STATE OF VERMONT
DEPARTMENT OF LABOR

Larry Brown, II	}	**Opinion No. 5**
	}	
v.	}	
	}	**By: Charles L. Powell, Esq.**
PMA Insurance Company	}	**Arbitrator**
And	}	
BB Trucking, Inc.	}	
	}	
&	}	
	}	
Travelers Insurance Company	}	**State File No. P-13113**
And	}	**and**
Larry Brown Logging	}	**State File No. AA-60175**

OPINION AND ORDER

Hearing held at Vermont District Court, White River Junction, VT on December 1, 2010 and December 2, 2010. Record closed on January 21, 2011.

APPEARANCES:

Corina N. Schaffner-Fegard, Esq., for PMA Insurance Company
Andrew C. Boxer, Esq. and Robert D. Mabey, Esq. for Travelers Insurance Company

ISSUES PRESENTED:

1. Was Mr. Brown's 1999 left knee injury aggravated after Mr. Brown reached medical end result (medical end result occurred in December 2002)?

2. If aggravated, did PMA/Gallagher-Bassett waive its defense of aggravation by virtue of payment of benefits until January, 2009?

3. Should benefits be apportioned amongst the carriers; if so, in what manner?

4. Should the attorney fees of Mr. Brown's lawyer, Bonnie Shappy, Esq., be the responsibility of PMA or Travelers?

EXHIBITS:

Exhibit 1: Joint Medical Records Binder

Exhibit 2: Anatomical Model of Human Knee

Exhibit 3: April 18, 2002 Operative Note, Arnold D. Scheller, M.D.

Exhibit 4:	John Deere Website Image of 648H Grapple Skidder – Image of Air-Ride Seat and Console
Exhibit 5:	John Deere Website – Image of Foot Pedals
Exhibit 6:	John Deere Website – Image of Driver's View of Steering Wheel and Controls
Exhibit 7:	Image of Fracture Across Malleolus, Illustration From Page 413 of Gray's Anatomy Almanac 16th Edition
Exhibit 8:	Dr. Wieneke Deposition (not admitted)
Exhibit 9:	August 17, 2009 Dr. Wieneke IME Intake Form With Notes
Exhibit 10:	Handwritten Notes By Dr. Wieneke Regarding Phone Call With Attorney Schaffner-Fegard
Exhibit 11:	Gallagher-Bassett Claim File Notes
Exhibit 12:	June 19, 2007 Note on Coverage and Compensability
Exhibit 13:	May 10, 2007 Gallagher-Bassett Note on Investigation of Claim
Exhibit 14:	John Deere Grapple Skidder Video
Exhibit 15:	September 28, 2009 Affidavit of Bonnie B. Shappy, Esq.
Exhibit 16:	July 14, 2009 Pleading on Behalf of Travelers Re: Idiopathic Injury
Exhibit 17:	June 29, 2009 E-Mail Correspondence Between Attorneys Shappy, Boxer and Schaffner-Fegard Regarding Scheduling Deposition of Dr. Scheller
Exhibit 18:	June 4, 2010 Deposition of Andrew L. Chen, M.D. With Exhibits
Exhibit 19:	July 27, 2009 Deposition of Arnold D. Scheller, M.D. With Exhibits
Exhibit 20:	Curt C. Hassler, PhD. Curriculum Vitae
Exhibit 21:	Report By Curt C. Hassler, PhD. (not submitted into evidence)
Exhibit 22:	Unredacted Gallagher-Bassett Claim File Notes
Exhibit 23:	Deposition of Dana Perkins
Exhibit 24:	Dr. Siliski Curriculum Vitae

FINDINGS OF FACT:

Background

1. This is an Arbitration case.

2. The Department of Labor ordered Arbitration of this matter June 30, 2009. The parties notified the Department of their Rule 8.3110 mutual selection of an arbitrator on January 19, 2010 and requested forwarding of the Department's file. The Arbitrator received a copy of the Department's file February 22, 2010. The Rule 8.3114 Initial Conference took place March 16, 2010, and additional time beyond the 90 days contemplated under Rule 8.3115 was jointly requested and granted and a two-day hearing was scheduled for July 15 and 16, 2010. On June 3, 2010, PMA Insurance Company requested a continuance of the hearing because the Department's Staff Attorney was on vacation and the resolution of PMA's motion was likely to be delayed. The requested continuance was unopposed. The continuance was granted. A two-day Arbitration Hearing was scheduled for September 30 and October 1, 2010, but to accommodate additional discovery was rescheduled to December 1, and December 2, 2010.

3. Prior to Arbitration Hearing, the following motions were filed and decided:

   - July 22, 2010 Ruling and Order granting in part and denying in part PMA Insurance Company's Motion to Compel Employee's Answers to Interrogatories (*Opinion No. 1)*

   - October 11, 2010 Ruling and Order (by email) denying Travelers Insurance Company's Motion to Compel Production of Gallagher-Bassett's Complete, Un-Redacted Claims File from December, 1999 to January 27, 2009.

   - November 3, 2010 Ruling and Order Granting PMA Insurance Company's Motion to Compel Larry Brown Logging & Chipping Company to Comply with Subpoena Dated July 6, 2010. (*Opinion No. 2*)

   - November 9, 2010 Ruling and Order denying Travelers' Motion in Limine to Exclude the Expert Testimony of Curt Hassler (*Opinion No. 3*)

   - November 9, 2010 Ruling and Order denying in part Travelers' Motion for Reconsideration Re: Motion in Limine to Exclude the Expert Testimony of Curt Hassler and Ordering PMA to produce a written report consistent with Rule 26(A)(4) (*Opinion No. 4*)

   - November 29, 2010 Ruling (via email) denying Travelers "renewed" request for exclusion of Dr. Curt Hassler.

Work Injury

4. Larry Brown, II, was born February 24, 1978. He is employed in a family business, in the industry of logging.

5. On December 28, 1999, Mr. Brown was at work and got out of an 18-wheeler tractor. His boot got stuck in between the step and the cab. His left knee twisted. The pain caused him to grab his knee, miss a handle, and fall backwards. The fall caused severe left knee bending and twisting. Mr. Brown felt his left knee snap and pop.

6. The left knee injury of December 28, 1999 was an accepted workers' compensation claim. The left knee injury was treated by a succession of orthopedic surgeons, as follows.

Medical Treatment – Lon Howard, MD

7. A February 8, 2000 Littleton Regional Hospital operative note by Lon Howard, MD, describes a procedure known as "arthroscopic partial medial meniscectomy, a chondroplasty of the medial femoral condyle, plicotomy" and a postoperative diagnosis of "torn medial meniscus, chondral defect of the medial femoral condyle, plica, and torn ACL." (Joint Medical Exhibit, Tab 3)

8. Following surgery by Dr. Howard, Mr. Brown sought a second opinion on March 29, 2000, with John J. O'Connor, MD of Concord Orthopedics on March 29, 2000.

Medical Treatment – John J. O'Connor, MD

9. A May 19, 2000 operative report by John J. O'Connor, MD at the Orthopedic Surgery Center in Concord, NH describes a procedure known as "Examination under anesthesia left knee. Diagnostic arthroscopy left knee, arthroscopic removal of loose body; open reconstruction of fibular collateral ligament and popliteal fibula ligament using autograft; semi-tendinosis graft; reefing of arcuate ligament" and a postoperative diagnosis of "1. Stretched fibular collateral ligament. 2. Torn popliteal fibula ligament."

10. A November 19, 2001 operative report at the orthopedic surgery center in Concord, NH by Dr. O'Connor describes a procedure of "Exam under anesthesia, left knee; diagnostic arthroscopy, left knee; partial anterior synovectomy; removal of small cartilage loose body" and a postoperative diagnosis of "Mild synovitis; synovial over-growth, anterior compartment and notch, left knee."

11. A November 27, 2001 follow-up note with Dr. O'Connor shows "a lot of pain in his knee. .... He can move his knee, but he does not like to."

12. A December 18, 2001 follow-up with Dr. O'Connor comments "I'm really at a loss to explain why he's had so much pain. He really can't even stand with it straight, much less bear weight on it. His effusion has resolved." He notes that Mr. Brown and his family, as well as Dr. O'Connor himself, desire another opinion.

13. A January 22, 2002 office note by Dr. O'Connor references Mr. Brown had a second opinion with Robert Johnson, MD at the University of Vermont, who reportedly could find no specific problem with the left knee except for hyperextension and did not recommend further surgery. However, Dr. O'Connor noted that Mr. Brown and his

mother had already scheduled another medical consultation with Dr. Scheller from New England Baptist Hospital. (Joint Medical Exhibit, Tab 4)

Medical Treatment – Arnold D. Scheller, MD

14. On March 15, 2002, Mr. Brown was seen by Arnold D. Scheller, MD, whose office note highlights an examination by Dr. Scheller as well as an orthopedic fellow, Dr. Kwock, and Dr. Scheller's partner, Dr. Glen Ross.

15. The March 15, 2002 office note by Dr. Scheller states that all three concurred that Mr. Brown "does have persistent instability and hyperextension and has about a 20-degree increase in external rotation when his left leg is in extension and it is relatively equal when his leg is at 90 degrees of flexion." Dr. Scheller felt the anterior cruciate ligament was intact, but the posterior ligament showed a grade two lesion and posterior draw. The arcuate complex was also stretched. Dr. Scheller wrote "my overall impression I think Mr. Brown has a severe work-related injury. He's left with laxity in his left knee, which has not been corrected with a reconstruction of the lateral ligament. … ." Surgery was recommended.

16. An April 18, 2002 operative report by Dr. Scheller from New England Baptist Hospital, Boston, MA, describes a procedure of "Left knee arthroscopy, arthrotomy, and examination under anesthesia. Reconstruction of arthroscopic reconstruction of the posterior cruciate ligament, anterior cruciate ligament, lateral collateral ligament, posterior tib/fib ligament and popliteus tendon. Neurolysis of the peroneal nerve. Allograft preparation utilizing an Achilles tendon allograft, and two posterior tendon allografts. This was a team surgery." The surgeons were Dr. Scheller, Dr. Ross, and Dr. Kwock.

17. The April 18, 2002 postoperative diagnosis was "Multi ligament instability of the left knee secondary to work-related accident occurred while getting out of a logging truck, including ruptured anterior cruciate ligament, posterior cruciate ligament, lateral collateral ligament, posterior oblique tib/fib ligament, and popliteus tendon. The patient was status post lateral collateral ligament reconstruction."

18. A December 6, 2002 office note by Dr. Scheller states that the patient "…has reached an end result from the surgical procedure. I have allowed Larry to return to work as long as he drives in the skidder."

19. Dr. Scheller, according to the same December 6, 2002 office note, also recommended fabrication of a second knee brace, continuation of ACL strengthening, and "I told him that he has post traumatic arthritic changes in the joint and in all probability this will progress with time, esp if he used a lot of closed kinetic chain exercises or if he had to do a lot of jumping, that is why I asked him to stay in the cab of the skidder and not jump to the logging truck and up to the buncher."

20. Dr. Scheller noted December 6, 2002 "with respect to stability, he has a one plus anterior drawer and one plus posterior drawer. He has good stability in the posterior lateral corner

and in the medial side of his knee. He has minor three-compartment arthrosis at this time, which in all probability will advance because of his labor type employment."

21. On May 23, 2003, Dr. Scheller issued a report following an examination which showed "full range of motion from minus 30 degrees of full flexion to full extension, two plus anterior drawer, negative posterior drawer, ... He has three compartment crepitus and arthritis."

22. On May 23, 2003, Dr. Scheller concluded there was a total of 29% whole person permanent partial disability.

23. On May 23, 2003, Dr. Scheller wrote in part:

> "Because of the underlying instability over time, Mr. Brown will probably require a total knee replacement, and he and his father were appraised of this."

24. Dr. Scheller noted that Mr. Brown was "a very motivated individual and continues to work despite the disability in his left knee."

25. A June 30, 2003 script by Dr. Scheller was issued to refurbish an existing knee brace, and again April 14, 2004, and again December 14, 2004.

26. A January 24, 2006 physician order by Dr. Scheller references a custom-made brace described as "carbon graphite lamination" brace. The order states the brace is designed to resist abnormal tibial translation associated with anterior cruciate ligament deficiency in postoperative and nonoperative patients. The brace is recommended to assist in the stabilization of anterior, medial, and lateral instabilities. The note further states it is necessary for the patient to wear this brace for all activities of normal living and that without the brace there is the possibility of the patient damaging the surgical repair. (Joint Medical Exhibit, Tab 4)

27. No treatment notes or therapy notes appear between May 23, 2003 and early-2007 regarding Mr. Brown's left knee. This shows a period of no treatment for the left knee for approximately four (4) consecutive years. During this time, Mr. Brown had returned to work for his family logging business.

28. An ankle injury occurred in 2006.

29. On January 31, 2006, Mr. Brown was seen at the emergency department at Weeks Medical Center in Lancaster, NH for left ankle fracture following an incident where he slipped on the ice. He was reportedly wearing his left knee brace at the time. A February 6, 2006 operative report from Weeks Medical Center, Lancaster, NH, by Peter E. Pascal, MD, describes a procedure of "open reduction, internal fixation of fracture of distal tibia, left ankle" and a pre- and post-operative diagnosis of "fracture of distal tibia, left ankle." (Joint Medical Exhibit, Tab 8)

30. The medical records of treatment of the left ankle injury do not reference any injury, or increased symptoms, to the subject left knee.

31. Left knee treatment notes began again in 2007.

32. An April 29, 2007 office note – also a duplicate in the Joint Medical Exhibit appears with a date of April 27, 2007 – by Arnold Scheller, MD, states that within the last year Mr. Brown:

> "has had increasing pain and symptoms. He has gone back to using the brace when he works as a logger. His pain is in the left knee, which was originally injured on 12/28/1999 when he was getting out of a truck at work. He does have pain, loss of motion, swelling, occasional burning and numbness. He does have mechanical symptoms, instability, and buckling. The pain is in the front of the knee and on the inside of the knee. It is sharp, dull, and related to activity. He does have pain at night. He has pain during activities and after activities. Things that aggravate his pain are stairs, long periods of sitting, crouching, walking on level ground, cutting, and jumping. He can walk approximately 1 city block before he needs rest. He's had to modify his work as a logger for this. .... He has had treatment over the last year which have included medications which have been of moderate help, physical therapy which has been no help, he has not had injections, and bracing and wraps have greatly helped, especially when he is at work."

33. Dr. Scheller's April 29, 2007 note also references the 2006 left ankle fracture: "...he has had a fall on his left ankle approximately a year ago and he had an open reduction, internal fixation, in Lancaster, NH with an excellent result." He did not attribute any clinical significance relative to the left knee.

34. Dr. Scheller's April 29, 2007 impression was that "...I think the majority of his problems are related to the patellofemoral mechanism and this would definitely go along with his severe knee injury that he had six years ago and a development of arthritis changes in the petellofemoral joint and I think this is causally and temporally related to his work-related injury."

35. Dr. Scheller's April 29, 2007, impression states that Mr. Brown has tried all conservative modalities and has not improved. Dr. Scheller recommended diagnostic arthroscopy to evaluate the patellofemoral joint, and predicted there would need to be some degree of lateral release and that there may be a need for medial imbrication. He recommended an evaluation of the ACL. The ACL showed a 2+ Lachman clinically, despite the MRI evidence that the ACL was intact. He thought there might be thermal shrinkage procedure that might be able to help.

36. Dr. Scheller's April 29, 2007, note states that Mr. Brown "is going to be in contact with his workmen's comp carrier and I've asked him to be in contact with Emma at my office to schedule a surgery."

Gallagher-Bassett Services, Inc. Review of Claim – May 2007

37. On May 9, 2007, Karen Provencher, Supervisor at Gallagher-Bassett Services, Inc., entered a claim note to the attention of the assigned adjuster, Darlene Bosell:

> "Supervisory Review
>
> Darlene:
>
> The claimant's wife called to state her husband is having surgery. This is a very old claim that was handled in Vt office. The claimant home number is 802-328-2671. I also spoke to Emma at Dr. Scheller office 617-738-8642. The claimant was seen on 04/27/07 and she will fax over notes. The claimant is scheduled for surgery on 05/16/07. She was unable to advise the type of surgery. Please make contact based on what is on the file to determine if we should pay for this surgery. Is there lost time?"

(Exhibit 22, page 100-101)

38. On May 10, 2007, the adjuster, Darlene Bosell, had a communication with Dr. Scheller's office who was looking for authority to proceed with surgery. She noted: "They've faxed information for my review. I advised that I would review and give them our decision." (Exhibit 22, page 101)

39. On May 10, 2007, the Gallagher-Bassett Services, Inc., adjuster, Darlene Bosell, made a claim note entry, 22 lines summarizing portions of Dr. Scheller's report of April 29, 2007 (Exhibit 22, page 101-102), but not Dr. Scheller's April 29, 2007 comment "Over the last 6 years, he has had a fall on his left ankle approximately a year ago and he had an open reduction, internal fixation in Lancaster, NH with an excellent result." (Joint Medical Exhibit, Tab 7)

40. On May 10, 2007, the adjuster also made the following file note entry:

> "Considering that the EE is a logger, I'd say that's a pretty physical job. Although the MRI doesn't show a tear, question whether the patella subluxation is something associated with an injury or just degenerative changes felt to be related to arthritic changes that the doctor seems to be relating to the original injury. Also wonder the current condition of the un-injured knee? Arthritic changes as well? Believe an IME may be necessary to get this clarified."

(Exhibit 22, page 102)

41. On May 11, 2007, the adjuster, Ms. Bosell, spoke with Mr. Brown's mother and made notes of her investigation, including Ms. Bosell's concern about the physical nature of the job: "I told her my concerns with the fact that he's been in the logging business and how significant of a physical job that is. But she [Mr. Brown's mother] argued the above about the fact that they knew that he'd have demise of knee over time based on the extent of injury at that time." Ms. Bosell also spoke with Mr. Brown the same day. Her notes indicate that Mr. Brown told her he works in the logging industry and it's a small business, and so he works in aspects involving the equipment to move the cut down logs.

He uses a machine to grab trees that are cut down by others. "He's in/out of the equipment all day. He also said that he sometimes has to do lifting associated with handling the farm equipment and that weight can vary. ... ." (Exhibit 22, page 103)

Arnold D. Scheller, MD Operative Note – May 16, 2007

42. A May 16, 2007 procedure note by Dr. Scheller describes a procedure of "Left knee arthroscopic thermal ACL reconstruction, ... and a lateral retinacular release, ... for subluxing patella" by Dr. Scheller. (Joint Medical Exhibit, Tab 7)

43. The May 16, 2007 post-operative diagnoses were: "Partial tear of the anterior cruciate ligament and a subluxing patella with chondromalacia of the patella, work-related."

Gallagher-Bassett Services, Inc. Claim Review – June, 2007

44. On June 12, 2007, a Gallagher-Bassett Services, Inc. supervisor entered the following claim note:

> "Supervisory Diary Review: Reopened file due to surgery request. Darlene pls clarify in notebook that you have accepted this claim for surgery since it appears that you were originally questioning the surgery and then accepted it.
>
> Recommend TCM/NCM due to the severity injury and time between surgeries. Let's get an IME and surv to see how clmt is spending his time – how do we know that he is not working the farm?
>
> I am not comfortable w/all the contact going thru clmt's mother who is also the ER. I strongly caution you in what you relay to her as she is not our typical ER contact since she is the clmt's mother and it is obvious where her loyalties lie based on your notes."

(Exhibit 22, page 113)

45. On June 18, 2007, the adjuster, Ms. Bosell, replied in a file note:

> "Comment to Supervisor: I agree with the indication of concern with the employer contact being the mother. ... .
>
> From what I reviewed in the notes, the original injury was severe and the old notes indicate that he'd more than likely require further surgery in approximately 5 years, which is where we are now. It also reflects that he may eventually need a total knee replacement. HOWEVER, in the recent surgery, I saw an indication of an actual tear so I'm asking that clarification be provided on whether that finding is a result of the original injury or possibly something that's occurred since then with his continued physically demanding job. If it is a new finding, it's possible the employer will need to file a new claim. I expect that a claim with this late date doesn't get affected by a mod anymore either. It all comes down to whether the tear is a new finding to make that determination on what will happen next. ... ."

(Exhibit 22, page 114-115)

46. The adjuster ordered the scheduling of some surveillance "to check on EE's activity level." (Exhibit 22, page 115)

Arnold D. Scheller, MD Notes – June 18, 2007

47. A June 18, 2007 follow-up visit note by Dr. Scheller states that Mr. Brown was now two-weeks status post an arthroscopic evaluation of the knee, that the surgical procedure had shown the PCL reconstruction was intact. The ACL had "about 50 to 60 percent fibers intact and we did a thermal shrinkage procedure as a conservative modality to prevent him from having a formal revision ACL. On examination today, he has a 2+ anterior drawer and he volunteers that he still feels like he has instability of the knee." There was also "marked quad atrophy with 3/8 of an inch atrophy in the left thigh... ."

48. Dr. Scheller stated his overall impression was that the March 16, 2007 surgery helped decrease anterior patellofemoral pain "...but that he still has residual anterior cruciate ligament laxity. I spent about one-half hour going over the importance of physical therapy with him and strengthening the leg. ...I will see him in the last part of July. If he has not seen significant advances from the physical therapy and the residual laxity in the knee is this major issue then I would recommend a formal revision of the ACL with removal of the transfixed pin and the BioScrew and a revision ACL reconstruction."

Gallagher-Bassett Services, Inc. Claim Review – June, 2007

49. On June 19, 2007, the Gallagher-Bassett Services, Inc., adjuster, Ms. Bosell, made the following claim note entry on coverage/compensability:

> "Compensability established. Original knee injury was significant and it was noted back then that he'd require further surgeries. Will evaluate records as they become available. May have a records review or an IME to determine if the tear found is considered a new finding from a different cause than the overall knee injury. If so, another claim may need to be filed by the employer."

(Exhibit 22, page 117)

50. On June 25, 2007, a "nurse note" was entered by Fabienne Gallant, AS, RN, in the Gallagher Bassett Services, Inc. claim notes stating, in part, "Claimant also reports he slipped on the ice approximately a year ago with some trauma to left ankle and this may have some bearing on this file as well." (Exhibit 22, page 130)

Continued Medical Records of Treatment – August, 2007

51. An August 8, 2007 operative note by Dr. Scheller describes the following procedures: "1. Left knee revision ACL reconstruction, ...with a 22 modifier for revision. 2. Removal of hardware, separate site, distal femur, one Arthrex TransFix Screw."

52. The August 8, 2007 postoperative diagnosis by Dr. Scheller was "Recurrent tear of the anterior cruciate ligament. The patient is five years status post a work-related injury in which he had posterior cruciate ligament, anterior cruciate ligament, and lateral collateral

ligament tear. He has had multiple ligament reconstructions five years ago and did well until this last year when he had a recurrent tear of his anterior cruciate ligament by MRI. We did an arthroscopy and found that about 60 percent of the bundle was intact and tried a thermal shrinkage earlier in the summer, but he had this failed and he has had recurrent instability, and, therefore, he was admitted for a formal revision of anterior cruciate ligament reconstruction. In addition, chondromalacia of the medial femoral condyle and patellofemoral joint."

53. The record does not indicate a particular incident or episode associated with the "recurrent tear of his interior cruciate ligament by MRI."

54. An August 8, 2007 physician order by Dr. Scheller references a script for a prefabricated splint for all activities during a specified time of 90 days.

55. On August 18, 2007, follow-up office note with Dr. Scheller confirms that Mr. Brown was started on a physical therapy program. His brace was adjusted.

56. A December 21, 2007 office note by Dr. Scheller indicates that Mr. Brown was expected to return to work in one month.

57. A January 2, 2008 Pro Sports Orthopaedics, Inc., letter confirmed that Dr. Scheller's office was "referring patient Larry to Dr. Andrew Chen for orthovisc injections for his left knee."

Andrew Chen, MD Records – 2008 to 2009

58. A January 29, 2008 office note by Andrew Chen, MD, of the Alpine Clinic, Littleton, NH, states that Mr. Brown was referred to him by Dr. Scheller, and Dr. Chen's impression was "the patient demonstrates evidence of left knee pain attributable to known chondral osteoarthritic changes. The treatment options were reviewed with the patient who has surprisingly excellent motion and stability given his multiple ligamentous reconstructions. I believe he would be a good candidate for orthovisc injections." An orthovisc injection was provided at that visit. (Joint Medical Exhibit, Tab 10)

59. Follow-up visit with Dr. Chen occurred on February 5, 2008. The office note states:

> "He was given his first shot last week which he has done very well. .... He denies numbness, tingling, or weakness and now presents for 2nd of 3."

60. Follow-up visit with Dr. Chen occurred on February 12, 2008 (orthovisc).

Arnold D. Scheller, MD Office Notes – May 2008 to July 2008

61. An April 4, 2008 product order form by Dr. Scheller indicates a script for a defiance brace, and again on May 4, 2008.

