BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F302526

JIMMY SINGLETON, EMPLOYEE	CLAIMANT
CITY OF PINE BLUFF, EMPLOYER	RESPONDENT NO. 1
ARKANSAS MUNICIPAL LEAGUE, WCT, INSURANCE CARRIER	RESPONDENT NO. 1
DEATH & PERMANENT TOTAL DISABILITY TRUST FUND	RESPONDENT NO. 2

OPINION FILED AUGUST 21, 2007

Upon review before the FULL COMMISSION in Little Rock, Pulaski County, Arkansas.

Claimant represented by the HONORABLE KENNETH A. HARPER, Attorney at Law, Monticello, Arkansas.

Respondents No. 1 represented by the HONORABLE J. CHRIS BRADLEY, Attorney at Law, North Little Rock, Arkansas.

Respondent No. 2 represented by the HONORABLE JUDY W. RUDD, Attorney at Law, Little Rock, Arkansas.

OPINION AND ORDER

The Arkansas Court of Appeals has reversed the Full Commission in the above-styled matter and has remanded for further proceedings. *Singleton v. City of Pine Bluff*, CA06-398 (Dec. 6, 2006). Based on our *de novo* review of the entire record, and pursuant to the remand from the Court of Appeals, the Full Commission finds that the claimant did not

prove he was entitled to benefits for a permanent physical impairment or wage loss.

I. HISTORY

Jimmy Singleton, age 42, testified that he worked as a law enforcement dispatcher while in high school and became a full-time police officer at the age of 21. Mr. Singleton worked in law enforcement and training, and testified that he was Police Chief for the McGehee Police Department from October 1993 until September 1999. The claimant then worked for Drew County Sheriff's Office until becoming employed with Pine Bluff Police Department in January 2003.

The parties stipulated that there was a compensable injury to the left ankle and head on March 1, 2003. The claimant testified on direct examination:

> Q. Tell us about that day.
>
> A. That was March 1st of 2003....I noticed a vehicle that was stopped in the road with the hood half-way up....There was an individual standing at the front of the truck. When I got out of my patrol unit, we met walking to one another at the bed of his pickup truck, and at that time I smelled the odor of what I believed to be marijuana. I began a pat-down search of him, and when I was searching on the left side, he came around with his right hand and stuck a pistol in my stomach....I reached up to try to get him off of me and I couldn't push him off, so I tried to pull him over. I couldn't pull him over, so at that point I decided to see if I could break his

> wrist over my knee. When I did that, the gun discharged.
> At that time I didn't know I was even shot.
> We began to go spinning around again, and at that point I was knocked unconscious by the other individual that was in the truck. And I don't know what went on between the time I was knocked unconscious and the time I got to the hospital.

A CT scan of the claimant's head was taken on March 1, 2003, with the following impression:

> 1) There is minimal soft tissue swelling on the right side of the head.
> 2) No acute calvarial fracture or intracerebral hemorrhage is demonstrated.

An x-ray of the claimant's left ankle, three views, was taken on March 1, 2003:

> There are bullet fragments embedded in the posterior aspect of the talus, and there are small chip fractures of the posterior talus. A small bone fragment at the tip of the lateral malleolus is probably a secondary ossification center or an old avulsion fracture. There also appears to be secondary ossification center of the cuboid. The ankle mortise is intact.

The claimant was admitted to Drew Memorial Hospital on March 24, 2003 and was discharged on March 25, 2003 with the following diagnoses: "FINAL DIAGNOSIS: 1. Depression. SECONDARY DIAGNOSIS: 1. Suicidal ideations. 2. Severe headache, secondary to concussion and head trauma with short-term memory loss. 3. Gun shot wound left ankle. 4. Urinary tract infection."

Electroencephalography was administered on or about March 25, 2003, with the following impression:

> This is an abnormal EEG due to relatively minor sharp and slow wave activity seen in the left temporal leads. This is a nonspecific finding and may be associated with an underlying paroxysmal disorder.

An MRI scan of the claimant's brain was taken on March 25, 2003, with the impression, "Negative MRI scan of the brain."

An MRI of the left foot on April 3, 2003 showed the following:

> Sagittal, axial and coronal T1 weighted spin echo and sagittal FLAIR images were obtained and show injury pattern through the posterior talus and the subjacent oscalcis. Posterior joint effusion is seen with soft tissue injury over the posterior superior aspect of the talus. The tibialis posterior tendons, flexor digitorum tendons and flexor hallucis tendons appear intact. Achilles tendon is intact as well.
>
> IMPRESSION: Osseous edema. Posterior talofibular ligament is intact.
> Medial ligament is intact. The posterior talofibular ligament is intact and the calcaneal fibular ligament is not confidently identified.
>
> IMPRESSION: No major tendinous disruption or injury.

Dr. Scott C. Claycomb, an ophthalmologist, reported on May 2, 2003, "Mr. Singleton does appear to have ocular

hypertension with possible early glaucomatous visual field deficits. The remainder of his examination does appear relatively unremarkable.”

Dr. Lon Burba examined the claimant on May 20, 2003 and reported, “I suspect this is a post-traumatic headache and frequently these originate in the neck.” Dr. Burba prescribed medication and planned a diagnostic image of the claimant’s neck.

Dr. Scott M. Schlesinger performed a neurosurgical consultation and reported on June 10, 2003:

> I have read the MRI scan of the brain. This study is unremarkable. I do not feel that there is any structural explanation for his headaches. Obviously, headaches could come from multiple sources including underlying structural lesions, tension headaches, migraine headaches, cluster headaches, etc. In his case, I think he has post-concussive headache and neurologic symptoms. There is nothing to do for him neurosurgically and nothing to base a permanent partial disability rating on. I think over the next 4-6 weeks he should reach maximum medical improvement from post-concussive syndrome. I will defer treatment and following of this patient to Dr. Burba....

