STATE OF VERMONT
DEPARTMENT OF LABOR

J. G.	)	Opinion No. 52-05WC
	)	
	)	By: Margaret A. Mangan
v.	)	Hearing Officer
	)	
Eden Park Nursing Home	)	For: Patricia A. McDonald
	)	Commissioner
	)	
	)	State File No. S-05592

Pretrial conference on April 26, 2005
Hearing held in Rutland on July 11, 2005
Record closed on August 12, 2005

APPEARANCES:

Joseph Paul O'Hara, Esq., for the Claimant
Jason R. Ferreira, Esq., for the Defendant

ISSUES:

1. Was claimant's diaphragmatic paralysis causally related to her September 4, 2001 shoulder injury?

2. If Claimant's diaphragmatic paralysis is causally related to her September 4, 2001 shoulder injury, is she permanently and totally disabled as a result?

EXHIBITS:

Joint Exhibits:

1. Medical Records

Defendant's Exhibits:

1. *Curriculum Vitae* of Dr. Jerome Siegel
2. *Curriculum Vitae* of John J. Halpin, MA, CRC

Claimant's Exhibits:

1. February 8, 2005, Deposition of Dr. Melbourne Boynton
2. May 20, 2005, Deposition of M. Gorman, Jr.
3. June 23, 2005, Deposition of Thomas LaPlaca
4. *Curriculum Vitae* of Jay Spiegel
5. Request for Claimant's Attorney Fees and Legal Costs

CLAIM:

1. Claimant's diaphragmatic paralysis is causally related to her work-related injury.

2. Permanently total disability.

3. Reasonable attorney fees and necessary costs.

FINDINGS OF FACT:

1. Eden Park Nursing Home (Eden Park) was an employer as defined by the Vermont Workers' Compensation Act at all relevant times. Claimant was an employee as defined by the Vermont Workers' Compensation Act at all relevant times.

2. Royal & SunAlliance was the workers' compensation carrier for Eden Park at all relevant times in this case. This claim was accepted by Royal & SunAlliance.

3. Claimant is a 69 year-old female, who was an employee of Eden Park for more than 23 years. In her 23 years at Eden Park, she never missed a day of work due to illness. Claimant was employed as a Registered Nurse earning an Average Weekly Wage of $653.32.

4. On September 4, 2001, while working as a nursing supervisor Claimant injured her left shoulder when a patient twisted her left arm.

5. During the time of her employment at Eden Park, claimant never missed a day of work due to illness. Immediately after the injury, she did not miss time from work, but received on-going medical care and treatment and attended her physical therapy and doctor's appointments on her own time.

6. Claimant's role as a nurse supervisor required her to supervise the care of approximately 125 patients on 3 floors of Eden Park. As well as her supervisory duties, she was also required to perform duties of a staff nurse. Her work was classified as a medium-duty work level.

7. Prior to her left shoulder injury, Eden Park gave claimant a retirement party. At the time of the left shoulder injury, claimant had reduced her hours to part-time and was working 3 nights a week for a total of 24 hours per week.

8. On September 27, 2001, claimant was evaluated by James Hollinshed, PA, at Vermont Orthopedic Clinic for pain and limited range of motion. Following x-rays and physical examination, Mr. Hollinshed's assessment was a possible rotator cuff tear and he recommended physical therapy and an MRI.

9. An MRI confirmed a rotator cuff tear in her left shoulder and shoulder surgery was scheduled for May 2, 2002.

10. Prior to shoulder surgery, claimant did not complain of or comment on any breathing, pulmonary, or respiratory problems.

11. A pre-operative physical examination took place on April 22, 2002. Dr. Mark Messier reported that she had normal heart and clear lungs. He proclaimed her a candidate for the proposed surgery with an ASA Classification II.

12. A chest x-ray of April 23, 2002 was read as showing mild chronic obstructive pulmonary disease. However, Dr. Melbourne Boynton, M.D. opined that he would not have operated on a patient with a respiratory disorder.

