

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F800831

RAYE A. WEST, EMPLOYEE CLAIMANT

STUTTGART REGIONAL MEDICAL CENTER,
EMPLOYER RESPONDENT

RISK MANAGEMENT RESOURCES, TPA RESPONDENT

OPINION FILED JUNE 12, 2009

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

Claimant is not represented by counsel, but appears *pro se*.

Respondent represented by HONORABLE GUY A. WADE, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed, in part, reversed, in part, and modified, in part.

OPINION AND ORDER

Respondents appeal and claimant cross-appeals from an opinion of the Administrative Law Judge finding that the claimant sustained a gradual onset injury to her right knee, caused by rapid and repetitive motion, for which she is entitled to medical and indemnity benefits. Based upon our de novo review of the entire record, without giving the benefit of the doubt to either party, we find that the claimant has failed to meet her burden of proof. Therefore

we find that the decision of the Administrative Law Judge must be reversed and this claim for benefits denied and dismissed.

Claimant was employed by respondents as a medical transcriptionist. Claimant contends that she developed a gradual onset injury to her right knee from the use of a foot pedal. When asked to explain how she used the foot pedal, the claimant testified:

I had a dictaphone which played the tape and we wore a headset. We had a foot pedal that you moved your foot in three directions, fast forward, play, or rewind. And that was basically it. When I first started working there I was shocked at the technology, how far behind Stuttgart was on their technology. We had really old computers. The dictation equipment was old, but I liked the worked, you know, and my supervisor told us to hang in there, it would get better. I really liked - - like I said, I liked the work.

Claimant testified that she did not have a production standard. When the claimant first started, she worked for five doctors who saw at a minimum thirty to forty patients each, every day. Claimant explained that she tried

to get all the work done in a day, but if she didn't, there were no penalties, she would just have to "keep hammering away. We kept - - we would get there the next day and just struggle to keep up..."

With regard to the actual movement of her foot, the claimant explained that she had to pick up the ball of her foot to move between the pedals, she did not have to actually lift her leg.

The record reveals that the claimant was hired by respondents in June of 2005. When claimant first began working for respondents she transcribed medical records for five physicians, but that was later reduced down to three. For a period of time, respondents only had two medical transcriptionists and the claimant worked many hours of overtime to keep up with her work load. However, at least six months prior to her injury, the respondents hired another transcriptionist and all overtime hours were ceased. The claimant worked eight hour days, forty hours a week with a 30 minute lunch break. The claimant also took a short break away from typing each hour. The claimant testified

that her work involved "just sitting and typing for long durations, heavy workload." It was basically "continuous typing." With regard to the amount of typing the claimant performed, the claimant testified that a transcriptionist would usually have 1,000 to 1,200 lines a day as an average, but that the employees for respondents were required to type twice that much, since they used a smaller font size.

According to the claimant's testimony, she began to have problems with her right leg four or five months after the third transcriptionist was hired. Since she thought her problem was muscular, she tired using her other foot to operate the pedal, but that was not easy, nor was it very helpful. The claimant described her symptoms as "like pressure was building up in the front part of my calf...." On January 17, 2008, claimant's pain was so severe that she sought medical treatment at the emergency room. The claimant explained that her right knee never actually hurt, it was just the front of her lower right leg down into her toes and the bottom of her foot. Claimant described her injury as "accumulative but not a sudden traumatic" injury.

Claimant testified that she initially sought treatment in the emergency room and was diagnosed with tendinitis. The medical report from this visit is not in the record. Claimant testified that she felt her pain was too severe for tendinitis, so she insisted on a referral to an orthopaedic specialist. On January 18, 2008, the claimant was examined by Dr. James W. Bryan of Martin, Bowen, and Hefley. The claimant provided Dr. Bryan with the following history:

The patient is seen for acute right leg pain that has worsened over the past 4 days. She thinks the aggravating factor was using the foot pedal on her start/stop pedal. She complains of lack of sensation and subjective weakness with difficulty raising her foot and she has almost tripped from dragging her foot a time or two. This has never happened before. She denied previous trauma to the area; either repetitive use, crush, or direct trauma. She denies fracture or stress fracture. She has no history of muscle enzyme deficiency or degenerative muscle condition.

