E. D. v. Colchester School District (March 13, 2008)

STATE OF VERMONT
DEPARTMENT OF LABOR

E. D. Opinion No. 09-08WC

By: George K. Belcher
Hearing Officer

v.

Colchester School District For: Patricia Moulton Powden
Commissioner

State File No. M-21476

Hearing held on September 13 and 14, 2007, and October 12 and 19, 2007 in Montpelier, Vermont
Record Closed, January 19, 2008

APPEARANCES:

Christopher McVeigh, Esq., for the Claimant
Joshua Simonds, Esq., for the Defendant

EXHIBITS:

Joint Medical Exhibit: Medical Records of the Claimant

Claimant's Exhibit 1: Form 1, First Report of Injury
Claimant's Exhibit 2: Calendar of January 1999
Claimant's Exhibit 3: Record of bomb threats from school/dates of school closure

Record of insurance payments for the Claimant's medical care
Deposition of Dr. John Johansson of October 9, 2006
Deposition of Dr. Nancy Binter of October 3, 2006
Deposition of Dr. James Cummings of October 9, 2006
Legal bill of Claimant's counsel

ISSUES:

1. Whether the Claimant suffered a slip and fall injury on January 22, 1999 or on January 26, 1999, while the Claimant was at work?

2. What, if any, injuries the Claimant had as a result of the alleged work-related injury?

3. To which, if any, Workers' Compensation benefits is the Claimant entitled as a result of the alleged work-related injury?

FINDINGS OF FACT:

1. The Claimant was born on March 13, 1944. She holds an Associate's degree in Medical Terminology and Medical Records. She has worked in a medical doctor's office for about ten years from 1964 to 1974. She holds a BA degree in the field of education from Potsdam State University, a Master's in Education Administration degree from St. Lawrence University, and an Educational Doctorate degree from Columbia University in Organizational Leadership. The Claimant was a contract employee of the Colchester School District from January 4, 1999 until June 20, 1999. Her position was interim Superintendent. The Claimant was an employee as defined in the act and the Defendant was an employer as defined in the act.

2. In October of 1997 (well before the work-place fall) the Claimant reported having a ten-year history of neck pain. Joint Medical Exhibit, Page 22. She likewise had a twelve-year history of migraine headaches. Joint Medical Exhibit, Pages 10-11. She began treatment with Dr. Gordon Ahlers in or around the summer of 1997. She had significant and continuous neck pain during her treatment with Dr. Ahlers. Dr. Ahlers also treated her for a back condition, migraine headaches, menopause symptoms, sleeping problems and depression.

3. On December 17, 1998 the Claimant was bending to attend to her shoe and she felt pain in her left hip. (Testimony of Claimant.) On December 23, 1998 she had a recurrence of the pain. She reported to Dr. Ahlers that she had pain radiating down her leg, with no trauma except she lifted a large suitcase. Joint Medical Exhibit, Page 45. During her next examination with Dr. Ahlers on December 29, 1998, she had a positive straight leg-raising test on her left leg. She appeared to be in more pain from her back and leg during this visit than she had been in previously. On December 29, 1998 (less than a month before the fall) she had a CAT scan as ordered by Dr. Ahlers. The CAT scan was done because of "Severe LBP" (understood to be severe low back pain). Joint Medical Exhibit Page 47. The CAT scan showed a small "right-sided disc herniation which is of uncertain clinical significance". Medical Record, Page 47. Because the small bulge was on the right side it was not thought to be causing her left sided leg pain. On January 4, 1999 she began her work at the Colchester School District.

4. The Claimant's job was a stressful job, in part because the school district was the target of numerous bomb threats during the period of the winter of 1999.

5. The Claimant described her injury as follows. On January 22, 1999 she was entering the Colchester High School in response to a bomb threat. The entrance to the school was icy due to an ice storm. The Claimant slipped and fell. It was a serious fall in which the Claimant went up in the air. The Claimant tore her suit when she "slammed on the ice". For a moment she thought she might have broken her ankle or her pelvis. She felt immediate numbness but no immediate pain. According to the Claimant, a witness, Ray Bezio, helped her off of the ground. She entered the school and continued her duties associated with the bomb threat.

