

STATE OF MICHIGAN
WORKER'S COMPENSATION APPELLATE COMMISSION

ROBERT HOLDEN
PLAINTIFF,

V

DOCKET #02-0383

ROCK TENN CORPORATION AND
LUMBERMENS MUTUAL CASUALTY COMPANY,
DEFENDANTS.

ON REMAND FROM MAGISTRATE FRANKLAND.

MARTIN D. GLISTA FOR PLAINTIFF,
ARTHUR G. KIRCHNER FOR DEFENDANTS.

OPINION

LESLIE, COMMISSIONER

This case returns to the Commission after remand to Magistrate Kenneth P. Frankland for further proceedings and a supplemental opinion pursuant to the Supreme Court's decision in *Rakestraw v General Dynamics Land Systems, Inc*, 469 Mich 220 (2003). On remand the only further testimony came from Quinter Burnett, M.D., a board-certified orthopedic specialist who treated plaintiff for his shoulder condition. The magistrate's supplemental opinion was mailed February 13, 2004. He found plaintiff established a work-related personal injury within the meaning of *Rakestraw*. We affirm.

In his supplemental decision, the magistrate summarized Dr. Burnett's testimony as follows:

Dr. Burnett was not deposed in the original proceeding. He is a board-certified orthopedic surgeon who performed arthroscopic subacromial decompression and distal clavicle resection of the left shoulder on August 21, 2000. His diagnosis contained in the operative note was left shoulder rotator cuff impingement and AC joint arthritis.

Dr. Burnett first examined plaintiff March 16, 2000 when plaintiff presented with left shoulder pain subsequent to an accident at work when plaintiff was crushed between a wall and a bale of paper. This office note and those of all visits through June 21, 2001 were typed into the transcript as a portion of the doctor's direct testimony.

Plaintiff reported pain in his left shoulder as well as low back. Plaintiff was scheduled for low back surgery and Dr. Burnett treated plaintiff conservatively. On March 16, Dr. Burnett x-rayed the left shoulder, showing no degenerative changes. Dr. Burnett was concerned that plaintiff had rotator cuff discomfort and that he could have had an injury to the cuff from the accident that was still lingering.

On May 18, 2000, the next visit plaintiff had his back surgery but still had left shoulder pain, very tender along the lateral acromion and slightly over the AC joint. An MRI had shown AC arthritis and partial thickness rotator cuff tear.

August 1, 2000 plaintiff's pain had returned to his pre-injection level. Dr. Burnett recommended outpatient arthroscopic and subacromial decompression based upon the MRI showing a significant impingement.

August 21, 2000 the operative note indicated no problems with the undersurface of the cuff, there were no full thickness tears, just some fraying, evidence of impingement, and spurring at the AC joint, with degenerative changes at the AC joint. Dr. Burnett also performed a distal clavicle excision. The diagnosis was left shoulder rotator cuff impingement and AC joint arthritis.

Post-operatively, Dr. Burnett followed plaintiff who reported significant discomfort October 2, 2000, October 23, 2000 November 13, 2000 and December 4, 2000. Plaintiff was performing physical therapy, was receiving injections and he had restrictions of no lifting or overhead activities. On January 9, 2001 plaintiff was to avoid repetitive overhead activities and no heavy lifting away from the body.

As of May 31, 2001 plaintiff still had some discomfort in the back of the shoulder. Plaintiff was still on restrictions.

After reviewing these records Dr. Burnett testified that the pathology he discovered during the operation was evidence of fraying of the rotator cuff, a partial thickness tear. There is also spurring and some degenerative changes in the acromioclavicular joint that were debrided.

Dr. Burnett was asked a hypothetical question based upon the found injury on January 28, 2000 and was asked whether the partial rotator cuff tear was caused by that incident. Dr. Burnett responded, "I think that type of force would easily cause this type of an injury; and if there was even some wear, such as the spurring in the AC joint that was even therefore, an injury like that could significantly aggravate it and accelerate that arthritis." Dr. Burnett further testified that plaintiff was disabled from performing heavy common labor from that surgery anywhere from 4 to 12 weeks.

