Wendy Bush v. Kelly Services (March 25, 2011)

STATE OF VERMONT
DEPARTMENT OF LABOR

Wendy Bush

v.

Kelly Services

Opinion No. 07-11WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. U-10436

OPINION AND ORDER

Hearing held in Montpelier, Vermont on December 2, 2010
Record closed on January 21, 2011

APPEARANCES:

William Skiff, Esq., for Claimant
Robert Cain, Esq., for Defendant

ISSUE PRESENTED:

Were Claimant's March 2009 right ankle symptoms and subsequent surgical treatment causally related to her compensable January 2004 work injury?

EXHIBITS:

Claimant's Exhibit 1: Deposition of Mark Charlson, M.D., November 19, 2010
Claimant's Exhibit 2: *Curriculum vitae*, Mark Charlson, M.D.
Claimant's Exhibit 3: Dr. Charlson diagrams
Claimant's Exhibit 4: Retainer agreement
Claimant's Exhibit 5: Various medical records (Charlson Deposition Exhibit 2)

Defendant's Exhibit A: Video deposition of Kristen DeStigter, M.D., November 19, 2010 (with attached exhibits)
Defendant's Exhibit B: Deposition of George White, M.D., November 16, 2010 (with attached exhibits)
Defendant's Exhibit C: Dr. Hernandez, problem list and chart notes (4 pages)
Defendant's Exhibit D: *Curriculum vitae*, John Johansson, D.O.

CLAIM:

Workers' compensation benefits causally related to treatment of Claimant's right ankle condition since March 23, 2009

Costs and attorney fees pursuant to 21 V.S.A. §678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was her employer as those terms are defined in Vermont's Workers' Compensation Act.

2. Judicial notice is taken of all relevant forms contained in the Department's file relating to this claim.

Claimant's 2004 Ankle Injury

3. On January 13, 2004 Claimant was engaged in the course and scope of her employment for Defendant, on an assignment at the National Life Building in Montpelier. As she was exiting the building on that day via the vestibule steps, her foot slipped and landed hard on the floor, causing her to fall.

4. Later that day Claimant presented to the emergency room, complaining of severe pain and difficulty walking. The mechanism of injury was described in part as "hyper-dorsiflexion of [right] foot," meaning that her foot had been bent sharply up towards her shin. Diagnostic studies, both x-ray and CT scan, revealed fractures of the anterior process of the calcaneus (the front of the heel bone) and of the navicular (a bone on top of the mid-foot), both non-displaced.

5. Also evident on the January 13, 2004 x-ray was an osteochondral defect, in layman's terms a "bone chip," adjacent to the talar dome of Claimant's right foot. The talar dome is the top portion of the talus, the bone that connects the leg to the foot. By transferring the energy associated with bearing weight to the horizontal bones of the foot, the talus is the upright bone that allows us to walk.

6. A bone chip is a small piece of bone and cartilage that separates off from its mother bone. Once detached, it can either remain in its groove, like a golf divot, or it can become dislodged and move further into the joint space as a free fragment or loose body. It is not uncommon for a non-displaced bone chip to remain in its "divot" for years before it moves and becomes dislocated. This can occur spontaneously or as the result of even minor trauma, such as from stepping off a curb awkwardly. If the chip moves in such a way as to interfere with the weight-bearing surface of the joint, it can be quite painful, akin to walking with a rock in one's shoe.

7. The bone chip revealed by the January 13, 2004 x-ray was well corticated, meaning that its surfaces were very smooth. This is an indication that the chip was old, and thus had not been caused by Claimant's fall earlier in the day. That the x-ray did not reveal any joint effusion, or swelling, in the area is another indication that the chip preexisted the fall.

8. The most common cause of a bone chip in the talus is an ankle sprain, which typically involves a sudden twisting motion, either inward or outward. Although Claimant could

not recall any specific times in the past when she might have twisted or sprained her ankle, nor could she deny that she might have done so at some point in her life.

9. Because Claimant's calcaneus and navicular fractures were non-displaced, she did not have to undergo surgery. She was prescribed a walking boot and later underwent a course of physical therapy. By June 2004 Claimant had returned to work. Aside from some residual weakness in her foot and ankle, which has persisted to this day, she enjoyed a complete recovery from these fractures.

10. Defendant accepted the compensability of Claimant's calcaneus and navicular fractures and paid workers' compensation benefits accordingly.

11. From June 2004 until March 23, 2009 Claimant did not experience any sharp, stabbing pain in her right ankle of the type that would be caused by a dislodged bone chip. Having been diagnosed with rheumatoid arthritis some twenty years ago, Claimant does suffer from burning pain and stiffness in her joints, including her ankles. The tenor of this pain is qualitatively different and easily distinguishable, however.