62. A May 23, 2008 office note with Dr. Scheller states in part that there would be a follow-up in one year or as needed. The same day the records show a left knee injection/aspiration.

63. A July 11, 2008 Pro Sports Orthpaedics, Inc. letter by Dr. Scheller states "I would like it to be known that there is no change in his permanent impairment. He is still considered at 29% permanently impaired."

Andrew Chen, MD Office Notes – July 2008 to February 2009

64. Follow-up visit with Dr. Chen occurred on July 17, 2008. The office note states excellent relief from past orthovisc injections. "The patient has experienced recurrent pain, although he denies locking, catching, or instability. He has been wearing his brace faithfully at work. He now presents for the possibility of repeat Orthovisc injections." There was also noted: "Positive drawer test is 1 to 2+ but with firm endpoint." An orthovisc injection was administered at this visit.

65. Follow-up visit with Dr. Chen's Physician Assistant occurred on July 24, 2008. A second orthovisc injection was administered.

66. Follow-up visit with Dr. Chen occurred on July 31, 2008. A third orthovisc injection was administered.

67. Follow-up visit with Dr. Chen occurred on January 20, 2009. The January 20, 2009 office note states in part: "The patient presents with recurrent pain to his left knee. He states that in October [2008] his knee became very sore. He did not contact us in this regard but states he has been compliant with the use of his brace. He has been working at full duty. He now presents for follow up. He denies numbness or tingling." An orthovisc injection is noted to have been administered.

68. Follow-up visit with Dr. Chen was scheduled for January 27, 2009.

69. The January 27, 2009 office note states in part: "The patient is a 29-year-old logger who is due for his second Orthovisc injection today, however, this morning while at work he stepped on an unlevel surface and twisted his left knee. He states that he felt his knee 'open' in which his pain went from 3 out of 10 at baseline up to 10 out of 10. His knee did not swell. However, it has been sore ever since. He has been ambulating with a limp. He denies numbness or tingling and now presents for follow-up."

70. Dr. Chen ordered an MRI for "possible recurrent injury to his anterior cruciate ligament." He decided to hold off on the orthovisc injection.

71. At a February 3, 2009 office visit, Dr. Chen noted that the patient stated that "he felt his left knee open in the anteromedial direction, which causes pain to increase to 10 out of 10. He has been ambulating with a limp." Dr. Chen reviewed the MRI of the left knee which showed "a recurrent complete tear of his ACL." He thought the patient should revisit Dr. Scheller.

Return Care, Arnold D. Scheller, MD – 2009

72. A February 10, 2009 office note follow-up visit by Dr. Scheller recites the previous surgical history and states that the patient more recently "has been maintained with Synvisc, bracing and modification of work activities and athletic activities, but he has continued to have pain." An MRI now demonstrated "a complete tear of the ACL and medial compartment chondromalacia probably grade III." The patient's main pain was "in the area of the medial side of the knee, and he notes that his knee gives away inside the brace. His referring physician felt that he needed a re-revision of his ACL reconstruction and probable medial collateral ligament releasing. On initial evaluation, it appears that he has a clear anterior cruciate ligament insufficiency with a 3+ anterior draw... ."

73. On February 10, 2009, Dr. Scheller brought in one of his partners for exam and they both felt "...the patient probably had a low-grade posterolateral rotatory insufficiency, which caused additional wear on the anterior cruciate ligament reconstruction and that this led final disruption. This would increase his medial compartment pain."

74. Dr. Scheller concluded "...that a revision ACL ligament reconstruction was appropriate for his level of symptomology since he was just doing absolutely miserably with the brace and at the same time we would do an advancement of the posterolateral corner after exposing the peroneal nerve." Dr. Scheller also commented that "the medial compartment arthrosis may need further reconstructive surgery, but at his tender age of 30 I did not want to go to any portion of the knee replacement at this time."

75. On March 4, 2009, Dr. Scheller wrote to Darlene Bosell at Gallagher-Bassett Services, Inc. Ms. Bosell had asked for an explanation how the current complaints relate to the injury of December 28, 1999. Dr. Scheller wrote:

> "Larry's current complaints are in result of aggravation from his work-related injury on 12/28/99. Larry's diagnosis is a re-tear of his ACL (current MRI from 12/08) probable posterolateral corner insufficiency and post-traumatic arthritis medial femoral condyle. The type of work Larry does will continue to aggravate his knee problem. I find it necessary for Larry to undergo an ACL and PCL surgery now to alleviate his pain. I also find it possible that a total knee replacement be recommended in the future, due to the initial injury and aggravation of his repetitive job throughout the years."

76. On March 10, 2009, Dr. Scheller wrote a letter to whom it may concern:

> "On December 28, 1999, Larry sustained a severe work-related injury to his left knee. Due to the extent of the injury, Larry will need to undergo further surgical intervention in the future regardless to the type of work he does."

77. A March 11, 2009 operative note by Dr. Scheller describes the following procedures: "1. Left knee revision allograft arthroscopically assisted ACL reconstruction, ...with a 22 modifier for revision surgery. 2. Removal of hardware, an Endobutton from the intramedullary canal of the femur, ... 3. Chondroplasty of the patellofemoral joint and the medial femoral condyle. ..." The postoperative diagnosis is described as: "anterior

cruciate ligament tear, minor posterior-lateral corner instability, and grade three changes in the medial femoral condyle and the patellofemoral joint."

78. A June 5, 2009 follow-up visit note by Dr. Scheller states in part:

> "I explained to him in detail that the impact injury on the medial femoral condyle correlates with the knee dislocation and rupture of the posterior cruciate and posterolateral collateral ligament. This is the area of the impaction on the knee and unfortunately he has developed a significant osteochondral lesion in the medial femoral condyle."

79. A June 8, 2009 follow-up visit note states the same as the June 5, 2009.

Independent Medical Examination, Kuhrt Wieneke, Jr., MD – September 9, 2009

80. On September 9, 2009, Kuhrt Wieneke, Jr., MD, of the Orthopedic Center, North Adams, MA, conducted an independent medical examination of Mr. Brown at the request of counsel for PMA/Gallagher-Bassett. Dr. Wieneke offered the following diagnosis and comment and opinion:

> "Diagnosis:
>
> 1. Original work injury in December of 1999 with partial tear lateral and collateral ligament, ACL, and PCL. Chondromalacia medial femoral condyle. Multiple subsequent surgeries with three documented ACL replacements.
>
> Comments: This young man does very heavy work in the woods and driving a log truck. I consider this very heavy duty work, with lot of stress/strain on both knees. My son, Andrew, is a logger, and drives a skidder in the woods as well as a log truck, both in the woods and on the highway. I have personally observed him in these activities and they involve heavy duty work, using both knees, jumping out of the skidder (there are no steps), it is stressful on both knees. This young man has continued to do very heavy work, in spite of a substantial left knee disability. The fact that he has worn his brace out multiple times and has required three separate ACL replacements over seven years, speaks to the continuing heavy duty work he performs.
>
> Ongoing clutching the log truck, jumping out of his skidder, getting in and out of the log truck, in my opinion, constitute aggravation of an underlying pre-existing condition and have obviously led to multiple additional surgeries including three documented ACL replacements. All of the care that he has received to date is, in my opinion, related to his original injury on 12/28/1999, while at work, as well as subsequent work-related aggravations as outlined."

Dr. Wieneke's theory of aggravating work conditions did not include aggravation caused by bracing and stabilizing oneself with the left leg during a skidder's rough ride.

Arnold D. Scheller, MD, Notes – September 2009 to December 2009

81. A September 18, 2009 follow-up visit note by Dr. Scheller was a follow-up of the repeat revision and ACL reconstruction done on March 11, 2009. The knee was described as "stable" and "very stable" and the present problem was described as "an articular surface problem."

82. A December 11, 2009 office note states that the patient continues to have pain in the left knee "... and he has giving away and he has pain, ..." Dr. Scheller thought that Mr. Brown had worked hard with all of his conservative modalities, but unfortunately "...he has posttraumatic arthrosis in the medial compartment and may have arthrosis in the patellofemoral joint. These are refractory to conservative options... ." Dr. Scheller stated in part that he felt conservative options had been exhausted. He felt the patient was completely disabled at that point and he began to discuss a total knee replacement in detail.

Independent Medical Examination, John M. Siliski MD – April 12, 2010

83. On April 12, 2010, John M. Siliski, MD, conducted an independent medical examination and issued a report at the request of counsel for Travelers Insurance. Dr. Siliski's impression was stated as follows:

> "Impression:
>
> Larry Brown, II, is a young man who sustained a severe left knee injury at work on 12/28/99. The records indicate that he had a multiple ligament disruption. He went on to have reconstruction of his anterior cruciate ligament, posterior cruciate ligament, and posterolateral corner (including lateral collateral ligament). He had ongoing problems with the left knee through 2009, including repeat ACL reconstruction, pain, and limited function. He had known arthritic changes developing in the knee. On 1/27/09 he had a minor event with his left knee at work when it buckled. His presentation on the day of this event did not indicate any objective findings of new injury. He went on subsequently to have yet a third ACL reconstruction performed.
>
> Within a reasonable degree of medical certainty, Mr. Brown had a severe pre-existing condition in his left knee that left him permanent impairment in the form of arthritis, atrophy of muscles, and altered mechanical function in the setting of multiple ligament reconstructions. He never had full recovery from the original injury 1999, and had ongoing treatment for the subsequent 10 years. The event of 1/27/09 was of a minor nature, and would never have caused any problem with the left knee had it not been for the pre-existing condition. His left knee was at constant risk for buckling and attenuation of the ACL graft. With or without the event of 1/27/09, he was destined to have continued problems with the left knee, including the ACL.
>
> His long-term prognosis with the left knee is relatively poor. It is likely that he will have persisting problems with pain and dysfunction, and more likely than not will end up with a knee replacement later in life."

Arnold D. Scheller, MD, Operative Report Regarding Total Knee Replacement – May 6, 2010

84. A May 6, 2010 operative report by Dr. Scheller at New England Baptist Hospital describes a procedure of "left total knee replacement" and a post-operative diagnosis of "left knee status post work-related trauma, multiple ligament reconstructions, multiple attempts to control post-traumatic arthritis refractory to conservative therapy."

Kuhrt Wieneke, Jr., MD, Supplemental Report – November 18, 2010

85. On November 18, 2010, Dr. Wieneke wrote a supplemental report to counsel for PMA Insurance, stating:

> "I have reviewed an additional 80+ pages of medical records on Larry Brown, which I had not seen before, at your request.
>
> He fell on ice, on January 30, 2006, sustaining a left distal tibia fracture, while wearing his left knee brace. This required open reduction/internal fixation at Dartmouth Hitchcock Medical Center. Recovery was prompt.
>
> I can't tell how long he was out of work, but after recovery he continued working for his father's logging company. He continued to drive a skidder in the woods.
>
> I consider this injury a major aggravation to his already ACL deficient left knee. His continuing logging work, thereafter, has also resulted in further damage to his left knee, resulting in further surgery, and ultimately in the recently performed left total knee replacement."

Testimony

Deposition Testimony of Dana W. Perkins

86. The November 2, 2010 deposition testimony of Dana Perkins was introduced and admitted into evidence. (Exhibit 23) Dana Perkins was born June 21, 1975 and lives in Northumberland, NH. He has been employed by the Brown family for six (6) years. He served in the Marine Corp. from 2000 to 2004.

87. Mr. Perkins testified he was hired by Larry Brown, Sr., as an equipment operator and mechanic. He already had 12 years of logging experience with other companies. (Dana Perkins Deposition, page 8) His experience included operating the shearers, skidders, chippers, cranes. Shearers are harvesters or feller bunchers. When he began working for the Browns, he was operating the same kind of equipment. He started out running the grapple skidder. (Dana Parkins Deposition, page 9)

88. There is a chain skidder, but it basically sits there, it doesn't ever get used. Mr. Perkins was working with Larry Brown, II, when he started in 2004, and has worked with him pretty much while he was there. (Dana Perkins Deposition, page 10)

89. The company's John Deere 648E was replaced about three (3) years ago, the new one is a John Deere 648H. The change was to get a newer model because parts would wear out

and mechanical problems would increase. Mr. Perkins would do mechanical work on the skidder, such as changing hoses, changing oil filters. Larry Brown, Jr. (presumably Larry Brown, II) did not usually do maintenance or mechanical work on skidders. (Dana Perkins Deposition, page 11-12)

90. There's one rubber step on the bottom step of a skidder. They get replaced as soon as they get ripped off. "We carry spares in our shop truck." Replacement occurs on-site. (Dana Perkins Deposition, page 12-13)

91. Larry Brown, Sr. is the boss and has ultimate say-so on things, including when to replace grapple skidder equipment. (Dana Perkins Deposition, page 14)

92. Mr. Perkins testified as to the general job site and set-up operations. The shearer, the feller buncher, is the machine that actually cuts down the trees. There's never any chainsaw work. It's all mechanical. Then the grapple skidder takes the trees down to the landing. The crane cuts the felled trees. The crane has a big bucket and picks up the trees, puts them on a bunk, saw and cuts them, and then the logs are piled. (Dana Perkins Deposition, page 15-16)

93. Mr. Perkins described the terrain as "hills, sometimes it's flats, sometimes it's hills, sometimes it's rocky, sometimes it's muddy. It all depends on where we are and obviously the ground." The time of year also is a factor in terms of mud. Generally, the job is "anywhere from 10 acres to 350 acres." (Dana Perkins Deposition, page 17) Usually in the springtime there is no logging, and that's when maintenance is done on the equipment. (Dana Perkins Deposition, page 17-18)

94. Mr. Perkins testified that once logs are cut down, Larry Brown, II would run the truck from the landing to the mill. If the company's doing "soft wood", then it's brought to a separate area on the landing first, to a de-limber. The company selects a landing site by "just looking for the best, flattest place" which is usually done by Larry Brown, Sr., who lays the landings out, builds the landings, roads, and gets that done before the crew comes. (Dana Perkins Deposition, page 19-20)

95. Chipping operation is basically the same idea, pulling the wood out to the crane, the crane then saws the logs, the pulp is apparent, and whatever's left for the tops goes into the chipper. Mr. Perkins sometimes operates the chipping equipment. (Dana Perkins Deposition, page 21)

96. Larry Brown, II, drives the truck and the skidder. That's it. (Dana Perkins Deposition, page 21)

97. Mr. Perkins was not present when Mr. Brown was injured in 1999. But afterwards, when he would work with Larry Brown, II, there could be times where every time Larry Brown, II operated a skidder in and out of the woods Mr. Perkins would see him and then there would be whole days when he wouldn't see him, because he would be off in a different part of the property. Most employees stop for lunch. But "Mikey" doesn't. He stays on the skidder and eats on the go. Mikey is the same as Larry Brown, II.

Employees call Larry Brown, II by his middle name, which is Michael and they just nickname him "Mikey." (Dana Perkins Deposition, page 22-23)

98. Usually in the mornings, Larry Brown, II, climbs into the skidder and Dana Perkins gets into his shearer. The skidder is left on the landing at night, but the shearer is left in the woods quite often. (Dana Perkins Deposition, page 24) Larry Brown, II, generally arrives at the landing by driving the Western Star truck. (Dana Perkins Deposition, page 25) If a site is on good ground with good wood, the crew could probably do five (5) or six (6) loads of chips in a day. (Dana Perkins Deposition, page 26)

99. Mr. Perkins testified that the trucking is done by Larry Brown, II, and his father, Larry Brown, Sr. The chip plants right now for delivery are Bethlehem Pine Tree Power in New Hampshire, and pulp wood is often trucked to Jay, ME. (Dana Perkins Deposition, page 29) Another mill is Whitefield Power in New Hampshire and Milan, NH. The tractor trailer is a single payload trailer, and Larry Brown, II backs the truck and does not need to hook the trailer up to the Western Star directly. (Dana Perkins Deposition, page 30)

100. Usually, just three (3) persons are at the job sites – Larry Brown, II; his father Larry Brown, Sr.; and also Mr. Perkins. When Larry Brown, II was not there, "things got really slow" and there were not really any replacement workers hired. (Dana Perkins Deposition, page 31) That's been the same since 2004 when Dana Perkins started. (Dana Perkins Deposition, page 31)

101. Mr. Perkins describes the skidders as having a regular seatbelt. Larry Brown, II would wear it. (Dana Perkins Deposition, page 34)

102. Running the grapple skidder is usually not a problem coming down:

> "Coming down, it's basically you've got a hitch of wood and it's actually helping you hold the skidder down, gives you better traction."

(Dana Perkins Deposition, page 37-38)

103. Getting "hung up" does happen on rocks, stumps, and stuff like that. If you get hung up, usually you can drop your hitch, put it on the ground, push yourself along, helps you push your equipment over the obstacle you are stuck on. You basically put the grapple down on the ground, which pushes the skidder forward, and you pick it back up, pull it back up to you, set it down, push yourself again. (Dana Perkins Deposition, page 37-38) You never have to get out of the grapple skidder to deal with hang-ups. (Dana Perkins Deposition, page 39)

104. Larry Brown, II is in the skidder anywhere from a couple of hours to all day, depending on the amount of logs being pulled. (Dana Perkins Deposition, page 40)

105. Mr. Perkins testified that he has seen Larry Brown, II climb into an out of a skidder. He has never seen Larry Brown, II come out facing forward. He's never seen Larry Brown, II jump off. Mr. Perkins, himself, does not want to jump down. If the rubber step gets

ripped off, it might be stepping up to the next step, 18, 20 inches. (Dana Perkins Deposition, page 43)

106. Even if the rubber step is ripped off, you don't have to jump off to the bottom ground, you can keep one foot in and reach the ground, because there are three (3) steps on it. (Dana Perkins Deposition, page 44)

107. Mr. Perkins usually saw Larry Brown, II get into the skidder in the morning, climbing in, but he would not usually see him getting out, only if he (Perkins) was in the landing at the end of the day. Larry Brown, II, does not get out of the grapple skidder all day, he brings a bag lunch like everybody else, and Larry Brown, II, eats his lunch inside the skidder. (Dana Perkins Deposition, page 44-45)

108. Mr. Perkins testified at some point he and Larry Brown, II, discussed the left knee injury sustained by Larry Brown, II. When Mr. Perkins first began working, he noticed it was bothering Mr. Brown because he always walked with a limp. He was always wearing a brace on his left leg. He often complained that his knee was sore. As far as worsening, Mr. Brown never really discussed it. (Dana Perkins Deposition, page 47-48)

109. Mr. Perkins testified that rolling a skidder does happen. The old skidder was never rolled, but then new one has been rolled over by Dana Perkins. Larry Brown, II, has never rolled over the new one. Mr. Perkins would know if Larry Brown, II had rolled over a skidder "because I would have to go put it back on its wheels." (Dana Perkins Deposition, page 50-51)

110. Mr. Perkins testified he never saw Larry Brown, II jump off a truck, miss a step, hop down. Mr. Perkins seldom observed Larry Brown, II getting in and out of the truck. (Dana Perkins Deposition, page 52-53)

111. Mr. Perkins said there's no difference between a John Deere Skidder 648H and 648E, except that one is a newer model. The cable skidder has never been used. (Dana Perkins Deposition, page 56-57)

112. Betty Brown's function at the company is to do paperwork. (Dana Perkins Deposition, page 60)

113. Mr. Perkins testified that he's never seen Larry Brown, II take off his brace. On the other hand, Larry Brown, II usually wore the brace underneath his jeans, so he wasn't able to know for sure if it was on. (Dana Perkins Deposition, page 61)

114. Larry Brown, Sr. would do the site prep work, including building roads. Roads are built depending upon the terrain. The purpose of building the roads is safety. It also reduces the roughness of the travel back and forth from the landing. (Dana Perkins Deposition, page 63)

115. Mr. Perkins testified that the skidder generally is operated faster without logs than when it is actually pulling logs or skidding logs. It also depends on the terrain. If it's really

rough terrain, you go slow. The wheels on the skidder from ground to the top of the wheel must be about 4 ½ to 5 feet. (Dana Perkins Deposition, page 65)

116. For an operator inside the cab of a skidder, it can be relatively rough.:

> "If it's rough, you get bounced around a little bit, but the seat belt keeps you in your seat, and it's an Air Ride seat, so you're not getting – it's kind of a nice, easy type of bounce."

(Dana Perkins Deposition, page 66) A lap belt holds the operator in the Air Ride seat.

117. You don't need to especially hold yourself stable in the seat. "You're always holding on because you've got one hand on the steering wheel and one hand on the control shift of the grapple." You don't need to keep your feet firmly on the ground to keep yourself in your seat. (Dana Perkins Deposition, page 67)

118. The terrain has rocks of all sizes. If they are huge rocks, the operator of the skidder goes around them. But there are smaller rocks that you cannot get around, but are small enough to drive over. Operators of skidders always maneuver in such a way to reduce the likelihood of being hung up on a boulder or a stump. (Dana Perkins Deposition, page 69)

119. Compared to a car ride, the skidder is a "little bit more jerkier, just because of the hydraulics, it steers on hydraulics, but other than that it's like driving a car. It's an automatic car, big car is what it is, a gas pedal, and a brake, and a shifting lever." (Dana Perkins Deposition, page 71)

120. Mr. Perkins testified that whenever he saw Larry Brown , II, get in and out of the skidder, he always used the ladder. The ladder has three steps. The bottom one is made of rubber. That one sometimes gets ripped off in the course of work. That doesn't happen very often. The rubber step is actually pretty tough, but it does get ripped off. The rubber step comes down as low as one's knee if you're standing on the ground. Mr. Perkins testified he's never seen Larry Brown, II exit the skidder that did not have the bottom rung on it. (Dana Perkins Deposition, page 73-74)

121. Mr. Perkins testified that it's not difficult for him to exit a skidder on occasions when the rubber step is ripped off. "You just climb down like you normally would, and then last step's a little bit further, but it's no issue." (Dana Perkins Deposition, page 74) The next step above the bottom rubber step is about 18-24 inches off the ground. (Dana Perkins Deposition, page 74)

122. Mr. Perkins testified he's never had any problems operating a skidder, no pain in either of his knees. (Dana Perkins Deposition, page 77)

123. Mr. Perkins testified that, depending on the terrain, there was "maybe, occasionally, I guess. I don't know. It's hard to tell when you are working exactly" whether the terrain ever was as much as 45°. (Dana Perkins Deposition, page 81)

124. Mr. Perkins testified that if the rubber step on the skidder was broken during the work day, it would be fixed. (Dana Perkins Deposition, page 82) Even if the rubber step was still there, if it appears worn or torn partially "we usually replace them immediately." (Dana Perkins Deposition, page 83) Before the skidder is taken out, the operator does a quick inspection, walking around, checking the tires, making sure everything's alright. (Dana Perkins Deposition, page 83)

Deposition Testimony of Arnold D. Scheller, Jr., MD

125. The deposition testimony of Arnold D. Scheller, Jr., MD, on July 29, 2009 was admitted into evidence. (Exhibit 19) Dr. Scheller's CV was marked as an exhibit and shows undergraduate and graduate training at Boston University School of Engineering (1965-1969), Brown University Bio-Medical Department (1969-1971), and Rush Medical College MD Degree Program (1971-1973). Dr. Scheller is licensed in Massachusetts and New Hampshire. He is Board Certified in orthopedic surgery. He received an award in 2003 from the American Academy of Orthopedic Surgeons for scientific exhibit on the evaluation and treatment of acute posterolateral corner anterior cruciate ligament injuries of the knee. He has given presentations, including a presentation to the American Orthopedic Society of Sports Medicine on allograft ACL fixation. He has been a team physician for professional sports teams and Olympic teams. He is the author or co-author of more than 40 publications on topics such as tendon injuries, hip arthroplasties, elbow dislocations, and subluxation of the patella, as well as allograft ACL reconstruction, arthroscopic posterior cruciate ligament repair, and evaluation and treatment of acute posterolateral corner anterior cruciate ligament injuries of the knee. Dr. Scheller holds trademarks or patents in design products relating to the hip, and has been a participant in film production and instruction for low back pain, total knee surgery, hip surgery, and ACL reconstruction closed kinetic chain exercise program. Dr. Scheller was awarded a Bronze Star Medal for service in both Iraq and Afghanistan. He is the former Chief of Sports Medicine Department at New England Baptist Hospital in Boston, MA.