After examining the claimant, Dr. Bryan diagnosed the claimant with "acute-on-chronic compartment syndrome"

and recommended a surgical consultation that same day with Dr. Jason Stewart. Dr. Stewart examined the claimant and concluded that her symptoms were not consistent with an acute compartment syndrome. He ordered a nerve conduction study and placed the claimant in a boot walker in the meantime. A nerve conduction study of the lower extremity was performed by Dr. Julia M. McCoy on January 22, 2008. This report was interpreted as revealing findings "most consistent with a right proximal sciatic neuropathy." Accordingly, pursuant to these findings, the claimant was referred to another physician to examine her back. Claimant came under the care of Dr. Badih Adada with UAMS. Dr. Adada recorded a history of right leg pain mostly below the knee. Dr. Adada ruled out the claimant's pre-existing hemangiomas as the cause of claimant's pain and opined that the pain was most likely associated with entrapment of the superficial peroneal nerve. Eventually, the claimant was referred to Dr. Scott Schlesinger who referred the claimant to Dr. Reginald Rutherford for electrodiagnostic testing. After performing the tests, Dr. Rutherford authored a report to

Dr. Schlesinger dated April 30, 2008, stating that the test did not disclose any definite abnormality. After examining the claimant, Dr. Rutherford noted that the claimant had normal pedal pulses, negative straight leg raising maneuver, normal muscle bulk and tone in both lower extremities, questionable weakness of the right dorsiflexors on manual muscle testing that was not corroborated by dynamic testing, unrestricted heel walking, and normal and symmetrical reflexes of knee and ankle jerks. Conclusive sensory loss was not demonstrated in either foot, although the claimant did have palpation sensitivity around the fibular head of her right leg. Accordingly, Dr. Rutherford ordered an MRI of the right knee with particular attention to be paid to the common peroneal nerve.

The MRI of the right knee performed on May 6, 2008, revealed the following impressions:

1. Mild thickening and edema of the common peroneal nerve adjacent to the head/neck junction of the fibula with no focal mass in the vicinity or fracture in the head/neck junction of the fibula.

2. Lateral meniscus tear without displaced fragment.
3. Grade IV chondromalacia patella and grade IV chondromalacia in the lateral compartment. Grade II/III chondromalacia in the medial compartment.

After reviewing the MRI, Dr. Rutherford authored a report to Dr. Schlesinger on May 6, 2008, in which he stated:

...MRI study of the right knee special attention common peroneal nerve demonstrates enlargement and signal change in the common peroneal nerve. This is the basis for her pain. There is also evidence for a meniscal tear. Relevance of the latter is uncertain...

With regard to the claimant's common peroneal nerve pain, Dr. Rutherford prescribed the claimant Lyrica 75mg twice a day, and ordered additional blood tests. As for her meniscal tear, Dr. Rutherford indicated in this letter that he was going to refer the claimant back to her orthopedist at Martin, Bowen and Hefley; however, he referred her to Dr. Eric Gordon with Arkansas Specialty Orthopaedics instead. Claimant came under Dr. Gordon's care

on May 20, 2008. For the first time in the medical records, the claimant provided a history of her knee "locking on January 17, 2008, while working...she was moving the leg one time when she felt a sharp pain in the knee. She subsequently had four or five different locking type episodes in the knee." After taking the claimant's history, examining the claimant and reviewing her diagnostic films, Dr. Gordon opined that the claimant's right knee pain and locking are likely due to patellar chondromalacia, as well as a lateral meniscus tear. After discussing the treatment options with the claimant, the claimant elected to proceed with arthroscopic surgery. Dr. Gordon further opined that the claimant's numbness and burning in the calf were due to irritation of her common peroneal nerve for which she was receiving treatment by Dr. Rutherford. After being seen by Dr. Gordon on May 20, 2008, the claimant followed up with Dr. Rutherford. Dr. Rutherford noted that the claimant's blood tests were unremarkable. The claimant advised Dr. Rutherford, that Metanx (sic) proved beneficial with regard to the sensitivity of the common peroneal nerve at

the fibular head so he continued her on this medication. The claimant was scheduled to follow up with Dr. Rutherford in two and a half months.