During cross-examination, Dr. Burnett agreed that there was no MRI prior to the injury to compare the left shoulder condition. He also agreed that fraying of the rotator cuff tendon is possible as a result of degenerative changes. He agreed that spurring was present for several months and could be a factor in causing symptoms.

During redirect examination, Dr. Burnett was asked whether it was more likely than not that the injury he reported caused a medically identifiable injury even if there were pre-existing degenerative changes. Dr. Burnett responded, "I would say I would go by the patient's symptoms. If he never had any discomfort in the shoulder, no history of previous pain, then -- and it started at this onset, then I would assume that this injury caused enough further damage to cause symptoms."

In response to a question whether symptoms by themselves don't necessarily mean a change in pathology, Dr. Burnett stated, "Well, I assume if symptoms increase, that means the pathology probably has changed. It may not be visible by xray. Sometimes it's more of a soft tissue synovitis, inflammatory type of problem."¹

The magistrate found this testimony established a personal injury within the meaning of *Rakestraw*. He wrote:

In my prior decision, I found both a work-related back condition and left shoulder condition. The Commission stated both conditions were based upon symptomatic aggravation and the record medical testimony did not support a finding of pathological change in either the shoulder or back conditions. Plaintiff has offered no additional testimony relative to the back condition and thus that portion of the appellate decision remains unchanged.

With respect to the left shoulder condition, I find that Dr. Burnett's testimony adequately resolves the *Rakestraw* issue. I find that there is a medically distinguishable condition post-injury. There is no record evidence that plaintiff had a prior injury to the left shoulder before January 28, 2000. He had an incident at work involving the left shoulder when he was cutting wires off a bale on the conveyor when a forklift driver pinned him against the wall.

There had been no prior suggestion of any rotator cuff impingement. I find it significant that during Dr. Burnett's initial evaluation on March 16, 2000, he believed plaintiff had rotator cuff discomfort and that he could have had an injury to the cuff from the accident. Dr. Burnett's premonitions were borne out during the operation when he did find the partial rotator cuff tear, which he refers to as fraying. (TT. 32-33) There was no evidence of rotator cuff injury before January 28 and accordingly I find that there is a clear medically distinguishable condition after January 28 that I find is also a pathological change as it relates to the partial rotator cuff tear.

With respect to other pathology in the left shoulder, there apparently were degenerative changes in the acromioclavicular joint that were causing some discomfort and they were debrided. Dr. Burnett's testimony was somewhat equivocal relative to the January 28 incident causing a medically distinguishable condition. In those instances where there is no specific incident at work but rather an accumulation of symptomatology associated with work activities of a pre-existing nonwork-related condition, then *Rakestraw* has significant applicability. However, when plaintiff does establish a specific work incident and no significant symptomatology before the incident, then I believe that plaintiff may establish a medically distinguishable condition of a pre-existing condition with the appropriate medical testimony. What is critical, is an actual work event that triggers the change. Here, Dr. Burnett testified that if the patient had no discomfort in the shoulder, and it started at this onset, then he would assume that this injury caused enough further damage to cause symptoms. The emphasis here is upon

¹ Magistrate's opinion at 2-5.

the phrase, “further damage”. That suggests progression, a worsening of the condition, which I attribute to mean a medical change.

When Dr. Burnett was closely examined by defense counsel on the issue of whether increased symptoms alone does not necessarily mean a change in pathology, he responded that there is a valid assumption when symptoms increase that there is a change in pathology. That change may not be visible by x-ray and may often be soft tissue synovitis or other inflammatory type problems.

As I view all the Dr. Burnett’s testimony, it is clear and there should be no question that the rotator cuff impingement was caused by the January 28 injury and was a pathological change of condition. I find this condition to be disabling alone. I also find that Dr. Burnett’s testimony regarding the significant change and further damage to pre-existing degenerative processes in the shoulder also is a medically distinguishable change from pre-January 28, 2000. Either or both conditions being work-related created a compensable disability through the previously found April 10, 2001.²

Defendant argues:

The only additional testimony for the Magistrate to consider was the transcript of the deposition of Dr. Burnett, which is attached. It is believed that while Magistrate Frankland found that this testimony satisfied the requirements of the *Rakestraw* decision for the Plaintiff to establish a work-related shoulder condition, the Defendants/Appellants respectfully disagree.