126. Dr. Scheller testified that Mr. Brown's knee in 2002 "...had a multi-ligament instability to the left knee and some minor sensory loss" according to the pre-operative note in April 2002. He testified that he understood that the condition was caused by a work injury in December of 1999. (Dr. Scheller Deposition, page 7) The post-operative diagnosis reviewed by Dr. Scheller "...included the anterior cruciate ligament, posterior cruciate ligament, the lateral collateral ligament, the posterior oblique tib-fib ligament, and the popliteus tendon." (Dr. Scheller Deposition, page 9)

127. Dr. Scheller testified that in April 2002 the surgery that he did was "an arthroscopy, an arthrotomy, examined under anesthesia the reconstruction of the posterior cruciate ligament, the anterior cruciate ligament, the lateral collateral ligament, the posterior tib-fib ligament, and reattachment of the popliteus tendon. We did a neurolysis of the peroneal nerve." (Dr. Scheller Deposition, page 10)

128. Allograft was done as part of the 2002 surgery. That means a cadaver ligament that is cut to size and inserted into the knee. "He had only one remaining ligament in the knee. All of the rest were gone." (Dr. Scheller Deposition, page 11)

129. Dr. Scheller testified that there are ligaments in the knee for the ACL, PCL, medial collateral ligament, lateral collateral ligament, posterior oblique ligament between the fibula, the small bone, and the tibia, and the popliteus tendon. "...the only one he had left was his medial collateral." Five (5) out of six (6) ligaments were gone and he "...essentially had a dislocated knee." (Dr. Scheller Deposition, page 11)

130. Cadaver tendons were used for the ACL, PCL, LCL, posterior oblique. (Dr. Scheller Deposition, page 11-12)

131. Dr. Scheller testified that during the operation and based on his observations during surgery "it was one of the more serious ones I have taken care of in 30 years; because he had damage to the articular surface and the medial femoral condyle, which goes along with a posterior lateral complex injury." There was damage to the articular surface of the femoral condyle, the medial femoral condyle, which leads to arthritis. (Dr. Scheller Deposition, page 12)

132. Dr. Scheller testified that arthritis in the knee has an impact on allograft ligaments because they work together:

> "You need to have a stable joint for the joint surfaces to articulate. And if there is any instability in the joint, much like a door with a hinge, if you undo the screws just a notch, you can open and close the door, but eventually, with the hinge loose, the door is going to fail.
>
> And this happens the same way in joints. As you get that extra micro motion, you will get abrasion and shear forces on the joint's surface, and that is what can increase your wear.
>
> His problem is when he fell from the truck, he had the ligaments rupture. He had a bone-to-bone bruise, which is real common, and that bruise of the cartilage is what really started the event going.
>
> ... .
>
> As far as the issue of the arthritis, which is the joint surface, he had a direct blow to the cartilage and the bone underneath, and he had an insult to the cartilage, and you're going to get wear of the cartilage.
>
> The ligament issue, he had severe instability of the joint, and he had a loss of all the ligament structures. He had to have allografts to come in and try to reconstruct it.
>
> And it is a non-perfect situation once you do to a reconstruction, so the ligaments are not as balanced as they were naturally before the injury. That extra stress or extra shear force is then going to exacerbate the joint injury, the articular injury. ... ."

(Dr. Scheller Deposition, page 13-15)

133. Dr. Scheller prescribed a knee brace because the knee remained unstable and because of the "articular problem on the inside of his knee." The brace addresses instability plus shifts the load to the more normal portion of the knee. (Dr. Scheller Deposition, page 18)

134. Dr. Scheller testified that the patient, Larry Brown, II, would report the left knee would sometimes twist even inside of the knee brace. That is because "...when the ligament stretches out, he can have more instability, and it can twist within the brace." In addition, Larry Brown, II, has a "pothole defect" on the articular surface which produces "...a sense of slipping and giving way." (Dr. Scheller Deposition, page 19)

135. Dr. Scheller testified that the 2007 surgery operative note confirms the findings of a partial tear of the anterior cruciate ligament "meaning the anterior cruciate ligament has stretched out." The patient also had a subluxing patella, meaning that the knee cap was riding to the outside. Dr. Scheller's goal for surgery was minimal intervention, "...to use heat to try and tighten the fibers." The heat shrinks the tissue, like cooking a piece of bacon, and though it is not as good as a full repair, the recovery is a lot quicker. Dr. Scheller felt that there was enough bulk to the ACL that he could just heat it rather than put the patient through a full repair. (Dr. Scheller Deposition, page 20-21)

136. Dr. Scheller described the 5-year timeframe between the 2002 surgery and the 2007 minimal intervention using heat to tighten the fibers of the ACL:

> "It is a multiple-ligament instability. And if you have got two bones, the femur and the tibia, to line up, when you have multiple ligaments torn, you don't know where the zero point is to reconstruct it. So you have got to reconstruct in extension.
>
> And if you put it too tight in extension, then you can't flex it. So what you do is get your fixation on the femur and leave the ligaments loose until you find out which degree of flex, and then you tighten the ligament down to the tibia.
>
> So it is like balancing a snow cone; and you have no reference points, because there is no ligaments that are attached. If people have just one torn ligament, you have got all the other ligaments to guide you on how tight to put it in.
>
> So there is a 5-year span here, and if it isn't just perfect, the same thing as the screws on the door hinge: it can fail with time. So it is an attritional-type failure."

(Dr. Scheller Deposition, page 22-23)

137. Dr. Scheller testified that if the alignment of ligaments "is not absolutely perfect," there is "stretching over a period of time." He concluded that's what happened between 2002 and 2007. (Dr. Scheller Deposition, page 23)

138. Dr. Scheller testified over objection, that "if it is not perfect," normal activities of daily living, like walking, will cause the stretching under such circumstances. (Dr. Scheller Deposition, page 23-24)

139. Dr. Scheller testified that later in 2007 he went back and did a formal revision of the ACL reconstruction, including removing the ACL and putting a brand new one in. He again encountered the same potential for running into the same problem, the challenge of getting it just perfect because of the articular problem of joint arthritis, the defect on the end of the medial femoral condyle, in addition to the problem of instability. (Dr. Scheller Deposition, page 25-26)

140. Dr. Scheller testified that two (2) years later he performed surgery, in March 2009, because the ACL cadaver ligament from August 2007 "stretched out and tore again." (Dr. Scheller Deposition, page 26-27)

141. Dr. Scheller testified that the 2009 surgery also included a new finding and he performed a chondroplasty of both the patellofemoral joint and the medial femoral condyle. The new problem was the patellofemoral problem:

> "What happens is one of the purposes of the ACL is to stabilize the foot as it impacts when you go to put your foot down as your leg decelerates. And when you have got laxity in the ACL, the tibia functionally changes position with respect to the femur, and the quadriceps contracts, so you get variable joint reaction forces across the patella.
>
> So it is a typical thing that the patellofemoral joint will start to wear out in time with laxity of this sort. He had started to wear the patellofemoral joint out. And the medial femoral condyle, that was the defect where he had the direct-blow bruise when he fell off the truck."

(Dr. Scheller Deposition, page 27-28)

142. Dr. Scheller testified that in 2008, Larry Brown, II, was receiving injections from Dr. Chen to help with the "articular issue" and to improve the nutrition and lubrication in the joint. (Dr. Scheller Deposition, page 31)

143. Dr. Scheller testified that if the incident of January 27, 2009 involved walking on a driveway without tripping or falling, and feeling the knee twist in the brace and feeling pain, then it means that the ACL "was unstable." And it means that it was unstable before the incident occurred. (Dr. Scheller Deposition, page 35)

144. Dr. Scheller testified that he could not say when the ACL tore, but he could say that Larry Brown, II "...had persistent instability right along, and he had a persistent articular problem right along." (Dr. Scheller Deposition, page 35-36)

145. Dr. Scheller testified that future resurfacing of the kneecap or future total knee replacement would be a direct consequence of the December 1999 work injury. (Dr. Scheller Deposition, page 39)

146. On cross-examination, Dr. Scheller testified that he understood Larry Brown, II's work duties before the 1999 injury involved the use of skidders, logging trucks, excavators to prepare the logging area. It is heavy work in bad conditions. (Dr. Scheller Deposition, page 40-41)

147. Dr. Scheller testified that after the 2002 surgery, he asked Larry Brown, II, to modify his work:

> "I asked him not to go back to logging with the skidder. If he did anything, to just stay in the machine and use a feller-buncher or a logging truck, but not necessarily going – the logging truck, you have got the loaders and things like that where you can just drive the logs over. So I just wanted him in one machine kind of thing. I just didn't want him jumping on an uneven surface."

(Dr. Scheller Deposition, page 41)

148. Dr. Scheller testified that after the 2002 surgery, Larry Brown, II, was provided with a "post-operative phase" brace from the ankle to the hip, and later a shorter brace for ligament instability. At the time of Dr. Scheller's testimony in July 2009, the patient was wearing "both a ligament instability brace and an unloader brace. ..., his articular damage is on the medial side of his knee, and the goal was to use a brace which would have distributed the force to the more lateral side." (Dr. Scheller Deposition, page 42)

149. Dr. Scheller testified that Larry Brown, II's "articular surface problem" was "problematic early on" and first observed by Larry Brown, II's first surgeon, Dr. Howard. (Dr. Scheller Deposition, page 42-43) Dr. Scheller testified that after the first surgery by Dr. Howard, a ligament reconstruction, Larry Brown, II's "medial pain became more significant, ..." (Dr. Scheller Deposition, page 43)

150. Dr. Scheller testified that medical end from a surgical procedure "is about one year after the surgical procedure. He has had a continuation of issues that have really extended that." (Dr. Scheller Deposition, page 43) That is in reference to Dr. Scheller's report in May 2003 of medical end result.

151. During the four (4) years between 2003 and 2007, Dr. Scheller did not see Larry Brown, II, and the knee brace replacements were signed by Dr. Scheller's signature stamp. (Dr. Scheller Deposition, page 44-46)

152. Dr. Scheller testified that the restriction against any jumping and modification of job duties was a permanent modification in 2003, using a reference point of the report by Dr. Scheller of May 23, 2003, where he found a 29% permanent impairment. (Dr. Scheller Deposition, page 46-47)

153. Dr. Scheller was asked about his April 29, 2007 follow-up visit note, specifically the language "gone back to using a brace." Dr. Scheller does not have an independent recollection of the conversation. Dr. Scheller didn't know that Larry Brown, II, was using the brace all the time, but had thought Larry Brown, II, was just using the brace while in the machines and things like that. He had asked Larry Brown, II, because of his level of injuries of the knee, to use the brace when he would be in an uncontrolled environment. (Dr. Scheller Deposition, page 50)

154. Dr. Scheller had asked Larry Brown, II, to stay in the machines and not to be bouncing in-and-out of them:

> "If he stays in the machines – I mean, he has still got to go around to oil and grease them and things like that. That is an unstable environment. But it is not heavy logging that he gets when he has got to cut a tree, go over uneven surfaces to chain it up, and things like that. So my knowledge was that he was staying to the cabs of the vehicles."

(Dr. Scheller Deposition, page 51)

155. Dr. Scheller classified that work as medium to heavy duty. (Dr. Scheller Deposition, page 51)

156. Dr. Scheller testified that Larry Brown, II, still had to use a clutch, which was "not easy." (Dr. Scheller Deposition, page 51) He said that an 18-wheeler clutch, about 8-12 inches off the ground to the bed of the truck, is a big clutch. When asked whether using such a clutch would worsen the ACL laxity over time, Dr. Scheller testified: "It could." (Dr. Scheller Deposition, page 52)

157. Dr. Scheller stated that the work Larry Brown, II, performed from 2003 to 2007 "could have" accelerated the condition of the knee requiring further treatment, but he said it is "speculative" and said "I don't know what he did for work." (Dr. Scheller Deposition, page 52) When provided information that Larry Brown, II, was driving a truck 50-100 miles on a daily run, Dr. Scheller testified that using a clutch "would affect the patellofemoral joint." He testified that it would worsen the condition. (Dr. Scheller Deposition, page 53) However, Dr. Scheller testified that it "shouldn't affect the ACL." (Dr. Scheller Deposition, page 53) Dr. Scheller testified that the use of the clutch pedal in a truck would accelerate arthritis. (Dr. Scheller Deposition, page 54)

158. Dr. Scheller testified that an allograft would be expected to last longer in a person with a sedentary job compared to a person who has more of a job where he is getting in and out of a truck or moving around. "It is a bit of the same analogy I made with the door hinges. If the screws are backed off, if you open the door less, it is going to last longer." (Dr. Scheller Deposition, page 56)

159. Dr. Scheller testified that the type of motion that would affect and possibly re-tear an ACL would be "a rotation and side-to-side motion." The brace was to prevent both. (Dr. Scheller Deposition, page 56)

160. Dr. Scheller testified that a person with a frayed ACL would experience symptoms of instability and giving way as well as pain. Getting in and out of a truck would affect the stability "if he landed on it wrong." (Dr. Scheller Deposition, page 57)

161. Dr. Scheller testified that "usually in fracture to the ankle, all the force goes to the fracture" and so he stated that he does not know if the left ankle fracture would affect the stability of the left ACL. (Dr. Scheller Deposition, page 57-58)

162. Similarly, the rehab process, being in a cast after the left ankle fracture, would not necessarily affect the ACL.

163. Dr. Scheller was shown his April 29, 2007 note where he wrote in part "...I think the majority of his problems are related to the patellofemoral mechanism and this would definitely go along with his severe knee injury that he had 6 years ago and a development of arthritis changes in the patellofemoral joint and I think this is causally and temporally related to his work-related injury." Dr. Scheller stated:

> "As I explained before, with ligament disruption, you get abnormal anterior-posterior shear; and the quadriceps muscle contracts at different points, and you get peak joint reaction forces across the patella.
>
> So with ACL instability, in time, or PCL instability, you will get arthritic wear of the patellofemoral joint. So this is an attritional thing that has happened over time, and I felt that pain in his kneecap was a big part of it. He had instability also, but."

(Dr. Scheller Deposition, page 59)

164. Dr. Scheller said that a patient in a sedentary position, a desk job, wearing a brace would probably still need refurbishment of a knee brace in a couple of years, but he also stated that he does not have any sedentary people in braces and usually they don't need a brace. He prescribes braces for people who are more active. (Dr. Scheller Deposition, page 60) Dr. Scheller testified that the work Mr. Brown performed from 2003 onwards caused the brace to wear out more rapidly than someone in a sedentary position. (Dr. Scheller Deposition, page 60)

165. Dr. Scheller testified that he did not know and he would "just be speculating" to say whether the need for surgery in 2007 had been accelerated as a result of Larry Brown, II's work. (Dr. Scheller Deposition, page 61) Dr. Scheller testified that the work Larry Brown, II, did aggravate the ACL condition, both the arthritis in the joint and the joint injury, and it stressed the knee. (Dr. Scheller Deposition, page 61) Dr. Scheller does not know what caused the ACL rupture. (Dr. Scheller Deposition, page 61) By "aggravation," Dr. Scheller means "pain, swelling." (Dr. Scheller Deposition, page 62)

166. Dr. Scheller testified that the "ligament issue" "can be aggravated by the increased use." (Dr. Scheller Deposition, page 63)

167. Dr. Scheller testified that the "articular issue" was "going to progress in time anyways, independent of anything." (Dr. Scheller Deposition, page 63) When asked if the articular issue was accelerated, Dr. Scheller testified "it is speculative. It could have, probably. It is a probable issue. I just see a lot of different patients, and patients progress at different rates. It is the initial injury that defines that progression." (Dr. Scheller Deposition, page 63)

168. Dr. Scheller testified that the use of a clutch driving a truck "is going to aggravate the patellofemoral." The damage to the medial femoral condyle "was damaged in the initial event" and "is going to go at its own pace. The patellofemoral is the one that is

aggravated by the persistent instability and the work with the clutch." The involvement of the ACL is that all relate to each other. (Dr. Scheller Deposition, page 64)

169. Dr. Scheller testified that the likely need for a total knee replacement would be to address pain coming from the patellofemoral joint and the medial femoral, but "I think the one that is going to cause the total knee is going to be the medial side. Because every time he bears weight when he walks, that is where he is bearing weight on that. The patellofemoral joint is when you extend the leg and push in like on a clutch." (Dr. Scheller Deposition, page 66)

170. When asked whether the work Larry Brown, II, was performing from 2003 onward accelerated the need for total knee replacement at some point, Dr. Scheller answered, over objection:

> "I think the injury that he got initially was a traumatic and devastating injury to the knee, and I think that is the determining factor. I think Larry is a very motivated person who tries to keep working, and he is trying to work with his disability. He has been dealt some poor cards, and I think he is trying as hard as he can, both with treatment and also in his work.
>
> But the increased use of it is going to exacerbate, clearly, the arthritis in the patellofemoral joint. The medial femoral condyle was defined at the time of the original blow. And the ligaments, the fact that we have had to reconstruct it 2 or 3 times shows the difficulty in trying to reconstruct the knee with no ligaments."

(Dr. Scheller Deposition, page 65)

171. By this answer, Dr. Scheller indicates that the original injury of 1999 was devastating and "the determining factor" and that arthritis in the patellofemoral joint will be exacerbated depending on increased use. He does not say how much increased use is necessary. He made it clear that in no event is the medial femoral condyle affected by any use of the knee after the original injury. Further, Dr. Scheller indicates that the reconstruction of ligaments is attributable to "the difficulty in trying to reconstruct the knee with no ligaments."

172. Dr. Scheller testified that the patient's reports of a feeling of grinding is the arthritis is getting worse. (Dr. Scheller Deposition, page 67)

173. On re-direct, Dr. Scheller testified that the medial femoral condyle damage from the original 1999 injury has followed at a natural progression. The patellofemoral joint symptoms are a combination of the anterior-posterior motion, and then the clutch. (Dr. Scheller Deposition, page 70)

174. A brace does not mitigate the impact of forces on the knee in the patellofemoral joint when pushing down a clutch. (Dr. Scheller Deposition, page 71)

175. Dr. Scheller does not know whether pushing down the clutch in the truck operated by Larry Brown, II, involved any more force than walking upstairs. (Dr. Scheller Deposition, page 71)

176. Dr. Scheller had assumed that Mr. Brown's clutch was like the 5-ton trucks and 2 ½ ton trucks he (Dr. Scheller) once personally operated during his experience in the military, and Dr. Scheller was "assuming by extrapolation" that the vehicle clutches were the same. Dr. Scheller has not pushed down a clutch on the type of truck operated by Larry Brown, II. He does not know if it is a heavy push or not. He does not know if the activity of Larry Brown, II, pushing down on the clutch in the truck he operated actually accelerated the patellofemoral joint arthritis. (Dr. Scheller Deposition, page 71-72)

177. Dr. Scheller testified that he continues to hold the opinion as noted in his April 29, 2007 note that development of arthritic changes in the patellofemoral joint are causally and temporally related to Mr. Brown's work-related injury. (Dr. Scheller Deposition, page 72-73)

178. Dr. Scheller testified that it would be speculative for him to say that the need for a total knee replacement could be attributable to the work Larry Brown, II, performed since 2002. (Dr. Scheller Deposition, page 73)

179. On re-cross examination, Dr. Scheller testified that the use of a regular car clutch on a regular basis would not affect the patellofemoral joint. "I don't think so, I don't think so. Not on a regular – like a truck, an F150 kind of truck? No." (Dr. Scheller Deposition, page 74)

180. Dr. Scheller does not know how much force would be needed to impact the patellofemoral joint in terms of pushing down on a clutch. (Dr. Scheller Deposition, page 74)

Arbitration Hearing Testimony of Bonnie B. Shappy, Esq.

181. Attorney Bonnie B. Shappy represents Mr. Brown in this workers' compensation matter. At one point, Attorney Shappy received notice that Travelers Insurance was making an argument that Mr. Brown allegedly suffered from "idiopathic" injury that was not compensable. Exhibit 16 is a pleading where Travelers raised the issue of idiopathic injury. It was raised before July 14, 2009.

182. On July 27, 2009, Attorney Shappy travelled to Brookline, MA, to meet with Dr. Scheller and to attend his deposition. Attorney Shappy testified that she would not have attended Dr. Scheller's July 27, 2009 deposition, but for the issue of idiopathic injury being raised. Attorney Shappy added "I also think that because of the nature of his expected testimony and the extent of his injuries I was going to attend anyway."

183. Exhibit 15 is the Affidavit of Attorney Shappy dated September 28, 2009, listing an itemization and attaching details of her attorney activity and time, beginning with her April 23, 2009 meeting with Mr. Brown regarding a Notice of Intention to Discontinue Benefits by Gallagher-Bassett services as well as a Form 2 Denial by Travelers Insurance Company.

184. Attorney Shappy's affidavit states that between April 23, 2009 and June 29, 2009, no benefits were being issued to Mr. Brown; then on June 29, 2009 the Department of Labor Specialist, Anne Coutermarsh, ordered benefits to be paid, and a separate order on August 29, 2009 charged Gallagher-Bassett with the obligation to pay benefits. The Affidavit identifies hours of attorney time and paralegal time incurred by Attorney Shappy's office as a direct result of the discontinuance and denials of benefits by Gallagher-Bassett and Travelers.

185. Attorney Shappy's affidavit's Exhibit A identifies time and activities, including August 11, 2009 "review of multiple motions filed by counsel for Travelers regarding arbitration and reconsideration of interim order." An August 12, 2009 entry identifies Attorney Shappy's review of motions and Form 27 filed by Travelers and drafting of a letter to the Department of Labor opposing the Form 27 on the issue of idiopathic injury.

186. Attorney Shappy testified that regarding the August 11, 2009 entry for time to "review multiple motions filed by counsel for Travelers regarding arbitration and reconsideration of interim order," she has "no idea" how much of that time related to Travelers contention of idiopathic injury.

187. Regarding the billing entries for August 11, 2009 and August 12, 2009, Attorney Shappy testified: "My understanding of those motions and my understanding of these entries indicates review multiple motions filed by counsel and my recollection is there were, there was more than just the idiopathic injury raised as reflected in the July filing." She did not identify what percentage of time was spent regarding a response to an idiopathic argument compared to any other arguments raised by the defense.

188. The entry itself for August 12, 2009 does contain a stand-alone entry for legal services – "Draft letter to Department of Labor opposing Form 27 on issue of idiopathic injury" – and records 1.7 hours at $90.00 per hour, or a total of $153.00 per the affidavit of Attorney Shappy. (Exhibit 15)

189. Regarding the August 13, 2009 billing entry by Attorney Shappy – "Finalize lengthy objection letter to Department of Labor regarding Form 27 on issue of compensability" – a charge of 1.4 hours at $90.00 per hour, or $126.00 total, appears per the affidavit of Attorney Shappy. Attorney Shappy testified that she would have to look at the letter to know exactly what was raised "in that objection." But she testified that "obviously the entry indicated the issue of compensability."

190. On cross-examination, Attorney Shappy confirmed that Exhibit 17 is a printout of an email string June 29, 2009 between Attorney Shappy and the attorneys for PMA/Gallagher-Bassett and Travelers Insurance; specifically, the email string is regarding the scheduling of the deposition of Dr. Scheller.

191. The email string on June 29, 2009 occurred before Travelers first raised a contention of idiopathic injury.

192. Attorney Shappy testified that Travelers' defense attorney had earlier spoken to her about the likely presentation of an idiopathic injury defense: "I was aware that it was out there for some time."

193. Attorney Shappy was asked for her opinion whether, at the time, the idiopathic defense was reasonable. She testified that she felt it was.

194. Attorney Shappy testified that she filed a motion for attorney fees with the Department of Labor because "it seemed apparent to me, based on the new rule for informal attorney fees, that this was precisely the case that that particular statute was intended, given that Mr. Brown was left without benefits and it appeared to be a sole carrier dispute for a claim that originated in 1999 and for a claim that had been paid right up until 2009."

195. Attorney Shappy testified that she probably would have filed a motion for attorney fees regardless of whether there was an idiopathic injury argument raised by Travelers.

Deposition Testimony of Andrew L. Chen, MD, MS

196. The deposition of Dr. Chen of June 8, 2010, was admitted into evidence as Exhibit 18. Dr. Chen obtained his Doctorate in Medicine from Johns Hopkins School of Medicine in 1997, and a Master of Science, Materials Science and Engineering in May 1994. He is ABOS Board Certified and holds a license to practice medicine in the State of New Hampshire. He has published numerous articles, peer reviewed publications, published abstracts, authored a book on musculoskeletal care of the mature athlete, and has been a contributing author to many book chapters, and has made numerous national and international presentations in his field of expertise. He holds a number of honors and awards. He has been the physician or team physician staff member for professional baseball and football teams, as well as US Olympic teams. (Exhibit 18, Part II)

197. Dr. Chen testified that the December 1999 injury to the left knee was "what we call a functionally dislocated knee." (Dr. Chen Deposition, page 8) He felt it left Mr. Brown with a "very guarded" prognosis:

> "When several ligaments are torn, it's often very difficult to balance a knee. When we reconstruct even a single ligament, we aim for tolerances within 3-5 millimeters of normal. And so to try to balance simultaneously 4 or 5 ligaments reconstructed at the same time in different directions is a challenge."

(Dr. Chen Deposition, page 9-10)

198. Dr. Chen reviewed the reconstruction surgery performed by Dr. Scheller in 2002. He described the problem if all ligaments aren't all perfectly aligned, balanced, and measured in the procedure:

> "In the short term, the patient may complain of instability, recurrent instability to the knee. In the long term, this may result in ultimate failure of one or more of the grafts and issues with degenerative changes within the knee."