On May 29, 2008, claimant underwent a right knee arthroscopy with partial lateral meniscectomy and abrasion chondroplasty of the medial femoral condyle performed by Dr. Gordon. Dr. Gordon noted in his operative report that the medial meniscus was intact, but the lateral meniscus had a complex tear. Dr. Gordon debrided a large unstable fragment and resected the torn portion of the lateral meniscus. In addition, loose flaps were removed from the medial femoral condyle due to extensive grade III chondromalacia.

With regard to the cause of claimant's condition, Dr. Gordon stated in his June 9, 2008, office report:

As for the cause of her pathology, it is difficult to me to say whether this is actually work related or not. Obviously, she used her right lower extremity quite a bit as a transcriptionist, and the type of injury she has is likely due to overuse or twisting of the knee.

Claimant asked Dr. Gordon for further information regarding causation which prompted him to author a letter to the claimant dated June 23, 2008. In this letter, Dr. Gordon related the claimant's history as follows:

You were having some pain in your right knee, as well as some locking in the knee, after a twisting type injury. You related this as being due to twisting your foot back and forth while hitting a dictation pedal. In addition, you were having some pain and burning in the leg, along the peroneal nerve distribution, that Dr. Rutherford was following you for....

In terms of what I think caused the problem I would start off by saying that meniscus tears are often caused by a twisting type injury, which you had related to me at your first clinic visit. When people are younger, this often takes a rather significant injury, such as while playing sports, but as people age the meniscus tissue does become more friable and a tear will often occur with a simple twisting injury. This, therefore, may have very well have been cause by the repetitive twisting you were doing with your leg while doing transcription.

Respondents scheduled the claimant for an IME with Dr. Earl Peeples; however, the claimant refused to attend

the appointment. As an alternative, the respondents asked Dr. Peeples to review the claimant's medical records. In a report to the nurse case manager dated August 18, 2008, Dr. Peeples recited the claimant's extensive medical treatment with regard to her right leg pain. Specifically, Dr. Peeples noted:

There was initially some concern on the part of her primary care physician, Dr. Bryon, about the possibility of compartment syndrome due to complaints of pain in the anterior compartment in January 2008. However, prompt transferred evaluation by Dr. Stewart, an orthopedic surgeon, with lower extremity emphasis indicated specifically, "She did not injury this leg" and did not have findings consistent with compartment syndrome. In March 2008 she was seen at an outpatient clinic and evaluate by Dr. Badih Adada. He did not feel that she had any radicular symptoms or symptoms related to spinal hemangioma. Dr. Schlesinger evaluated and referred her to Dr. Rutherford, a neurologist, for testing. Dr. Rutherford performed his usual thorough history and exam. Significant weakness was not corroborated by dynamic testing and neurological exam was normal. NCV/EMG of the lower extremities also failed to reveal any neurological abnormality.

MRI study of the knee was done to assess the peroneal nerve and indicated some evidence of possible entrapment. However, it also indicated evidence of a meniscal abnormality. She was, therefore, evaluated by Dr. Gordon, an orthopedist, who commented on the patellofemoral abnormality as well as degenerative changes and the meniscal abnormality. His surgical description is quite detailed and specifically describes a classic appearance of tri-compartmental degenerative change or osteoarthritis. It is noted that the medial compartment had Grade III chondromalacia, the patellofemoral compartment had Grade II to III and the lateral femoral compartment had Grade II to III. Associated with this was a "Complex tear of the lateral meniscus involving the middle one third. This was a multiplanar tear." (This is the classic description of a degenerative tear.) Meniscectomy produced some improvement and all symptoms of the lower extremity.

