimant had lied to Dr. Weiner. The assertion that the claimant lied to Dr. Weiner came from the witness. Secondly, the hearing officer did not assert that the claimant lied to another doctor. She asked, Dr. Savage, are you aware that Mr. Lippard told a psychiatrist that he reported pain and migraine headaches and suicidal ideation with the express purpose of obtaining medication? In fact, Dr. Weiner s testimony was that the claimant had dismissed the alleged suicide attempts as efforts to obtain medications. This was not a significant misstatement of the evidence.

10. The further questions by the hearing officer were intended to elicit the basis for Dr. Savage s opinions with regard to the claimant s symptoms, and her opinion on the possibility of intervening events having accelerated or aggravated the claimant s condition. This is an appropriate field of inquiry in this case, and one that should have been explored by the parties. As it was not, and the time for Dr. Savage s testimony was limited, the hearing officer s questions were pertinent and relevant. The hearing officer in a workers compensation hearing is the designee of the Commissioner, whose obligation is to ascertain the substantial rights of the parties. 21 V.S.A. §604. In a formal hearing, when the parties do not address the issues pertinent to the claim at hand, and that failing can be easily remedied by a few questions from the hearing officer, the hearing officer is obligated to ask then. The purpose of the formal hearing is to determine the rights of the parties by a speedy and inexpensive procedure. Rule 7 of Workers Compensation and Occupational Disease Rules. The alternative to the hearing officer asking questions is a remand by the Commissioner for the parties to address the issue, a time consuming and costly procedure. The hearing officer s questions in this case effectuated the purpose of the statute and the rule, and allowed the Commissioner to reach a decision based on adequate evidence, evidence that the parties had not produced on their own.

11. The claimant makes two other complaints about the hearing

officer which can be quickly addressed. The claimant asserts that there is no evidence that he was involved in luthiery or harping or other repetitve behavior during the period in question. He is referred to the medical, psychological and rehabilitation records enumerated in the findings of fact. The claimant produced the notebook in which those records were found, and cannot be heard to complain now about its contents. Secondly, the claimant alleges that his attorney made two objections during the hearing officer s questioning of Dr. Savage, which were not addressed. The claimant s own transcript suggests that neither objection was clearly made. The burden is on an objecting party to make an objection clearly and to bring it to the attention of the hearing officer in a timely manner. See, e.g., L Ecuyer v. L Ecuyer et al., 124 Vt. 462 (1965). The transcript indicates that Mr. Adler stated Uh, I m going to object. Thereafter, there is the parenthetical note Can hear very faintly to object but it was not clear because Dr. Savage started speaking. In fact, the objection was not audible, as a rehearing of the audiotape confirms. The second alleged objection is the single word I , apparently said by Mr. Adler. Mr. Adler is reportedly an experienced and accomplished trial attorney. If he has an objection to make, he knows how to do so in a way that will preserve his rights. This he has failed to do here, and his complaint now will not be heard.

12. The claimant was at an end medical result for his 1989 injury as of May 1, 1990. At that time, he was entitled to permanency from T. Copeland and Sons and Aetna Insurance in the amount of 12% of the right upper extremity, as assessed by Dr. Wieneke, or 25.8 weeks. This was never paid, and hence the claimant is now entitled to it. Because of the delay in paying it, the employer will be charged interest for the nearly six years of delay, at the rate of 12% a year simple interest. On the other hand, the claimant has received temporary total disability compensation based on the Interim Order for a period in excess of three years. The claimant has therefore been overpaid some undetermined amount, as of the date of this decision. The insurer is to calculate the amount overpaid. In the event that the claimant is ever entitled to further benefits as a result of his injury, the insurer is to be credited the amount of the overpayment before paying any additional benefits.

13. The defendant Montgomery Wire is a New Hampshire company, and at all times that the claimant worked for it, he worked in New Hampshire. This Department has no jurisdiction over the claim against Montgomery Wire, although Montgomery Wire is,

based on this decision, entitled to a favorable ruling on the merits, were jursidiction present.

14. Because the claimant has not prevailed on his claims, he is not entitled to an award of costs or attorney s fees.

ORDER

THEREFORE, based on the foregoing findings of fact and conclusions of law, it is hereby ORDERED that:

1. Aenta Insurance Company, or in the event of its default T. Copeland and Sons, calculate the amount overpaid the claimant in accordance with the terms of this opinion, and notify the Department and the claimant of the amount; and

2. All other claims by Ronald D. Lippard by and hereby are DENIED.

DATED at Montpelier, Vermont, this 5th day of February 1996.

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Mary S. Hooper
Commissioner