(Dr. Chen Deposition, page 11)

199. He testified that it would be "very highly unlikely" to return the knee as good as it was pre-injury. (Dr. Chen Deposition, page 12) Dr. Chen testified that there was a 3-year span in which he believes the incorrect diagnosis was made, or the incorrect treatment was rendered, which left Mr. Brown "with an unstable knee that sort of predisposed him to perhaps not having the best results once the final reconstruction was done." (Dr. Chen Deposition, page 15)

200. Following the 2002 surgery, Mr. Brown continued to have symptoms which indicated to Dr. Chen that there was perhaps still instability and maybe less than ideal balancing of the knee. More importantly to Dr. Chen, however, was the finding at the 2002 surgery of osteoarthritic changes and the reports of continued pain. Dr. Chen testified the pain symptoms related to arthritis in the knee. (Dr. Chen Deposition, page 16)

201. Dr. Chen testified as to the complexity of the reconstruction surgery:

> "I think that even under the most ideal circumstances in a procedure that is perfectly executed, there are factors that occurred at the time of injury that we are simply not accounting for when we perform these surgeries. For instance, it used to be that we would focus on reconstructing the major four ligaments of the knee, and we sort of let the other ones just "scar in". But as we've come to appreciate, even under the most ideal circumstances of reconstructing those major four ligaments, patients went on to have recurrent instability. And that led to the appreciation that other things around the knee were important, in this case the posterolateral corner. And now that we can reconstruct the posterolateral corner, I still think that there were other elements that were missing that will lead to a recurrent instability even under the best of circumstances for reconstruction. So, yes, he presented me with evidence that his knee was imperfectly balanced and that he was continuing to have issues with the knee. As I said, I shouldn't say that his knee wasn't perfectly balanced at the time of surgery, because I don't know that because perhaps it was, but maybe there are some factors, some small ligaments that we haven't yet identified or haven't yet identified as important, that we need to be reconstructing.
>
> So he was continuing to have instability to his knee. Whether or not that was related to a perfect balancing of his knee, I don't know that."

(Dr. Chen Deposition, page 17-18)

202. Dr. Chen testified that on January 27, 2009, Mr. Brown had already completed several courses of orthovisc. (Dr. Chen Deposition, page 20)

203. Dr. Chen testified that he learned at that appointment "that he was having dramatically or very much increased pain as compared with his typical. And he had indicated that that morning, while walking on his driveway, he sustained a twisting injury to his left knee that resulted in the dramatic increase of his pain. He also stated that he was limping subsequent to this event." (Dr. Chen Deposition, page 20-21)

204. The patient had not come for that incident, but for a pre-scheduled injection of orthovisc. (Dr. Chen Deposition, page 21)

205. Dr. Chen testified that he reviewed Mr. Brown's deposition transcript where Mr. Brown described that on January 27, 2009, he had been walking on a flat, level surface which was described by Mr. Brown as prepared gravel. Dr. Chen testified that he (Dr. Chen) does not consider a gravel driveway to be a level surface. "In other words, anything that has irregularity that may cause your foot to fall in unpredictable ways I believe is an unlevel surface, so, for instance, if I can't rest a glass on it, I don't consider it a level surface." (Dr. Chen Deposition, page 22)

206. Mr. Brown did not mention anything at the January 27, 2009 office visit about tripping or slipping or stumbling or falling. (Dr. Chen Deposition, page 23)

207. "And from what he had told me or what he had told me previous to this, as well as that day, he still had twisting episodes while in his brace, so that was not necessarily unusual for him. What was unusual was the dramatic increase in his pain subsequent to this episode." (Dr. Chen Deposition, page 23)

208. Dr. Chen understood that Mr. Brown had been wearing his brace at the time of the described incident and onset of increased pain. (Dr. Chen Deposition, page 24)

209. In Dr. Chen's opinion, a stable knee is not expected to buckle while in a brace and walking across a level surface. (Dr. Chen Deposition, page 24)

210. Dr. Chen's opinion was that Mr. Brown's knee was neither unstable nor perfectly stable. (Dr. Chen Deposition, page 24)

211. In Dr. Chen's opinion, there's no way to conclude with any reasonable degree of medical certainty that the act of walking normally in a knee brace down a level, prepared gravel driveway would cause a ligament rupture in Mr. Brown's knee, absent any trip, slip, fall, or stumble. (Dr. Chen Deposition, page 24-25)

212. Dr. Chen attributes the disruption of the tendon which had been used for ACL repair – the disruption confirmed on MRI of January 30, 2009 – to the incident of January 27, 2009. (Dr. Chen Deposition, page 25-26) Dr. Chen found it significant that Mr. Brown was limping after the incident. (Dr. Chen Deposition, page 27)

213. In Dr. Chen's opinion, Mr. Brown's episode of left knee buckling on January 27, 2009, was caused by the fact that Mr. Brown "did not have a stable knee." (Dr. Chen Deposition, page 28)

214. In Dr. Chen's opinion, the condition of Mr. Brown's left knee from December 1999 forward was one of "a steady progression of going downhill." He testified that there were times of improvement, but without resolution. (Dr. Chen Deposition, page 31) He did not feel there were any times of temporary remission of symptoms. Dr. Chen also considered Dr. Scheller's testimony and continued to conclude that Mr. Brown "...had small areas of improvement with the big surgery that he had, and then subsequently regaining more stability with his revision ACL, but still never feeling quite perfect, you know, leading up to those injections which helped him for very short periods of time and

then ultimately leading to a re-rupture of his ACL, ..." (Dr. Chen Deposition, page 31-32)

215. Dr. Chen offered that all of the episodes following the original injury were the natural consequence of the original injury. Specifically, the January 27, 2009 buckling event was also causally related to the original December 1999 injury. (Dr. Chen Deposition, page 32)

216. Dr. Chen was asked to consider the opinions of Dr. Wieneke expressed in Dr. Wieneke's deposition; specifically, the opinion that Dr. Wieneke offered that a plausible explanation of the cause of Mr. Brown's complains of left knee pain after 2002 is repeated trauma of the knee on the skidder, primarily running the skidder in the woods over boulders, over logs, having to stabilize oneself with both feet firmly on the floor, and repeatedly loading and stressing the ligaments in the knees. Dr. Chen disagreed with those opinions of Dr. Wieneke. Dr. Chen testified as to his reasons for disagreeing with Dr. Wieneke's theory as follows:

> "First of all, I have never heard of anyone rupturing a native ligament, or any ligament, riding in a skidder, unless there was an accident. I think that if that was within the realm of possibility, it probably would have happened by now.
>
> The second thing, and perhaps the most important piece of data, is that when we attempt to strengthen someone's knee after any sort of reconstruction procedure, we typically start with isometric exercises, going on to what we call closed chain exercises, in which we tell people that the only exercise you can do is with your foot firmly planted against something. It's a much safer way to condition the muscles of your knee in that it allows for strengthening of the muscle while having the proximal and distal elements around the knee stabilized.
>
> So I think the notion that running a skidder, even pushing a heavy clutch could result in a re-rupture of a ligament is implausible."

(Dr. Chen Deposition, page 33-35)

217. Dr. Chen was later informed that there was no clutch in the skidder. (Dr. Chen Deposition, page 36) Dr. Chen does not have any idea how much stress would be placed on a knee as a result of stabilizing oneself while seated with a seatbelt on in a skidder. (Dr. Chen Deposition, page 36)

218. It would be "completely speculative, to conclude that operating a skidder in a seated position would put any more force on the knee than walking up steps; walking up and down steps can confer anywhere from 4-8 times body weight, and even then that is what we call a concentric motion. Even things like jumps, which place up to, you know, 12 to 6 times body weight jumping and landing, have not necessarily been associated with ligament ruptures unless it's landing in an awkward fashion. ..." (Dr. Chen Deposition, page 36)

219. In Dr. Chen's opinion, wearing a brace would mitigate the impact on the left knee while operating a skidder. (Dr. Chen Deposition, page 37)

220. Dr. Chen does not agree with Dr. Wieneke's opinion that putting force into the knee joint in responding to a skidder going up and down is stressing the ACL. (Dr. Chen Deposition, page 39)

221. Dr. Chen disagrees with Dr. Wieneke's opinion that repeated anterior stresses on the knee, sudden, severe, followed by relaxation, stretches and tears fibers in the ACL. Dr. Chen believes the reason for recurrent re-rupture of the ACL is "instability within his knee" which includes the ACL "but also the other ligaments that were reconstructed and perhaps weren't ideally balanced." (Dr. Chen Deposition, page 39-40)

222. Dr. Chen testified that if you have an ACL reconstruction "and a posterolateral corner, if you don't fix the posterolateral corner, they're going to re-rupture their ACL." (Dr. Chen Deposition, page 41)

223. Dr. Chen testified that using a clutch on a truck imitates the kind of exercises that he purposefully puts patients in after an ACL reconstruction. It does not contribute to worsening of the ACL, but it can cause increased pain in the patellofemoral joint. (Dr. Chen Deposition, page 43-44)

224. In Dr. Chen's opinion, there is no way to conclude with any reasonable degree of medical certainty that using a clutch aggravated the pre-existing left knee condition. (Dr. Chen Deposition, page 44)

225. Dr. Chen testified that getting out of a truck or skidder would not aggravate Mr. Brown's pre-existing left knee condition unless he twisted the knee doing so. (Dr. Chen Deposition, page 44)

226. On cross-examination, Dr. Chen acknowledged that he had not seen the records from surgery in 2002 or the results or any notes from the revision ACL in 2009. (Dr. Chen Deposition, page 52) He is aware that there was no treatment after 2003 until 2007 other than a knee brace replacement occasionally, and he obtained that information from reading Dr. Scheller's deposition. (Dr. Chen Deposition, page 52)

227. Dr. Chen has never ridden in a skidder and has never evaluated one for the forces involved. He agrees he has no experience in what forces are applied when riding in a skidder. (Dr. Chen Deposition, page 53) Dr. Chen operates on 20-30 logger-employee patients a year for knee problems, most typically meniscus tears. (Dr. Chen Deposition, page 53) He has never seen a logger with the kind of injury sustained by Mr. Brown. (Dr. Chen Deposition, page 53-54) He does see multi-ligamentous injuries several times a year, one or two ligament tears at a time at most, not as many as Mr. Brown. None of the multi-ligamentous injuries he has seen have been followed by three additional ligament repair surgeries. (Dr. Chen Deposition, page 54)

228. Dr. Chen ordinarily would not recommend using a heavy clutch for patients with patellofemoral arthritis if it caused recurrence of pain. (Dr. Chen Deposition, page 60-61) But with Mr. Brown's instability, Dr. Chen does not think repetitive motion like using a clutch would worsen his instability. (Dr. Chen Deposition, page 61) Dr. Chen

left the matter of restrictions with Dr. Scheller, as Dr. Chen reviewed his primary responsibility as doing orthovisc injections. (Dr. Chen Deposition, page 62-63)

229. According to Dr. Chen, the use of cadaver ligaments does not involve a tendency to have more problems over time when a person with instability in the knee is doing a heavy-duty job. Dr. Chen states that after nine (9) or 12 months an allograft is the same as one's own ligament. (Dr. Chen Deposition, page 66)

230. According to Dr. Chen, activities such as getting in and out of a skidder, jumping in and out of a truck, using the clutch to shift gears and bracing oneself in the skidder, place the patient at risk for re-injury, but "those activities without another injury do not necessarily mean he's going to re-rupture his graft." Dr. Chen would require a type of twisting injury, not the activity itself. (Dr. Chen Deposition, page 68-69)

231. Dr. Chen testified that visco supplementation patients do not necessarily have a set number of series of injections. (Dr. Chen Deposition, page 71) After the first injection, usually there is dramatic relief. After the second and third, there is relief but it's undetermined how long it will last. Dr. Chen tells his patients that they will wean from it, and it is just a matter of time. (Dr. Chen Deposition, page 73)

232. Dr. Chen agrees that jumping out of a skidder and then experiencing substantial increase in pain would contribute to the worsening of the underlying condition. (Dr. Chen Deposition, page 75-76)

233. Dr. Chen remembers on January 27, 2009 that Mr. Brown told him that he had been walking on a gravel driveway. He does not remember whether Mr. Brown described it as planed or smoothed out. He remembers that Mr. Brown previously told him that the knee occasionally twists when it's in the brace. (Dr. Chen Deposition, page 77)

234. If Mr. Brown had been working a desk job, probably he would not have been required to wear a brace all day. (Dr. Chen Deposition, page 79)

235. The frequency of revising a brace is "extremely variable." (Dr. Chen Deposition, page 79)

236. Increased instability affects the wear and tear of ligaments. (Dr. Chen Deposition, page 81) It may affect whether or not ultimately a rupture would occur, depending on the degree of instability over time. (Dr. Chen Deposition, page 81-82)

237. Patella shearing on the distal femur would not affect an ACL, nor would rotational sliding of the patellofemoral joint. (Dr. Chen Deposition, page 82) However, tibiofemoral movements would affect the ACL. The ACL has no attachments to the patella. (Dr. Chen Deposition, page 82)

238. It's difficult for Dr. Chen to say whether Mr. Brown would have needed additional ACL repairs after the 2002 surgery if Mr. Brown had been assigned to a desk job. (Dr. Chen Deposition, page 82-83)

239. Increased activity would accelerate a failure of a graft to a certain degree, but it would have to be beyond a certain degree. (Dr. Chen Deposition, page 84) Dr. Chen was under the impression that when Mr. Brown would tell him that he had been experiencing issues with twisting in the brace, Dr. Chen assumed it was both home and at work, and that it was occurring several times a day. (Dr. Chen Deposition, page 84-85) He did not make this notation in his records of treatment. (Dr. Chen Deposition, page 85)

240. Orthovisc is generally a maintenance-type procedure, and it is not intended to correct anything, but rather to buy the patient time and make the patient more comfortable. There is no expectation of significant improvement of the underlying condition as the result of orthovisc or Synvisc injections. (Dr. Chen Deposition, page 86)

241. If Dr. Scheller placed a patient at medical end point, Dr. Chen would not have a basis to disagree. (Dr. Chen Deposition, page 88-89)

242. On re-direct examination, Dr. Chen testified that he has no information or recollection that Mr. Brown described in January 27, 2009 that the ground was un-level. Dr. Chen put that word "un-level" in his report because he personally has a gravel walkway and thus assumed a similarity. (Dr. Chen Deposition, page 90)

243. If jumping off a skidder or jumping four (4) to five (5) feet produced sufficient forces to shear portions on the tibia with the femur and an ACL tear occurred, it would be traumatic, not repetitive. (Dr. Chen Deposition, page 92-93)

244. On re-cross, Dr. Chen testified that in the last five (5) years there have been significant improvements in fixation techniques.

245. Dr. Chen testified that he had not seen any records other than the operative report shown to him from April 2002 and the 2007 operative note from Dr. Scheller. (Dr. Chen Deposition, page 110) He was just handed the 2002 operative report and it does not change his opinions, even though he did not study the report in detail. (Dr. Chen Deposition, pages 109-110)

Arbitration Hearing Testimony of Kuhrt Wieneke, MD

246. Dr. Wieneke graduated from Williams College in 1959 and Cornell Medical School in 1963. He served as Division Surgeon in the armed forces. His orthopedic residency was in New York City. He was in private practice in Williamstown, MA from 1970 through 1998. Presently, Dr. Wieneke is involved in independent medical exams in his office, one and a half days per week. Dr. Wieneke is board certified in orthopedic surgery, spine surgery, and in forensic medicine. Dr. Wieneke has a license to practice medicine in the State of Massachusetts.

247. Dr. Wieneke testified that knee surgery "is a large part of orthopedic surgery." Dr. Wieneke has personally performed "many knee surgeries, including ligament reconstructions, including acute trauma, and including knee replacement surgery."

248. Dr. Wieneke reviewed forwarded medical records on Mr. Brown, depositions of Mr. Brown, Dr. Scheller, Dr. Chen, and the medical records reviewed included the review of physical therapy records. He believes he reviewed the deposition of Dana Perkins. "I believe that I did, I'm not as certain about that, but I believe that I did." He reviewed all of Dr. Scheller's records, not just the operative reports. He reviewed Dr. Siliski's independent medical examination.

249. Dr. Wieneke has not done a triple ligament repair in the knee. "The reason is this is a complicated surgery requiring more than one surgeon, at least two, usually three, and we don't have these resources in a small community hospital." However, Dr. Wieneke feels this does not affect his ability to testify as to causation. "I mean, causation is basically what I do." Dr. Wieneke testified that he has seen probably 20 or 25 injury cases like Mr. Brown's over many years.

250. Exhibit 2 is an anatomical model of a human knee. Dr. Wieneke used the model to demonstrate the anterior cruciate ligament location where it was torn in the front of the knee, as well as the posterolateral corner above the head of the fibula which was torn, and other ligaments as well as the posterolateral capsule.

251. Dr. Wieneke testified that the outcome of the 2002 surgery by Dr. Scheller "was actually quite good. He now had a stable knee with respect to this posterocruciate, his anterior cruciate, the posterolateral corner, and the lateral collateral ligament."

252. Dr. Wieneke testified that the outcome would be affected by ongoing stresses the patient might put on his knee after the surgery.

253. Dr. Wieneke would expect a cadaver ligament to last a lifetime in someone who has a sedentary job. The likelihood of repeat ligament surgery is increased by the amount of stress the patient puts on the knee.

254. Dr. Wieneke testified that the typical treatment after surgery is physical therapy to restore motion and then to restore strength. Occasionally there are post-operative complications.

255. Dr. Wieneke observed that there was "a little less than 5 years of little to no treatment after the 2002 surgery. The patient had an unloader derotation brace on his left knee during work activities. After the 2002 surgery, Mr. Brown had a course of physical therapy which improved his motion and improved his strength. He may have taken anti-inflammatories during this time. He also had the unloader derotation brace. The brace was refurbished about every 6 months."

256. Dr. Wieneke testified that it is unusual for a derotation brace to be refurbished as frequently as every 6 months. "The braces either aren't worn, in which case they remain pristine, or they're worn during physical activities but not to the point where the leather linings are worn through and metal is showing." Dr. Wieneke testified that during his independent medical exam Mr. Brown's brace "looked very well worn. Parts of the metal were showing through and the leather straps were in poor condition." Dr. Wieneke concluded that the condition of the knee brace was "consistent with working in a wet, muddy climate." Dr. Wieneke testified that in his own patient practice he would

prescribe an unloader brace for a patient if there are arthritic changes in the knee on the medial side or the lateral side, so that the unloader brace "would take weight off that side."

257. Dr. Wieneke would not expect someone who works a desk job to need refurbishing of the brace as frequently as Mr. Brown did.

258. Dr. Wieneke testified that a derotation brace prevents rotation "in one direction." He testified, illustrating with Exhibit 2:

> "... . And if the knee rotates interiorly or medially with the femur on the tibia it tends to tighten the ligament structure. And if it rotates in the opposite direction or exterior rotation of the femur on the tibia, it opens up the anterior and posterior cruciate ligaments crossing and loosens the knee so the knee is, as it externally rotates, it's now able to slip or shuck forward with the medial femoral condyle on the tibia and the derotation brace basically is a strap across the front of the knee to the brace on the medial side that holds the knee in internal rotation of the femur on the tibia and prevents that rotational instability component."

259. Dr. Wieneke testified that arthritis progresses from "an instability pattern in the knees in which the opposing joint surfaces slide, rather than glide." He testified that the type of work the patient does affects the progression of arthritis. Dr. Wieneke testified that the type of work Mr. Brown did accelerated the arthritis in his knee from the time he returned to work in 2003 to 2007.

260. At the time of his independent medical examination, September 9, 2009, Dr. Wieneke noted left anterior cruciate instability and minimal medial collateral instability, left patellofemoral crepitus consistent with chondramalacia or arthritis in the patellofemoral joint. That he found no posterocruciate instability. He did find left thigh atrophy and left calf atrophy.

261. Dr. Wieneke testified that Mr. Brown was 31 years old at the time of the independent medical exam and he looked like a person who did physical work.

262. Dr. Wieneke testified that Mr. Brown described his work as being a logger and driving a John Deere skidder with automatic transmission and also driving a large log truck with an 18-gear clutch transmission.

263. Dr. Wieneke testified that Mr. Brown did not give what appeared to him to be an accurate description of his job. He said that Mr. Brown "...presented it to me as a, a relatively easy going, non-stressful job."

264. Dr. Wieneke testified that his own son, Andy, is a logger and "does exactly the same work."

265. Dr. Wieneke testified that he has personally had an opportunity to ride in a skidder, probably five (5) or six (6) times.

266. Dr. Wieneke described a skidder as being made of steel and that the floor is made of steel, with the brake and accelerator on the right side operated by the right foot, with seats sometimes spring seats and sometimes air seats which are "almost always very worn, cracked with seat material showing through" which he said is "common."

267. Dr. Wieneke testified that an operator of a skidder would have both feet "firmly on the steel floor." He described the operator of a skidder as seated in a position where the knees are at 90° flexion and feet firmly on the steel floor. He testified that the right foot, right heel would be on the floor and the right toes and forefoot would be operating the accelerator. The left foot would be used for stability:

> "You couldn't sit upright without having both feet on the floor. Even with a seatbelt on, in the environment of a skidder which is very rough terrain it includes going over boulders, going over downed logs, going over trees, going over rough and very irregular ground."

268. Dr. Wieneke stated that there is "considerable" force on the left knee when operating a skidder:

> "The, in the first place, the knee is at 90 degrees. And what you are trying to prevent is forward or backward subluxation of the knee joint and you do that primarily by tensing the patellar tendon through the quadriceps tendon to the front of the knee and that basically holds it in position so that typically it would not either rotate excessively or subluxate anteriorly or posteriorly. But conversely if you tense the anterior patella mechanism, that tends to pull the femur forward on the tibia. It tends to do that. So this is the motion that you're trying to prevent and this is the motion which is occurring when you're trying to stay upright in the seat."

269. Dr. Wieneke stated that the use of the left foot to stabilize oneself in the seat while operating a skidder "would stretch the ACL" each time it is used. He testified that driving a skidder would affect the ACL strongly. "There would be constant intermittent stressing of the ACL which would be sudden and sometimes severe."

270. Dr. Wieneke testified that Mr. Brown told him that he climbed up and down the skidder. He testified that Mr. Brown described it as once a day, once in the morning, and then got off at the end of the day.

271. Dr. Wieneke testified that Mr. Brown told him that he had jumped off the skidder: "He told me that on one occasion he had jumped off the skidder and that he had several days, I don't remember exactly, how long, but several days of left knee pain as a result."

272. Exhibits 4, 5, and 6 are photographic images of a skidder demonstrating the general set-up which Dr. Wieneke has observed in skidder cabs:

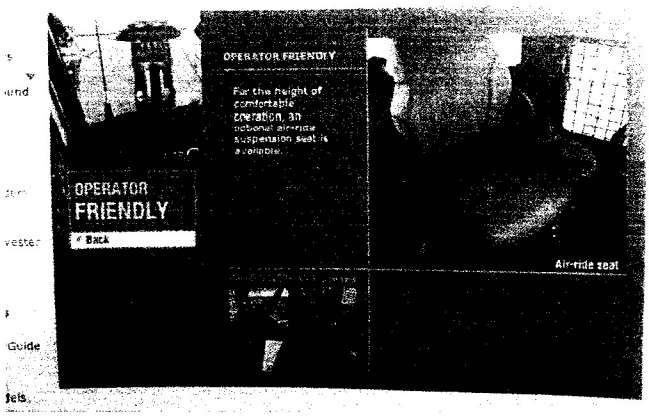


Exhibit 4

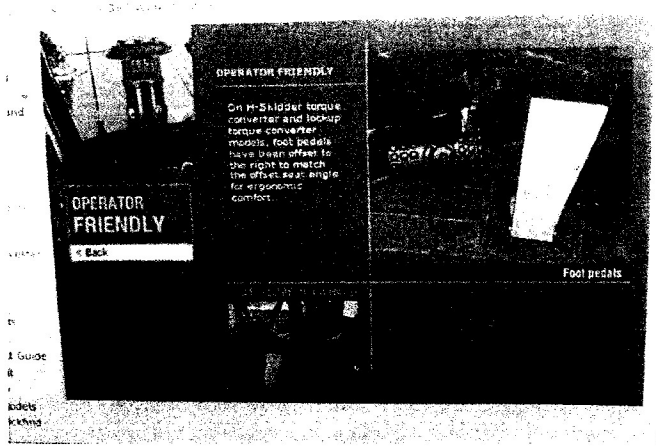


Exhibit 5

Exhibit 6

273. Dr. Wieneke testified that an air-ride seat would ameliorate forces up-and-down, but not from side-to-side or front-to-back.

274. Dr. Wieneke testified that operating a skidder involves "constant" sudden tipping of the cab going over an obstacle.