13. Also noted in the pre-operative report was a pre-existing history of hypothyroidism, bilateral neuropathy in her feet, and exertional chest pain. The report stated that claimant was previously a smoker, but quit over 15 years prior to surgery. Her hypothyroidism was controlled by medication. The end result of the pre-operative examination was that she was deemed in good health and a suitable candidate for the left shoulder surgery.

14. In addition to the pre-operative physical examination, claimant underwent a pre-anesthesia evaluation. Thomas LaPlaca, M.D. opined that Claimant's pre-operative condition was Level III, pursuant to the American Society of Anesthesia classification system. Level III is for patients with significant disease. Dr. LaPlaca did not know why Claimant was classified as a Level III risk patient, but speculated that this classification was based on Claimant's history of hypothyroidism, surgeries, neuropathy, and smoking. Level III patients are seen by nurse anesthetists and then, if need be, by an anesthesiologist.

15. Dr. LaPlaca did not recall if he met with Claimant to discuss her Level III classification, and Claimant also did not recall anybody discussing her Level III classification. Nowhere in the Medical Record is Level III classification noted.

16. Dr. LaPlaca opined that anesthesia is stressful on the body and there are often serious risks with its application.

17. Claimant arrived at the hospital for shoulder surgery with the expectation she would be discharged the same day.

18. While claimant was prepped and intubated for anesthesia, she was placed in a supine position. The anesthesia record maintained during surgery has a circle around both the 2 and 3 for the ASA level.

19. On May 2, 2002, claimant underwent a left shoulder arthroscopic subacromial decompression and rotator cuff repair with Dr. Boynton. Clamant was placed in a "beach chair" position and sedated for surgery using general anesthesia by Dr. LaPlaca. The surgery lasted just under two hours, during which time her blood pressure dropped from 120/78 to approximately 60/40, then rose again with medication. Her pulse was in the 40's and 50's during surgery; it was 60 preoperatively.

20. Dr. Boynton did not report any unusual orthopedic events during surgery and considered the procedure a success. He did not consider the surgery to be complicated.

21. Claimant was transferred from the operating room to the post anesthesia unit for several hours then to the intensive care unit.

22. Stephen Gorman, M.D., a pulmonary specialist who reviewed the operative report, opined that Claimant's drop in blood pressure during surgery was a reaction to the narcotics that were administered.

23. Claimant's breathing was not noted as significantly inhibited immediately following surgery, but shortly later claimant began struggling with breathing.

24. In the afternoon following the surgery, Dr. Boynton ordered a chest x-ray to determine the cause of Claimant's respiratory distress. The x-ray showed pneumonia, but it was also thought that claimant was suffering from a collapsed lung.

25. After three days in the hospital, including two days in the Intensive Care Unit, claimant was released from the hospital, but required the use of supplemental oxygen.

26. Claimant continued to use oxygen 24 hours per day for a couple of months and then tapered off to only using oxygen at night. In December of 2002, she discontinued using oxygen at night as well.

27. On May 30, 2002, a chest x-ray by Mark Messier, M.D., Claimant's primary care physician, revealed that there was near complete resolution of the basilar infiltrates associated with pneumonia.

28. On June 12, 2002, Stephen Gorman, M.D., a pulmonary specialist, examined claimant for shortness of breath. Dr. Gorman continues to treat claimant for her shortness of breath.

29. Dr. Gorman has repeatedly examined and run tests to determine the nature and cause of Claimant's respiratory problems. CT scans and x-rays have been negative for pulmonary emboli and acute lung pathology. Dr. Gorman opined that the claimant suffers from a paralyzed diaphragm.

30. Throughout 2002, Dr. Gorman opined that claimant was 100% disabled and incapable of returning to work. In fact, Dr. Gorman opined that it is unlikely that claimant will be able to return to work in any meaningful way.

31. On July 17, 2002, claimant underwent a cardiopulmonary stress test. The results of the test indicated that claimant had a severe breathing limitation.