6. According to the Claimant, on the day of the fall she knew that she seriously injured herself. She felt pain towards the end of the day. She telephoned Dr. Ahler's office and reported that she had a serious fall. The receptionist told her that Dr. Ahler was not in the office, but she should go to a hospital emergency room. Despite this direction, she did not go to the emergency room. The Claimant did not explain why she did not go. Instead, according to her testimony, she was called by Dr. Johansson's office and told that he had ordered a prescription for a "Med Dose Pack" and valium. Medical Exhibit, Page 49. The prescription made the Claimant "very surprised" since she had never met Dr. Johansson and she did not know who requested this prescription. Despite her surprise, she arranged for her partner to pick up the medication that day.

7. According to the Claimant, her back and left leg became a "severe medical problem for me". She could do very little work. On February 3, 1999 she told the school board that she was "very sick" and was not sure that she would be able to continue with her job.

8. The Claimant continued to work at her job as Superintendent throughout the rest of her contract term (into June of 1999). She testified that she was in pain much of this time and often had to work from home or with pain medication. It does not appear that she missed work due to her condition. According to the Claimant she left her job as Superintendent because the injury prevented her from doing the job.

9. Joan Wood was the business manager of the Colchester School District in the winter and spring of 1999. Ms. Wood delivered to the Claimant a First Report of Injury form shortly after the alleged fall. She asked the Claimant several times to fill out a first report of injury associated with the alleged fall. Despite the Claimant's testimony that the Claimant knew on the day of the fall that she had "seriously injured herself", she did not complete a Form 1 (Employees Claim and Employer's First Report of Injury) until April 16, 1999 (almost three months after the fall). The injury as described by the Claimant in the First Report of Injury is "Reinjury to herniated disks and ruptured disk." Claimant's Exhibit 1[1]. There was no evidence presented to show that the Claimant had ever been diagnosed with a "ruptured disk." Ms. Derocher stated on the same form that the date of the injury was January 26, 1999.

10. The Claimant seeks temporary and permanent disability benefits as well as medical benefits. The Defendant denies that there is any compensable injury or work-related impairment. The Claimant has a complex medical history before and after the date of the injury. The Claimant also has a complex history of physical activity before and after the injury.

[1] The injury section of the Form One, Employer's First Report of Injury, was completed by Ms. Durocher in black ink. (Testimony of Ms. Wood).

11. On January 7, 1999, January 25, 1999 and February18, 1999 the Claimant had epidural injections by Dr. James Cummings. Dr. Cummings was doing these injections as an attempt to alleviate the pain of the Claimant associated with her back. The first injection occurred before the date of the fall. Dr. Ahlers had referred the Claimant to Dr. Cummings because of the back condition as he understood it (with no reference to the fall). Dr. Cummings' medical records do not reflect that the Claimant reported a recent traumatic fall despite the fact that he gave her a treatment for low back pain just three days after the alleged fall. Medical Record Exhibit, Page 50.[2]

12. Dr. Ahler referred the Claimant for a surgical consult with Dr. Nancy Binter, which occurred on February 9, 1999. Dr. Binter made no mention of an alleged fall in her consultation note. What she did state was, "She is not a surgical candidate given the fact that she has a minimal bulge, which is actually on the opposite side to that of her symptoms and *with no correlating physical findings*." Joint Medical Exhibit, Page 53. (emphasis added). Dr. Binter was quite clear in her testimony that the Claimant did not tell her about the fall and that it would have been reflected in Dr. Binter's records if it had been reported. Likewise, Dr. Binter testified that she would have required additional testing if she had known about the fall. The Claimant contradicted Dr. Binter on this point quite strenuously. The Claimant testified that she told Dr. Binter about the injury and was "dragging her left leg and using a cane" when she saw Dr. Binter. As between Dr. Binter and the Claimant, I find Dr. Binter to be more credible.