275. Dr. Wieneke did not testify that he did any investigation of skidders and cab ride phenomenon or forces in preparation for his testimony in this case.

276. Dr. Wieneke testified that when he has been in a skidder cab with his son, his son does not go at "production speed," but rather his son is "going very slowly" when he has Dr. Wieneke as a passenger. Dr. Wieneke testified that it's still "a very rough ride. I mean, it's very hard to stay upright."

277. Dr. Wieneke again testified as to his opinion about Mr. Brown's description of his job duties. Dr. Wieneke testified that Mr. Brown was "minimizing" the stresses on his left knee. Dr. Wieneke stated:

> "For example, he told me that he always climbed up and down the steps and never jumped out of the skidder, and I've seen lots of loggers and they always jump out of the skidder. And it's a pretty high jump. It's probably a 4 ½ to 5 feet high. I'm not saying he didn't do it, it's just that he would be the only one who didn't do it if what he told me was true. He also said that he never had any accidents with his left knee except the one time when he jumped out of the skidder and his knee was sore for several days."

278. Dr. Wieneke recalls his past observation of loggers, and his five (5) or six (6) personal experiences with his son, and concludes that loggers always jump from skidders and never use the steps and that Mr. Brown was probably doing the same thing.

279. Exhibit 7 is an image of fracture cross malleolus illustration from page 413 of Grays Anatomy Almanac 16th Edition. It is an image of the ankle and foot, the skeletal components. Dr. Wieneke identified the location of Mr. Brown's ankle fracture from a slip-and-fall on ice. Dr. Wieneke testified that the ankle fracture was a "displaced fracture that required a screw."

280. Dr. Wieneke testified that more likely than not the ankle fracture affected the left knee "because he got into progressive difficulty after that with regard to his left knee." The manner in which he believes the left knee was affected "will depend at least in part on whether or not he had his brace on at the time." He testified that "if he had his brace on, then he likely would have had the same force that broke his ankle be transmitted through his knee and through his hip."

281. Dr. Wieneke testified that ongoing logging work would have impacted the left knee "...particularly the skidder work would have impacted his knee whenever he did that, whenever he performed that work." Dr. Wieneke offered an opinion that the skidder work "definitely accelerated the underlying condition and accelerated the need for ultimate surgery."

282. Dr. Wieneke testified that the knee brace would be ineffective in reducing stress on the left knee while operating a skidder:

> "And the reason is the derotation brace and the unloader side of the brace function with the knee in extension. With the knee in flexion as in sitting in the cab, the components of the brace particularly with regard to the derotation strap are relaxed. So there isn't any significant help gained with wearing the unloader brace in a seated position."

283. Dr. Wieneke testified that more likely than not Mr. Brown's continued work in the logging industry in the skidder and the truck driving worsened or accelerated the need for the surgeries that were done in 2007; and again the return to work in 2008 and 2009 contributed to an acceleration of the underlying condition.

284. Dr. Wieneke testified that it was "a little bit more, a little bit more difficult to say" whether, in his opinion, driving a skidder and driving a log truck accelerated the arthritic component of the left knee. Dr. Wieneke ultimately testified that those work activities had a "substantial effect, more than one would expect, from the typical wear and tear in a slightly unstable knee." He stated "more likely than not" the work activity contributed to additional development of arthritis in the knee. He said it occurred from 2002 forward.

285. Dr. Wieneke testified that there was no way an operator of a skidder can avoid using his left leg and planting his left foot firmly on the floor, otherwise, even with a lap belt, he would not be able to stay upright.

286. Dr. Wieneke testified that it is "extremely unusual" to have as many replacements of the ACL as experienced by Mr. Brown. He testified that the work activity contributed to the cause of multiple anterior crucial ligament surgeries:

> "The shucking motion or sudden transmission of force through a flexed knee the effect of the sudden force up the shaft of the, of the tibia is the individual tends to tighten the ligament below the patella through the, through the musculature above the knee through the quadriceps musculature and the effect of that is to shuck the femur forward on the tibia. So, that would tend to occur whether or not the brace was being worn at the time."

287. Dr. Wieneke testified that the change from 2002 with mild early arthritis chondromalacia to the findings at the 2010 total knee replacement of grade 3 and 4 chondromalacia was caused by "an instability pattern in his left knee with respect to the anterior cruciate ligament" and that work activities contributed to and accelerated these conditions.

288. Dr. Wieneke testified that using the clutch in the log truck created "substantial pressure in extension on the knee with tightening of the quadriceps muscle group above the knee, transmitted through the patella tendon as the knee is extended against the clutching mechanism." Dr. Wieneke did not know the exact force, but he stated "my understanding is it's about 40 lbs."

289. Dr. Wieneke denied the activity of going upstairs is similar to the activity of working in a skidder.

290. Dr. Wieneke offered an opinion that the surgery performed by Dr. Scheller in 2009 was due to ongoing work in the skidder and also, to some extent, clutching the 18-gear truck transmission.

291. Dr. Wieneke testified that there are no studies which measure the amount of force applied to the left knee when operating a skidder. Nevertheless, Dr. Wieneke testified that his experience of being in a skidder gives him a very good conception of the forces at work on the left knee.

292. Dr. Wieneke testified that at the independent medical exam there was muscle wasting in the left quadriceps and in the left calf. He concluded that this was evidence of long-term use of the brace or limited physical activities using the left leg.

293. On cross-examination, Dr. Wieneke testified that the December 1999 injury left Mr. Brown with basically a "junk knee." Mr. Brown went through the year 2000 with a junk knee. Dr. Wieneke agreed that Mr. Brown went through the years 2000 and 2001 with a junk knee, and that his previous surgeons did not recognize what the issues were.

294. Dr. Wieneke agreed that Mr. Brown went through half of 2002 with a junk knee until meeting Dr. Scheller.

295. Dr. Wieneke agrees that the term "junk knee" refers to a knee that is unstable and with multiple failed ligaments.

296. Dr. Wieneke agrees that for a period of 2 ½ years Mr. Brown was developing arthritis in his left knee.

297. Dr. Wieneke agrees that "the arthritis horse was out of the barn" even before Mr. Brown was first seen by Dr. Scheller. Specifically, for an initial period of 2 ½ years, Mr. Brown was walking around and working with a junk knee that was unstable with a femur shucking over the tibia, or vice versa, whenever walking, and was developing arthritis in that knee over those 2 ½ years.

298. Dr. Wieneke agrees that Dr. Scheller is a very highly respected surgeon and that there aren't many surgeons that do the kind of procedure Dr. Scheller performs, only a handful in New England: "Not that many in the country, and fewer than 5 in New England." Dr. Scheller is one of them. Dr. Wieneke is not.

299. Dr. Wieneke's opinion about what should be expected after a complicated surgery such as performed by Dr. Scheller does not come from Dr. Wieneke's personal treatment of any patients with that condition. Dr. Wieneke agrees that Dr. Scheller and Dr. Siliski would be better resources than he (Dr. Wieneke) regarding complex or multiple ligament repairs.

300. Dr. Wieneke agrees that the 2002 surgery on Mr. Brown's left knee was a "monster surgery." It was technically very complicated. It required more than one surgeon to do it. The surgeon doing the procedure has to start from scratch in terms of trying to figure out the appropriate lengths of the tendons that he needs to replace. Dr. Wieneke agrees that Dr. Scheller was the physician who had to figure out the appropriate length of the ligament as he is doing the surgery. Then the surgeon has to secure it when he feels he's got the right length.

301. Dr. Wieneke agrees that when the patient has lost five (5) or six (6) ligaments in the knee, they all affect each other as the surgeon tightens them down, and it gets to be a very complicated surgery. Ultimately, there's a little bit of guess work involved. Dr. Wieneke agrees that when the surgeon tightens one ligament down it's going to affect the other and vice versa. He agrees that it's awful hard to get that right, let alone having to deal with three (3) or four (4) other foreign ligaments in the knee.

302. Dr. Wieneke agrees that there are two plausible explanations why Mr. Brown's knee continued to worsen after the 2002 surgery and ultimately required total knee replacement in 2010.

303. Dr. Wieneke agrees that the first plausible explanation for causation is that work activity worsened the knee.

304. Dr. Wieneke agrees that the second plausible explanation is that Dr. Scheller didn't get it quite right when he did the procedure in 2002.

305. Dr. Wieneke concludes that it was the first of two (2) plausible explanations; specifically, work activity made the knee worse.

306. Dr. Wieneke agrees that in order to determine whether or not the second plausible explanation is correct or not, one must look at the medical record and take a history and try to piece it all together. Dr. Wieneke agrees that it is part of his job, as an independent medical examiner, to do a history and an exam, and review all the records. Dr. Wieneke agrees that Mr. Brown gave him a history that his knee was unstable ever since Dr. Scheller's surgery in 2002. Dr. Wieneke agrees that Mr. Brown gave him that information, and that Dr. Wieneke took that to be true. Dr. Wieneke agrees that Mr. Brown told him that the knee was always painful for him right after the 2002 surgery. This subjective evidence from the employee, Larry Brown, suggests the knee was unstable after the 2002 surgery.

307. Another piece of evidence to determine whether or not the second plausible explanation is correct or not is to look at the actual medical records. Dr. Wieneke agrees that a patient who walks around with an unstable knee is going to experience a femur shucking or rotating over the tibia, which can lead to worsening arthritis, and also lead to stretching of the ligaments.

308. Dr. Wieneke agrees that if the medical records show objective evidence that Mr. Brown's left knee was, in fact, unstable following the 2002 surgery, that would assist in trying to piece together whether the second plausible explanation is supported.

309. Dr. Wieneke agrees that a July 8, 2002 physical therapy note by Dan Wyand, PT, shows "hyper mobile left ACL with anterior drawer." Dr. Wieneke agrees that the anterior drawer test is to determine if there's some deficiency in the ACL, specifically laxity. Dr. Wieneke agrees that it is fair to read that physical therapy note of July 8, 2002 and conclude that the ACL was loose, based on the testing done on July 8, 2002.

310. Dr. Wieneke agrees that the July 17, 2002 physical therapy note by Dan Wyand, PT, indicates an objective assessment which showed a lax ACL as well as a little excessive forward tibial glide. That could also be described as 1+ or 2+ anterior drawer. Dr. Wieneke agrees it means essentially that because the ACL is lax it's not at the right tightness. The tibia is sliding in the joint. Dr. Wieneke agrees that when the tibia slides in the joint, that's the kind of thing that can lead over time to arthritis. It can also cause an individual's leg to give way while walking.

311. Dr. Wieneke agrees that the physical therapy note of August 30, 2002 reports that the patient is having persistent bouts of instability. Dr. Wieneke agrees that this comment is consistent with what Mr. Brown told him (Dr. Wieneke) at the 2009 independent medical evaluation; specifically, that Mr. Brown was experiencing instability in the knee ever since 2002.

312. The subjective reports in 2002 and the objective testing in 2002 paints a picture that the second plausible explanation is supported and "...certainly would be one answer." Dr. Wieneke agrees that in 2002 there is subjective and objective evidence of instability in the knee, even before Mr. Brown had attempted to return to work.

313. Dr. Wieneke agrees that the physical therapist, Dan Wyand, PT, wrote to the surgeon in August 2002 noting continued instability, or patient sensations of it. Dr. Wieneke agrees that, according to Dan Wyand, PT's records, Dr. Scheller had told him that he thought it was most likely posterior cruciate ligament laxity, as opposed to ACL laxity.

314. Dr. Wieneke agrees that Dr. Scheller felt the ligament lengths weren't quite right from the 2002 procedure. Dr. Scheller's own notes confirmed laxity in the knee after the 2002 surgery, but before Mr. Brown returned to work. Dr. Wieneke agrees that the Dr. Scheller note of December 6, 2002 confirmed a posterior drawer as positive at 1 ½, meaning that the posterior cruciate ligament was lax.

315. Dr. Wieneke agrees that the December 6, 2002 office note by Dr. Scheller also shows a 1+ anterior drawer test result, prior to Mr. Brown returning to work, and that from the December 6, 2002 note Mr. Brown has a lax ACL and a lax PCL prior to going to work.

316. Dr. Wieneke agrees that before returning to work in 2002, Mr. Brown had an unstable knee, and that the unstable knee made Mr. Brown more at risk for developing arthritis.

317. Dr. Wieneke agrees that a cadaver ligament doesn't tighten up on its own.

318. Dr. Wieneke later clarified in his opinion that Mr. Brown had an unstable knee before returning to work. He testified that Mr. Brown "had basically a stable knee" because the ACL was not deficient and it's more difficult to tell deficiency in the PCL.

319. Exhibit 10 is an August 17, 2009 fax received by Dr. Wieneke with certain records, and on the front are notes of information taken by Dr. Wieneke. Dr. Wieneke testified that he received this preliminary information from counsel for PMA/Gallagher-Bassett. It describes the date of injury being the responsibility of defense counsel's insurer client, and notes that the employee drives a log truck and skidder.

320. Dr. Wieneke identified Exhibit 9 as his IME intake form, with the top half filled out by Mr. Brown and the bottom half Dr. Wieneke's own notes. The notes by Dr. Wieneke indicate "multiple small aggravations: driving logging truck (Pat/fem) and jumping or landing on Lt knee." Dr. Wieneke testified that it was "a comment to myself of what was going on driving the logging truck" and that his comment about "multiple small aggravations" was consistent with a thought he had right after speaking with the attorney and immediately before doing his examination and reviewing all medical records.

321. Dr. Wieneke acknowledged that as a scientist he reaches opinions based on all of the information he can get his hands on, relevant to the case. One of his opinions is that the forces in the skidder worsened the knee joint.

322. Dr. Wieneke acknowledged that he's never driven a skidder before. He was not measuring forces in the skidder while sitting in a seat while his son drove one. He does not know the pounds per square inch and does not know the measurement of forces involved. He made no effort to measure it.

323. Dr. Wieneke acknowledged that the pounds per square foot in walking upstairs is known to be approximately four (4) times body weight across the patellofemoral joint. Dr. Wieneke agrees that in Mr. Brown's case four (4) times body weight would be 600 pounds on the left knee.

324. Dr. Wieneke testified that if the 2002 surgery had been done correctly, Mr. Brown would be able to do normal activities of daily living, including going upstairs, in other words placing 600 pounds per square inch over the left knee joint.

325. Dr. Wieneke disagrees that it would be speculation to reach an opinion that the forces on the knee inside a skidder worsened the knee without knowing the pounds per square inch or other force measurements:

> "A: I wouldn't call it speculation. I mean, you know, I have ridden in a skidder. I've watched my son drive a skidder. I know what's involved. I know how rough a ride it is, and I know that this young man before he was 30 years old, had undergone three separate ACL repairs.
>
> Q: Doctor, how many pounds per square inch of force is applied to the knee, of Larry's knee, while operating the skidder on a rough road?
>
> A: I don't know how many pounds.

Q: How about front to back. How many pounds?

A: I don't know how many pounds are involved in any of these activities.

Q: OK. How much better is it for the knee, in terms of pounds per square inch, when you're operating on an air seat as opposed to a spring seat?

A: If the foot is planted firmly on the steel floor, I don't think the air seat has any effect at all.

Q: What's the difference in pounds per square inch?

A: I don't know."

326. Dr. Wieneke testified that arthritis always worsens with time, but, more likely than not, it is especially going to get worse if, after leaving the surgery, the knee is left in an unstable status.

327. Dr. Wieneke testified that he has never seen anyone tear his ACL while driving a skidder, setting aside the case with Larry Brown.

328. Dr. Wieneke has never seen anyone tear his ACL just operating an 18-wheeler in normal fashion.

329. Dr. Wieneke agrees that the pounds per square inch involved in depressing a clutch is about 40 pounds.

330. Dr. Wieneke testified that the excessive wear on Mr. Brown's brace may be due to the fact that Mr. Brown, unlike other people Dr. Wieneke has seen, wears the brace every single day and begins as soon as he's up in the morning.

331. Dr. Wieneke agrees that the atrophy in the muscles on the left leg suggest that Mr. Brown is not using his left leg and knee as much as the right.

332. Dr. Wieneke agreed that it is unclear whether the January 2009 incident walking on the driveway caused any significant injury to the knee: "I think we don't know. I mean it was a series of events over an extended period of time."

333. On re-direct examination, Dr. Wieneke testified that he has sufficient training and experience to comment and render opinions on the question of causation; merely because he has not done a multi-ligamentous surgery does not disqualify him.

334. Dr. Wieneke testified that after the 2002 surgery the left knee was "basically" stable.

335. Dr. Wieneke testified that three (3) separate failures of the ACL is virtually unheard of:

"... . All three failed for a reason. They failed because the ACL was overloaded and the only logical explanation for that is the work he does.

...

> The forces in a bucking, tipping skidder with both feet on the steel floor trying to remain upright are severe. I'm not saying they're substantial, I'm saying they're severe. But having said that, nothing happened to his right knee and yet he failed, his ACL failed three times on the left side. An ACL replacement is not a normal ligament."

336. Dr. Wieneke doubted Larry Brown's factual account that there was stairs on the skidder he uses. Dr. Wieneke bases that on seeing a lot of skidders in the woods.

337. Dr. Wieneke doubts Larry Brown's accounts that he uses the stairs, but rather concludes that Mr. Brown jumps off the skidder. He said his son's skidder doesn't have stairs on it anymore, and they don't last very long.

338. On re-cross examination, Dr. Wieneke acknowledged that other operators do not have junk knees, but rather have excellent knees. He acknowledges that Mr. Brown would have an incentive to use stairs and to want a good set of stairs.

339. On re-re-direct, Dr. Wieneke testified that Mr. Brown told him he had jumped out of the skidder once.

Arbitration Hearing Testimony of Larry M. Brown, II

340. Mr. Brown testified that he's been working for the family logging business for many years.

341. He described the December 28, 1999 work injury. He was getting out of an 18-wheeler tractor when the heel of his boot accidentally got caught and became stuck between the step and the cab, which caused his left knee to twist and, due to the pain, he grabbed his left knee and missed a handle and fell backwards. His left knee bent and twisted further, and he felt the left knee snap and pop. He could not walk on it.

342. Mr. Brown testified that treatment by Dr. Howard and then by Dr. O'Conner was not successful. He eventually came under the care of Dr. Scheller.

343. Mr. Brown testified that if he attempted to stand on his left leg "it wasn't completely there." He had the sensation all the time that he might fall.

344. Mr. Brown testified that between 1999 and 2002, he wore a number of different braces, but they did not help with the feeling of instability. He also had continued pain in the left knee.

345. Mr. Brown testified that in April 2002 Dr. Scheller replaced a number of ligaments. He was out of work for some time after that. After the surgery, however, Mr. Brown still experienced feelings of instability in the left knee, and it increased. Mr. Brown communicated the feeling of instability to his physical therapist.

346. Mr. Brown testified that when evaluated for permanent impairment, Dr. Scheller told him that he was always going to have problems with the knee forever. He was told that he would have to have a total knee replacement. Mr. Brown testified that he had to be careful in the use of his left knee because it hurt. Mr. Brown said he "would pretty much just think twice before I do stuff. Try to put more weight on my right leg than on the left." He testified that he always wore a knee brace all the time.

347. Mr. Brown testified that no medical provider ever told him that he was putting his knee brace on incorrectly. He was told by his doctor that it was best to keep the knee brace good and tight. However, the Velcro wears out.

348. Mr. Brown stated that he reduced the amount of hiking that he would normally do, as part of being careful about his left knee. He also stated that he would "get up and down the steps, make sure just to do it one at a time, rather than go two at a time." He said that included steps to a truck and steps into a skidder.

349. Mr. Brown testified he also would not go into the woods as much, but was more in the machinery, in the skidder "if they were going, you know, if we had a wood lot to walk, I wouldn't walk it."

350. Mr. Brown testified that he would not have to get out of his skidder to grab onto logs and skid them out of the woods. He could do that by pushing a button.

351. Mr. Brown testified that the 18-wheeler truck did not require using a clutch except for first gear because all of the gears afterwards were synchronized and you just use your throttle.

352. Mr. Brown testified that when he returned to work in December 2002, his job duties were restricted to driving the skidder and driving the 18-wheeler. However, with the passage of time, the left knee hurt more.

353. Mr. Brown testified that there was never a time since the 1999 injury that he was pain free. There was never a time since 1999 that Mr. Brown felt his knee was stable.

354. Mr. Brown denied that there was any specific event that happened that prompted him to go back for treatment in 2007. Mr. Brown testified his wife and mother told him to return to the doctors in 2007.

355. Mr. Brown testified that after two procedures done in 2007 he was still in a lot of pain and still felt the left knee instability. He testified that he was referred for surgical injections with Dr. Chen in 2008.

356. Mr. Brown testified that he remembered talking to Darlene Bosell of Gallagher-Bassett in 2007 when he returned to his doctor. He told Ms. Bosell how his knee was feeling. He told Ms. Bosell what he did for work. He personally didn't speak to her much, because his mother spoke with Ms. Bosell most of the time.

357. The 2006 slip-and-fall on ice and left ankle fracture occurred outside of work. Mr. Brown testified that he was wearing his left knee brace at the time he fell down on the ice. He testified there was no increased pain in his left knee and no increased instability in his left knee after the ankle fracture. The left ankle fracture, according to Mr. Brown, did not affect the left knee.

358. Mr. Brown testified that he could not think of anything that he felt he did between 2002 and 2009 which contributed to the need for total knee replacement in 2010.

359. Mr. Brown testified there were instances between 2004 and 2009 where his left knee felt like it would buckle. It happened whenever it wanted to, and would just catch him off-guard. There were instances between 2002 and 2009 where the knee actually did buckle. He testified that there usually wasn't a month where there was a time when the knee didn't buckle at some point during the month. He said that he had been living with this kind of buckling problem for about 10 years. With time, he began to feel grinding in the knee.

360. Mr. Brown testified that even while wearing the brace for his knee, he still felt like his knee could buckle.

361. Mr. Brown testified that on January 27, 2009, he was walking across his driveway when his knee buckled in the brace. He testified that he did not trip, slip, or fall. He did stumble afterwards. It occurred during the daytime, and he was not having any problems seeing where he was going. He already planned to go to Dr. Chen for an appointment that day.

362. Mr. Brown testified that at the appointment with Dr. Chen he was asked if anything had happened recently to make the pain increase. Mr. Brown said that he understood that the question was being asked because he had already had an injection in the knee the week before. Mr. Brown testified that he told Dr. Chen that the knee buckled on him once in a while. He said Dr. Chen then asked when the last time of buckling had occurred. Mr. Brown said that he replied by telling him that it had occurred "this morning."

363. Mr. Brown denied that he felt any different sensation after the particular buckling incident, when compared to the sensations he would experience from previous buckling episodes.

364. Mr. Brown testified that once in the skidder, he would have no reason to get out of the skidder.

365. Mr. Brown testified that standing bothered the left knee. So would buckling episodes. Mr. Brown testified that between 2002 and 2009, standing still would bother him, standing just to be shaving, and anything when he stood still without moving for a while would bother him. There is nothing about work activities in particular that bothered his left knee.

366. On cross-examination, Mr. Brown was shown Exhibits 6, 4, and 5. Exhibit 6 is an image of a cab that looks pretty much like the skidder he operated. Exhibit 4 shows a seat

similar to the seat of the skidder he operated. It also showed the gas pedal and brake pedal that looks familiar.

367. Mr. Brown does not know the size of the skidder wheels.

368. Mr. Brown testified that Skidder Model 648, purchased in 2006 or 2007 by the family business, is the one that he's using now. He does not use a cable skidder.

369. Mr. Brown testified that operating a skidder he uses the right foot for braking and for speed. Sometimes the left foot is used when "grabbing the hitch" and getting the logs.

370. Mr. Brown testified that the average distance from logging landing to the actual site where logs are pulled out is a half mile. He operates the skidder on logging roads. Logging roads are fairly rugged and he would not drive his own car on them. Sometimes in the skidder he's on hills. Sometimes he goes over rocks. He has, in the past, flipped a skidder more than once from going up on a stump wrong.

371. Mr. Brown testified that the average speed operating a skidder is maybe 5 MPH, probably faster without logs hitched on the back.

372. Mr. Brown always wears a lap belt when operating a skidder. He uses his left foot to help brace as the cab shifts. If it's a bumpy ride, you go slower.

373. Mr. Brown testified that another person named Dana cuts the skid trails. Trees are just cut out of the way, and sometimes if it's going to be rough and cause issues, boulders and stumps will be moved out of the way too. If it's a skid trail, Dana always did this.