12. In August 2008 Claimant was involved in a motor vehicle accident when she failed to negotiate a turn and drove her car off the road. Claimant likely used her right foot to apply the brakes as the accident was occurring. She suffered bruises on her legs and left foot as a result of hitting her side against the car, but did not require medical treatment. Claimant did not experience any right ankle pain as a result of this incident.

13. Between June 2004 and August 2008 Claimant worked at Sugarbush Resort as a credit manager. During the winter months, she had to park her car in an employee lot that was located down a hill, some distance away from the building in which she worked. Claimant never experienced any right ankle pain associated with her daily walks to and from her car.

Claimant's March 2009 Symptoms

14. On March 23, 2009 Claimant presented to the emergency room complaining of right ankle pain. The pain had begun a few days earlier, without any specific incident or trauma. Gradually it had worsened to the point where Claimant had difficulty standing on it.

15. X-rays revealed the same bone chip that had been present at the time of Claimant's 2004 injury, as well as some small joint swelling. Though still minimally displaced, the chip had moved slightly as compared with its previous position, enough to cause the symptoms Claimant now was experiencing.

16. Claimant treated with Dr. Charlson, an orthopedic surgeon. After conservative measures failed to alleviate her pain, in December 2009 Dr. Charlson surgically removed the bone chip. Thereafter, Claimant's symptoms quickly subsided. By April 2010 she was reporting only minimal discomfort. At the formal hearing, she reported that her ankle is no longer painful at all.

Expert Medical Opinions

17. Four expert witnesses testified as to the causal relationship, if any, between Claimant's January 2004 work injury and her symptoms in March 2009. Testifying on Claimant's behalf, Dr. Charlson concluded that such a relationship existed. Testifying for Defendant, Drs. DeStigter, White and Johansson concluded otherwise.

18. There was significant variation among the experts in terms of their areas of specialization, most notably between Dr. Charlson and Dr. DeStigter. As noted above, Dr. Charlson was Claimant's treating orthopedic surgeon. He is board certified in orthopedics, with a sub-specialty in conditions involving the foot and ankle. Dr. Charlson has performed close to a thousand foot and ankle surgeries over the past five years. In addition, he has prepared and presented lectures on the etiology and treatment of osteochondral lesions of the talus, the specific injury at issue here.

19. Dr. DeStigter is the radiologist who initially interpreted Claimant's 2004 x-ray. She is board certified, and serves as the Vice-Chair of the Radiology Department at Fletcher Allen Health Care. Dr. DeStigter has impressive credentials in the area of diagnostic radiology.

20. Dr. White evaluated Claimant at Defendant's request in November 2009. Dr. White is board certified in occupational medicine. Independent medical examinations and medical records reviews comprise a significant part of his practice.

21. Dr. Johansson evaluated Claimant at Defendant's request in October 2004. More recently, he has reviewed Claimant's medical records, as well as both hers and the other expert witnesses' depositions. Dr. Johansson is an osteopathic physician who is board certified in family practice. His clinical practice involves the evaluation and treatment of musculoskeletal injuries, with a strong sports medicine focus.

22. Before evaluating the differences among the experts' conclusions, it is instructive to review the areas in which they agreed. All four experts agreed, first of all, that the bone chip that Dr. Charlson surgically removed in 2009 pre-dated Claimant's 2004 injury and was not in any way caused by it. Upon comparing the x-rays, furthermore, all agreed that while the chip was occupying essentially the same "divot" in 2009 as it had been in 2004, it had become somewhat more displaced in the interim.

23. Where the experts diverged was as to the impact, if any, that Claimant's January 2004 calcaneus fracture had on the bone chip's displacement. In Dr. Charland's experience, it is not uncommon to see a non-displaced calcaneus fracture of the exact type that Claimant suffered together with a bone chip of the type she exhibited. This is because both injuries occur as the result of a similar mechanism – an inversion-type injury where the ankle is rolled inward. When that occurs, the talus shifts slightly outward, and with almost a suction effect the bone chip is displaced.

24. According to Dr. Charlson, to a reasonable degree of medical certainty, while Claimant's fall did not cause the bone chip to occur, it likely did cause it to become displaced. Because the bone chip was located in a region of the joint which was non-weight bearing, it remained asymptomatic for a long period of time thereafter. Over the course of five years, however, the cumulative effect of walking, which involves a cyclical motion of the ankle, caused the chip to move somewhat further from its divot, to the point where it became a source of irritation and needed to be removed.

25. Dr. DeStigter disagreed with this analysis. In her opinion, for Claimant's bone chip to have become symptomatic in 2009 there had to have been another precipitating traumatic event. Dr. DeStigter hypothesized that Claimant's 2008 motor vehicle accident could have been such a precipitating incident. Assuming that Claimant applied her brakes with some force as that accident was occurring, she would have dorsiflexed her ankle in exactly the same manner as is typical for impact injuries to the talar dome.