32. On August 20, 2002, Scott Wagers, M.D. and Daniel Weiss, M.D. at Fletcher Allen Pulmonary Clinic examined Claimant. Both doctors opined that it was not clear what was causing Claimant's shortness of breath. Both doctors opined that the shortness of breath was related to diaphragmatic paralysis. It was recommended that claimant undergo a sniff test under fluoroscopy, a full pulmonary function test, and a cardiac evaluation.

33. On August 27, 2002, a sniff test under fluoroscopy was performed and did not show evidence of diaphragmatic paralysis.

34. On September 20, 2002, David Charnock, M.D. from Mid-Vermont Ear, Nose and Throat Specialists, examined claimant. Dr. Charnock found no evidence of an obstructed upper airway.

35. Additional pulmonary function testing on September 27, 2002, by Dr. Wagers and Dr. Weiss, strongly suggested respiratory muscle weakness.

36. On March 7, 2003, claimant underwent EMG and nerve conducting studies by Rup Tandan, M.D. Dr. Tandan found no response from bilateral phrenic nerve stimulation. Dr. Tandan's conclusion was idiopathic diaphragmatic paralysis.

37. On May 8, 2003, after a follow-up appointment, Dr. Wagers opined that claimant's diaphragm weakness was bilateral. Dr. Wagers suggested treatment at a pacing clinic at Yale Hospital, but he reported that the claimant was not interested in any further surgical intervention.

38. On May 13, 2003, Dr. Boynton saw claimant for an evaluation of her shoulder and reported that she was still having problems with breathing, which was disabling her and keeping her out of work.

39. Kenneth Mar, M.D. examined claimant on June 26, 2003. Like Dr. Wagers, he opined that claimant's diagnosis was bilateral idiopathic diaphragmatic paralysis. Dr. Mar recommended a bronchoscopy to rule out any laryngeal or tracheal obstruction, but claimant refused this procedure.

40. Claimant is not interested in the pacing clinic or bronchoscopy because her experience from the shoulder surgery has made her reluctant to have any further invasive procedure.

41. On July 28, 2003, Dr. Gorman examined claimant at the Sleep Center at Rutland Regional Medical Center. Dr. Gorman opined that claimant was suffering from significant sleep deprivation secondary to her respiratory distress. When claimant is sleeping the only muscle to ventilate her is her diaphragm, and since her diaphragm is paralyzed, she has to wake up to use other respiratory muscles. When claimant is awake she is able to breathe using her neck and chest muscles. As a result, Dr. Gorman opined that Claimant's sleep was fitful and fragmented. Dr. Gorman recommended a BiPAP machine to help Claimant's nighttime breathing and improve her sleep. The BiPAP machine has significantly increased Claimant's ability to sleep and she continues to use it while sleeping.

Expert Medical Opinions

42. On July 14, 2004, Jerome Siegel, M.D. performed an independent medical examination of claimant on behalf of Royal & SunAlliance. Based on his opinion, payments were shortly discontinued by Royal & SunAlliance.

43. Dr. Siegel opined that claimant has idiopathic bilateral diaphragmatic paralysis based on the lack of medical evidence documenting a surgical complication that led to the respiratory problems. Dr. Siegel agreed that a temporal relationship exists and that diaphragmatic paralysis is rare, but he did not find a causal relationship between the surgery and the diaphragmatic paralysis.

44. Dr. Siegel based his opinion in part on academic research he undertook demonstrating that shoulder surgery or orthopedic surgery is not recognized as a cause for diaphragmatic paralysis.

45. Dr. Siegel did not research whether anesthesia, non-orthopedic surgeries, narcotics, or any other mechanism caused diaphragmatic paralysis.

46. Dr. Siegel provided alternative explanations for Claimant's diaphragmatic paralysis. He opined that Claimant's hypothyroidism, history of peripheral neuropathy, or history of smoking might be the cause of her paralysis. However, he did not know an exact cause for the paralysis.

47. Dr. Siegel admitted that if claimant was capable of lying on her back prior to surgery, it would be impossible for her to have suffered from bilateral diaphragmatic paralysis before the surgery.