13. According to Dr. Ahler, the Claimant never mentioned the fall to him either. His medical chart notes do not report anything about the fall and, it was his opinion that if he had been told of a traumatic fall associated with the Claimant's back, he would have recorded it in his notes. After the date of the fall, Dr. Ahler treated her twenty different dates between February 8, 1999 and April 30, 1999 and made notes of the visits without any mention of a slip and fall. According to Dr. Ahler, she never mentioned the fall to him during the entire time that he was her primary, treating physician, despite the fact that he was treating her for low back pain.

14. Shaun O'Connor is a physical therapist with Timberlane Physical Therapy. He treated the Claimant in physical therapy for nine sessions in August and September of 1997 (before the fall) and again from July 1998 to October 1998 (before the fall). The purpose of these two series of treatments was to treat cervical spine degenerative joint disease.

[2] Dr. Cummings in his deposition indicated that a report of a fall might not make it into his records and that he was a technician doing a procedure at the request of the treating physician. Nonetheless, it would seem that a traumatic fall without treatment, if reported, would at least be investigated.

15. Physical Therapist O'Connor saw her again on February 10, 1999 for her condition of low back pain and left leg pain. In the intake, the Claimant told Mr. O'Connor that the date of the onset of this problem was January 6, 1999 (16 days before the fall at school). Mr. O'Connor reported the Claimant was in "severe" low back pain. He noted, "Mechanism insidious onset. I woke up one day and had this pain." See Joint Medical Exhibit, Page 55. In Mr. O'Connor's closing report of July 22, 1999 he continued the diagnosis of "low back pain with lumbar disc disease/OA". Medical Exhibit, Page 97. No mention of traumatic injury or fall was reflected by Mr. O'Connor.

16. The first definitive report of the fall in the medical records was when the Claimant appeared at the Littleton Regional Hospital on May 15, 1999 seeking treatment for back pain. That record reported, "She states that she fell down in January, 1999 hitting her back and she was diagnosed with nonsurgical disc disease." The examining emergency room doctor questioned her symptoms and noted, "Clearly there are not the symptoms of a herniated disc and what the symptoms are is not at all clear but since the woman appears in distress we will give her the benefit of the doubt." Joint Medical Exhibit, Page 72. She again reported to an emergency room for treatment of her low back pain at the York Hospital in York, Maine, on May 29, 1999. She received pain medication. Joint Medical Exhibit, Pages 79-81.

17. On June 10, 1999 the Claimant was evaluated by orthopedic surgeon Dr. Stanley Grzyb. His notes state in part, "She can't remember any incident directly relating to the onset of her low back discomfort. She had indicated when I was obtaining her history that she had a fall on some ice at the school while investigating a bomb threat in the Winter of 1999. She thinks that her symptoms may have increased after that but she cannot really attribute the onset of her discomfort to that fall." Joint Medical Exhibit, Page 88.

18. She visited the emergency room at Fletcher Allen Health Care on September 27, 1999 complaining that the original injury was in January of 1999 and that she was out of her pain medication. She visited the Fletcher Allen Health care emergency room again on November 26, 1999 and reported that her January fall had damaged her vertebrae and her sciatic nerve. Medical Record Exhibit, Pages 119-124. She also reported that she had been doing quite a bit of lifting around the house associated with houseguests. She was given a prescription for Percocet from the Fletcher Allen Emergency room.

19. A similar emergency room visit occurred at the Copley Hospital Emergency room in December of 1999 in which the Claimant was seen due to sciatic pain aggravated by a cough while she was on a ski vacation. The chart notes state in part, "[She] has come to the emergency room for assistance; primarily because of the dry hacking cough that she is experiencing is aggravating a sciatic nerve injury which has been recovering since she injured it two months ago." Joint Medical Exhibit, Page 133. She was prescribed Phenergan with Codeine and discharged.[3]

[3] The medical records show a history of the Claimant going to emergency rooms for treatment for pain. The emergency room visits in 1999 often referred to the fall, but they were inconsistent as to whether the fall was the origin of the problem or not. The visits were at four different hospitals. It is peculiar that the falls were reported to emergency room doctors but not to the treating physician or the consulting specialists who were treating her back pain. (Dr. Ahler, Dr. Binter, Shaun O'Connor).