Dr. A.J. Zolten provided a psychological evaluation and reported on or about August 4, 2003, “His current interview and psychologic test results are all clearly consistent with severe posttraumatic stress disorder and it is unfortunate that he has not yet received adequate psychiatric care with

the exception of see (sic) Dr. Street (a child psychiatrist) in the emergency room." Dr. Zolten referred the claimant to a physician for "psychiatric medication management," and he also referred the claimant to an "anxiety and trauma" specialist for "his trauma issues."

An Electroencephalogram Report was entered on October 2, 2003, with the following impression: "This is an abnormal EEG characterized by occasional left temporal sharp activity which may reflect an area of cortex irritation in this region of the brain, but is a non-specific finding. Compared to the previous EEG, this is not much changed."

Dr. Andrew W. Lawton, a neuro-ophthalmologist, corresponded with Dr. Burba on October 2, 2003:

> Per your request, I saw Mr. Singleton for a comprehensive examination today. Enclosed is my report on Mr. Singleton. I found no organic explanation for the reported decrease in vision in Mr. Singleton's left eye. In fact, when he was dilated, I dissociated his eyes using a 4 diopter base-up prism over his right eye and he read 20/25 with his left eye. I believe he has a conversion reaction related to his left eye. He does have open angle glaucoma managed by Dr. Claycomb that appears unrelated to his trauma. His intraocular pressures were higher than they should be considering his visual field results and optic cup appearance. I will relay the information to Dr. Claycomb so he can adjust Mr. Singleton's eye drops as needed. I will see him again as requested....

A Licensed Clinical Social Worker interviewed the claimant on October 23, 2003. The LCSW's diagnostic impression included Mood Disorder due to Posttraumatic Stress Disorder, Adjustment Disorder with Depressed Mood, and brain trauma.

Dr. Barry D. Baskin evaluated the claimant on November 10, 2003:

> Mr. Singleton is a 38 year old police officer who was involved in an altercation on 3/1/03. He had a pistol stuck in his abdomen and when he grabbed the gun pushing it down the gun discharged into his left ankle and he does have retained bullet fragments, probably a small caliber gun by review of the films per Dr. Clark's notes. He also subsequently was hit with a blunt object in the head and had a concussion and has had some subtle memory problems, nightmare, symptoms consistent with posttraumatic stress disorder and posttraumatic headaches. He has been see (sic) by Dr. A.J. Zolten and also Dr. Lon Burba. He is seeking his retirement. He is not suitable, I don't think at this point, to go back to the work on the police force due to their residual stress that he is experiencing from his injury. He still has headaches and is taking Methadone, Ultracet and a variety of other medications....
>
> I am going to leave him off work for now. I don't think he has reached maximum medical improvement. I do not have an impairment rating for him at this point but he will have an impairment rating, probably about 1 year post injury....

The claimant underwent a Psychiatric Evaluation and was diagnosed with the following on or about November 13, 2003:

"1. Posttraumatic Stress Disorder. 2. Adjustment Disorder with Depressed Mood. 3. Caffeine Intoxication with Caffeine withdrawal headaches. 4. Caffeine Induced Sleep Disorder."

Dr. Jason G. Stewart examined the claimant on February 25, 2004:

> This is a 38-year-old former police officer that was shot about one year ago in the ankle with a residual bullet fragment in the posteromedial aspect of the talus. The bullet entered just slightly posterior to the medial malleolus and downward in lateral trajectory and somehow avoided injuring the neurovascular and tendinous structures of the ankle. It came to rest in the posterior most aspect of the talus extraarticular. He has had chronic problems after this injury....
>
> Left Lower Extremity: There is a small area where a bullet entered just posterior to the medial malleolus. There is a mild amount of edema present throughout the entire ankle. He has 5 degrees dorsiflexion and 25 degrees plantarflexion with no instability. No crepitus with movement is noted. The foot is slightly cool to the touch. Pulses are present. Sensation is intact.
>
> IMAGING:
> Two views of the ankle show a small bullet fragment in the posterior aspect of the talus in extraarticular position with some fragmentation of the bullet. No bony fractures are noted.
>
> IMPRESSION:
> Left ankle pain related to gunshot wound with residual bullet in the ankle.
>
> PLAN:

1. I have cautioned him against excision of this fragment stating the obvious risk of neurovascular injury to get this deep in the ankle and creating a problem that does not already exist. I think his burning and pain is such a broad complaint that simply removing the bullet fragment is not going to alleviate the discomfort.
2. I have recommended antiinflammatories only.
3. Regarding his work status, I do not think that he will ever be able to do a job that requires running, climbing, carrying or lifting anything. It mostly needs to be a sedentary job standing no more than two hours in an eight-hour period.
4. Regarding his recovery, I think that he has reached maximum medical improvement at this time, but the AMA Guide to Permanent Impairment does not have a rating based on residual bullet fragment. He does not have leg-length discrepancy, girth discrepancy, or any fractures, fusions or amputations and therefore, I cannot give him a rating at this time.
5. I will see him on an as-needed basis.

Dr. Baskin noted the following on March 25, 2004:

> Mr. Singleton is 1 year out from his injury. He has mild residual traumatic brain injury type findings. He has diagnosis of post traumatic stress disorder. He has residual antalgic gait on the left due to a gunshot wound in the left foot. Left foot pain. Again, mild cognitive deficits.
>
> Using the AMA Guidelines Fourth Edition, Page 142, Table 2, under mental status impairments, Mr. Singleton has a mild mental status impairment but he is able to perform satisfactorily most activities of daily living. He has an 8% impairment to the whole person based on mental status impairment. In Table III, Page 142, emotional and behavior impairment, Mr. Singleton would have an impairment in the mild category which would give him a 10% whole person impairment rating. Due to the patient's post traumatic

> headaches, which seem to be migraine in nature, he would have an 8% whole person impairment rating. Due to the patient's bullet wound to the left foot with antalgic gait using Table 13, Page 148 he would have an 8% impairment rating to the whole person.
>
> Using the combined chart on Page 322, Mr. Singleton would have 30% impairment to the whole person based on mental status impairment, emotional disturbance, gait disturbance and post traumatic headache. He is at a point of maximum medical improvement. I will still follow him for his medications and periodic follow up. We will see him back in follow up in 2 months.