The Appellate Commission is requested to review the concessions made by Dr. Burnet on cross-examination that the findings he made at the time of the MRI as well as at the time of the arthroscopic procedure could be degenerative. He agreed that the fraying of the cuff can be degenerative. He agreed that a type 3 acromion and/or spurring can cause the fraying found. He also agreed that degenerative changes of the AC joint can cause symptoms.

The doctor agreed that these kinds of findings can be present in a patient without a history of trauma. He also agreed that absent prior studies with which to compare, he could not state what specific effect the alleged incident had on the Plaintiff’s condition. The doctor agreed that symptoms alone do not necessarily mean that there is a pathological change. The doctor agreed that, based on the Plaintiff’s age, it would not be unusual for him to have the type of degenerative changes found.

Magistrate Frankland concedes, at page 6 of his decision, “Dr. Burnett’s testimony was somewhat equivocal relative to the January 28th incident causing a medically distinguishable condition.” While the Magistrate relies on the testimony of Dr.

² Id. at 5-7.

Burnett that symptoms alone would indicate a change in pathology, there is no objective medical basis in this case for that opinion.³

Plaintiff responds that the testimony of Dr. Burkett supports a finding of a change in pathology brought about by the work event.

We begin with the magistrate's statement of legal principle. He wrote:

In those instances where there is no specific incident at work but rather an accumulation of symptomatology associated with work activities of a preexisting nonwork-related condition, then *Rakestraw* has significant applicability. However, when plaintiff does establish a specific work incident and no significant symptomatology before the incident then I believe that plaintiff may establish a medically distinguishable condition of a preexisting condition with the appropriate medical testimony. What is critical, is an actual event that triggers the change.

We find this statement of the law ambiguous. To the extent the magistrate understood that a specific work event precipitating symptoms of a pre-existing condition is sufficient to establish a medically distinguishable condition under *Rakestraw*, it is incorrect. The magistrate went on to state, however, that an injury could be established with the "appropriate medical testimony", and found a pathological aggravation of both the rotator cuff tear and the shoulder joint arthritis. A well-grounded factual finding of pathological aggravation meets the *Rakestraw* requirement of proving a medically distinguishable injury.⁴ Thus, we consider whether the magistrate's conclusion of pathological aggravation is well grounded in Dr. Burkett's testimony.

The Supreme Court specifically defined "injury" to be medical consequences of work events. The court stated: "'Injury' is defined as 'harm or damage done or sustained, especially bodily harm. . . .' *Random House Webster's College Dictionary* (2001)."⁵

As a result, the occurrence of "injury" within the meaning of *Rakestraw* cannot be shown simply by testimony of a specific event at work precipitating or aggravating symptoms of a preexisting condition. Rather, injury must be demonstrated by evidence the work activity or event has changed the state of plaintiff's pre-existing illness beyond a mere manifestation of or aggravation of symptoms.

In our original decision we reviewed the medical testimony and found it did not establish a personal injury within the meaning of *Rakestraw*. As a result, the question of whether the magistrate's decision is supported by competent, material, and substantial evidence and is legally correct depends on the substance of Dr. Burnett's testimony.

³ Defendant's supplemental brief at 1.

⁴ *Harwood v Mercy Amicare*, 2003 ACO #213.

⁵ *Rakestraw* at 230 n 8.

We evaluate the deposition of Dr. Burnett and the magistrate’s findings against the legal backdrop of *Rakestraw*. In doing so we discern the following essential elements from the Supreme Court’s decision:

1. Pain standing alone does not establish a personal injury:

On several occasions, this Court has held that symptoms such as pain, standing alone, do not establish a personal injury under the statute. Rather, a claimant must also establish that the symptom complained of is causally linked to an injury that arises “out of and in the course of employment” in order to be compensable.⁶