20. In August of 2001 she was evaluated by Carol Blattspeiler, Orthopedic Nurse Practitioner. By this time, Dr. Ahler was no longer her treating physician and she was under the care of Dr. Frank Landry. Carol Blattspeiler found that the Claimant had a "multitude of problems" including right shoulder pain, neck pain, a periformis problem, hip problems. The Claimant reported to Carol Blattspeiler "a recent episode in October of 2000 when she fell during a bomb threat at the Colchester schools." She reported that she was taking Loricet, Soma, Atenolol, Zyrtec, Prozac, and hormone replacement therapy. Nurse Blattspeiler expressed the concern, "She is on at least two Loricets a day and has been taking this for almost a year. This is quite worrisome to me additionally." Joint Medical Exhibit, Page 170.

21. In January of 2002 the Claimant started a program of walking. In March of 2002 the Claimant decided that she would travel to Spain to hike the El Camino de Santiago Trail. In preparation for this event, she was walking six days per week, about 20 miles per day in the City of Burlington. Testimony of Claimant and Toni Bouchard. In July of 2002 she reported slipping in her bathtub and having back pain and leg pain. Joint Medical Exhibit, Page 184.

22. Between August 19, 2002 and September 27, 2002 the Claimant went on an extended hiking trip in Spain as a "pilgrimage". (Testimony of Claimant.) During this period she was off all her pain medications and was hiking from 13 to 23 miles per day with a backpack. She did this for 37 days continuously, six days per week, for a total of about 500 miles.

23. When she returned from her trip to Spain in October 2002, she was pain free and off all medications. In December, 2002, the pain returned and was the same as it had been before her trip. (Testimony of Claimant.)

24. The Claimant appeared at the Emergency Room of Fletcher Allen Health Care on June 4, 2004 and wanted to enter a detoxification program. She reported to the emergency room staff that she had been abusing narcotics and sedative hypnotics for one and one-half years. She reported that she had abused Soma and narcotics as prescribed by her primary care physician (Dr. Landry) and then started ordering other drugs on the internet, taking Ativan, Soma, and Loricet. The Claimant completed a rehab program at Act 1 in the Burlington area. The Claimant discussed the medication problem with her psychologist, Dr. Robert Keith on June 15, 2004, June 25, 2004, and June 29, 2004. In those meetings she admitted some abuse of her prescribed drugs and reported that Dr. Landry wanted to limit her drug use. She terminated her relationship with Dr. Landry soon thereafter because of "a communication issue" and began treatment in August, 2004 with Dr. Patricia Whitney. (Medical Exhibit, Page 258).

25. By December of 2004 she was again receiving significant pain medication including morphine and valium. Her psychologist noted slurred speech during an appointment. (Joint Medical Exhibit, Page 287)

26. This same month she reported to Dr. Whitney that she had fallen in the bathroom and was having increased back pain. (Joint Medical Exhibit, Page 288A)

27. Dr. Bruce Tramner, Professor of Neurology at the University of Vermont and at the Fletcher Allen Health Center examined MRI films of the Claimant on July 6, 2004. He stated, "I see no evidence of nerve root impingement or spinal cord impingement." He recommended conservative treatment.

28. On January 28, 2005 the Claimant appeared at the Fletcher Allen Emergency room and was examined by Dr. Stephen Leffler who noted negative straight leg raising tests on both legs.

29. On March 3, 2005 the Claimant was examined by Dr. Jonathan Fenton, D.O. He concluded that she was not a good candidate for interventional procedures because, "She is extremely pain amplified with abnormal responses in terms of mood/affect appropriateness. As was discussed by Dr. Waddell, the presence of such signs makes the outcomes for spinal surgery (which includes anesthesia procedures) in doubt." (Joint Medical Exhibit, page 343.)