48. Dr. LaPlaca also opined that a temporal relationship exists, but that a causal relationship between the surgery and the paralysis was not present. Dr. LaPlaca bases his opinion on a presumption that the claimant had bilateral paralysis prior to surgery. However, Dr. LaPlaca could not find support in claimant's prior medical records for preexisting diaphragmatic paralysis.

49. Dr. LaPlaca hypothesized that Claimant's history of peripheral neuropathy could be a possible cause of her diaphragmatic paralysis. Dr. LaPlaca also opined that it was possible that a 1997 neck surgery might be the cause of Claimant's paralysis. Further, he denied that the surgery or anesthesia could have caused the diaphragmatic paralysis.

50. Dr. LaPlaca was not clear as to claimant's pre-operative physical condition, and assumed she worked a sedentary job. Dr. LaPlaca acknowledged that claimant's post-operative condition is worse then it was pre-operatively.

51. Dr. Gorman, Claimant's pulmonary specialist, disagrees with Dr. LaPlaca and Dr. Siegel and he opined that the Claimant's respiratory problems were caused by complications from the left shoulder surgery. Dr. Gorman based his opinion on the temporal relationship between the shoulder surgery and claimant's bilateral diaphragmatic paralysis. Dr. Gorman also opined that the diaphragmatic paralysis was not serious prior to surgery or else the anesthesiologist would not have anesthetized her without a serious evaluation prior to surgery. He noted that a person with diaphragmatic paralysis would have problems breathing while sleeping, as well as difficulty accomplishing activities of daily living.

52. Dr. Gorman did not know exactly what mechanism caused claimant's paralysis, but opined that it was clear that the paralysis did not exist prior to surgery. He noted that phrenic nerve damage during surgery is a common cause of diaphragmatic paralysis. However, Dr. Gorman opined that bilateral diaphragmatic paralysis is rare and the majority of the time it is hard to determine the exact cause.

53. Dr. Gorman is Board Certified in internal medicine, pulmonary disease, sleep medicine, and critical care.

54. In October of 2004, Dr. Boynton opined that because of the temporal relation to the shoulder surgery, this is the most likely cause of the disorder.

Work Capacity

55. Dr. Gorman opined that claimant had a very sedentary work capacity, but requested that her physicians at Fletcher Allen Hospital complete the work capacity forms.

56. It was Dr. Gorman's opinion that based on the records, the results of claimant's exercise test placed her in the worst quadrant of VO_2 max pursuant to the AMA Guide's criteria. Dr. Wagers, Dr. Kaminsky, and Dr. Siegel all agree with a Class 4 level of respiratory impairment.

57. A Class 4 level of respiratory impairment translates to a 51%-100% whole person impairment based on the AMA Guides 5th Edition, Table 5-12.

58. Based on a November 5, 2003 examination, Dr. Wagers opined that claimant was able to stand and walk for 1-3 hours a day; sit 1-3 hours a day; and drive 1-3 hours a day. In addition, Dr. Wagers placed a 10-pound lifting restriction on claimant, stated that she could not bend or climb, but could squat, twist and reach above her shoulders occasionally. Dr. Wagers concluded that claimant has the ability to work 15 hours a week.

59. Claimant presently works two evenings a week at Eden Park for a total of approximately 7-8 hours a week. She often works her 3 to 4 hour shifts straight without a break. She drives 18 miles to work, which takes approximately a half hour. Claimant is being paid approximately $19.99 per hour.

60. Claimant's current work is at a desk and is considered sedentary work. However, she often is fatigued and becomes short of breath when walking to the copy machine and carrying heavy charts.

61. Eden Park placed claimant in a part-time position where she reviews medical charts and records, which are transported to her. Eden Park's goal is to gradually increase her hours. Eden Park has more deskwork available for claimant.

62. Eden Park wanted claimant to return to work because of their long relationship with claimant, her expertise in nursing, and because there was work that needed to be done.