The parties stipulated that the claimant reached maximum medical improvement and the end of his healing period on March 25, 2004.

The claimant followed up with Dr. Baskin on May 6, 2004: "I will try to find something for him to do. He is receiving retirement from work as well as social security disability. He is still only 39 and has a long life ahead of him. I hope he can find something suitable in the employment line or volunteer work. He has worked in law enforcement primarily, and I think he should stick with that area, if possible. I will see him back in about two months. I renewed his prescriptions."

A Left Lower Extremity Venous Doppler Ultrasound was taken on June 8, 2004:

> Venous Doppler ultrasound of the left lower extremity reveals normal flow at all levels. The flow is spontaneous, augmentable, and compressible and appears normal.
> IMPRESSION: No definite left lower extremity venous pathology.

Dr. Baskin examined the claimant on July 8, 2004 and noted "a moderate amount of edema in the left leg....Mr. Singleton is having problems with depression and edema in the left lower extremity."

Dr. W. R. Oglesby wrote to a representative of the respondent-carrier on August 5, 2004:

> Mr. Jimmy Singleton was seen at Delta Counseling Associates earlier this year and terminated treatment only after a few visits. His diagnoses were Depression and Post Traumatic Stress Disorder which are treatable conditions from which full recovery was expected. Any mental impairment he may have had at the time of his visits here was considered temporary.
>
> We usually do not give disability or impairment ratings, however, in reviewing Dr. Baskin's Clinic Note, I do not agree with his conclusion regarding the percentage of mental impairment or that Mr. Singleton was at a point of maximum improvement.

Dr. William F. Blankenship informed the respondent-carrier on September 9, 2004:

> Regarding your letter of 09/07/04 concerning this individual and impairment ratings, with regard to his impairment rating as far as his mental status and migraine headaches, this is not in the purview of orthopedic surgery. Therefore, this examiner does not feel he should give any rating regarding

> this matter. However, regarding a rating for his left foot, which is based on an antalgic gait as described by Dr. Baskin, there is disagreement. This is a subjective gait. Although it may be rated in the permanent impairment, there is no objective basis for any permanent impairment rating for the structures around the left ankle. In the records furnished, there are no objective findings that mention any permanent structural damage to the areas he complained of.

A pre-hearing order was filed on December 6, 2004. The claimant contended that he had "received anatomical impairment ratings both to his ankle and his head and seeks payment of past and future medical, permanent and total disability or in the alternative, wage loss, and permanent partial disability and attorney's fees." Respondent No. 1 contended, among other things, that the claimant was not entitled to a permanent impairment rating. The parties agreed to litigate the following issues: "Extent of anatomical impairment, if any, and wage loss, if any."

The claimant followed up with Dr. Baskin on January 10, 2005: "He has fairly good strength in the extremities. The left calf has atrophy compared to the right. This may just be from disuse. He is tender along the medial aspect of the left ankle, along the medial calcaneus and the instep of the left foot....Mr. Singleton is about the same overall. He has had left leg pain, headaches, some insomnia. He still

continues to have symptoms of mild traumatic brain injury and he was diagnosed by Dr. Oglesby with posttraumatic stress disorder and depression. His affect is still flat."

A hearing was held on February 11, 2005. The claimant testified that he was continuing to follow up with Dr. Baskin every three months, and that Dr. Baskin was re-filling his medication. The claimant testified that he was unable to hold a regular job because of his post-injury physical condition and the medication he was taking. The claimant testified that he suffered from chronic headaches as a result of the compensable injury. The claimant testified that his medical bills were being paid and that he was unaware of any medical bills that had not been paid. The claimant testified under cross-examination that he had recently attempted to work as a criminal investigator but was physically unable to do so. The claimant testified that he had not attempted to secure any other type of employment.

The respondents' attorney also cross-examined the claimant with regard to surveillance videotape. The claimant's testimony in this regard indicated that he was able to take out the garbage, ride a small tractor, and occasionally walk without a cane. The claimant testified on

cross-examination, "when I find this guy that shot me, he hasn't been found yet, I'm going to kill him."

An administrative law judge filed an opinion on May 12, 2005. The administrative law judge found, among other things, that the claimant proved he was entitled to a 30% anatomical impairment rating and additional 50% wage-loss disability. The respondents appealed to the Full Commission. The Full Commission filed an opinion on February 23, 2006 and found, among other things, that the claimant did not prove he was entitled to a permanent physical impairment or wage-loss disability. The claimant appealed to the Arkansas Court of Appeals. The Court of Appeals has reversed the Full Commission's findings with regard to anatomical impairment and wage-loss disability and has remanded for further proceedings consistent with the Court's opinion.

II. ADJUDICATION

"Permanent impairment" has been defined as any permanent functional or anatomical loss remaining after the healing period has ended. *Excelsior Hotel v. Squires*, 83 Ark. App. 26, 115 S.W.2d 823 (2003), citing *Johnson v. General Dynamics*, 46 Ark. App. 188, 878 S.W.2d 411 (1994).

Any determination of the existence or extent of physical impairment must be supported by objective and measurable physical findings. Ark. Code Ann. §11-9-704(c). Pursuant to Ark. Code Ann. §11-9-522(g), the Commission must adopt an impairment rating guide to be used in assessing anatomical impairment. The Commission has therefore adopted the Guides to the Evaluation of Permanent Impairment (4th Ed. 1993) published by the American Medical Association. *See, Workers' Compensation Laws And Rules, Rule 099.34*.