In conjunction with the difficulties in the lower extremity, she was seen during the same period of time in 2008 with advancing difficulties from left thumb CMC arthritis and elective intervention for this osteoarthritis was recommended by Dr. Jeanine Anderson

In a letter of June 23, 2008, Dr. Gordon listed multiple factors that might possibly relate her meniscal abnormality to an injury and mentioned the

possibility of a twisting injury. He did not mention the correlation of tricompartmental arthritis to a very high degree with abnormal menisci.

After reviewing and summarizing the claimant's medical records, Dr. Peeples opined:

Ms. West is involved in an occupation using a pedal. This does not provide load to the meniscus but does provide some mild repetitive rotation to her knee. It is clear that she was pre-disposed to arthritis genetically having CMC arthritis requiring surgical intervention as well as tricompartmental osteoarthritis in the form of advanced chondral changes. It is also clear that she had neither compartment syndrome nor conduction delay involving the nerve and that no treatment was necessary, despite the fact that there were some MRI changes around the peroneal nerve at the knee. Dr. Gordon wisely avoided operating on this.

Dr. Stewart was very specific in that there was no history of injury. I do not believe that the findings in the knee, specifically the meniscus, were attributable to injury but rather are part and parcel of the osteoarthritic changes that are developing in her knee. This record does not substantiate a specific injury at work on which to explain her changes of the lateral meniscus. However, there is abundant

literature including MRI correlation of a high incidence of meniscal tears which are essentially always associated with tricompartmental degenerative changes. Of particular interest is the pattern of this meniscal abnormality which is multiplanar and complex, again fitting a pattern of gradually acquired degenerative tear rather than accidental traumatic tear....

At the hearing the claimant testified that although she had never injured her right knee prior to this alleged injury, she did have occasional popping in both of her knees. Claimant described the popping as follows:

...it just happened occasionally if I had been like squatting, working in a flower bed or something and get up, it might occasionally pop. It wasn't like popping all the time that I felt I needed to see the doctor.

Since the claimant asserts that she sustained a work-related gradual onset knee injury, claimant must prove that she sustained a gradual onset injury arising out of and in the course of employment, that was caused by rapid repetitive motion, that the work-related injury is the major

cause of her disability or need for medical treatment, and the compensable injury must be established by objective medical findings. See, Id.

The standard set out in Malone v. Texarkana Pub. Schs., 333 Ark. 343, 969 S.W.2d 644 (1988), for analyzing whether an injury is caused by rapid repetitive motion, is a two-pronged test: (1) the tasks must be repetitive, and (2) the repetitive motion must be rapid. As a threshold issue, the tasks must be repetitive, or the rapidity element is not reached. Westside High School v. Patterson, 79 Ark. App. 281, 86 S.W.3d 412 (2002). Arguably, even repetitive tasks and rapid work, standing alone, do not satisfy the definition; the repetitive tasks must be completed rapidly. Westside High School, supra. The issue of whether an injury meets the rapid repetitive motion requirement will ordinarily be a question of fact, not one of law. However, although a question of fact, the Commission must apply the appropriate law to the evidence to reach a conclusion. Westside High School, supra; Malone, supra. The Arkansas Supreme Court in Malone, supra, explained that because the

legislature had not established guidelines necessary to the determination of what constitutes "rapid and repetitive motion", that determination is made on a case-by-case basis.