63. Claimant had a special arrangement with Eden Park that allows her to work when she was capable and functional.

64. Eden Park has a part-time night nursing supervisor position open, which is 2 to 3 nights a week, from 11:00 p.m. to 3:00 a.m. This position involves supervision of the facility, overseeing nurse care, troubleshooting, calling physicians, and assisting with schedules. Eden Park would be willing to modify the position to fit claimant's physical limitations. Specifically, Eden Park would make sure that claimant did not have to lift patients. If claimant could not work some days because of fatigue or shortness of breath, then she would not be able to work this position.

65. Claimant has made no complaints about her current amount of work and duties, and is willing to work more hours if accommodations are made for her.

66. Dr. Siegel opined that claimant was capable of performing work duties 4 hours a day, 5 days a week, for a total of 20 hours per week. Dr Siegel based his conclusion on his physical examination of claimant and her reported activities of daily living.

67. Claimant's activities of daily living include: short drives to visit her children and run errands; cooking; washing dishes; laundry; cleaning; light work in the garden.

68. Claimant also rides her bike up to a mile a day and uses the pool when at her home in Florida. When she is at her house in Vermont, she rides the exercise bike for up to one mile per day or walks up to a mile per day on the treadmill. Although claimant has not done so this summer, since her surgery claimant has taken her motorized boat out on the lake and gone fishing.

69. Although claimant still engages in activities of daily living, she has been impaired by shortness of breath and fatigue since the shoulder surgery. It takes her much longer to accomplish simple tasks that she had no problems with before the surgery. Claimant has also had to cutback on the amount of tasks she can accomplish in one day. Whenever she bends over she experiences shortness of breath. Talking for an extended period of time makes claimant short of breath. Claimant no longer goes shopping at the mall because there are no carts for her to lean on and it requires excessive walking.

70. Claimant's Vocational Rehabilitation Counselor, Jay Spiegel opined that she could not return to work in her pre-operative position.

71. Mr. Spiegel opined that claimant could not find gainful employment because she has not been able to achieve more than 7 hours a week of work, she is limited by her medical condition, and the medical record does not show that her physical condition will improve. Mr. Spiegel opined that to be gainfully employed claimant would have to work 10-12 hours per week.

72. Mr. Spiegel undertook a labor market analysis and opined that no viable market existed for her or her position at Eden Park. He opined that claimant's position was specifically created for her and did not exist anywhere else.

73. John J. Halpin, Vocational Rehabilitation Counselor prepared an Independent Vocational Evaluation at the request of Royal & SunAlliance. Mr. Halpin only reviewed the records, and did not talk with claimant, her treating physicians, or her employer.

74. Mr. Halpin opined that the skills claimant is performing at Eden Park could be transferred to other employers in other types of employment. It was also his opinion that her abilities to perform activities of daily living, her education, and work experience made her a suitable candidate for other positions. Mr. Halpin suggested a telemarketer as a potential position for Claimant.

75. It was Mr. Halpin's opinion that claimant is currently engaged in regular gainful employment because her work is not casual or sporadic, and it is not charitable. He relied on claimant's physicians' opinion that she could work 15-20 hours per week to draw his conclusion.

76. HIPAA requirements would not allow claimant to work from home.

77. Claimant does not own a computer, and is not familiar with computer use.

78. Claimant's attorney fees request is for $32,546.00, based on 259.2 hours and costs $1,579.71.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *Goodwin v. Fairbanks*, 123 Vt. 161 (1962). The claimant must establish by sufficient credible evidence the character and extent of the injury and disability as well as the causal connection between the injury and the employment. *Egbert v. Book Press*, 144 Vt. 367 (1984).

2. There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden & Martin Lumber Co*., 112 Vt. 17 (1941).

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

Causation

4. At issue is whether claimant's bilateral diaphragmatic paralysis is causally related to her September 4, 2001 shoulder injury. The shoulder injury was accepted by Eden Park as a work-related injury.