26. Dr. DeStigter failed to explain why, in her opinion, a dorsiflexion injury in 2008 might have precipitated movement of a preexisting bone chip, but to a reasonable degree of medical certainty a fall such as the one Claimant experienced in 2004, which according to the emergency room record also involved dorsiflexion, did not.

27. Consistent with the other experts' opinions, Dr. White testified that Claimant's bone chip preexisted her 2004 fall. However, he did not have a definitive opinion as to why it became symptomatic in 2009. According to Dr. White, the cause could have been spontaneous and idiopathic, or it could have been due to additional trauma.

28. Dr. Johansson's opinion was essentially the same as Dr. White's. Without identifying a particular reason for Claimant's bone chip to have shifted position in 2009, Dr. Johansson theorized that whatever caused it to do so likely occurred shortly before she began to experience symptoms in the area.

29. Noting that there was no evidence of any joint effusion on Claimant's radiologic studies in 2004, Dr. Johansson discounted Dr. Charlson's theory that the 2004 fall caused the bone chip to move slightly from its preexisting divot. In Dr. Johansson's opinion, movement of the bone chip would have caused friction within the joint, which would have resulted in both swelling and pain, neither of which Claimant experienced at the time. According to Dr. Charlson, however, such friction would only occur once the bone chip moved far enough to interfere with the weight-bearing surface of the joint.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she 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). 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 resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. The disputed issue here is one of medical causation. Did Claimant's compensable work-related fall in January 2004 set in motion the circumstances by which her preexisting bone chip became symptomatic in 2009? To answer this question competent expert medical testimony is required, "to remove the final decision from the realm of speculation." *Marsigli's Estate v. Granite City Auto Sales, Inc.*, 124 Vt. 95, 103 (1964).

3. Where expert medical opinions are conflicting, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

4. Considering all of these factors here, I conclude that Dr. Charlson's opinion is the most credible. In reaching this conclusion, I am mindful of the fact that, as the treating surgeon, Dr. Charlson was able to glean knowledge not just from Claimant's radiologic studies but also from personally observing her physical presentation and discussing the specific mechanism of her injury with her. Having this additional information strengthened his opinion.

5. I also find Dr. Charlson's expert qualifications to be particularly compelling in this case. Of the four experts who rendered opinions, Dr. Charlson is the only one who has specialized training and experience not just in foot and ankle injuries, but specifically in evaluating and treating osteochondral defects of the talus.

6. By virtue of both Dr. Charlson's qualifications and his treating relationship with Claimant I conclude that he was better positioned than the other experts were to determine the mechanism by which Claimant's 2004 fall led to her 2009 symptoms. His explanation made logical sense and adequately incorporated the available evidence. I accept it as the most credible.

7. It is true, as Defendant asserts, that there is no x-ray evidence from which to determine the exact position of Claimant's bone chip immediately before her 2004 fall. Defendant is correct, therefore, that there is no way to know with one hundred percent certainty whether Dr. Charlson's theory – that the fall started the process by which the chip dislodged from its preexisting position and ultimately became symptomatic – is correct. This does not automatically render his opinion too speculative to accept, however. The standard is not one hundred percent certainty; it is "reasonable probability." *Jackson v. True Temper Corp.*, 151 Vt. 592, 596 (1989), citing *Campbell v. Heinrich Savelberg, Inc.*, 139 Vt. 31, 34 (1980). Considering the available support for Dr. Charlson's opinions, I conclude that he adequately satisfied that test.

8. I conclude that Claimant has satisfied her burden of proving that the symptoms she experienced in 2009, which ultimately required surgical treatment to resolve, were causally related to her January 2004 compensable work injury.

9. As Claimant has prevailed on her claim for compensability, she is entitled to an award of costs and attorney fees under 21 V.S.A. §678. Claimant has submitted a request for costs totaling $2,694.62 and attorney fees totaling $10,449.00.[1] An award of costs to a prevailing claimant is mandatory under the statute, and therefore these costs are awarded. As for attorney fees, these lie within the Commissioner's discretion. I find they are appropriate here, and therefore these are awarded as well.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Defendant is hereby **ORDERED** to pay:

1. All workers' compensation benefits to which Claimant proves her entitlement as causally related to her right ankle symptoms since March 23, 2009, including those related to her December 2009 surgery; and

2. Costs totaling $2,694.62 and attorney fees totaling $10,449.00.

DATED at Montpelier, Vermont this 25th day of March 2011.

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Anne M. Noonan
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. §§670, 672.

[1] Attorney fees incurred after June 15, 2010 are billable at the updated reimbursement rate, $145.00 per hour. *Workers' Compensation Rule 10.1210*; *Erickson v. Kennedy Brothers, Inc.*, Opinion No. 36A-11WC (March 25, 2011).