2. Some form of new, discernible medical injury is required:

The difference between a “personal injury” under §301(1) and symptoms of a preexisting injury or illness that do *not* constitute a compensable injury was explored in *Kostamo v Marquette Iron Mining Co*, 405 Mich 105; 274 NW2d 411 (1979). *Kostamo* was a consolidation of cases in which the five plaintiffs either suffered a heart attack or experienced chest pain and sought compensation. Regarding plaintiffs Fiszer and Hannula, the board determined that they had not suffered heart attacks. Rather, these plaintiffs were determined to suffer chest pain as a result of nonwork-related arteriosclerosis. In finding compensation unavailable to them, the *Kostamo* court stated:

The workers’ compensation law does not provide compensation for a person afflicted by an illness or disease not caused or aggravated by his work or working conditions. Nor is a different result required because debility has progressed to the point where the worker cannot work without pain or injury. Accordingly, compensation cannot be awarded because the worker may suffer heart damage which would be work-related if he continued to work. Unless the work has accelerated or aggravated the illness, disease or deterioration and, thus, contributed to it, or the work, coupled with the illness, disease or deterioration, in fact causes an injury, compensation is not payable. [*Id.* at 116.] [Footnote omitted.]⁷

3. The claimant must demonstrate identifiable injury more than the manifestation of symptoms of the underlying disease or condition:

In *Farrington v Total Petroleum, Inc*, 442 Mich 201; 501 NW2d 76 (1993), this Court reviewed the 1980 legislative amendments that added the “significant manner” test to

⁶ *Id.* at 225.

⁷ *Id.* at 226.

recovery of benefits for mental disabilities and conditions of the aging process. The Court cited the *Kostamo* holding, stating that a claimant must prove “[t]hat the alleged cardiac injury resulting from work activities went *beyond the manifestation of symptoms of the underlying disease*. The heart injury must be significantly caused or aggravated by employment considering the totality of all the occupational factors and the claimant’s health circumstances and nonoccupational factors.” *Id.* at 216-217 (emphasis added).

Thus, several cases from this Court have articulated the principle that, where an employee claims to have suffered an injury whose symptoms are consistent with a preexisting condition, the claimant must establish the existence of a work-related injury that extends “beyond the manifestation of symptoms” of the underlying preexisting condition. *Id.* at 216.⁸

4. Where the symptoms complained of are equally attributable to the preexisting condition or a work-related injury, the employee has failed to establish causation:

Where a claimant experiences symptoms that are consistent with the progression of a preexisting condition, the burden rests on the claimant to differentiate between the preexisting condition, which is *not* compensable, and the work-related injury, which *is* compensable.¹⁰ Where evidence of a medically distinguishable injury is offered, the differentiation is easily made and causation is established. However, where the symptoms complained of are *equally* attributable to the progression of a preexisting condition or a work-related injury, a plaintiff will fail to meet his burden of proving by a preponderance of the evidence that the injury arose “out of and in the course of employment”; stated otherwise, plaintiff will have failed to establish causation. Therefore, as a practical consideration, a claimant must prove that the injury claimed is distinct from the preexisting condition in order to establish “a personal injury arising out of and in the course of employment” under §301(1).⁹

¹⁰ An employee bears the burden of proving the relationship between the injury and the workplace by a preponderance of the evidence. *Aquilina v Gen Motors Corp*, 403 Mich 206, 211; 267 NW2d 923 (1978).

⁸ *Id.* at 227-228.

⁹ *Id.* at 231-232.

Dr. Burnett first saw plaintiff March 16, 2000. He was present at plaintiff's second surgery, and did not see him after June 21, 2001.¹⁰ In his initial report, the doctor described plaintiff's history:

This is a 58-year-old male who was in an accident when he got crushed, I believe, between a wall and a bale of paper at work. He developed quite a bit of pain in his left shoulder. He has other problems including his back and is actually scheduled for some back surgery in a couple of weeks. He has had cervical spine surgery in the form of a hemilaminectomy, foraminotomy, and C-7 nerve root exploration and excision of a disc by Dr. Meyer. He has had pain in his neck and shoulder area even before this accident, but it has seemed to get worse recently and he is here for my opinion regarding any possible shoulder problems.