5. As the leading commentator has stated, all natural consequences that flow from the primary work related injury are compensable unless they are the result of an independent intervening cause. 1 *Larson's Workers' Compensation Law* §10.01. The simplest application of this principle is the rule that all the medical consequences and sequelae that flow from the primary injury are compensable. *Id.*

6. In this case, all physicians agree claimant has bilateral diaphragmatic paralysis.

7. Dr. Siegel, Dr. Boynton, Dr. Gorman, Dr. Messier, Dr. LaPlaca, and Dr. Wagers all agree that there is a temporal relationship between Claimant's paralyzed diaphragm and her left shoulder surgery.

8. All doctors, including Dr. LaPlaca and Dr. Siegel, agree that claimant's respiratory problems were worse after the shoulder surgery.

9. An unknown event occurred during claimant's left shoulder surgery, which awakened a quiescent respiratory condition or caused a new one. Claimant's surgery was not a complicated procedure for Dr. Boynton, and should not have led to her spending two days in an intensive care unit because of respiratory problems. Dr. Boynton does not ever recall any of his patients suffering from diaphragmatic paralysis after surgery. Dr. Boynton opined that he would never operate on a patient who has respiratory problems. Although it is undetermined whether it was an error with surgery, anesthesia, medication or a reaction claimant's body had, it is clear that the procedure did not go as planned. It is clear that the staff at the hospital was concerned by the Claimant's post-operative condition and she now has severe limitations on her ability to breathe.

10. In those cases involving intentional conduct of the claimant, a break in the chain of compensable consequences is encountered. 1 *Larson's Workers' Compensation Law* §10.09(4). However, this claimant's paralyzed diaphragm is not the result of any intentional conduct on her part, as it is evident through the immediate nature of her paralysis that there was nothing she intentionally did to break the chain of causation.

11. Dr. LaPlaca and Dr. Siegel presume that Claimant's diaphragm was paralyzed prior to surgery. Dr. LaPlaca and Dr. Siegel base their presumption on claimant's history of peripheral neuropathy, hypothyroidism, previous neck surgery, and smoking. They cannot identify any specific mechanism that would have caused diaphragmatic paralysis prior to shoulder surgery, but they presume it was one of these pre-existing conditions, which caused her paralysis.

12. Dr. LaPlaca and Dr. Siegel fail to account for Claimant's pre-operative condition. Prior to surgery, claimant had no problems sleeping, accomplishing all required tasks at her employer's three-story business, and performing activities of daily living. The record is clear that after the surgery, claimant could not undertake any of these tasks without becoming severely short of breath. Neither Dr. LaPlaca nor Dr. Siegel explains how any of Claimant's pre-existing conditions produced such a drastic change in respiratory condition.

13. Further, if claimant had diaphragmatic paralysis prior to left shoulder surgery, Dr. LaPlaca and Dr. Siegel fail to explain how anesthesia could be administered while lying flat. Dr. Siegel opines that the anesthesia is administered while claimant was lying down, and Dr. Gorman opines that it would not have been possible to accomplish this if claimant had diaphragmatic paralysis prior to surgery.

14. A temporal relationship alone is an insufficient basis to support causation. *See Tammy Bockus v. Datatrac Information Services*, Opinion No. 14-05 WC (Feb. 8, 2005) (" opinions support only a temporal relationship, impermissible post hoc ergo propter hoc reasoning, which is an insufficient basis for an award."). Likewise, the Vermont Supreme Court noted that it is well established that "because something comes into existence after the fact, standing alone, does not justify a conclusion that it came into existence because of the fact." *Norse v. Melsur Corp.*, 143 Vt. 241, 244 (1983).

15. However, a temporal relationship combined with other factors may be sufficient to show causation. In *Norse*, a temporal relationship alone was not enough to form a causal connection. However, *Norse* may be distinguished from the current case because in *Norse* the Commissioner made no findings as to other possible causes of the injury. Also, *Norse* contained a large gap in the record that is not present in this case.