30. While the medical records vary greatly concerning the nexus between the fall and the Claimant's back pain, testimony from Joan Wood and Antonia (Toni) Bouchard was more consistent. Joan Wood is an accountant who worked with the Claimant at the Colchester School District at the time of the Claimant's fall. She was aware that the Claimant had neck and back problems before the fall but she noticed that the Claimant seemed to be in much greater pain after the fall. While Ms. Wood noted a change in the apparent pain and function of the Claimant after the fall, she did not know whether the increased pain was due to her neck problem or her back problem or some other problem. Ms. Wood also had limited opportunity to evaluate the Claimant's condition before the alleged fall. She worked with her for about one month before the fall during a period where the medical records indicate that the Claimant's back condition was worsening, even before the fall.

31. Ms. Wood is a personal friend of the Claimant and worked with her for several months at Applied Earth Technologies in Winooski, Vermont, after both women had left the Colchester School District. Likewise, she visited the Claimant in 2006 in Arizona (where the Claimant now lives).

32. Antonia Bouchard is the partner of the Claimant and they have lived together (except for a period in 2005-2006) since 1996. She testified that before the fall the Claimant had mostly neck pain with some back pain. After the fall she testified that the Claimant had much greater pain, less physical function and reduced activity. She also testified that the Claimant had concealed from her the drug abuse.

Medical Opinions

33. Dr. Patricia Whitney was the treating physician for the Claimant for about two years from August, 2004, to October, 2005. Dr. Whitney is a graduate of UVM Medical School and is Board Certified in Family Practice. She completed her residence in 2003. Dr. Whitney treated the Claimant for neck problems, migraine headaches, and other problems but the low back pain was prominent as a problem. Dr. Whitney testified that, in her opinion, the Claimant suffered a major exacerbation during the fall at school. She also opined that the Claimant had no work capacity during the period of treatment with Dr. Whitney because of the great pain that she suffered. Dr. Whitney had not spoken with Dr. Landry about the Claimant's medical or medication history. Dr. Whitney was also not aware of the Claimant's history of emergency room visits. Likewise, the Claimant did not disclose a history of substance abuse to Dr. Whitney when she first became her patient.

34. Dr. Jay Landry is a medical doctor who received his medical degree from Tufts University. He is Board certified in Internal Medicine. From 1997 to 2000 he worked as a Professor of Medicine at Uniform Services University and from 2000 to the present he has worked in a clinical practice. He was the treating physician for the Claimant from 2001 to 2004. He treated her for a variety of problems over this period including chronic neck pain, shoulder pain, migraine headaches, foot pain, depression, and low-back pain. Her neck pain was the prominent problem. Her low back pain was not the prominent problem and only arose as an issue for treatment when specific events (such as falling off a treadmill in September of 2003) brought her back pain to the forefront again.

35. Dr. Mark J. Bucksbaum is a medical doctor with specialties in pain management and independent medical examinations. He performed an evaluation of the Claimant on May 13, 2004. He diagnosed her as having "chronic mechanical low back pain" caused by a degenerative disruption of the spine. Dr. Bucksbaum attributed the Claimant's back problems to multiple factors including a spondylosis (slipage) defect, laxity of ligaments in the L4-5 region, and the fall. He believed the fall aggravated the Claimant's low back problems because of: (1) the history which she gave of greater pain following the incident and (2) his belief that the spondylosis appeared after the injury. (Testimony of Dr. Bucksbaum; see also Joint Medical Exhibit, page 238). Dr. Bucksbaum attributed an eight per cent whole person impairment to the claimant based upon the magnitude of the injury, the frequency of flare-ups and the overall impact upon her life. He felt that she was capable of light duty work. The Claimant reported to Dr. Bucksbaum that the date of the injury was January 26, 1999. Medical Exhibit, Page 228. On cross-examination, Dr. Bucksbaum was confronted with an MRI report performed on July 9, 1999 and reviewed by Dr. Stanley Grzyb which showed a small right bulge at L4-5 but no spondylosis in the lumbar region.