A number of records were sent with the patient, including two EMGs and nerve conduction studies, one dated before and one after his recent accident. Both were normal. He does complain of occasional numbness and tingling down the left upper extremity, sometimes down the right.¹¹

The doctor described his initial impression:

I am concerned that this gentleman does have some rotator cuff discomfort, that he could have had an injury to the cuff from this accident that is lingering still.¹²

The medical plan included further testing including MRI studies to identify the precise pathology present in the shoulder. In the meantime, the doctor put plaintiff on anti-inflammatory medication. In a follow up visit, May 18, 2000, plaintiff was still having a lot of left-shoulder pain and had limited motion and strength because of this. The doctor noted plaintiff's shoulder was very tender along the lateral acromion and slightly over the AC joint. He noted that a previous MRI "did show AC arthritis and partial thickness rotator cuff tear but not a full thickness tear."¹³ Plaintiff received injections which provided significant improvement, leading Dr. Burnett to conclude plaintiff had a "significant impingement" in the shoulder.

Surgery was performed August 21, 2000. The diagnosis was left shoulder rotator cuff impingement and AC joint arthritis.¹⁴ At his deposition Dr. Burnett further described the condition found when the surgery was done. He testified:

¹⁰ Deposition of Dr. Burnett at 15.

¹¹ Id. at 16-17.

¹² Id. at 18.

¹³ Id. at 19-20.

¹⁴ Id. at 22.

Q. And can you -- I know it's in there in writing already and typed up, but what pathology did you discover when you did that surgery that was, in your opinion, the result of a traumatic injury?

A. Well, he had evidence of fraying of the rotator cuff, which we call a partial thickness tear. It's not a normal condition. It wasn't a full thickness hole in the muscle like people who have a complete rotator cuff tear. This was more of a fraying type of an injury.

He also had spurring and some degenerative changes in the acromioclavicular joint, which is at the end of the collar bone, which can also cause some discomfort, and we debrided that at the same time we did the arthroscopic procedure.¹⁵

In response to an accurate hypothetical, the doctor was asked whether the partial rotator cuff tear was caused by the incident at work. The doctor stated:

A. I think that the type of force would easily cause this type of an injury; and if there was even some wear, such as the spurring in the AC joint that was even there before, an injury like that could significantly aggravate it and accelerate that arthritis.¹⁶

On cross-examination the doctor further explained the nature of plaintiff's shoulder pathology:

Q. Doctor, you didn't have the benefit of any diagnostic studies of Mr. Holden's left shoulder prior to the MRI that was performed at your request, is that correct?

A. Other than the MRI?

Q. Prior to the MRI.

A. Prior to the MRI, no, that's correct, other than I had information that I think he had had some physical therapy or something but no other tests.

Q. Okay. And it's my understanding that fraying of this rotator cuff tendon can also occur as a result of degenerative changes, isn't that true?

A. That's correct.

Q. This man was found to have a Type III acromion?

A. I don't recall, but that is possible. I don't remember that but --

¹⁵ Id. at 32-33.

¹⁶ Id. at 34.

Q. He had spurring which actually indented one of the muscles in the cuff, is that correct?

A. Correct.

Q. That spurring is something that had been present for a period of time or took many months to develop?

A. That's correct.

Q. All right. And that can also be a factor in causing the symptoms that may be resulting from the fraying that is occurring, is that right?

A. That's correct.

Q. In other words, you don't have to have a history of an injury to -- a trauma to the shoulder in order to develop symptoms based upon the findings that you saw by way of MRI and arthroscopic procedure, true?

A. That's correct.¹⁷

The doctor agreed that the changes found on MRI and at the time of surgery can occur in the absence of trauma, can be related to arthritis and that the effect of the work incident on the underlying condition was difficult if not impossible to assess:

Q. All right. And, again, the kind of changes that you found -- well, not again, but just to clarify, the kind of changes you found on the MRI and by scope can occur in the absence of a history of a trauma?

A. That's correct.

Q. All right. Just a couple follow-up and I should be done. You didn't find any evidence of a labrale tear at the time of your first procedure, the 8-21 procedure, true?

A. That's correct.

Q. And you didn't find any evidence of instability?

A. Correct.

Q. So, it was my understanding the findings that you reported were the fraying, the spurring, and the degenerative changes at the AC joint?