The Commission is authorized to decide which portions of the medical evidence to credit and to translate this medical evidence into a finding of permanent impairment using the AMA *Guides*. *See, Avaya v. Bryant*, 82 Ark. App. 273, 105 S.W.3d 811 (2003), citing *Polk County v. Jones*, 74 Ark. App. 159, 47 S.W.3d 904 (2001). The Commission may assess its own impairment rating rather than rely solely on its determination of the validity of ratings assigned by physicians. *Id*.

The parties stipulated in the present matter that the claimant sustained a compensable injury to his left ankle and head. The claimant did not prove that he was entitled to a permanent impairment rating for the compensable injury

to his head. The claimant testified that he was "knocked unconscious" on March 1, 2003. A CT scan on that date showed minimal soft tissue swelling on the right side of the claimant's head, with no acute calvarial (skull) fracture or intracerebral hemorrhage. An EEG was taken on March 25, 2003 and was interpreted to be abnormal but was also "a nonspecific finding." The March 25, 2003 EEG is not evidence demonstrating a permanent injury to the claimant's head or brain. An MRI scan of the claimant's brain was taken on March 25, 2003, with the impression, "Negative MRI scan of the brain." None of the diagnostic testing performed after the compensable injury demonstrated a permanent injury to the claimant's head or brain.

Dr. Schlesinger, a neurosurgeon, reported on June 10, 2003, "I have read the MRI scan of the brain. This study is unremarkable. I do not feel that there is any structural explanation for his headaches....There is nothing to do for him neurosurgically and nothing to base a permanent partial disability rating on. I think over the next 4-6 weeks he should reach maximum medical improvement from post-concussive syndrome." Another EEG, taken in October 2003, was interpreted as being abnormal. Like the first EEG taken

in March 2003, this EEG study was nonspecific and cannot be relied on as evidence demonstrating a permanent injury to the claimant's head or brain. We recognize the Court's holding that medical evidence supported by objective findings is not required to establish each and every element of compensability. *Stephens Truck Lines v. Millican*, 58 Ark. App. 275, 950 S.W.2d 472 (1997). In the present matter, however, there is no medical evidence supported by objective findings establishing a permanent anatomical impairment to the claimant's head or brain. Nor do the Guides, upon which the Commission must rely, show a permanent anatomical impairment to the claimant's head or brain in the instant matter. The Full Commission is aware of the ratings assigned by Dr. Baskin in March 2004 for purported "mental status impairment," "emotional disturbance," and "post traumatic headache." The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). In the present matter, there is not one objective medical finding of record supporting Dr. Baskin's impairment ratings for the claimant's alleged mental or emotional impairments

or the claimant's headaches. The Full Commission expressly attaches more evidentiary weight to the expert opinion of Dr. Schlesinger, who explicitly opined that the claimant was not entitled to a permanent rating for his brain.

The Full Commission finds that the claimant did not prove he was entitled to a permanent impairment rating for his compensable head injury.

The Full Commission also finds that the claimant did not prove he was entitled to a permanent impairment rating for his compensable left ankle injury. The parties stipulated that the claimant sustained a compensable injury to his left ankle on March 1, 2003. An x-ray taken on the date of injury showed bullet fragments in the posterior aspect of the claimant's talus (ankle bone). The claimant was diagnosed as having a gunshot wound to the left ankle. An MRI on April 3, 2003 showed osseous edema in the claimant's left ankle region but no major tendinous disruption or injury. The impression of Dr. Stewart in February 2004 was "Left ankle pain related to gunshot wound with residual bullet in the ankle." Dr. Stewart determined, "I think that he has reached maximum medical improvement at this time, but the AMA Guide to Permanent Impairment does

not have a rating based on residual bullet fragment. He does not have leg-length discrepancy, girth discrepancy, or any fractures, fusions or amputations and therefore, I cannot give him a rating at this time."

Dr. Baskin attempted to assign a permanent impairment rating for the claimant's ankle on March 25, 2004: "Due to the patient's bullet wound to the left foot with antalgic gait using Table 13, Page 148 he would have an 8% impairment rating to the whole person." Yet there is no indication of record that Dr. Baskin's rating was based on an objective medical finding. Dr. Blankenship specifically noted in September 2004 that antalgic gait as described by Dr. Baskin was "a subjective gait." Dr. Blankenship also stated, "there is no objective basis for any permanent impairment rating for the structures around the left ankle. In the records furnished, there are no objective findings that mention any permanent structural damage to the areas he complained of."

The Full Commission again recognizes the Court's holding that objective medical evidence is not required to establish each and every element of compensability. *Millican, supra*. We also recognize, however, that public

policy is declared by the Arkansas General Assembly, not the courts. *Nabholz Constr. Corp. v. Graham*, 319 Ark. 396, 892 S.W.2d 456 (1995), citing *Murphy v. Epes*, 283 Ark. 517, 678 S.W.2d 352 (1984). Pursuant to the law as enacted by the General Assembly, the Commission has adopted the 4th Edition of the Guides to be used in evaluating permanent anatomical impairment. In the present matter, the Full Commission attaches significant evidentiary weight to the expert opinions of Dr. Stewart and Dr. Blankenship. Both Dr. Stewart and Dr. Blankenship credibly opined that there was not a permanent anatomical rating, pursuant to the Guides, for the claimant’s compensable injury. The Full Commission finds that the opinions of Dr. Stewart and Dr. Blankenship are entitled to greater weight than the opinion of Dr. Baskin in this matter. There is not a single table or figure in the Guides to the Evaluation of Permanent Impairment, Fourth Edition, which allows the Commission to assign a permanent anatomical impairment to the instant claimant’s left ankle in accordance with the relevant standards of Act 796 of 1993.