16. The Commissioner in the past has used a temporal relationship as one factor supporting evidence of causation. In *Mattson v. C.E. Bradley Laboratories*, Opinion No. 52-95WC, 1995), the temporal relationship of a heart attack, even considering the claimant's coronary risk factors, combined with the extraordinary circumstances of the claimant's employment was enough to support a causal connection. Likewise, in *Hatin v. Our Lady of Providence and ICV Construction*, Opinion No. 21-03WC (April 29, 2003), Dr. Tadan's opinion of causation was accepted, even though he based it in part on a temporal relationship. The Commissioner held that Dr. Tandan's explanation of causation was convincing because it was not based solely on a temporal relationship, but also included evidence of a lack of previous medical problems, and a clear indication that something new happened. *See also Rusch v. Visiting Nurse Alliance of VT/NH*, Opinion No. 02-01WC (2001) (Commissioner includes a temporal relationship as part of the evidence to be weighed when looking at all the factors of causation together).

17. In this case, the surgery is the cause of claimant's current diaphragmatic paralysis. Just as in *Mattson*, the temporal relationship is strong, as all doctors agree that one exists. Also, as in *Mattson*, the circumstances surrounding the event were extraordinary. Claimant's reaction to surgery was highly unusual, including a rare result of diaphragmatic paralysis. It is also not likely that claimant suffered from diaphragmatic paralysis prior to surgery. Finally, surgery is the more probable causation for the sudden respiratory paralysis.

Permanent Total Disability

18. Section 644(b) of Title 21 and Workers' Compensation Rule 11.3100 govern the creation of the odd-lot doctrine . Rule 11.3100 states:

> "A claimant shall be permanently and totally disabled if their work injury causes a physical or mental impairment, or both, the result of which renders them unable to perform regular, gainful work. In evaluating whether or not a claimant is permanently and totally disabled, the claimant's age, experience, training, education, occupation and mental capacity shall be considered in addition to his or her physical or mental limitations and/or pain. In all claims for permanent total disability under the Odd Lot Doctrine, a Functional Capacity Evaluation (FCE) should be performed to evaluate claimant's physical capabilities and a vocational assessment should be conducted and should conclude that the claimant is not reasonably expected to be able to return to regular, gainful employment.
>
> A claimant shall not be permanently totally disabled if he or she is able to successfully perform regular, gainful work. Regular, gainful work shall refer to regular employment in any well-known branch of the labor market. Regular, gainful work shall not apply to work that is so limited in quality, dependability, or quantity that a reasonable stable market for such work does not exist."

19. The commissioner shall consider specific characteristics of the claimant, including the claimant's age, experience, training, education, and mental capacity when evaluating a permanent total disability claim. 21 V.S.A. §644(b).

20. Regular employment means work that is not casual and sporadic, whereby hiring is not charitable and the person earns wages. *Kreuzer v. Ben & Jerry's Homemade, Inc.*, Opinion No. 15-03WC (2003).

21. All doctors that commented on claimant's work capacity determined that she has at least a sedentary work capacity. Dr. Wagers, Dr. Gorman, and Dr. Siegel agree that claimant can work at a sedentary level.

22. No doctor has limited claimant's work capacity to 7 or 8 hours a week. Dr. Wagers opined that claimant was able to stand and walk for 1-3 hours a day; sit 1-3 hours a day; and drive 1-3 hours a day. Dr. Wagers opined that claimant has the ability to work 15 hours a week. Dr. Siegel concluded that claimant has the ability to work 4 hours a day or 20 hours a week. Dr. Gorman deferred to Dr. Wagers opinion on Claimant's work capacity.

23. Despite Claimant's respiratory complications from surgery and her inability to breathe with the ease she did prior to surgery, claimant, to her credit, still remains active. She is able to accomplish, albeit with considerable more effort and in a much longer time, activities of daily living. Claimant cooks for herself, cleans the house, cleans dishes, does the laundry, vacuums, does light garden work, and travels to do errands. She also is able to go on short bike rides, walk on the treadmill, and partake in pool activities. These activities are consistent with the sedentary work capacity that doctors have given her.