¹⁷ Id. at 35-37.

- A. Correct.
- Q. And this distal clavicle excision, is that done to allow for more room, if you will, more tolerance for all those structures to move within the joint?
- A. To some degree because you do remove the lower spurs that would be irritating the rotator cuff, but it also gets rid of the possibility that if pain was coming from the AC joint this would cure that problem also.
- Q. Okay. So, the impingement can be related to the spurring, true?
- A. It can.
- Q. Okay. And the spurring can be a function of the arthritis, is that right?
- A. Correct.
- Q. All right. And what effect this incident had on that arthritis, it would be difficult, if not impossible to know without prior studies to compare?
- A. Correct.¹⁸

On redirect examination, the doctor was specifically asked whether the event at work caused a medically identifiable injury. He testified:

- Q. Even though, Doctor, you said it is possible that this is degenerative in nature, from everything that you saw at the time of surgery, and it's possible it preexisted the injury that he reported, do you have an opinion it's more likely than not that the injury he reports caused a medically identifiable injury?

[Objection omitted.]

- A. I would say I would go by the patient's symptoms. If he never had any discomfort in the shoulder, no history of previous pain, then -- and it started at this onset, then I would assume that this injury caused enough further damage to cause symptoms.¹⁹

On re-cross-examination the doctor also agreed that symptoms alone do not necessarily equate with a change in pathology:

- Q. Doctor, just to follow up on that, in fairness, symptoms alone do not necessarily equate with a change in pathology, would you agree?

¹⁸ Id. at 38-39.

¹⁹ Id. at 39-40.

- A. Correct. Sometimes someone with known degenerative changes on x-ray can have no symptoms, but a specific event can trigger an onset of pain that can continue unless it's treated.
- Q. All right. But you agree with my statement that symptoms by themselves don't necessarily mean that there has been a change in pathology, is that correct? You'd agree with that, right?
- A. Well, I assume if symptoms increase, that means the pathology probably has changed. It may not be visible by x-ray. Sometimes it's more of a soft tissue synovitis, inflammatory type of problem.
- Q. Uh-huh.
- A. Because it takes quite a while for the bone changes to occur to see on an x-ray, so, a lot of times the initial pain isn't -- isn't bone-related; it's more soft tissue-related.
- Q. It's also true that degenerative changes like this patient was found to have in his shoulder joint, those can result in symptoms that wax and wane?
- A. Correct.²⁰

In this case the magistrate relied on the testimony of Dr. Burkett to prove that both plaintiff's rotator cuff condition and his arthritic condition were pathologically aggravated by the work event. We have quoted at length the pertinent portions of the doctor's testimony. Initially the doctor testified the work event "would easily cause this type of injury" and "could significantly aggravate and accelerate plaintiff's arthritis.

The magistrate reviewed the entirety of Dr. Burnett's testimony and acknowledged the doctor's testimony on causation was equivocal, but chose to accept his statement that the absence of symptoms prior to the very dramatic work event precipitated a change in plaintiff's shoulder pathologies. Although this is a very close case, we find the doctor's opinion that new symptoms occurring immediately after a dramatic work event, even though compatible with a pre-existing condition, are evidence of pathological change is sufficient to meet the Supreme Court's standard in *Rakestraw* of a medically distinguishable condition.²¹

We affirm the magistrate's opinion after remand.

²⁰ Id. at 40-41.

²¹ See, e.g., *Meyer v Vanguard Staffing Services, Inc.*, 2004 ACO #88.

Chairperson Reamon and Commissioner Kent concur.

Richard B. Leslie Commissioner

William G. Reamon, Jr. Chairperson

James J. Kent Commissioner

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This case returns to the Commission after remand to Magistrate Kenneth P. Frankland for further proceedings and a supplemental opinion. The Commission has considered the record and counsel's briefs, and believes that the magistrate's decision should be affirmed. Therefore,

IT IS ORDERED that the magistrate's decision is affirmed after remand.

Richard B. Leslie Commissioner

William G. Reamon, Jr. Chairperson

James J. Kent Commissioner