Based on our *de novo* review of the entire record, and pursuant to the remand from the Arkansas Court of Appeals,

the Full Commission finds that the claimant did not prove that he sustained any permanent physical impairment as a result of the compensable injuries to the claimant's left ankle and head. Since the claimant did not prove he was entitled to permanent physical impairment, the claimant did not prove he was entitled to wage-loss disability. *Wal-Mart Stores, Inc. v. Connell*, 340 Ark. 475, 10 S.W.3d 727 (2000). The claim for permanent partial disability benefits in the present matter is denied and dismissed.

IT IS SO ORDERED.

____
OLAN W. REEVES, Chairman

____
KAREN H. McKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority opinion which finds the claimant is not entitled to permanent impairment ratings for his closed head and ankle injuries. I must also dissent from the Majority's

finding that the claimant is not entitled to wage loss benefits in relation to those injuries.

After reviewing the record and the remand order from the Court of Appeals, I am quite concerned by the opinion of the Majority. In the Court of Appeals' opinion issued on December 6, 2006, the Commission was directed to reconsider the claimant's entitlement to the requested impairment ratings because it had arbitrarily ignored all subjective evidence showing the claimant had an impairment rating. The Court of Appeals specifically noted that the Commission had erred in finding that the opinion from Dr. Baskin could not arbitrarily be disregarded simply because it was based, in part, on subjective criteria. Despite the rather explicit directions given by the Court of Appeals, the Majority again refuses to consider any subjective evidence in determining whether the claimant is entitled to impairment ratings. As has been outlined in a multitude of recent cases, this is an error of law and, in my opinion, a disturbing and blatant disregard of the law on this issue. Accordingly, I must respectfully dissent.

I first address the claimant's entitlement to an impairment rating for his organic brain injury. The medical records are wrought with references that show the claimant had abnormal EEGs, post-concussive headaches, neurological complaints, and memory loss. As these problems were caused by the work-related injury, the parties have stipulated that he is at MMI, and yet he still continues to have abnormal diagnostic tests and other subjective problems, I am simply baffled by the Majority's refusal to award an impairment rating for the claimant's cognitive deficits.

It appears that the Majority has found that the claimant has no lasting organic brain injury. However, to reach such a conclusion, one has to ignore virtually every medical report in the record. In fact, the only evidence to support the Majority's finding is found in the opinion of Dr. Schlesinger, who opined the claimant's MRI did not show a defect which would cause the claimant's headaches. However, as discussed below, it is apparent that Dr. Schlesinger believed the claimant had a legitimate injury and that he was not

privy to later diagnostic testing which confirmed the claimant had an objective injury to his brain.

As noted by the Court of Appeals, the claimant is only required to have objective findings which support a finding of compensability. Furthermore, the Court of Appeals has clearly indicated that an impairment rating only need be supported by objective findings. Coleman v. Pro Transportation, CA 06-525 (Ark. App. 2-7-2007). It is well settled that while subjective criteria, by itself, is not enough to support an award of an impairment rating, it may be considered in assessing an impairment rating if any objective findings showing impairment exist. Furthermore, a medical opinion which takes into account both objective and subjective criteria may not be disregarded simply because subjective criteria is used. Id., Singleton v. City of Pine Bluff, ___ Ark. App. ___, ___ S.W. 3d ___ (Dec. 6, 2006). Finally, it should be noted that the Court has, in the past, awarded benefits for a closed head injury when the claimant initially presented with objective injury, and then later presented with subjective complaints and memory defects shown by

neuropsychological testing, which was based on subjective responses. <u>Wentz v. Service Master</u>, 75 Ark. App. 296, 57 S.W.3d 753 (2001).

In this instance, I find that it is apparent the Majority has arbitrarily disregarded the medical opinion of Dr. Baskin simply because it was based, in part, on subjective criteria. Furthermore, the Majority has erred in concluding that there is no evidence to show that the claimant sustained a permanent injury as shown by objective findings.

In this instance, the medical records are wrought with examples of both objective and subjective neurological complaints which are attributable to the claimant's work injury. The Majority denies the claimant an impairment based on the finding that, "There is not one objective medical finding of record supporting Dr. Baskin's impairment ratings for the claimant's alleged mental or emotional impairments or the claimant's headaches." This statement is simply not supported by the facts in this record. Likewise, it completely fails to address whether the claimant

sustained a permanent impairment in the form of memory loss due to a neurological defect.

The Commission has the authority to accept or reject medical opinions, and its resolution of the medical evidence has the force and effect of a jury verdict. Poulan Weed Eater v. Marshall, 79 Ark. App. 129, 84 S.W.3d 878 (2002). However, the, the Commission cannot arbitrarily disregard any medical evidence or a witness's testimony. Freeman v. Con-Agra Frozen Foods, 344 Ark. 296, 40 S.W.3d 760 (2001), See also, Stone v. Dollar General Stores, 91 Ark. App. 260, 209 S.W. 3d 445.

The medical records showing the severity and permanency of the claimant’s impairment due to his closed head injury are overwhelming. On the date of the compensable injury, a CT Scan was performed on the claimant. It revealed soft tissue swelling on the right side of the claimant’s head. On the same date, the claimant was noted to have a laceration and to suffer from swelling of his head. Shortly thereafter, he presented with persistent headaches, dizziness, and memory loss. The record is devoid of any indication

that the claimant had ever suffered from similar symptoms in the past. Further evidencing the claimant’s brain injury is the Electroencephalography performed on March 26, 2003, which indicated that the claimant had abnormal brain activity.

On March 24, 2003, a report form Drew Memorial Hospital indicated that the claimant suffered a “severe headache, secondary to concussion and head trauma with short term memory loss.” Further evidencing the claimant’s brain injury is the note dated May 5, 2003, which opined the claimant suffered from post-concussive headaches. Likewise, the note from Dr. Lon Burba, dated May 20, 2003, indicates the claimant lost consciousness for eight to twelve minutes and was disoriented and confused after being taken to the hospital.