24. Although fatiguing, claimant has successfully returned to work at Eden Park and works 7 to 8 hours per week. She works a sedentary desk job, and Eden Park is happy with her work-product. Eden Park is willing to accommodate claimant because of her expertise, high quality of work, and long standing relationship.

25. Eden Park's suggestion to have claimant fill a part-time nurse supervisor position is not a reasonable form of employment for Claimant. The accommodations that would have to be made by the employer so that claimant is able to meet the work capacity restrictions set out by Dr. Wagers would alter the job duties drastically. The accommodations, and the inability to meet the job requirements would be such an extreme alteration of the position of nurse supervisor that it would not be considered regular work and instead would be considered charitable. An employer cannot defeat a PTD claim by creating a position not open to others, which substantially alters duties, hours, and modifies the characteristic of the job to accommodate the claimant's disability. In light of the hour changes to 4 hours per night, the substantial alteration of job duties, and the modification of the character of job, the nurse supervisor position is charitable work and cannot defeat PTD.

26. Claimant's current position at Eden Park is not charitable, casual, or sporadic. Claimant is providing a valuable service for Eden Park, and it is clear that Eden Park respects Claimant's expertise in the field of nursing. Claimant works 2 times a week for scheduled periods and often works her schedules without a break.

27. No restrictions have been placed on claimant's increasing her number of hours at her current position. Although Mr. Spiegel opined that claimant may not be able to increase her work hours, no doctor has restricted claimant's hours of work to fewer than 15 a week. In fact, Dr. Siegel opined that it is possible for claimant to increase her hours to as many as 20 hours a week. Claimant is fatigued from her current position, but she works without pain, taking breaks, and on a regular basis.

28. Claimant is a hard-working, affable, sharp woman with years of nursing experience. She still has the ability to provide valuable services to Eden Park in sedentary level positions.

29. Claimant's increase to 15 hours a week at approximately $19.99 per hour is regular gainful employment in light of her reduction to 24 hours prior to her injury. Neither the Claimant, employer, nor any doctor have said that claimant could not physically increase her days to 4 days a week, working 3 to 4 hours a day. Claimant's PTD claim is denied based on Eden Park's need for claimant's services, claimant's desire to work, the lack of restrictions placed on claimant by any doctor from working more hours, and the lack of physical restrictions reported by claimant or her employer.

Permanent Partial Disability

30. Claimant argues in the alternative that she has a permanent partial disability. Permanent partial disability benefits shall be awarded when the injury results in a partial impairment which is permanent and which does not result in permanent total disability. 21 V.S.A. § 648(a).

31. All of the doctors that have examined claimant have put her in Class 4 pulmonary impairment according to the Table 5-12 of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, page 107. The Class 4 pulmonary impairment translates to a 51%-100% whole person impairment. Based on the testimony and evidence adduced at the hearing, I find claimant to be 51% impaired.

Attorney's Fees and Costs

32. A prevailing claimant is entitled to reasonable attorney fees as a matter of discretion and necessary costs as a matter of law. 21 V.S.A. § 678(a).

33. Pursuant to the discretionary power provided to the Commissioner pursuant to 21 V.S.A. § 678(a) and WC Rule 10.0000, a full award of $32,546.00 is inappropriate because claimant has not prevailed on her claim for PTD. This fee is extraordinary in relation to the amount of work required for the case and in light of the fact that the Claimant was only partially successful. I instead award an attorney fee of half of the hours worked for a fee of $16,273 because of the extraordinary work required to establish causation.

34. Necessary costs are awarded as a matter of law for a total award of $1,579.71.

ORDER:

Based on the foregoing findings of fact and conclusions of law:

A. Defendant is ORDERED to pay:

1. Medical benefits associated with this claim;

2. PPD based on 51% whole person impairment;

3. Attorney fees of $16,273 and costs of $1,579.71.

B. The claim for permanent total disability benefits is DENIED.

Dated at Montpelier, Vermont this 8th day of September 2005.

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Patricia A. McDonald
Commissioner

Appeal:

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