36. Dr. George White is a medical doctor who received his medical degree from the University of Vermont in 1982. He is Board Certified in Occupational Medicine. He is also certified by the American Board of Independent Medical Examiners to conduct independent medical examinations. His opinion was that it was not likely that the Claimant suffered an aggravation as a result of the fall. His opinion was that the Claimant was suffering from the "classic pattern" of waxing and waning of pain which often comes with degenerative disc disease and that the pain was simply cycling up and down depending upon her life events. He noted specific pain treatments being rendered after the Claimant doing some vacuuming (Nov. 15, 1999), lifting mixer (November 26, 1999), lifting and gardening (May 16, 2001), slide in tub (July 29, 2002), lifting heavy object (March 12, 2003), strain on treadmill (Sept. 9, 2003) and travel (Nov. 20, 2003). He reached this conclusion, in part, because of the long hike which the Claimant took in 2002 without pain or difficulty.[4]

37. Mary Louise Hymen is a Master's level Occupational Therapist. She performed a Functional Capacity evaluation on the Claimant on June 21, 2007. In her report, she reported that the "Onset Date" of the medical history was the Claimant's fall on January 22, 1999. It was the opinion of Ms. Hymen that the Claimant could not work full time, but that she might be able to work part time if she had frequent breaks. Ms. Hymen did not express an opinion as to causation.

38. Louise F. Lynch did a Functional Capacity Evaluation on January 31, 2005. The date of injury was reported to be January 26, 1999. Ms. Lynch determined that the Claimant had no work capacity on her bad days and that the Claimant's pain impacted her ability to work. She did express the view that the level of incapacity was inconsistent with the Claimant's walking 106 miles per week.

[4] Claimant has argued that Dr. White's opinion of May 23, 2005 that it was "possible" that the Claimant aggravated her back condition by the fall (Joint Medical Exhibit, Page 348), is inconsistent with his later opinion of October 2, 2006 that the Claimant's condition, to a medical degree of certainty, was not related to her fall. Joint Medical Exhibit, Page 360. The difference was adequately explained by Dr. White. His ultimate opinion was certainly not "backtracking" or "highly disturbing" as was found in *Brace v. Vergennes Auto, Inc*., Addison Superior Court Docket No. 279-12-06 AnCv dated September 28, 2007. The difference between his two reports was not significant and was explained by the additional information available to Dr. White and his reflection upon it.

CONCLUSIONS OF LAW:

39. In Worker's Compensation cases the claimant has the burden of establishing all facts essential to the rights asserted. *Goodwin v. Fairbanks*, 123 Vt. 161 (1963). The claimant must establish by sufficient *credible* evidence the character and extent of the injury and disability as well as the causal connection between the injury and the employment. *Egbert v. Book Press*, 144 Vt. 367 (1984). The Claimant's version of events was suspect by reason of her inconsistent reporting of the date of the injury (January 22, 1999; January 26, 1999; October, 2000), the lack of corroboration of her fall (Mr. Belisle was not presented as a witness nor were any corroborating minutes presented by the Colchester School District of her report to them of the problem), her late report of injury (report filed in April, 1999), and her failure to report her serious fall to her treating physicians in a timely manner. Sometimes these sorts of inconsistencies can be explained if there are simple explanations. The Claimant offered none. Her answers to simple questions were indirect and unresponsive. In her testimony she gave great detail about irrelevant matters but would fail to answer simple questions such as, "What did you mean by 'Very sick'?" She gave no plausible explanation why her recollection of facts was so inconsistent with the medical records. See *Miner v The Auto Exchange*, Opinion No. 8-96 WC (1996) concerning failure to report serious knee injury in a timely manner, coupled with other issues of credibility, and *Reed v Fay's Drugs*, Opinion No. 65-96 (1996) where medical tests were consistently uncorroborative of subjective complaints.