Another abnormality in the claimant’s brain was seen on October 2, 2003. On that date, an EEG revealed that the claimant continued to have, “occasional left temporal sharp activity...”. The report also indicated that the abnormal brain activity, “may reflect an area of cortex irritation in this region of the brain.” Certainly, given the nature of the

claimant’s injury, such irritation would be consistent with the claimant’s complaints and the nature of his injury.

Likewise, the claimant was noted to have memory loss during his psychological treatment. On October 23, 2003, Belknap specifically noted the claimant suffered from short-term memory loss. This further exemplifies the fact that the claimant suffered a brain injury which was lasting in nature.

Dr. Barry Baskin agreed with Dr. Burba’s assessment that the claimant sustained a brain injury. As early as November 10, 2003, Dr. Baskin noted that the claimant had two abnormal EEGs. He noted that the claimant suffered from a concussion due to the incident. On January 22, 2004, he opined, “He has had causation for being off work due to his brain injury, his headaches and the left foot injury.” He further noted the claimant was having, “mild cognitive defects.” Lastly, he noted the claimant’s abnormal EEGs. In February 2004, Dr. Baskin noted that the claimant was suffering from short term memory problems. On March 25, 2004, he assigned the claimant an impairment rating and

noted that the claimant had suffered from a mild traumatic brain injury. On the same date, he noted that the claimant had mild cognitive defects. On January 10, 2005, Dr. Barry Baskin also opined that the claimant suffered from symptoms of a mild traumatic brain injury.

I find the case of Swift-Eckrich, Inc. v. Brock, 63 Ark. App. 118; 975 S.W.2d 857, (1998) to be instructive in assessing the claimant's entitlement to an impairment rating for his organic brain injury. In Brock, the claimant sustained a compensable injury when she was knocked unconscious. CT scans revealed that the claimant had cerebral edema and interhemispheric hemorrhage. Neurological testing indicated the claimant had defects in verbal memory, higher level balance, and that she had loss of smell and taste due to cranial nerve damage. The Court of Appeals found that the claimant was entitled to a 5% permanent impairment rating. In making that determination, the Court noted that the while the claimant had control over her complaints of pain and headaches, the CAT scan showed results that were indicative of an objective finding. Accordingly, they awarded benefits.

Likewise, in this instance, the claimant does not have to show that his impairment rating was based solely on objective findings. Instead, he is only required to show that the claimant's objective findings supported the award of a permanent impairment rating. The overwhelming weight of the evidence shows he has met this burden.

Dr. Baskin's explanation of his assignment of impairment ratings for the claimant is as follows:

> Using the AMA Guidelines Fourth Edition, Page 142, Table 2, under mental status impairments, Mr. Singleton has a mild mental status impairment but he is able to perform satisfactorily most activities of daily living. He has an 8% impairment to the whole person based on mental status impairment. In table III, Page 142, emotional and behavior impairment, Mr. Singleton would have an impairment in the mild category which would give him a 10% whole person impairment rating. Due to the patient's post traumatic headaches, which seem to be migraine in nature, he would have an 8% whole person impairment rating. Due to the patient's bullet would to the left foot with antalgic gait using Table 13, Page 148 he wound have an 8% impairment rating to the whole person.

I find that the claimant's short-term memory loss would entitle him to an additional impairment rating pursuant to Table 2 and Table 3 of the AMA Guides to the Evaluation of Permanent Impairment (4th ed. 1993). These amounts should be the 8% and 10% previously assessed by Dr. Baskin. Located on page 142 of the Guides, Table 2 provides for an impairment rating for deficits in the general effects of, "organic brain syndrome, dementia, and some specific, focal, neurologic deficiencies." The Guides provide that the ability to document such conditions would include information regarding the claimant's capability regarding,

> (1)orientation concerning time, person and place; (2) recent recall; (3) ability to remember and repeat a series of digits and repeat them in reverse order; (4) ability to perform serial subtractions of 7s from 100 or 3s from 20; (5) ability to do other simple calculations; (6) ability to spell a word such as "world forward and backward"; (8) ability to repeat a short paragraph; (9) ability to understand and explain proverbs or abstract thoughts; and (10) judgment.

In my opinion, the language in the Guides indicating that the rating applies to neurological

defects such as an organic brain injury indicates that the claimant's impairment rating was based on the organic brain injury. Furthermore, the medical reports indicated that the claimant sustained short-term memory loss and a brain injury. Accordingly, I find the claimant sustained an organic brain injury which would be distinguishable from his depression. Therefore, I find that Dr. Baskin's recommendation to give the claimant impairment ratings based on Table 2 and Table 3, located on page 142 of the Guides to be appropriate.

The Majority relies on the opinion of Dr. Scott Schlesinger, who on June 10, 2003, opined that the claimant had no evidence of higher cognitive cerebral dysfunction. However, it is apparent that Dr. Schlesinger was basing the claimant's condition only on the claimant's MRI. It is significant to note that Dr. Schlesinger did not indicate if he had reviewed any of the claimant's other medical records. This is noteworthy as many of the other tests, including the claimant's CT scan and EEG showed abnormalities. More importantly, Dr. Schlesinger gave his opinion prior to the end of the claimant's healing period and prior to

the second EEG which confirmed that the claimant had lasting abnormalities due to his brain injury.

It is also important to note that Dr. Schlesinger does not dispute the claimant sustained a legitimate injury which had not resolved. On the day Dr. Schlesinger indicated the claimant had no impairment, he also explicitly indicated the claimant had neurological symptoms, diagnosed the claimant with post concussive syndrome, and deferred treatment and care of the patient to Dr. Burba. Certainly, this referral indicates that Dr. Schlesinger believed the claimant to have legitimate neurological complaints associated with the trauma to his head.