In determining whether a worker's injury was the result of repetitive and rapid motion, the appellate courts have required some showing of how rapidly the repetitive actions were performed. See, Hapney v. Rheem Mfg. Co., 342 Ark. 11, 26 S.W.3d 777 (2000) (Commission's denial of benefits reversed where movements repeated every twenty seconds); Parker v. Atlantic Research Corp., 87 Ark. App. 145, 189 S.W.3d 449 (2004) (where the Commission found that appellant's job duties fell within the meaning of rapid repetitive motion, considering the multiple tasks that she was required to perform at high volume and with quick and fast movements in a repetitive nature over the course of a sometimes ten-to-twelve hour shift, six to seven days a week, there was substantial evidence to support the Commission's finding that appellant's job duties required rapid repetitive motion); Boyd v. Dana Corp., 62 Ark. App. 78, 966 S.W.2d 946 (1998) (a series of repetitive motions,

performed 115 to 120 times per day separated by periods of only 1.5 minutes, constituted rapid motion within the meaning of the statute); High Capacity Prods. v. Moore, 61 Ark. App. 1, 962 S.W.2d 831 (1998) (movements repeated every fifteen seconds found to be sufficiently "rapid").

In Boyd, the Court of Appeals compared the duties of a worker who repeated a four-step metal fabricating process approximately 100 to 125 times per shift to the duties of a delivery man whose repetitive motions were separated by intervals of several minutes. In comparing these two situations, the Court of Appeals in Boyd found that the metal fabricating process involving 100 to 125 parts per hour was sufficiently rapid and repetitive to satisfy the requirements of Act 796 of 1993. In this regard, the Court stated:

...[i]n the instant case, the evidence is that the appellant's series of repetitive motions were performed 115 to 120 times per day separated by periods of only 1.5 minutes, and we do not think that this brief interval rises to a period of "several minutes or more" as stated in Lay. Boyd, Supra, at 83.

Likewise, the Commission has addressed the issue of rapid and repetitive movement, as it applies to our statute. For example, in Le v. Superior Industries, Full Commission Opinion, February 12, 1999 (Claim No. E708248), the Commission determined that the claimant's position required rapid and repetitive motion sufficient to satisfy the Act where the claimant handled approximately 30 tire rims per hour for 50 or more hours per week. She processed approximately 300 wheels per shift using essentially the same four steps: (1) lifting a wheel rim onto a table, (2) sanding the wheel with a circular motion, (3) deburring the wheel with a pneumatic grinder, and (4) lifting the wheel onto a cart or bin. When the plant ran chrome wheels, the claimant was also required to use a four-pound stamper and a five pound shop hammer to mark each wheel. The tasks were clearly repetitive. The Commission applied the analysis of the Court of Appeals in Boyd, supra, to determine that the tasks were performed rapidly under the Act.

In contrast to Le, supra, in McDonald v. Tyson Foods, Inc., Full Commission Opinion, June 3, 1999 (Claim No. E713336), the claimant failed to satisfy the elements of proof for a gradual onset injury. In McDonald, the claimant's physicians opined that her work was conducive to or was sufficient to account for the claimant's clinical findings. However, this was insufficient to make a finding that the claimant had satisfied the rapid repetitive motion element of proof necessary to prove the compensability of her claim. "Claimant must present more evidence than medical opinions linking her condition to her work." The claimant had failed to satisfy her burden of proof where there was no evidence with regard to the rate of speed within which the claimant performed the tasks of lifting the belts on the machine which she contended was the repetitive task responsible for her injury. On cross-examination, the claimant was asked how long it would take for her to lift the wire belts for bracing, to which she responded:

It depends on what kind of mood you are working in. If you are in a hurry, it's going to take anywhere from ten minutes,

maybe a little longer, but if you are just taking your time - I can't tell you how long it takes, I really can't. Because everybody is different and I haven't been doing that in so long and all.