40. In considering late reports of injury, the Department has evaluated the credibility of witnesses by looking at four criteria. (1) Are there medical records contemporaneous with the claimed injury and/or a credible history of continuing complaints? (2) Does the Claimant lack knowledge of the Workers Compensation reporting process? (3) Is the work performed consistent with the Claimant's injury? (4) Is the persuasive medical evidence supporting causation? *See Seguin v. Ethan Allen*, Opinion No. 28S-02 WC (2002). In this case, the failure of the Claimant to promptly file a First Report of Injury only adds to the skepticism of any relationship between the alleged fall and the medical condition complained of. There is a stark absence of medical records contemporaneous with the fall. While there is a history of complaints, that history does not begin in the records until May of 1999. While she testified that she complained of the injury to the school board and the chair of the school board, no records of this were presented. The Claimant was the top employee in a school district with many subordinate employees. She must have been aware in her experience of the importance of filing a report of injury. Moreover, as reported by the Claimant, the injury was sudden, traumatic and life-altering. Under these circumstances one would think that the report would be promptly filed. Finally, there is no objective medical evidence of trauma as a result of the fall. The claim is completely subjective despite exhaustive testing of the Claimant over a five-year period.

41. 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 proven must be the more probable hypothesis. *Burton v. Holden and Martin Lumber Co.* 112 Vt. 17 (1941). Here, the lower back and leg pain of the Claimant could easily be related to a number of physical events (degenerative joint disease, slipping in a bathtub, lifting a mixer, falling on a treadmill). It is difficult to reach any reasonable conclusion that the alleged fall is more probably the cause of her ailments than any of these other events.

42. Where the causal connection between the accident and the injury is obscure and a layperson would have no well-grounded opinion as to causation, expert medical opinion is necessary. *Lapan v. Burno's Inc.*, 137 Vt. 393 (1979).

43. When choosing between conflicting medical opinions, the Department has looked at several factors: (1) whether the expert has a treating relationship with the claimant; (2) the professional education and experience of the expert; (3) the evaluation performed, including whether the expert had all the medical records in making the assessment; and (4) the objective basis underlying the opinion. *Yee v. IBM*, Op. No. 38-00 WC (2000).

44. Here Drs. Bucksbaum and White have similar experience, education, and history with the Claimant. It appears that both had all the medical records, although Dr. Bucksbaum failed to highlight or recount the July 9, 1999 lumbar MRI and the report of Dr. Grzyb of July 13, 1999 in his summary of records. Joint Medical Exhibit, Page 218. This is significant because Dr. Bucksbaum relied upon the spondylosis as a physical defect which appeared after the alleged fall in order to tie the fall to a physical injury of the spine. (Testimony of Dr. Bucksbaum) The July 9, 1999 MRI (after the fall) did not show this spinal defect, thus, removing this basis for Dr. Bucksbaum's opinion. Dr. White's opinion, on the other hand, is well supported by the various medical records and the up and down history of the Claimant's back problems. I find Dr. White's opinion to be more persuasive.

45. Dr. Bucksbaum's basis for his opinion was based in large measure upon the pain reports of the Claimant. Where the reports of a claimant are suspect and incredible, the medical opinions which are based upon them may lack the soundness to support an award. *Bowen v. E. F. Wall*, Opinion No. 17-04 WC (April 20, 2004).

46. Dr. Whitney treated the Claimant for about 14 months in 2004 and 2005. Dr. Whitney expressed the opinion that the Claimant's fall exacerbated her back problem. Dr. Whitney did not have the benefit of a full review of the medical records from Dr. Ahler, or Dr. Landry. She had not talked with Dr. Landry about this patient. She was not told in the first instance by the Claimant about her substance abuse. She was unaware of the history of emergency room visits for pain medication. The impression was given that Dr. Whitney did not have all the relevant information to make a conclusive and persuasive judgment concerning the relationship between the back problems of the Claimant and all the possible causes.

47. Because of the failure of the Claimant to prove by a preponderance of the evidence that the Claimant's fall was the cause of her back problems, her claim for workers' compensation benefits is denied.

ORDER:

Therefore, based upon the foregoing findings of fact and conclusions of law, the Commissioner determines that the Claimant's claim for workers' compensation benefits, including attorney fees and costs is DENIED.

Dated at Montpelier, this 13th day of March 2008.

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Patricia Moulton Powden
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. Sec. 670, 672.