Likewise, it is important to note that even after this time, the claimant continued to present with abnormalities which were both subjective and objective. Notably, one of the objective findings that presented afterwards was a second abnormal EEG. I also note that, as previously discussed, multiple doctors diagnosed the claimant with memory loss after this time. As such, there is simply no way to logically conclude the blow to the claimant’s head did not cause permanent damage.____

Though the abnormal results of the claimant's EEGs are not even acknowledged by the Majority, the respondent argues that the abnormal EEGs both showed non-specific findings. I reject this argument as there are a multitude of medical reports, each indicating that the claimant suffered from an organic brain injury. Though the claimant has not been diagnosed with a particular disease or named dysfunction as a result of his EEG tests, he has consistently suffered from neurological problems, including short-term memory loss and headaches after being struck on the head. Though the respondents would attempt to assert that these symptoms are related to the claimant's PTSD or glaucoma, there is simply no evidence to support these conclusions. In fact, as the claimant has been receiving treatment for his glaucoma, it would be reasonable to assert that if that were the cause of his symptoms, they would subside. Likewise, with regard to the PTSD, I note that throughout the medical records, the claimant's headaches are generally related to his closed-head injury; not to his depression. In fact, in Fall 2004, the claimant's headache medication was

changed so as to lessen the negative impact on the claimant’s depression. Finally, even if one believes the claimant’s headaches are due to PTSD, there is simply no indication from the medical records that the claimant’s PTSD would cause memory loss.

In short, the facts show the claimant was rendered unconscious for several minutes after being struck, was disoriented and had no memory of being struck, and that he consistently and continually suffered from what was diagnosed as post-concussive headaches and short term memory loss. These problems were accompanied by two abnormal diagnostic tests which would be consistent with the claimant being injured and the claimant’s neurological defects were recognized by every physician in the record. The Majority has arbitrarily disregarded the clear evidence showing that the claimant sustained a brain injury which did not subside in favor of an opinion from Dr. Schlesinger, a physician who assessed the claimant’s impairment before the end of his healing period and on the results of an MRI, which coincidentally was one of the few diagnostic tests which returned as normal. While the Commission

admittedly has the ability to weigh medical evidence, their refusal to consider the multitude of records showing the permanency of the claimant’s condition is impermissible and not in accordance with the law.

The Majority also denies the claimant an impairment rating for his admittedly compensable ankle injury. In its previous decision, the Commission denied the rating on the basis that the claimant had no structural damage to his ankle. The Commission further found that, while the claimant had residual swelling, the Guides do not provide a rating for an ankle that still has a bullet fragment in it. Finally, the Commission declined to assess a rating on the basis that Dr. Baskin had used the charts for a neurological condition which required subjective responses from the claimant in determining his gait. Notably, the Court of Appeals has rejected the argument that the claimant did not have objective findings of a structural defect in his ankle. Additionally, they have clearly expressed that the claimant is not required to show entitlement to a rating based solely on objective criteria.

Yet, despite the opinion of the Court, this Majority again denies benefits on the rationale that the claimant had no objective defect in his ankle and because the Guides do not specifically provide a rating for having a bullet lodged in one's bone.

Specifically, the Majority concludes that there is no indication that Dr. Baskin based the claimant's impairment rating on an objective finding. In making this finding they note that Dr. Blankenship opined the claimant's antalgic gait was subjective nature. They further note Dr. Blankenship's opinion that, "there is no objective basis for any permanent impairment rating for the structures around the left ankle. In the records furnished, there are no objective findings that mention any permanent structural damage to the areas he complained of."

The Majority's reliance on the opinion of Dr. Blankenship is simply not in accordance with the law on this issue. In my opinion, there is simply no way to deny that the claimant has a palpable defect in the form of having a bullet lodged in his ankle. Due to that defect, the claimant has residual swelling and pain

which has caused him to suffer from an antalgic gait for which he is entitled to an impairment rating. Clearly, to now rely on the opinion of Dr. Blankenship, who has erroneously determined the claimant has no permanent structural damage in his ankle is reversible error.

In fact, I note that in the prior opinion of this case, the Court of Appeals has already apparently rejected the Majority's arguments. The Court of Appeals indicated,

> Here, the claimant's allegations of a foot injury affecting his mobility are quite clearly supported by observed bullet fragments embedded in his foot. Nevertheless, although the requirement of support by objective findings had been satisfied, the Commission rejected the medical opinion offered by Dr. Baskin that appellant's ankle injury resulted in eight-percent anatomical impairment simply because it was based in part upon non-objective evidence, i.e., Dr. Baskin's observation that appellant exhibited an antalgic gait. After rejecting Dr Baskin's observations of a defective gait because they did not meet the statutory standard of objectivity, the Commission concluded that, although appellant still had bullet fragments in his ankle that cause discomfort and occasional swelling, he "miraculously . . . sustained no permanent structural damage to his

> ankle as a result of his gunshot
> wound."

Given the above language, I find it is abundantly clear that the Court believes that the claimant had an objective injury to his ankle and that the reliance on Dr. Blankenship's opinion that the claimant had no structural defect is erroneous. Likewise, in my opinion, it is quite apparent that the Court has expressed its opinion that the claimant's objective defect has caused his altered gait. Yet, for unexplained reasons, the Majority continues to rely on the opinions of Dr. Blankenship and Dr. Stewart that the claimant had no physical defect. They also refuse to acknowledge that the claimant's gait derangement is not solely subjective in nature. In my opinion, this is reversible error and is in direct contrast with the law on this issue.

The Majority also uses a thinly veiled rationale that the Guides do not provide a rating for the claimant's defect as a way to deny an impairment. However, regardless of whether the Guides provide a rating for a bullet lodged in a bone, the fact remains

that the rationale for rejecting Dr. Baskin's rating is not supported by the law.

Furthermore, even if one does not believe Dr. Baskin's rating is correct, there is no rational basis for refusing to award the claimant a rating for swelling or pursuant to Table 36. Finally, and as previously referenced, I note that despite the assertions of the Majority, there are appropriate sections which allow the claimant a rating.