In Rodman v. ACX Technologies, Full Commission Opinion, July 8, 1999 (Claim No. E804579), the Commission noted that the Court of Appeals has stated it "must consider the positioning of the part of the body as well as the number of movements the claimant has to undergo to determine if the movement is 'rapid and repetitive'." See, Patterson v. Frito-Lay, Inc., 66 Ark. App. 159, 992 S.W.2d 130 (1999). In Rodman, the claimant failed to prove a gradual onset cervical injury where there was no evidence as to the position of her neck or cervical spine during the repetitive tasks she performed with her upper extremities. The Commission also found that the claimant had failed to prove that the repetitive motions of her upper extremities were performed rapidly under the two-prong test set forth in Malone, supra, because the claimant testified that "she had to be deliberate and careful in performing her job

functions, but that she also tried to perform these deliberate and careful moves as fast as she could." The Commission stated that "this testimony does not satisfy the rapid repetitive motion requirement. There is void from the record any persuasive evidence which would establish the speed at which claimant performed her job duties."

It is axiomatic that in order to prove a compensable rapid repetitive gradual onset injury some evidence of how fast and how often the particular injured body part is moved in order to perform the job function must be submitted into evidence. In Piper v. Benton County Judge, Full Commission Opinion file October 16, 2008 (F706526) the Full Commission found that although the claimant presented evidence that her continuous work duties included stamping documents, scanning, microfilming, and filing, she failed to present evidence that she performed repetitive tasks which were completed rapidly. Likewise, in Sisemore v. Cooper Power Systems, Full Commission Opinion filed June 5, 2007 (F512666), the Full Commission found that even when the claimant's physicians opine that an injury may be caused by

overuse or repetitive use, such evidence is not sufficient to prove that an injury arose out of and in the course of employment as the result of rapid repetitive motion.

Finally, and most persuasively, the Court of Appeals has held that even when a claimant presents proof that her work activities were repetitive, when the claimant fails to present any evidence that the work activities were performed rapidly, reasonable minds cannot find that the injury was caused by rapid repetitive motion. Holland Group, Inc. v. Hughes, 95 Ark. App. 369, 237 S.W.3d 120 (2006). In Holland Group the claimant presented credible evidence regarding the repetitive work she performed with her arms, all day, every day; however the record was silent with regard to just how fast she had to performed these tasks with her arms.

In the present claim, the claimant has presented credible evidence that she performed repetitive work typing for respondents which required her to use a pedal to operate the dictaphone. Claimant testified and presented a self-prepared document entitled "Proof of Workload" of the amount of typing she did every day. This evidence may be persuasive

with regard to just how much typing and upper extremity movements the claimant was required to perform everyday. However, absent from the record is any evidence with regard to just how often the claimant was required to actually move her right leg and knee in order to perform her job duties. The claimant testified that she had to press the play pedal to operate the dictaphone, and that the pedals she used most often were "Reverse" and "Play." However, we are left to speculate just how many times she had to press a pedal in order to perform her job duties. Did she press "Play" once a minute, once every two minutes, once every five minutes, or once every five to ten seconds? How often did she have to rewind or fast forward the tape and move the position of her foot? Was her machine programmed to automatically rewind a few seconds every time she lifted her foot off of "Play" or did she have to manually move her foot to "Rewind" every time she stopped the tape in order to pick back up where she left off? These are questions that we cannot answer on the record before us. Accordingly, as in Holland Group v. Hughes, supra. reasonable minds cannot find based upon the

evidence before us that the claimant's work activity to operate her dictation pedal was performed rapidly.

Therefore, we are constrained to find that the claimant has failed to prove by a preponderance of the evidence that she sustained a rapid repetitive injury to her right knee.

Even, if we were to find that the claimant's work activities were rapid and repetitive, a finding we specifically cannot reach, we cannot find that the claimant has proven by a preponderance of the evidence that her injury arose out of and in the course of her employment. The claimant testified that her pain was never in her knee, but in the front of her lower leg, below her knee and into her foot. This testimony is contrary to the history of a popping and locking injury in her right knee which she reported to Dr. Gordon. It is this history upon which Dr. Gordon relied to opine that the claimant's condition was possibly related to her employment. We do not find this history of injury of popping and locking to be credible. The claimant never provided this history to any of her other treating physicians. More specifically, when she was examined by Dr.