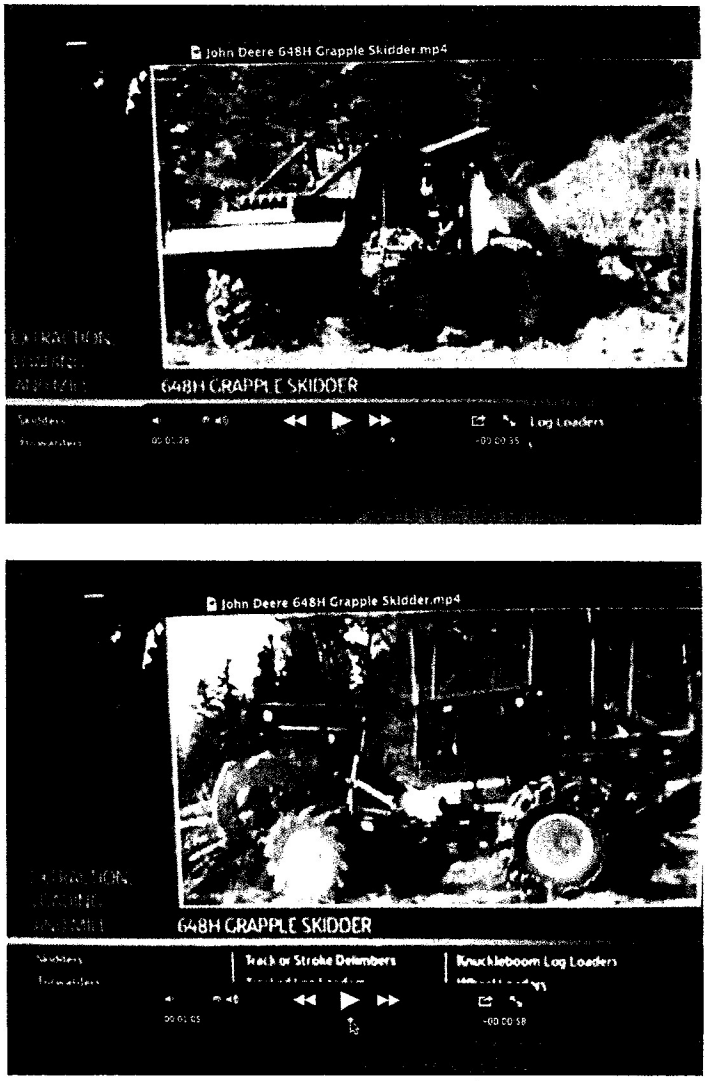
374. Most of the logging occurs on pretty rough terrain.

375. Four (4) or five (5) times the lower step of the skidder has been torn off.

376. Mr. Brown testified that he still did hike through the woods once in a while as part of his job. That happened maybe once a month.

377. Mr. Brown denied that he told Dr. Wieneke that he had jumped off of a skidder. Mr. Brown testified that he read Dr. Wieneke's deposition and concluded that Dr. Wieneke "did nothing but lie. I never told him any of that stuff. He looked at me and told me I don't agree with what you say. My son is a logger. I know you had a very hard job."

378. Mr. Brown was shown a John Deere 648H grapple skidder video (Exhibit 14):



Excerpts from Exhibit 14

Mr. Brown testified "It looks like he's aiming for every stump he can hit." The video depicts the operation of a skidder on fairly level ground. Mr. Brown testified that he operates a skidder in terrain that's much steeper than shown in the video, depending on the area. Mr. Brown said that he tries not to get much more than a 20% angle or slope when logging on hills. He testified that he did not know whether he ever is on a grade of 45°. When asked about Dana Perkins's testimony indicating that would happen pretty much on a daily basis, Mr. Brown replied "maybe." Mr. Brown stated that the video was a fair and accurate representation of what he does with his skidder. However, he testified that in the video "They're trying to dramatize it." He tries not to go over stumps. Mr. Brown testified that he either goes around stumps or tries to avoid hitting them with the tire. There are times when some stumps can't be cleared.

379. Mr. Brown testified that he can do sometimes 10, sometimes 20, runs on an average when in rough terrain. Mr. Brown acknowledged that he is in the skidder about five (5) hours a day, and the rest of the time he is driving. When he pulls logs out, someone loads them

onto the truck, and then he drives the truck to the mill. There are short runs, and then there are longer ones. He uses the clutch at least 12 times on a longer run. The truck is 18 inches off the ground.

380. Mr. Brown acknowledged that the faster you go the rougher the ride in the cab of a skidder if it's a rough trail. Inside the cab is a lot like driving a car, according to Mr. Brown, because it has a steering wheel, a throttle, and the shift lever.

381. Mr. Brown testified that buckling of the knee feels like it kind of gives out, like if you step, it doesn't feel like it's there. The buckling doesn't cause him to fall down or trip. "You kind of just, ow that hurt, and then try to bend it and straighten it a few times, and continue on."

382. Mr. Brown admitted he had not seen a doctor from 2003 until 2007, except for issues with the knee brace. During that time he continued his regular job, plus some mechanical greasing, air hose and oil changes, sometimes. When he returned to work again in 2008, he went back to the same job. He continued to do skidding and trucking, without any significant changes in the amount of time spent in a skidder or driving a truck.

383. Mr. Brown testified that sometimes he would be doing skidding work and leave that same day to drop off logs at the mill. A co-worker walks out and gets the skidder.

384. Mr. Brown testified he gets in or out of a skidder at least twice a day. He does not go to lunch.

385. Mr. Brown testified he remembers telling Darlene Bosell that he was trying to get Dr. Chen's record changed to reflect the fact that he had a problem all along.

386. Mr. Brown testified that the January 2009 incident actually occurred at work.

387. Mr. Brown acknowledged that he went back to Dr. Scheller in 2007 because the grinding got louder and louder. For a time after the 2002 surgery, he didn't have any grinding.

388. Mr. Brown does not remember telling Darlene Bosell that clutching the truck makes the left knee pain worse. Anything pretty much makes it worse.

389. Mr. Brown testified that between 2002 and his 2010 total knee surgery the only time he would not wear a knee brace was when he was sleeping.

390. Mr. Brown admits that the cab of a skidder does shake sometimes.

391. Mr. Brown testified he would generally be out in a skidder about five (5) hours in a day. He does not know what 45° angle means, but thinks that sounds pretty steep. Sometimes, maybe, the skidder would be at that degree.

392. On re-direct examination, Mr. Brown testified that after 2002 he divided his time in the 18-wheeler and in the skidder about 50/50.

393. The January 2009 incident occurred while walking across the driveway at work to get into the truck, but he doesn't remember exactly.

394. On the four (4) or five (5) occasions where the stairs to the skidder were ripped off, they were replaced the next day or so.

395. On re-cross, Mr. Brown testified that to get out of the skidder when the steps ripped off, he would lower himself down, not jump down.

Arbitration Hearing Testimony of Darlene Bosell

396. Ms. Bosell testified that she started her career in the insurance industry with Wausau Insurance. Following a huge layoff in 2004, she interviewed and was hired by Gallagher-Bassett Services in October, 2004, initially as a temporary employee and became a permanent employee in November 2004, as a Senior Claims Representative. She handles workers' compensation claims from various states in the Northeast, with frequent interviews.

397. Ms. Bosell testified that in and around May 9, 2007, her supervisor, Karen Provencher, assigned her to the claim of Larry Brown, II. Ms. Bosell testified that in a case where there's a lot that was done initially, she would just be looking for information on what's going on now, what causes the need for the claim to be re-opened, and to gather all that information again. Ms. Bosell testified that she made contact with the employer and learned that it was a family-owned logging business. She spoke with Larry Brown, II's mother, who was also the owner. Larry Brown's mother said that Larry Brown needed the surgery to stabilize his leg, and Mrs. Brown stated that the type of injury involved was one where they expected that Larry Brown would have future medical needs. She told Ms. Bosell that Larry Brown was wearing a brace on a regular basis and had it replaced every six (6) months or so, and that generally the surgery now needed was the result of the original injury in 1999.

398. Ms. Bosell testified that she eventually spoke directly with Larry Brown, II. She said that he described his duties as driving a truck and running equipment in the business, and that he said his knee had been bothering him more and more over the last year, that conservative measures weren't helping him anymore, and that the doctors felt that he needed surgery to stabilize his knee, and that they thought the ACL repair from the past had stretched out.

399. Ms. Bosell testified that Larry Brown, II did not tell her about the 2006 left ankle fracture, nor did Mrs. Brown.

400. Ms. Bosell testified that she normally works in the spirit of collaboration with the employer. In this case, however, Ms. Bosell testified that she learned that the employer's reference to the same insurance was incorrect. Betty Brown had told Ms. Bosell that the insurance was still carried through Gallagher-Bassett Services. Ms. Bosell testified that she (Ms. Bosell) learned much later, sometime in 2009, that the coverage was not with Gallagher-Bassett. According to Ms. Bosell, coverage for BB Trucking ran from April 1, 1997 through April 1, 2005, and that coverage for Larry Brown Logging & Chipping ran

from April 1, 1997 through April 1, 2004. Ms. Bosell testified that BB Trucking was identified in the original Form 1. Ms. Bosell testified that Betty Brown later said that the claim should have been filed under Larry Brown Logging.

401. Ms. Bosell testified that part of her investigation in 2007 was discovering that the MRI that year failed to show any new tears, and also that Dr. Scheller described it as a recurrence of the original injury from 1999.

402. Ms. Bosell acknowledged that she had the opportunity to arrange for an independent medical examination in 2007. She testified that she did not order an independent medical examination in 2007 due to the severity of the injury, her belief that Mr. Brown would have complications in the future from that original injury, Dr. Scheller's comment that it was a recurrence, plus Ms. Bosell had also assigned a nurse case manager to gather information and the nurse case manager informed Ms. Bosell that Dr. Scheller's opinion is a highly regarded opinion in the mind of the Department of Labor. Ms. Bosell testified that she concluded that the current complaints in 2007 were the result of the original injury. She therefore did not feel it was necessary to secure an independent medical examination.

403. Ms. Bosell testified, however, that on February 27, 2009, she filed a Notice of Discontinuance of Benefits. That was because she learned of a new tear on MRI, asked Dr. Scheller if this was a new injury or the original injury, and Dr. Scheller "came back stating that he felt it was an aggravation of the original injury." Thus, Ms. Bosell filed a denial.

404. Ms. Bosell testified that if she had the 2009 information back in 2007, she would have filed a Denial in 2007.

405. Ms. Bosell testified that had she been aware of the 2006 left ankle fracture, it would have affected how she approached the case in 2007.

406. Ms. Bosell testified that she was missing material facts in 2007 that would have allowed her to deny the surgical intervention at that time:

> "Well, I didn't have any medical evidence that said that this was an aggravation of a condition and I did not know about a fractured ankle at that time and the other issue being the coverage aspect, you know, whether that was a valid response that I had at that time which is, now I know it was not."

407. Ms. Bosell's file notes indicate Mr. Brown returned to work on February 18, 2008. She confirmed that on page 233 (Exhibit 11).

408. Ms. Bosell testified that after she filed a Denial in 2009, Larry Brown, II, called her in March 2009. She testified that he informed her that he had contacted Dr. Chen's office saying that he thought they didn't put all the information in the note and that he wanted them to alter the medical note and also, according to Ms. Bosell's testimony, Mr. Brown stated that he had had the same problem all along, and that he felt the doctor only put down a portion of his statement. Ms. Bosell testified that she replied to Mr. Brown that

the medical note reflected that there was an actual incident and that that was why the claim was denied. She also testified that she asked Mr. Brown if he used a clutch.

409. Ms. Bosell testified that she did not feel that she had all of the information in 2007:

> "The, knowing about the ankle fracture I would say that would have made a difference. Knowing about the coverage, ...could have or could not have but really ultimately Dr. Scheller saying at that time that it was a recurrence and not an aggravation didn't leave me to believe that I'd be able to have a new claim or file at that time anyway."

410. Ms. Bosell testified that in 2007 she was unfamiliar with skidder operations:

> "I wasn't, I did not know much about how a skidder operator worked when I did the initial investigation. I mean I knew from what Larry had said that he gets in and out of the equipment and that kind of information, but nothing more specific than that."

411. On cross-examination, Ms. Bosell testified that her acceptance of the claim in 2007 was caused by the strength of Dr. Scheller's opinion, and she did not think she needed to address the question further. Based on Dr. Scheller's opinion, Ms. Bosell felt that the claim was still related to the original injury, and thus coverage and getting an independent medical examination were not decisive factors.

412. Ms. Bosell testified that in 2007 she could have ordered an independent medical examination if she wanted too. Ms. Bosell testified that the nurse case manager with Genex hired by the company suggested to Ms. Bosell that it was possible to get an independent medical examination to look at the question of whether it is still related to the 1999 injury. Ms. Bosell testified that she understood from the nurse case manager that Dr. Scheller's opinion is highly regarded. Therefore, Ms. Bosell chose in 2007 not to order an independent medical examination because Dr. Scheller's opinion was so highly regarded, and because Ms. Bosell believed Dr. Scheller's opinion was accurate.

413. In 2007, Ms. Bosell was a senior adjuster at Gallagher-Bassett. She testified that part of her responsibility was to figure out whether or not the new treatment in 2007 being requested and planned was compensable; specifically, whether it was something Gallagher-Bassett was obligated to pay. Ms. Bosell testified that in order to discharge her obligation to investigate the claim, she did a number of things. She collected medical records. She made contact with Dr. Scheller's office. She received his opinions. She also hired a nurse case manager. She spoke with the employer. She spoke with the employee who told her, in part, that he was getting in and out of the equipment. He described his job responsibilities.

414. Ms. Bosell testified that she wasn't told about the left ankle fracture that had occurred in 2006. She testified "so, you know, to me that makes a huge difference in, you know, what information I was given at the time. I did the original investigation."

415. On further cross-examination, Ms. Bosell acknowledged her testimony from a deposition she gave before the arbitration hearing. In that deposition she acknowledged saying that

the MRI did not show a new tear. She acknowledged being asked to look back and state whether there was anything she felt she didn't have that she should have had in May 2007 in order to make a determination as to compensability. She testified that her answer to that question at her deposition was "no." Ms. Bosell testified that she did not understand at the deposition that the question pertained to looking back as opposed to imagining it was still 2007.

416. Ms. Bosell testified that in 2007 she made the decision to pay medical benefits, indemnity benefits, because after her full investigation as a senior adjuster for Gallagher-Bassett she decided that the current medical situation was all related to 1999.

417. Ms. Bosell testified that she obtained medical records. She claimed that the medical records did not reference the ankle fracture.

418. Ms. Bosell testified that she wasn't sure that Dr. Scheller was aware of the 2006 ankle fracture.

419. Ms. Bosell testified that in 2008, Mr. Brown continued in medical treatment, and that she knew the job Mr. Brown was doing. Ms. Bosell admitted that she knew Mr. Brown was working in all aspects of his logging business, and that she understood Mr. Brown in 2008 was using machines to grab trees, and that he was in and out of the equipment in 2008, and that she was continuing to pay benefits for treatment with Dr. Chen. She acknowledged that she was aware that Mr. Brown's left knee was still bothering him in 2008. She was getting Mr. Brown's bills and medical records.

420. Ms. Bosell testified that what prompted her to order an independent medical examination with Dr. Wieneke was an indication that there was some new event in January 2009. She specifically identified the MRI which showed a tear.

421. Ms. Bosell testified that she was reporting to people at PMA in the form of "Plan of Action" reports, and that someone from Agri Services would also get the reports. The insurer was PMA. Ms. Bosell testified that no one from PMA ever replied saying that there was no coverage or that there hadn't been coverage for more than two (2) years, and no one from PMA Insurance asked why are we paying? Ms. Bosell testified that the reason for that was because she (Ms. Bosell) had put in her notes that coverage was good.

422. Ms. Bosell identified Exhibit 12 as a June 19, 2007 entry she made in the claim filed:

> "Compensability established. Original knee injury was significant and it was noted back then that he'd require further surgeries. Will evaluate records as they become available. May have a records review or an IME to determine if the tear found is considered a new finding from a different cause than the overall knee injury. If so, another claim may need to be filed by this employer."

423. Ms. Bosell testified that her claim note on page 102 (Exhibit 22) contains her own assessment of Mr. Brown's job over the last few years, where she wrote on May 10, 2007 at 9:42 AM:

> "Considering that the EE is a logger, I'd say that's a pretty physical job."

424. This was written the day that Ms. Bosell started her investigation. Ms. Bosell testified that even on the first day of her investigation, she was already considering whether or not an independent medical examination would be necessary.

425. Ms. Bosell testified that she made a "diary review" in the claim file on May 18, 2007, which stated in part: "This is a family owned farm so it's expected that he'll go back to work in a timely manner and return to his pre-injury capacity." Ms. Bosell testified that by this she knew that Mr. Brown worked a heavy, manual, physical labor job, and that she expected as soon as he went through this time of medical issues he would go right back into logging.

426. Ms. Bosell identified page 109 of the claim notes (Exhibit 22) and identified her own comment on June 11, 2007: "If EE doesn't improve from this, it's possible that further surgery will be due. If so, IME before apprvl." Ms. Bosell testified that this was a month into the claim and that she had already reviewed medical records, gotten contact from the doctor's office, spoken with the employee's mother Betty Brown, as well as the employee Larry Brown, II, and she had made payments.

427. Ms. Bosell identified page 113 of her claim file notes (Exhibit 22) where her supervisor provided an electronic note to her: "Darlene pls clarify in notebook that you have accepted this claim for surgery since it appears that you were originally questioning the surgery and then accepted it." Ms. Bosell testified that she received additional notation on June 13, 2007 from her supervisor which stated, in part: "I am not comfortable with all the contact going through claimant's mother who is also the employer. I strongly caution you in what you relay to her as she is not our typical employer contact since she is the claimant's mother and it is obvious where her loyalties lie based on your notes." (Exhibit 22, page 113) Ms. Bosell testified that she replied on June 18, 2007:

> "Comment to Supervisor: I agree with the indication of concern with employer contact being the mother. I've been careful about what I've said due to this. I've also advised her that I cannot just speak with her and that her son is an adult and should be speaking with me directly. ... . From what I reviewed in the notes, the original injury was severe and the old notes indicated that he'd more than likely require further surgery in approximately 5 years, which is where we are now. It also reflects that he may eventually need a total knee replacement. HOWEVER, in the recent surgery I saw indication of an actual tear, so I'm asking that clarification be provided on whether that finding is a result of the original injury or possibly something that's occurred since then with his continued physically-demanding job. If it's a new finding, it's possible the employer will need to file a new claim. I expect that a claim with this late date doesn't get affected by a mod anymore either. It all comes down to whether the tear is a new finding to make that determination on what will happen next."

428. Ms. Bosell testified that her supervisor then recommended on June 18, 2007 that she (Ms. Bosell) get an independent medical examination and also start surveillance on Mr. Brown to check on what he was doing.

429. Ms. Bosell testified that even though she had some concerns about the loyalties of Betty Brown, as articulated by her supervisor's note, and, for example, she could not discuss with Betty Brown surveillance activities to be started, she (Ms. Bosell) felt she could still trust Betty Brown on coverage. Ms. Bosell was paying benefits on the 1999 injury.

430. Ms. Bosell testified that her understanding gained in her investigation included review of older notes which had indicated that the original injury was severe and that Mr. Brown would more than likely require further surgery in five (5) years, and also eventually a total knee replacement surgery. Ms. Bosell testified that those comments also further clarified why she paid benefits in 2007 on the original injury claim from 1999.

431. Ms. Bosell testified that her notes in mid-June 2007 include her desire to confirm whether or not a new tear represented a new finding and whether it should be part of the original 1999 claim. She testified that she decided eventually that it was still part of the original injury. Ms. Bosell testified that it was due to the information that she received from Dr. Scheller. Ms. Bosell testified that she paid benefits through 2007 and through 2008 based on her investigation and her conclusion after reviewing everything referenced in the claim file notes, including medical information that all was caused by and related to the 1999 injury. Ms. Bosell testified that she did not order an independent medical examination in 2007 or 2008 because of the investigation information. She specifically stated:

> "I believed that the information provided from Dr. Scheller was highly regarded and I did accept his opinion at that time."

432. Ms. Bosell testified that she recognizes that the nurse case manager note in the claim notes from June 25, 2007 (Exhibit 22, page 130) state that the employee reported slipping on ice about a year earlier with trauma to the left ankle "...and this may have some bearing on this file as well." Ms. Bosell testified she did not recall if she saw that note or not: "I don't recall if I did or not. I would have to review all my notes, but I do not recall anything about it, no."

433. Ms. Bosell testified that on August 16, 2007 she entered a claim note which stated in part: "Have the nurse follow the medical care to be sure that subsequent surgery is still relating to this incident. Considering the extent of damage, it's believed to be." (Exhibit 22, page 151) Ms. Bosell testified those represent her though processes on deciding whether or not to pay the claim under the 1999 injury.

434. Ms. Bosell identified in a claim note entry she made on August 16, 2007 for the attention of her supervisor, which stated in part: "I await notes from f/u to determine success. Unfortunately, it's expected that EE will have numerous medical needs over his lifetime due to the extent of original injury." (Exhibit 22, page 152) Ms. Bosell commented that this meant she was expecting Mr. Brown in 2007 to have problems over his lifetime due to the 1999 injury, and that it was her belief at that time that Mr. Brown might have to deal with a total knee replacement. Ms. Bosell testified that, despite the fact that she expected Mr. Brown to have problems over his lifetime due to the severity of his injury in 1999, the goal she had was still to return him back to work. Ms. Bosell identified the nurse's note entry in the claim notes of December 4, 2007, that Mr. Brown was reporting

his best money-making is winter and that Mr. Brown was working hard to return to work by the next appointment scheduled with Dr. Scheller. Ms. Bosell testified that she knew that Mr. Brown was going back in December 2007 into the same, heavy, physical, manual labor job that he had been doing previously.

435. Ms. Bosell testified that she made an entry into her claim notes on December 11, 2007 (Exhibit 22, page 203) which stated in part "expectation of complicated issues from significance of initial injury have been addressed and ongoing needs are related." Ms. Bosell testified that she was referencing her expectation of complicated medical issues attributable to the original injury of 1999.

436. On re-direct examination, Ms. Bosell testified that the nurse never told her that Mr. Brown fractured his left ankle.

437. Ms. Bosell testified that she never saw any medical records that indicated that there was a left ankle fracture.

438. Ms. Bosell testified that references in the claim notes indicating that the injury is accepted really means that the original injury had been accepted in 1999.

439. Ms. Bosell testified that her first knowledge of the left ankle fracture occurred when it was raised in the deposition of Mr. Brown. She denied knowledge of the left ankle fracture prior to 2009.

440. Ms. Bosell testified that her previous deposition answers that looking back on things she didn't lack anything to make a determination as to compensability, she did lack the opinion from Dr. Wieneke in 2007. Ms. Bosell testified that if she had Dr. Wieneke's opinion, together with clarification of coverage, she "...definitely would have questioned more if those material facts would have changed the course the case would have gone."

Arbitration Hearing Testimony of Curt C. Hassler, PhD

441. Dr. Hassler's 23-page CV shows that he holds a Ph.D. in Forestry, a Masters in Forest Biometrics, and a Bachelors in Forest Resources Management. He is currently President of Balken Tier Consulting, a business of consulting services, applied research and development in wood products manufacturing, forestry, and occupational safety and health. He was a member of the West Virginia Forestry Association, serving on its Workers' Compensation Committee and Chair of its Safety Committee. His publications include "Skidders, Trucking, and Fellers Limiting Factors in WV Logging Industry" (16th publication), "Logger Certification and Training" (28th publication), "OSHA Inspections of Loggers in West Virginia" (30th publication), "Safe, Health, and Regulatory Issues for the Wood Industry" (31st article), "Analysis of West Virginia Workers' Compensation Records for the Wood Products Industry (1989-1990)" (48th publication), "Comprehensive Mine Safety Program for Loggers" (70th publication), "Safety, Health, and Regulatory Issues for the Wood Industry – An Overview" (88th publication), and "SKIDLOG – An Interactive Skidding Model" (107th publication). Dr. Hassler's listed research projects reports include "Ground-based Skidding Cost Estimators" (5th research project), "Skidding Productivity and Cost Estimators for Thinning to Reduce Gypsy

Moth Impacts" (32nd research project), and "Productivity and Cost Estimators for Conventional Ground-based Skidding on Steep Terrain Using Preplanned Skid Roads" (33rd research project). Dr. Hassler's presentations listed include "OSHA Compliance for Loggers" (12th and 13th listed presentations), "West Virginia Loggers Safety Initiative Safety Inspections" (14th presentation). Dr. Hassler's list of funded projects include "Logging Safety Training Grant" (15th funded project), "Logging Safety Training Grant" (18th funded project,), "Safety Training Grant") (24th through 28th, 32nd, 39th, and 48th through 50th funded projects), "Determining High Risk Factors in the Log Loading and Unloading Process" (37th funded project), "Ground-based Skidding Estimators" (90th funded project), and "Ground-based Skidding on Steep Terrain" (100th funded project).