In addressing this issue, it is important to note that the Majority appears to be concluding that the claimant's gait is not ratable because it contains subjective criteria. They further seem to be asserting that the claimant must show their impairment is caused by an injury which is specifically provided for by the Guides. However, it is important to note that the Court of Appeals has, in the past, indicated that it is the physical condition and impairment caused by an injury which is ratable. As such, it stands to reason that because the claimant sustained a permanent impairment due to the bullet remaining in his ankle, his condition is ratable under the Guides.

In Avaya v. Bryant, 82 Ark. App. 273; 105 S.W.3d 811 (2003), the Court of Appeals stated,

> Any determination of the existence or extent of physical impairment must be supported by objective and measurable physical findings. Pursuant to Ark. Code Ann. § 11-9-522(g)(1) (Repl. 2002), the Commission must adopt an impairment rating guide to be used in the assessment of anatomical impairment, and the Commission has adopted the AMA Guides to be used in this assessment. The Commission is authorized to decide which portions of the medical evidence to credit and to translate this medical evidence into a finding of permanent impairment using the AMA Guides. Thus, the Commission may assess its own impairment rating rather than rely solely on its determination of the validity of ratings assigned by physicians. (Internal citations omitted).

I find the case of Tom Williams v. Willamette Industries,(CA 04-974, March 16, 2005), to be instructive in determining whether the claimant is entitled to an impairment rating on his ankle. See also, Williams v. Willamette Industries, Claim No. E700242, (Full Commission Opinion Filed June 21, 2005). In Williams, the claimant suffered from an admittedly compensable injury to his right foot, ankle, and lower

leg. To treat these conditions, a fist sized mass of muscle tissue was grafted from the claimant's abdomen and grafted to his lower leg. As a result of the graft, the claimant suffered from an abdominal defect similar to that occurring from a hernia. The Commission found the claimant was not entitled to an impairment rating based on the abdominal defect because the Guides do not provide for impairment ratings in stomach conditions absent the presence of a hernia. The Court of Appeals reversed and remanded the case to the Commission in order to assign an impairment rating. The Court of Appeals indicated that while the claimant did not suffer from a hernia, that did not preclude a finding that he had suffered an impairment rating in accordance with the Guides. The Court of Appeals noted that the claimant suffered a palpable defect in his abdominal wall and that the condition was due to his admittedly compensable injury. They further noted that while the doctor that had previously assigned an impairment rating to the claimant's condition used language from the Guides, the doctor never indicated that the claimant suffered from a

hernia; instead, he simply gave a rating based off the claimant's abdominal defects. Id.

In my opinion, the claimant in the present case suffers from the same dilemma as the claimant in the Williams case. He suffers from an objective defect in his body which is undisputedly from his admittedly compensable injury. However, he also has the misfortune of having obtained that defect from a source not specifically covered by the Guides. Just as in Williams, the claimant's treating physician rated the claimant with an impairment rating based on what he believed to be the appropriate language in the Guides and based on the claimant's objective medical findings. However, unfortunately for the claimant, he now has bullet fragments in his ankle and the Guides do not provide a rating for such a condition. Despite this, his doctor appropriately found that his defect was ratable under the Guides, as there was still a way to rate the defect the bullet fragments caused to his ankle.

Specifically, the claimant in the present case was given an impairment rating based on gait

derangement. The medical records are clear that he has bullet fragments that remain in his ankle and that as a result he has swelling, atrophy, and gait derangement due to being shot in the ankle. In my opinion, Dr. Baskin based the impairment rating on the objective defect of remaining bullet fragments and the claimant's resultant problems of swelling, atrophy, pain, and gait derangement.

In my opinion, it is contrary to the holding in Williams to find that the claimant now has to show that the cause for his condition is specifically considered in assigning an impairment rating; particularly when the ratings for ankle injuries in the Guides largely do not contain language requiring one to show the reason for the injury. Additionally, it is apparent that the claimant's physician did not assign a rating entirely on the existence of bullet fragments; instead, he worked within the confines of the Guides to assign a rating to the claimant's now defective ankle.

Furthermore, even if one does find that Dr. Baskin's rating should be rejected, there is simply no

reason for this Commission to ignore the content of the Guides and issue a rating itself. In my opinion, there is more than one way to properly assign the claimant an ankle rating due to his injury. I find that either using the portion of the Guides regarding ankle injuries, or the portion of the Guides pertaining to the central nervous system, that was apparently used by Dr. Baskin to be appropriate. Finally, I note that in the past, this Commission has found it appropriate to award impairment ratings based on swelling, which would provide another way to give the claimant a rating.

Regardless of what chart of the Guides, is used, I find that the claimant would be entitled to an impairment rating based on the finding that the claimant suffered a palpable defect in his ankle due to the admittedly compensable injury. Just as in Williams, where the doctor assigned the rating on the claimant's resultant condition rather than whether the defect was due to a hernia, in the present case, the evidence indicates the claimant's rating was given on the resultant conditions that were directly due to the palpable defect of having bullet fragments in his ankle.

There is no evidence that Dr. Baskin's assessment was based on any finding that the claimant's ankle impairment was due to a defect in his central nervous system. Rather, it appears that he simply assigned a rating based on the end result to the claimant's ankle; which is an ankle that now has permanent defects in the form of swelling and resultant gait derangement. Pursuant to the rationale of Coleman and the prior opinion in the instant case, there is simply no basis to deny the claimant a rating when the Guides provide multiple mechanisms to rate the claimant.

In short, I find that the clear evidence of this case shows the claimant had objective impairments due to his closed head injury and due to his ankle injury. This case is particularly tragic as the claimant, who served the public, has suffered injuries that are severe and lasting in nature. The overwhelming weight of the medical records show the claimant has sustained permanent conditions due to these injuries. Despite the clarity of the law indicating that if any objective findings exist, subjective criteria may be considered in assessing an impairment rating, this

Majority has simply refused to apply the law and instead denied the claimant impairment ratings. I simply cannot support this and must now respectfully dissent.

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PHILIP A. HOOD, Commissioner