Stewart just days after initially seeking treatment, the claimant unequivocally denied the existence of any type of injury to her right knee or leg. Furthermore, when the claimant was asked about any previous injury or problems with her right knee, the claimant admitted on cross-examination that she had experienced popping in her knees on occasion prior to the onset of pain in January 2008 which sent her to the emergency room, making her history even more suspect.

Moreover, Dr. Gordon's medical opinion regarding causation which is based upon this unsubstantiated history is highly equivocal. Dr. Gordon began his opinion by stating that "it is difficult for me to say whether this is actually work related or not." Dr. Gordon confirms that the claimant's injury is "likely due to overuse or twisting of the knee" but he failed to state with any conviction that the claimant's work as a transcriptionist actually caused this overuse or twisting of the knee. In his letter to the claimant Dr. Gordon states that the claimant's tear "may very well have been caused by the repetitive twisting you

were doing with your leg while doing transcription.”

However, even this causation opinion is equivocal. Medical opinions addressing compensability must be stated within a reasonable degree of medical certainty. Ark. Code Ann. §11-9-102(16) (B). Where a medical opinion is sufficiently clear to remove any reason for the trier of fact to have to guess at the cause of the injury, that opinion is stated within a reasonable degree of medical certainty. Huffy Service First v. Ledbetter, 76 Ark. App. 533, 69 S.W.3d 449 (2002), citing Howell v. Scroll Technologies, 343 Ark. 297, 35 S.W.3d 800 (2001).

Medical opinions based upon “could”, “may”, “possibly”, and “can” lack the definiteness required to satisfy Ark. Code Ann. §11-9-102(16) (B), which requires that medical opinions be stated within a reasonable degree of medical certainty. Frances v. Gaylord Container Corporation, 341 Ark. 527, 20 S.W.3d 280 (2000). In Frances, the Arkansas Supreme Court expressly overruled a prior Court of Appeals decision to the extent that the Court of Appeals had held that such indefinite terms were sufficient to meet the

requirements of Ark. Code Ann. §11-9-102(16)(B). The Arkansas Supreme Court held that a doctor's opinion that an accident "could" produce a lumbar disc injury was insufficient to satisfy the standard of within a reasonable degree of medical certainty. Moreover, in Crudup v. Regal Ware, Inc., 341 Ark. 804, 20 S.W.3d 900 (2000), the Arkansas Supreme Court held that a medical opinion based upon the theoretical possibility of a causal connection did not meet the standard of proof. In Freeman v. Con-Agra Frozen Foods, 344 Ark. 296, 40 S.W.3d 760 (2001), the Arkansas Supreme Court held that in order for a medical opinion regarding causation to "pass muster" such opinion must be more than speculation, and go beyond possibilities. Accordingly, after we review Dr. Gordon's causation opinions in light of the statute and interpreting case law, we find that Dr. Gordon failed to state within a reasonable degree of medical certainty that the claimant's knee injury was caused by her work as a transcriptionist.

Finally, we place greater weight upon the opinion of Dr. Peeples, a highly respected orthopaedist, in which he

stated that the claimant's surgical findings were remarkably consistent with degenerative changes, and not a traumatic injury. Specifically Dr. Peeples opined:

I do not believe that the findings in the knee, specifically the meniscus, were attributable to injury but rather are part and parcel of the osteoarthritic changes that are developing in her knee. This record does not substantiate a specific injury at work on which to explain her changes of the lateral meniscus. However, there is abundant literature including MRI correlation of a high incidence of meniscal tears which are essentially always associated with tricompartmental degenerative changes. Of particular interest is the pattern of this meniscal abnormality which is multiplanar and complex, again fitting a pattern of gradually acquired degenerative tear rather than accidental traumatic tear....