442. Dr. Hassler testified that he has been involved with logging research, safety-related aspects, for decades. His experience involves research and study of logging systems from an economic cost standpoint, collecting time and motion data, and publishing, which includes observing work operations from felling trees through the skidding operations. The other component of his experience is on the safety-side of logging, including OSHA grants, providing safety training and services to the industry in general, including four (4) years conducting safety inspections for logger safety initiatives throughout West Virginia which required anywhere from 150 to 200 field inspections per year for four (4) years. He has also provided safety training and field inspections for companies in other States besides West Virginia.

443. Dr. Hassler reviewed materials in this claim, including the deposition of Mr. Brown, Dr. Wieneke, Dr. Scheller, and other materials, including articles from the Historical Society referencing Larry Brown Logging, plus the medical records, plus a review of Dr. Wieneke's report. He also reviewed claim file notes which include references to Mr. Brown's conversations with the insurance adjuster at Gallagher-Bassett.

444. On *voir dire* by defense counsel for Travelers, Dr. Hassler testified that his PhD is in forestry, which involves studying on-the-ground logging operations and how they interact between individual components in the woods, their productivity and cost. Dr. Hassler is not a medical doctor, and has no specialized training in medicine, including orthopedics. He has no specialized training in bio-mechanics, kinematics, kinetics, ergonomics. Dr. Hassler has no training related to the forces exerted on lower extremities of humans while operating a skidder.

445. Dr. Hassler's previous experience as an expert witness has concerned many issues of safety, one involving the evaluation of timber, none involving workers' compensation claims.

446. Dr. Hassler understood that the purpose of his testimony was to establish that there was a deviation from the appropriate standard of care. In his previous testimony in other cases, he was called by the logging companies to establish that the person who was injured was somehow negligent and that the person was not complying with safety regulations which led to the injury. Dr. Hassler could not recall any case where has testified where negligence was not an issue.

447. Dr. Hassler testified that he feels qualified to offer an opinion about Mr. Brown's need for surgeries in 2002, 2007, and 2009 "because I think there was a potential for a number of unsafe acts that Mr. Brown may have engaged in..." He also felt qualified to offer an opinion that "...the day-to-day operation of the skidder also has a potential to impact that as well."

448. Dr. Hassler acknowledged that regarding the forces that may be exerted on Mr. Brown's knee joints while operating a skidder are not something he can quantify: "...so I can't quantify forces as an engineer would."

449. PMA/Gallagher-Bassett's counsel represented that Dr. Hassler was offered as an expert primarily to provide information about the operation of a grapple skidder and how it impacts an operator, some of which differs from Mr. Brown's testimony; specifically, Dr. Hassler was to be offered as a "skilled, experienced individual to testify as an expert on the subject. He has been in skidders, he has done tons of research as can be seen from his CV on operating procedures of the logging industry." He was offered to give testimony as to skidder operations and what's involved inside, "how the forces are exerted on the knee, not necessarily a pounds per square inch. It's primarily observations of how the knee is forced around and the impact of the skidder on the operator." Dr. Hassler's testimony was offered also to support Dr. Wieneke's explanation about how forces impact on the knee, as well as to partially challenge the credibility of Mr. Brown's description of the operations of a skidder.

450. On direct testimony, Dr. Hassler testified that he has observed grapple skidders in the course of research and safety inspection, probably close to 30 years of observing grapple skidders in research and safety. He has also been inside of grapple skidders. He has had the opportunity to see operators operating inside the cab.

451. Dr. Hassler described the cage of a John Deere 648H, that the right foot is normally operating the throttle and brake, the left foot is either on the deck of the skidder to provide stability or occasionally may be used to brake. The left hand is usually on the steering wheel, and the right hand used for operating the gear shift, the controls for the grapple skidder, and blade.

452. Dr. Hassler testified that there is no way to physically not use the left leg to stabilize oneself during normal operations in a skidder. You have forces, both forward and backward, up-and-down or side-to-side, as the skidder traverses over rough terrain, ruts, stumps, and rocks. Dr. Hassler said the seatbelt obviously keeps the operator in the seat primarily for up and down motions and with less effect for side-to-side and front-to-back. The Air Ride seat does not impact the motion of the rider inside the cab, it just mitigates up and down forces for comfort level.

453. Dr. Hassler testified two things impact the operator. First the terrain, and second the speed. If you are maintaining a higher speed over bumps, rocks, ruts, etc., "...you are going to experience higher levels of impact on the knee. If he's slowing down as he moves over a stump or a rock, then the, the impact would be less."

454. Dr. Hassler testified that if testimony is correct, that the skidder occasionally operated on 45° of angle, there's a very high possibility of regular overturning of the skidder.

455. Dr. Hassler testified that the range of a skidder for speed is between 2 MPH and 10 MPH, so Mr. Brown's estimate of 5 MPH on average would be "reasonable."

456. Dr. Hassler stated that the terrain in Vermont is similar to West Virginia, and, therefore, Mr. Brown would have been encountering a little heavier stress than average.

457. Dr. Hassler testified that when weather gets wetter, the roads begin to rut, and you get stones, big rocks, and that increases the stresses on the operator inside the skidder, front-to-back, side-to-side, and up-and-down.

458. Dr. Hassler testified that it's reasonably common that a low-slung lower step gets ripped off from a snag on a rock. Dr. Hassler's understanding was that Mr. Brown was operating on uneven and rough terrain.

459. Dr. Hassler testified that the proper procedure to get in and out of a skidder is a three-point mount or dismount, using hands on handles and steps. Depending on the size of the skidder tires, a skidder is between five (5) and six (6) feet off the ground. That means that if an operator jumps from the cab, he will jump between five (5) and six (6) feet down.

460. Dr. Hassler testified that Mr. Brown's estimate of 18 inches from the ground to the first step would still be within his (Dr. Hassler's) own range of a skidder being about five (5) to six (6) feet off the ground.

461. On cross-examination, Dr. Hassler admitted that he did not perform any scientific testing or measuring in forming his opinions. The information on heights of cabs came from experts in the field, and the information on skidder speeds is based on his own research from 1992.

462. Dr. Hassler testified he does not know how many pounds per square inch of force is exerted on the knee joint when operating a skidder.

463. Dr. Hassler did not measure the forces that are exerted on an operator of a skidder, whether side-to-side, front-to-back, up-and-down.

464. Dr. Hassler did not know what type of suspension system existed on the skidder Mr. Brown was operating in the field. He did not know whether it had any shocks. He admitted that the skidder machine itself is designed to go through the woods.

465. Dr. Hassler testified that he relied upon Mr. Brown's estimate of 5 MPH average speed, which would be "about 40% faster than my research shows for a skidder of a similar size." However, Dr. Hassler acknowledges that a skidder has no speedometer, and there's no way for the operator to know exactly his speed without the benefit of a speedometer.

466. Dr. Hassler believes that operating a skidder is a "rough ride," but he did not use any uniform system to determine the varying degrees of roughness.

467. Dr. Hassler cannot qualify the degree of "roughness" and cannot provide a "pound per square inch" description. Dr. Hassler does not know how much "roughness" it takes to cause a recurrent tear of the anterior cruciate ligament of a skidder operator.

468. Dr. Hassler has never been to a work site of the employer of Mr. Brown. Dr. Hassler has never done logging work in Vermont, and has never seen the actual terrain that Mr. Brown has been working on. Dr. Hassler is not familiar with the logging roads on which Mr. Brown has operated a skidder, and therefore cannot give testimony on the quantity of stumps or rocks, the slope of that terrain.

469. Dr. Hassler never inspected the actual skidder, nor has he seen Mr. Brown get in and out of his skidder.

470. Dr. Hassler was not aware that Mr. Brown testified that he tried not to operate the skidder in a manner to make ruts in the road. Dr. Hassler stated that it would be impossible to avoid developing ruts when traveling in the skidder several times during the course of a day. When weather is wet, the skidder creates ruts.

471. Dr. Hassler is unable to offer any opinion whether a knee brace mitigates the side-to-side forces when operating a skidder.

472. On re-direct examination, Dr. Hassler testified that he relied on information from depositions in the case to gain an understanding of the terrain on which Mr. Brown operated a skidder, particularly the deposition of Dana Perkins who described it as uneven terrain. Dr. Hassler therefore concluded that there could be ruts, could be flat or sloped, but in any case it was always rough because it was rocky, and always with stumps.

473. On re-cross examination, Dr. Hassler testified that he understood that Dana Perkins gave testimony that he would slow down for obstacles when operating a skidder.

474. On re-re-direct, Dr. Hassler testified that if you go over an obstacle, you would get the side-to-side and front-to-back motion regardless of how quickly or slowly the skidder moves.

Arbitration Hearing Testimony of John M. Siliski, MD

475. John M. Siliski, MD is a graduate of Harvard College and Harvard Medical School with post-doctoral training, including Chief Resident in Orthopedic Surgery at Massachusetts General Hospital, a fellow in orthopedic surgery at Brigham and Women's Hospital. He holds a license to practice medicine in the State of Massachusetts. He is board certified in orthopedic surgery and serves as an instructor in orthopedic surgery at Harvard Medical School. His clinical practice is limited to adult lower extremity orthopedics with 95% of his patient cases involving the hip and knee. He is the author of numerous original articles primarily on lower extremity orthopedic issues, and is the author and co-

author of books and monographs on lower extremity orthopedic issues. (Dr. Siliski CV, Exhibit 24)

476. Dr. Siliski testified that his current practice is mostly elective, involving a lot of arthroscopic work on the knee and knee replacements, those being the two most common procedures he performs. He does about 500 surgeries per year. He does some independent evaluations and record reviews, less than 5% of his total professional time.

477. Dr. Siliski testified that he reviewed medical records from 2000 through the last operative procedure done by Dr. Scheller in March 2009; additionally, he reviewed records and deposition transcripts, including the deposition of Dana Perkins and Larry Brown, Dr. Wieneke, and Dr. Scheller, plus some records of the ankle fracture from 2006.

478. Dr. Siliski testified that he examined Mr. Brown on December 3, 2009 and prepared his independent medical report on April 12, 2010. The exam included taking a history from Mr. Brown, which Dr. Siliski said was consistent with the medical records.

479. Dr. Siliski testified:

> "My impression was that going back to the 1999 injury he had sustained multiple ligament tears in his left knee. He had had reconstruction of three of the four main ligaments of the knee, those being the anterior posterior cruciate ligaments and the lateral collateral complex on the outer side of the knee. He had subsequently had further multiple reconstructions of the anterior cruciate ligament for failure of the acl graft and at the time I had seen him had also developed degenerative arthritis of the knee."

480. Dr. Siliski testified that in his opinion, the need for all of the surgeries was due to the original accident in 1999.

481. Dr. Siliski testified that he has performed multi-ligament revision surgeries like the one Dr. Scheller performed on Mr. Brown.

482. Dr. Siliski has performed such revision surgery 100 times "which makes me one of the more experienced people with this type of surgery because number 1, these type of surgeries are not terribly common and number 2, only a limited number of surgeons has substantial experience having done this." Dr. Siliski testified that he believes only a few people have done 50 or more such surgeries.

483. Dr. Siliski described a particular margin of error whenever performing multi-ligament revision surgery:

> "Well, in general, when we're doing ligament reconstructions we'd like to think that we're accurate within 2-3 millimeters of placement of the attachment slice of the new grafts. So the margin of error is very tight or very small with each ligament. The difficulty with the multi-ligament cases is trying to get all of the ligaments accurate and the clinical problem is that even if each one of those ligaments is done accurately because there is a window of inaccuracy inherent with the surgery, ... these multiple ligament reconstructions never, and I can say

that like 100% of them don't end up with normal stability at the end even if the surgery overall has gone well."

484. Dr. Siliski testified that most patients come back for follow-up over the years. Dr. Siliski and a former resident tested a very large number of post-operative patients, examining their reconstructed knees and putting them through KT1000 (a sort of mechanical testing to assess residual instability) and "they all have residual instability."

485. Dr. Siliski testified that the effect of instability results in an alteration of normal biomechanics of the knee. The knee is a very precise, albeit complex, system of rolling and gliding. Instability increases the risk of stress to the soft tissues, resulting in the stretching out of ligaments as well as shear forces being delivered to the joint surfaces which then produce degenerative arthritis. A single sports injury and tear of the ACL once reconstructed has about a 10-20% chance of re-rupture over 10 years. But with multiple ligamentous reconstruction of the knee, the risk of re-rupture is much more common.

486. Instability in the knee causes the patient to subjectively experience the knee buckling and giving out, as well as a sense of shifting. The patient may need to wear a brace in order to feel stable. A particular episode of subluxation may produce transient pain that can last a day or a week.

487. Dr. Siliski testified that a ligament such as an ACL graft doesn't necessarily tear in a single episode, but can tear from attrition over time.

488. Instability would cause a provider to note objective signs. That's because there are two main directions of instability in any knee. One is a sort of side-to-side instability, which would be related to the collateral ligament. The other would be a sort of front-to-back instability, which is reflective of the cruciate ligaments. The front-to-back testing is most commonly referred to as a drawer sign, because the examiner grasps a lower leg below the knee and pulls the tibia forward and then pushes it back, and thereby does the anterior drawer test and the posterior drawer test. If there is an isolated ligament problem, such as an ACL, then there may be a positive anterior drawer sign. An examiner does have difficulty knowing for sure how much the drawer sign is anterior and how much is posterior, but will notice relatively increased sliding front-to-back, and therefore a positive drawer sign.

489. Dr. Siliski reviewed physical therapy examination notes following Mr. Brown's surgery in 2002. Dr. Siliski testified that the notes are significant for positive drawer tests. Dr. Siliski concludes "that the patient had some degree of instability during the 2002 physical therapy treatment after the reconstruction."

490. Dr. Siliski offered the following opinion concerning the 2002 surgery by Dr. Scheller:

"My conclusions are that, based upon reviewing the medical record and my knowledge of this type of injury and surgery, that the surgery Dr. Sheller performed was successful but that's understanding that one, no surgeon can make this type of knee perfectly stable again. So a patient's outcome as recorded in the records through 2002, both Dr. Sheller's records themself and those of the

physical therapist indicate that there was some residual laxity in the knee which is typical of the reconstructed acl/pcl combination."

491. Dr. Siliski testified that in his opinion the continued residual laxity is the more plausible explanation for the cause of revision surgeries in 2007 and 2009, as well as the total knee replacement surgery in 2010.

492. Dr. Siliski testified that it's not uncommon to refurbish a knee brace every six (6) months if the patient is wearing it on a daily basis.

493. Dr. Siliski reviewed the deposition of Dr. Wieneke, and concluded that he disagrees with Dr. Wieneke's opinion. Dr. Siliski testified that operating a skidder would not have loaded the medial and anterior cruciate ligaments sufficiently to cause damage to the ligaments.

494. Dr. Siliski has not yet seen a case where repetitive use of the knee in a seated position caused damage to a knee. Further, he does not agree that placing feet on the floor while seated would load the knee sufficiently to damage it.

495. Dr. Siliski testified that mounting and dismounting a skidder would not aggravate the left knee, unless the patient fell off the skidder, twisted the knee, or had some other traumatic-type injury.

496. Dr. Siliski testified that the 2006 left ankle fracture had no effect on the left knee. Dr. Siliski testified that there was no report of any acute problem with the knee associated with the ankle fracture. He concludes from both a bio-mechanical point of view, as well as a review of records, that there is no relationship between the left ankle fracture and any suggested aggravation to the left knee.

497. Dr. Siliski testified he sees no evidence to suggest that Mr. Brown's work activity between 2002 and 2007 accelerated or aggravated the left knee condition. Dr. Siliski testified that the 2002 surgery and the result with instability destined Mr. Brown for the problems that he had in 2007 and 2009, and ultimately total knee replacement in 2010.

498. On cross-examination, Dr. Siliski admitted that he had not reviewed the deposition of Dr. Chen. Dr. Siliski has never driven in a skidder and has never driven an 18-wheeler. Dr. Siliski has not worked in the logging industry, but has been around it and has seen it done.

499. Dr. Siliski testified that it is not surprising that Mr. Brown had three (3) ACL repairs within a short period of time, even though the patient is/was in his 20s, given the multiple ligament injury initially sustained.

500. Dr. Siliski has had one patient that underwent three (3) ACL repairs. There may have been others, but a lot of patients get lost in follow-up because either they're a younger age group or the patients have come from all points of Northeast and have relocated after surgeries.

501. Dr. Siliski's exam of Mr. Brown lasted about 30 minutes.

502. Dr. Siliski testified that a patient who is behind a desk is probably at much lesser risk for re-rupture of the ACL than somebody who's constantly using the left knee, but he does not think anyone knows if that applies to a patient with multi-ligamentous reconstruction surgery.

503. Dr. Siliski testified that he does not know if activity factors into the likelihood and risk of re-rupture. It's never been scientifically correlated with activity level, and is therefore conjectural, as all that is known is that multiple-ligamentous operated knees do have a high incidence of ACL failure.

504. The outcome study by Dr. Siliski and a former resident considered patients who had knee dislocations with multiple ligament reconstructions.

505. Dr. Siliski has seen skidders in operation near his house in the Northern New England woods, but has never operated one himself, and knows of no studies that specifically assess the mechanics through the knee when a person operates a skidder.

506. Dr. Siliski was not aware of any restrictions upon Mr. Brown's return to work, except that he was wearing a brace.

507. On re-direct, Dr. Siliski testified that a knee that is unstable means that it moves in planes outside of what its design intends, and that puts unique forces on the ligaments. Ligaments would be caused to stretch even for standard activities, like doing stairs and walking, if the knee is unstable.

CONCLUSIONS OF LAW

Aggravation vs. Recurrence

1. PMA Insurance Company seeks to hold Travelers Insurance Company responsible for Mr. Brown's "knee surgery in 2007 and his additional treatment in 2009 as well as his total knee replacement in 2010" and also to hold Travelers Insurance Company responsible for reimbursement of the portions of Attorney Shappy's fee that "pertain to an idiopathic injury argument raised by Travelers in the event that they remain on the risk." (PMA's Findings of Facts & Conclusions of Law, page 30)

2. PMA Insurance Company contends that Mr. Brown's symptoms and medical expenses since 2007 are the result of an "aggravation." Department of Labor Rule 2.1110 defines "aggravation" as: "an acceleration or exacerbation of a pre-existing condition caused by some intervening event or events."

3. Travelers Insurance Company contends that Mr. Brown's 2007 left knee symptoms, surgery, as well as all subsequent medical expense, are the result of a "recurrence" of the December 28, 1999 injury. Department of Labor Rule 2.1312 defines "recurrence" as: "the return of symptoms following a temporary remission."

4. In *Trask v. Richburg Builders*, Opinion No. 51-98WC (August 25, 1998), the Commissioner differentiated between an aggravation and recurrence by identifying five (5) factors that typically will support a finding of aggravation, thus severing the causal connection back to an earlier injury:

   (1) Whether there has been a subsequent incident or work condition which destabilized a previously stable condition;

   (2) Whether the claimant had stopped treating medically;

   (3) Whether the claimant had successfully returned to work;

   (4) Whether the claimant had reached an end medical result; and

   (5) Whether the subsequent incident or work condition contributed independently to the final disability.

   The fifth factor – whether the subsequent incident or work condition contributed independently to the final disability – is given the greatest weight. *Patcher v. Fairdale Farms*, 166 Vt. 626 (1997)

5. On the first *Trask* factor – whether a subsequent incident or work condition destabilized a previously stable condition – Mr. Brown's left knee suffered from a condition of instability. The instability was persistent. (Finding of Fact No. 144, 489) Instability created sensations of buckling. (Finding of Fact No. 213-215; 236) The employee, Mr. Brown, reported left knee instability regularly, even after the 2002 multi-ligamentous surgery. (Finding of Fact No. 359) Dr. Wieneke agreed the left knee following the 2002 multi-ligamentous surgery as an unstable knee. (Finding of Fact No. 316, 334) Dr. Wieneke later qualified his description to "basically" stable. (Finding of Fact No. 318) The degree of instability was noted in the 2002 physical therapy treatment after reconstruction surgery. (Finding of Fact No. 489) It was noted in 2003 by the surgeon, with the surgeon's opinion in writing at that time that the instability would probably cause the requirement of a total knee replacement. (Finding of Fact No. 23) As the evidence shows that prior to 2007 the left knee was not in a stable condition, the first *Trask* factor favors Travelers Insurance Company.

6. Regarding the second *Trask* factor – whether the claimant had stopped treating medically – during the years 2003 through 2007, there was no medical treatment except for maintenance or replacement of knee braces. (Finding of Fact No. 25-27; 151) As the evidence shows that for four (4) years leading up to the April 29, 2007 visit with Dr. Scheller Mr. Brown had stopped treating medically, the second *Trask* favors PMA Insurance Company.

7. Regarding the third *Trask* factor – whether the claimant had successfully returned to work – the evidence shows that Mr. Brown returned to work after the 2002 surgery and until the 2007 surgery, wearing a knee brace and with some restrictions to stay inside his vehicles and not jump. (Finding of Fact No. 147, 154) The third *Trask* factor favors PMA Insurance Company.

8. Regarding the fourth *Trask* factor – whether the claimant had reached an end medical result – Dr. Scheller placed Mr. Brown at medical end result in 2003 with a 29% whole person permanent partial disability rating. (Finding of Fact No. 22) The fourth *Trask* factor favors PMA Insurance Company.

9. Regarding the fifth *Trask* factor – whether a subsequent incident or work condition contributed independently to the final disability – it is noted that on July 11, 2008, Dr. Scheller wrote "...there is no change in his permanent impairment." (Finding of Fact No. 63) PMA Insurance cites (a) a subsequent incident of left ankle fracture trauma, sustained by Mr. Brown in January 2006, as well as (b) a disputed admission of jumping from a skidder and inferences of frequent jumping from a skidder; (c) the use of a clutch on the 18-wheeler logging truck; (d) getting in and out of the skidder and 18-wheeler; and (e) the rough ride operating a grapple skidder. It was unclear whether the January 2009 incident walking on a driveway constituted a significant injury. (Finding of Fact No. 332, 211, 70, 72) These are reviewed as follows:

(a) *Left Ankle Fracture Incident January 2006*

10. The left ankle fracture of 2006 from Mr. Brown's slip and fall on ice required open reduction, internal fixation of a fracture of distal tibia. (Finding of Fact No. 29)

11. Dr. Wieneke offered an opinion that the left ankle fracture incident caused an aggravation of the left knee. Dr. Scheller and Dr. Siliski offer opinions to the contrary.

12. Dr. Wieneke is a board certified orthopedic surgeon with many, many years of clinical experience. He is well qualified to give testimony on whether a left ankle fracture could, and did, exacerbate or aggravate the left knee of Mr. Brown. (Finding of Fact No. 246-247, 333) Dr. Wieneke reviewed all pertinent records. (Finding of Fact No. 248) He was not a treating provider of Mr. Brown, and there was no patient/provider relationship. The comprehensiveness of Dr. Wieneke's evaluation of Mr. Brown's knee was not challenged. Dr. Wieneke's supplemental report of November 18, 2010 offered an opinion that the January 30, 2006 left ankle fracture incident constituted a "major aggravation to his already ACL deficient left knee." (Finding of Fact No. 85) With reference to Exhibit 7, a Gray's Anatomy image, Dr. Wieneke gave testimony that the ankle fracture would have communicated "the same force that broke his ankle" upwards "through his knee and through his hip." (Finding of Fact No. 280)

13. Dr. Scheller, on the other hand, has been the employee's treating orthopedic surgeon since 2002. He has at least equal qualifications as Dr. Wieneke to offer opinions whether a left ankle fracture incident could, and did, exacerbate or aggravate the left knee injury. (Finding of Fact No. 125) Dr. Scheller had his own records available and also was aware of the incident of January 2006 when the patient returned to him in 2007 and Dr. Scheller made a note in his own records about it. (Finding of Fact No. 33) The comprehensiveness of Dr. Scheller's evaluations was not in dispute. Dr. Scheller did not attribute any clinical significance of the slip/fall relative to the left knee when he saw the patient in 2007. (Finding of Fact No. 33) On July 11, 2008, Dr. Scheller wrote that Mr. Brown's 29% impairment rating from 2003 was unchanged. (Finding of Fact No. 63)

Dr. Scheller testified that usually fracture in the ankle absorbs all the force required for the fracture and does not affect the knee. Dr. Scheller concluded that the left ankle fracture incident in January 2006 had no effect upon the left knee. (Finding of Fact No. 161, 162)

14. Dr. Siliski had no patient/provider relationship with Mr. Brown. Like Dr. Wieneke, Dr. Siliski saw Mr. Brown only for purposes of a one-time independent medical examination. He reviewed all the pertinent records. (Finding of Fact No. 477) His evaluation of the employee's left knee was not disputed. Dr. Siliski's expertise and training is at least equal to Dr. Wieneke and Dr. Scheller on the question whether the ankle fracture incident aggravated the knee. (Finding of Fact No. 475, 481-482) Dr. Siliski testified that the left ankle fracture incident of January 2006 had no effect on the employee's left knee. (Finding of Fact No. 496)

15. Where expert medical opinions are in conflict, 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); *Boutin v. United Parcel Service*, Opinion No. 21-11WC (August 5, 2011)

16. The first test favors Dr. Scheller, who has a long term patient/provider relationship with Mr. Brown. The second test, examining all pertinent records, is to the material advantage of no one expert over the other. The same neutrality applies for test number 4, the comprehensiveness of the evaluation, and test number 5, the qualifications of the experts.

17. As to test number 3 – the clarity, thoroughness, and objective support underlying the opinion – the following is noted. Dr. Scheller had the opportunity to examine the patient's left knee sooner than the others. His office note of April 29, 2007 recognized the ankle fracture incident, but did not attribute any physical finding of significance to the left knee. Mr. Brown testified he felt no increased pain in his left knee and no increased instability in his left knee after the ankle fracture. He had been wearing his brace. (Finding of Fact No. 357) The records of left ankle fracture and injury treatment in 2006 do not reference any increased symptoms, or any symptoms, involving the left knee. (Finding of Fact No. 29, 30) On July 11, 2008, Dr. Scheller determined that there was no change in permanent impairment. (Finding of Fact No. 63) Dr. Wieneke did not assess

permanent impairment. Dr. Wieneke's opinion that the forces sufficient to break the ankle would have also traveled upwards into the left knee and through the left hip is not supported by any objective evidence. The opinions of Dr. Scheller and Dr. Siliski are supported by the patient's reports, by the record of treatment from January 2006, by the patient exam in 2007, and by the finding of no change in permanent partial impairment. Test numbers 1 and 3 tip the scales of credibility in favor of Dr. Scheller and test number 3 in favor of Dr. Siliski. Their opinions are the most persuasive. The January 2006 left ankle fracture did not contribute independently to the final disability.

(b) *Disputed Jumping Off the Skidder*

18. Dr. Wieneke offered testimony that during his September 9, 2009 independent medical examination Mr. Brown admitted to him that he had jumped off the skidder on one occasion, and that it had resulted in several days' worth of left knee pain. (Finding of Fact No. 271) The limitation of several days' worth of pain, if true, indicates something temporary.

19. Dr. Wieneke also suggested that Mr. Brown probably jumped from his skidder on a regular basis (Finding of Fact No. 277) based on Dr. Wieneke's past experience of seeing loggers jump from skidders (Finding of Fact No. 277) and based on Dr. Wieneke's feeling that Mr. Brown was being less than candid when interviewed by him. (Finding of Fact No. 263)

20. Mr. Brown denied telling Dr. Wieneke that he jumped from a skidder. (Finding of Fact No. 377)

21. Jumping from the skidder by Mr. Brown was not suggested by the forestry and logging industry expert, Curt Hassler, PhD.

22. There are no documented incidents of jumping, nor documented incidents of jumping injury.

23. The evidence is not sufficient to establish that jumping off the skidder contributed independently to the final disability.

(c) *Use of Clutch on the 18-Wheeler Logging Truck*

24. Dr. Wieneke offered an opinion that Mr. Brown's use of his left leg to push in the clutch mechanism on the employer's 18-wheeler logging truck aggravated his left knee. (Finding of Fact No. 288, 290) Dr. Wieneke did not know the force required to push in the clutch on Mr. Brown's 18-wheeler. Dr. Wieneke testified "my understanding" that it was "about 40 pounds." (Finding of Fact No. 288)

25. Dr. Scheller, on the other hand, testified that the use of a car clutch on a regular basis would not affect the left knee and would not affect the patellofemoral joint, nor even use of a clutch found in an F-150 truck. (Finding of Fact No. 179) Dr. Scheller does not know how much force would be needed to impact the patellofemoral joint in terms of pushing down on a clutch (Finding of Fact No. 180), and does not know whether pushing

down the clutch in the 18-wheeler operated by Mr. Brown involved any more force than walking up stairs. (Finding of Fact No. 175)

26. Dr. Chen was Mr. Brown's treating provider for the limited purpose of orthovisc injections and local oversight of the patient's left knee treatment between 2008 and 2009. Dr. Chen examined pertinent records, although not with the comprehensiveness as others. (Finding of Fact No. 245) The comprehensiveness of Dr. Chen's evaluation of Mr. Brown's left knee was not disputed. Dr. Chen's experience and expertise and training is in the given field of orthopedic surgery, including board certification in orthopedic surgery. (Finding of Fact No. 196) Dr. Chen testified that pushing down on a clutch imitates the kind of exercises that he purposefully puts patients in after ACL reconstruction surgeries and that it is a movement which does not contribute to worsening of the ACL, although it can cause increased pain in the patellofemoral joint. (Finding of Fact No. 223) Dr. Chen offered an opinion that one cannot, within a reasonable degree of medical certainty, conclude that using a clutch aggravated the pre-existing left knee condition. (Finding of Fact No. 224)

27. No studies were supplied of knee injury caused by use of a clutch pedal.

28. Mr. Brown testified that the he only required use of the clutch for first gear.

29. All the other gears after first gear were "synchronized," allowing Mr. Brown to use the throttle to shift gears and not use the clutch. (Finding of Fact No. 351)

30. The evidence is not sufficient to establish that the use of the clutch by Mr. Brown contributed independently to the final disability.

(d) *Getting in and out of the Skidder and 18-Wheeler*

31. Mr. Brown testified that he would not have to get out of his skidder machine to grab onto logs and skid them out of the woods, because that was done by pushing a button. (Finding of Fact No. 350) Once in the skidder, Mr. Brown would have no reason to get out of the skidder. (Finding of Fact No. 364) Mr. Brown's testimony was not controverted by any other witness. Mr. Dana Perkins confirmed Mr. Brown's account to the extent that he (Mr. Perkins) would see Mr. Brown. (Finding of Fact No. 97)

32. On occasion the rubber step on a skidder is ripped off, but it still does not require jumping to get down. (Finding of Fact No. 106, 121) Whenever the rubber step on the skidder has been broken or partially worn or torn, it usually is replaced immediately. (Finding of Fact No. 124)

33. The evidence is insufficient to demonstrate climbing in or climbing out of the 18-wheeler or skidder contributed independently to the final disability.

(e) *Operating a Grapple Skidder*

34. Emphasis was given to the operation of a skidder. The photographic images (Exhibits 4, 5, and 6) of the type of skidder machine operated by Mr. Brown confirm an interior

operator's seat, a set of foot pedals for acceleration and brake, as well as a circular steering wheel and hand controls inside a caged and reinforced interior.

35. The John Deere demonstration video (Exhibit 14) shows a John Deere 648H Grapple Skidder in motion over stumps and/or bumps on relatively unsloped, outdoor terrain, with a grapple, moving in slow and deliberate speed. (Finding of Fact No. 378) Mr. Brown felt the video was a bit dramatized.

36. Mr. Brown testified that he uses his left foot to help brace him as the cab shifts. (Finding of Fact No. 372) It was not specified how much force he uses, or how frequently he uses his left foot. In areas involving bumps, he slows down from the normal average of about five (5) miles per hour. He tries to avoid bumps and stumps. (Finding of Fact No. 378)

37. Dana Perkins testified, based on his own experience as an operator of a grapple skidder, that one does not need to keep the left leg on the floor of the skidder cab. One does not need to use the left leg to stabilize oneself. (Finding of Fact No. 117)

38. Mr. Perkins described the skidder as one that steers by hydraulics, which make it a little jerkier than a car, but it's otherwise like driving a big automatic car. (Finding of Fact No. 119)

39. Dr. Hassler is an accomplished expert in forestry and forest biometrics and forest resources management, with experience testifying in employee safety violation cases (Finding of Fact No. 441, 442, 445), but has no training or testimony experience related to the measurement of forces exerted on lower extremities while operating a skidder. (Finding of Fact No. 444, 462-465)

40. Dr. Hassler offered to show the "why" and the "how" of the forces which are exerted by the skidder in operation. (Finding of Fact No. 449) A skidder tilts forward, backward, and side-to-side, as it moves about five (5) miles per hour over bumps, stumps, rocks, and ruts (Finding of Fact No. 453-455), based on personal observation and personal experience riding (Finding of Fact No. 450) inside skidders.

41. As to "what" forces may be upon a skidder operator's left knee, Dr. Hassler offered that those forces create a "rough ride" (Finding of Fact No. 466-467), suggesting possible injurious force not based on a comprehensive assessment, objective measurements, or any scientific method to advance the suggestion to reasonable scientific probability.

42. Dr. Wieneke also testified that the operator of a skidder has a "very rough ride" (Finding of Fact No. 276) and that using the left foot to stabilize oneself would stretch the anterior cruciate ligament suddenly, severely, and intermittently (Finding of Fact No. 269) based, similar to Dr. Hassler, on Dr. Wieneke's personal recollection of riding as a passenger five or six times in the past in a skidder operated by his son Andrew who is a logger. (Finding of Fact No. 80, 264-265)

43. Dr. Scheller, on the other hand, offered a contrary opinion. Dr. Scheller offered an opinion that instability of the knee caused Mr. Brown's surgeries from 2007 onwards. Instability was initially caused by the December 28, 1999 injury, and the knee was not

sufficiently stabilized by the multi-ligamentous surgery performed in 2002. (Finding of Fact No. 132, 136, 163, 165, 170)

44. Dr. Siliski, like Dr. Scheller, concluded that the continued residual instability or laxity in Mr. Brown's left knee is the more plausible explanation for the cause of revision surgeries in 2007, 2009, as well as the total knee replacement surgery in 2010. (Finding of Fact No. 490, 491)

45. Dr. Chen was not clear whether instability in the knee was due to Dr. Scheller's surgical technique. (Finding of Fact No. 201, 221) Dr. Chen offered an opinion that the instability nevertheless was present after the 2002 surgery and instability was the cause of subsequent problems. (Finding of Fact No. 215, 216) Dr. Chen concluded that it would be completely speculative to offer an opinion that operating a skidder would put any more force on the knee than walking up steps. Walking up steps can deliver anywhere from four to eight times one's body weight. (Finding of Fact No. 218)

46. Applying the five-part test to determine which expert's opinion is the most persuasive, the first test – the nature of treatment and the length of time there has been a patient/provider relationship – favors Mr. Brown's treating orthopedic specialists, Dr. Scheller and Dr. Chen.

47. The second test – whether the expert examined all pertinent records – is to the material advantage of no one expert over another, except some disadvantage to Dr. Chen who had not reviewed pre-2007 records except the 2002 operative report shown to him at the time of his testimony. (Finding of Fact No. 245)

48. Regarding the third test – the clarity, thoroughness, and objective support underlying the opinion – Dr. Hassler and Dr. Wieneke supposed with no research, measurement, or experiment to support them that a rough ride in a John Deere 648H grapple skidder produces personally injurious force upon the operator's left knee. It is unclear why Dr. Wieneke prepared a report September 9, 2009 stating that "ongoing clutching the log truck, jumping out of his skidder, getting in and out of the log truck, in my opinion, constitute aggravation..." but did not include his theory of aggravation from forces on the left knee while operating a skidder ("rough ride"). Dr. Siliski performed a follow-up study of post-multi-ligamentous surgery patient results and found that all of them have residual instability. (Finding of Fact No. 484) No record is known of any skidder operator population having left knee issues or injuries due to driving a skidder. (Finding of Fact No. 327) There has never been a scientific correlation of knee disease or injury with the operation of skidders or even with activity level, but there is a scientific correlation between multi-ligamentous operated knees and high repeat ACL failures post-op. (Finding of Fact No. 503) Mr. Brown's most painful activity was standing, not any particular work activity. (Finding of Fact No. 365) Mr. Brown's left leg physical examination demonstrated wasting, objective evidence of less use than the right leg. (Finding of Fact No. 331) Medical records of testing of the left knee confirmed left knee instability. Dr. Wieneke agreed that the opinions of Drs. Scheller and Siliski – that "instability" of the left knee following the December 28, 1999 original injury, and the 2002 multi-ligamentous knee reconstruction surgery is the cause of recurrent tears and surgery, including the time frame of 2007 through the present – represent a "plausible"

explanation. (Finding of Fact No. 304) Dr. Wieneke also agreed that medical records show objective evidence that the knee was unstable following the 2002 surgery. (Finding of Fact No. 309-316) Dr. Wieneke also agreed that for approximately 2 ½ years following the initial injury, Mr. Brown was developing post-traumatic arthritis in the left knee because of multiple failed ligaments and instability. (Finding of Fact No. 295-296) The third test favors Dr. Scheller, Dr. Chen, and Dr. Siliski.

49. Regarding the fourth test – the comprehensiveness of the evaluation – Dr. Hassler and Dr. Wieneke's evaluations of the forces on a skidder operator's knee were not done. Their opinions were based on past recollections of riding in non-specific make and model skidder vehicles. Dr. Scheller, Dr. Chen, and Dr. Siliski did not have past experiences riding in a skidder. Dr. Siliski has some casual familiarity from seeing skidders in operation. (Finding of Fact No. 498) No expert purposefully rode in or operated a skidder to address the question whether injurious force was applied to Mr. Brown's left knee; nor did any expert conduct a scientific test or experiment, take any measurement, or perform any research to address the question. The comprehensiveness of the evaluation of the subsequent work condition inside the skidder is of no advantage to any expert. The comprehensiveness of the evaluation of Mr. Brown's knee itself is of no advantage to one medical expert over another. The fourth test favors no one expert over the other.

50. With regard to the fifth test – the qualifications of the experts, including training and experience – Dr. Scheller is one of only a very few orthopedic surgeons with experience in multi-ligamentous knee surgeries, and is highly qualified to discuss the phenomenon of instability of knee and the attritional injurious consequence of instability of the knee following multi-ligamentous surgeries. Dr. Siliski, like Dr. Scheller, has the superior qualification of expertise to offer opinions on the complexity of knee instability following multi-ligamentous surgeries. Dr. Siliski is also among the few surgeons who perform multi-ligamentous revision surgeries like the one Dr. Scheller performed on Mr. Brown. Dr. Siliski has done multi-ligamentous revision surgery 100 times. Dr. Wieneke agreed that the better expert resource on what should be expected after multi-ligamentous surgeries would be the opinions of Dr. Scheller and Dr. Siliski because they are among fewer than five surgeons in New England who perform that orthopedic procedure, and Dr. Wieneke is not among them. (Finding of Fact No. 298, 299) On the question of instability, with particular focus on recurrent injurious consequence post-multi-ligamentous surgery, the fifth test favors Dr. Scheller and Dr. Siliski.

51. Under the five-part test, the second and fourth tests favor no one expert over another. The first test favors Dr. Scheller and Dr. Chen. The third test favors Dr. Scheller, Dr. Chen, and Dr. Siliski. The fifth test favors Dr. Scheller and Dr. Siliski. The opinions of Dr. Scheller, Dr. Chen, and Dr. Siliski are the most persuasive. The evidence is not sufficient to establish Mr. Brown's operation of a skidder contributed independently to the final disability.

52. Under the fifth *Trask* factor – whether the subsequent incident or subsequent work conditions contributed independently to the final disability – the evidence shows the above-considered subsequent incident in January 2006 slip and fall ankle fracture as well as the above-considered subsequent work conditions of jumping, use of a clutch pedal, getting in and out of skidder and logging vehicles, and operating a skidder, did not

contribute independently to the final disability. The fifth *Trask* factor favors Travelers Insurance Company.

53. Having now considered all five *Trask* factors which typically will support a finding of aggravation, factors two, three, and four favor PMA Insurance Company though not without evidence of ongoing medical treatment in the form of physician-authorized knee brace replacements without exam between 2003 and 2007, and not without practical concern that the May 23, 2003 medical end result determination was, as described by Dr. Chen (Finding of Fact No. 214), a time of improved, unresolved instability in the context of a steady progress downhill. The first factor favors Travelers Insurance Company because the condition of the left knee was not previously stable. The fifth factor (the fifth receiving the greatest weight) favors Travelers Insurance Company, because no subsequent incident or work condition contributed independently to the final disability. The evidence shows that Mr. Brown's 2007 left knee symptoms, surgeries, as well as subsequent medical expense, represent a recurrence of the December 28, 1999 injury.

Waiver

54. Travelers Insurance Company also contends that PMA Insurance, through Gallagher-Bassett Services, Inc., waived its defense of aggravation by virtue of payment of benefits until January 2009, citing the case of *Carroll Humphrey v. Vermont Tap and Die*, Opinion No. 10-96WC (March 12, 1996).

55. PMA Insurance denies that there was a waiver of a right to pursue reimbursement of benefits paid out from 2007 to 2009. PMA Insurance maintains, furthermore, that waiver does not apply here, because PMA Insurance was pursuing reimbursement as governed by applicable statutes of limitations.

56. Waiver is the intentional relinquishment or abandonment of a known right and may be inferred from the party's words or conduct. The "...essence of a waiver is a voluntary choice. And thus the party must have acted with a knowledge of all the material facts." *David Hojohn v. Howard Johnson*, Opinion No. 43-04WC (September 28, 2004)

57. The adjuster for Gallagher Bassett had knowledge of the 2006 left ankle fracture when she first investigated the claim in 2007, including her May 10, 2007 review of Dr. Scheller's report of April 29, 2007 which specifically referenced it (Finding of Fact No. 39) and including a nurse note by Fabienne Gallant, AS, RN in the claim notes on June 25, 2007, which also reported that Mr. Brown himself had told the nurse case manager about it. (Finding of Fact No. 50) Therefore, Ms. Bosell's repeated testimony that she was not aware in 2007 of the 2006 left ankle fracture (Finding of Fact No. 405, 409, 414, 417, 418, 432, 437, 439) is not supported by the evidence. The adjuster had conversations with Mr. Brown in 2007 and the employee's mother and business owner (Finding of Fact No. 397, 398) and with Dr. Scheller (Finding of Fact No. 38) and formed an understanding that Mr. Brown got in and out of equipment, was a skidder operator (Finding of Fact No. 410), and that Mr. Brown was a logger and that it was a "pretty physical job." (Finding of Fact No. 423) The adjuster considered on the first day of investigation in 2007 whether or not to order an independent medical examination. (Finding of Fact No. 424) Mr. Brown had not treated medically for approximately four

(4) years, except for knee brace replacement or adjustment, and had been determined to be at medical end result in 2003. The adjuster chose not to order an independent medical examination in 2007, in part because of the advice from the nurse case manager that Dr. Scheller's opinion was highly regarded. (Finding of Fact No. 412)

58. The adjuster had knowledge of the original injury, the treatment, the present doctor's assessment and reports, interviews with the employee and his mother and employer, records of past treatment and present assessment including records of a left ankle fracture, knowledge that Mr. Brown was a logger engaged in a heavy, physical job and climbed in and out of machines, that he had been placed at medical end result four (4) years earlier with no medical examinations or treatment for the past four (4) years, but now presenting with a need for left knee surgery, and knowledge of the availability, if desired, to order an independent medical examination on the question of causation. The adjuster elected to forego an independent medical examination. The adjuster chose to establish compensability. (Finding of Fact No. 422)

59. The fact that the adjuster elected not to order an independent medical examination is not to be confused with whether there was knowledge of all material facts. Knowledge is not hindsight. Knowledge provides the basis for insight. The adjuster made a fully informed, voluntary business decision in 2007 based on knowledge of all material facts, including consultation with her supervisor and nurse case manager.

60. However, the first issue of aggravation versus recurrence has been decided in favor of Travelers Insurance Company. The question whether PMA Insurance, through Gallagher Bassett Services, Inc., waived its defense of aggravation is unnecessary to decide.

Apportionment

61. The first issue of aggravation versus recurrence having been decided in favor of Travelers Insurance Company, apportionment of liability among the respective insurers is not appropriate.

Attorney's Fees

62. Attorney Shappy began representing Mr. Brown in his workers' compensation case beginning with her initial meeting with Mr. Brown on April 23, 2009, because between April 2009 and June 2009 no benefits were being issued to Mr. Brown as a result of PMA Insurance/Gallagher-Bassett Services, Inc. notice of intention to discontinue and also a Form 2 Denial by Travelers Insurance Company. (Finding of Fact No. 183-184) In June 2009, the Department of Labor ordered benefits to be paid, and on August 29, 2009 the Department of Labor charged Gallagher Bassett with the obligation to pay benefits. Attorney Shappy succeeded in her request for attorney fees for hours of attorney and paralegal time incurred as a direct result of the respective discontinuance and denial. (Finding of Fact No. 184)

63. On August 11, 12, and 13, 2009, Attorney Shappy recorded time spent to review multiple motions filed by counsel for Travelers Insurance, and Attorney Shappy drafted a letter

opposing a Form 27 filed by Travelers Insurance on the issue of idiopathic injury and finalized it on August 13, 2009. (Finding of Fact No. 189)

64. The time entries pertinent to Attorney Shappy's services in response to the idiopathic injury defense of Travelers Insurance are August 12, 2009 and August 13, 2009. (Finding of Fact No. 188, 189) The others, such as August 11, 2009, Attorney Shappy testified that she had "no idea" how much of her time specifically related to work pertaining to the idiopathic injury defense by Travelers Insurance.

65. Similarly, Attorney Shappy testified that she traveled to Brookline, MA for Dr. Scheller's deposition on July 27, 2009 in part because of the issue of the idiopathic injury, but she testified she would have attended anyway even if there was no idiopathic injury defense being raised simply to protect Mr. Brown's interests at the time of Dr. Scheller's expected testimony, and because of the extensive injuries of Mr. Brown. (Finding of Fact No. 182)

66. The first issue of aggravation versus recurrence having been decided, Travelers Insurance Company does not remain on the risk. Therefore, the request for reimbursement of attorney fees paid out to Attorney Shappy relating to those items that pertain to an idiopathic injury argument raised by Travelers Insurance is denied.

ORDER

Based on the foregoing findings of fact and conclusions of law, PMA Insurance Group's request that Travelers Insurance Company be held responsible for Mr. Brown's left knee surgery in 2007 and additional treatment in 2009 as well as his total knee replacement in 2010 is **DENIED**. PMA Insurance Group's request that Travelers Insurance Company be responsible for reimbursement of attorney fees paid out to Attorney Shappy relating to those items that pertain to an idiopathic injury argument raised by Travelers Insurance Company is **DENIED**. PMA Insurance Group/Gallagher-Bassett Services, Inc. is hereby **ORDERED** to pay all benefits associated with Mr. Brown's 2007 left knee surgery and subsequent surgeries and medical care associated with the left knee up to the present and continuing.

Dated at White River Jct., Vermont on this 20th day of December 2011.

Charles L. Powell, Esq.
Gates-Briggs Building, Ste. 312
5 Main Street
White River Junction, VT 04001
Phone: 802-295-7773
Email: cpowell@fortheinjured.net

Stephen D. Ellis (NY)
Andrew C. Boxer (NH)
William J. Blake

Wesley M. Lawrence (NH)
Robert D. Mabey (MA)
Julia D. Stensby (NY)
J. Justin Sluka (NH)
Jennifer K. Moore

ELLIS BOXER & BLAKE
ATTORNEYS

www.ellisboxer.com

24 Summer Hill Street
P.O. Box 948
Springfield, Vermont 05156

(802) 885-2141
FAX (802) 885-2131

December 28, 2011

Anne Coutermarsh
Vermont Department of Labor
Workers' Compensation Division
P.O. Box 488
Montpelier, VT 05601-0488

RE: Larry M. Brown II v. Larry M. Brown Logging & Chipping
State File No. AA60175
Claim No. 092-CB-CHI8361N

Dear Anne:

Enclosed please find a copy of Arbitrator Charles L. Powell's December 20, 2011, *Opinion and Order* to be included in the Department's file in the above mentioned matter.

Thank you.

Yours very truly,

ROBERT D. MABEY

RDM/mll
Enclosure

Cc: Bonnie B. Shappy, Esq. (w/o encl.)
Corina Schaffner-Fegard, Esq. (w/o encl.)
Patricia Greene (w/o encl.)

Law Office of Charles L. Powell PLLC

Charles L. Powell*

*Also admitted in Pennsylvania

Gates-Briggs Building, Suite 312
5 South Main Street
White River Junction, VT 05001

Phone: 802-295-7773
Fax: 802-295-7775

December 20, 2011

Corina N. Schaffner-Fegard, Esq.
Ryan Smith & Carbine, Ltd.
PO Box 310
98 Merchants Row
Rutland, VT 05702

Andrew C. Boxer, Esq.
Ellis, Boxer & Blake
PO Box 948
27 Summer Street
Springfield, VT 05156

Bonnie B. Shappy, Esq.
Hayes & Windish, PC
45 Pleasant Street
Woodstock, VT 05091

Re: *Larry Michael Brown II v. BB Trucking (now d/b/a Larry M. Brown Logging and Chipping, Inc.) – ARBITRATION CASE*

Dear Counselors:

Enclosed please find my **Opinion and Order** with respect to the arbitration hearing held on December 1, 2010 and December 2, 2010.

Thank you.

Very truly yours,

Charles L. Powell

Charles L. Powell, Esq.
Arbitrator

CLP/smb

Enclosure