The Commission has a duty to translate the evidence on all the issues before it into findings of fact. Weldon v. Pierce Bros. Const. Co., 54 Ark. App. 344, 925 S.W.2d 179 (1996). Moreover, the Commission has the authority to resolve conflicting evidence and this extends to medical testimony. Foxx v. American Transp., 54 Ark. App.

115, 924 S.W.2d 814 (1996). The Commission has the duty of weighing the medical evidence as it does any other evidence, and the resolution of any conflicting medical evidence is a question of fact for the Commission to resolve. Emerson Electric v. Gaston, 75 Ark. App. 232, 58 S.W.3d 848 (2001); CDI Contractors McHale, 41 Ark. App. 57, 848 S.W.2d 941 (1993); McClain v. Texaco, Inc., 29 Ark. App. 218, 780 S.W.2d 34 (1989).

It is well within the Commission's province to weigh all the medical evidence and determine what is most credible. Smith-Blair, Inc. v. Jones, 77 Ark. App. 273, 72 S.W.3d 560 (2002). The Commission is entitled to review the basis for a doctor's opinion in deciding the weight and credibility of the opinion and medical evidence. Id. In addition, the Commission has the authority to accept or reject a medical opinion and determine its medical soundness and probative force. Green Bay Packaging v. Bartlett, 67 Ark. App. 332, 999 S.W.2d 695 (1999). The Commission's resolution of the medical evidence has the force and effect of a jury verdict. McClain, supra.

The Commission is entitled to review the basis for a doctor's opinion in deciding the weight of the opinion. Further, a medical opinion based solely upon claimant's history and own subjective belief that a medical condition is related to a compensable injury is not a substitute for credible evidence. Brewer v. Paragould Housing Authority, Full Commission Opinion, January 22, 1996 (Claim No. E417617). The Commission is not bound by a doctor's opinion which is based largely on facts related to him by claimant where there is no sufficient independent knowledge upon which to corroborate the claimant's claim. Roberts v. Leo-Levi Hospital, 8 Ark. App. 184, 649 S.W.2d 402 (1983). Moreover, the Commission need not base a decision on how the medical profession may characterize a given condition, but rather primarily on factors germane to the purposes of the Workers' Compensation Law. Weldon v. Pierce Bros. Constr., 54 Ark. App. 344, 925 S.W.2d 179 (1996). Dr. Peeples's causation opinion is not tainted by an unreliable history, but rather relies upon the objective medical findings reported during surgery. Dr. Gordon, on the other hand, was

provided an unreliable history by the claimant. We attach greater weight upon the causation opinion of Dr. Peeples who opined that the claimant's knee injury did not arise out of her employment but was the result of a degenerative condition. Therefore, we find that the claimant has failed to prove by a preponderance of the evidence that her knee injury was causally related to her work activities. See, Ford v. Chemipulp Process, Inc., 63 Ark. App. 260, 977 S.W.2d 5 (1998).

Accordingly, for those reasons stated herein, we find that this claim for benefits must be denied and dismissed.

IT IS SO ORDERED.

A. WATSON BELL, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

The majority is reversing an Administrative Law Judge's award of benefits. In my opinion, the Administrative Law Judge reached the correct decision in finding the claimant had established a compensable injury and awarding her appropriate medical and disability benefits. In denying this claim, the majority has overlooked the nature of the employment and has chosen to rely upon the opinions of a doctor who never examined or even saw the claimant and has a well deserved reputation for partiality. In my opinion, this decision is in error and the Administrative Law Judge's should have been affirmed. For that reason, I must respectfully dissent from the majority's Opinion.

As outlined by the majority, the claimant was employed as a transcriptionist in the respondent's hospital. Her duties required her to spend virtually her entire work day typing medical dictation using a foot operated control. Doing this, required her to continually move and flex her foot and leg. The claimant alleges this near constant

movement caused her to develop a knee injury in the form of a torn lateral meniscus.

The initial reason given by the majority for denying this claim is the claimant did not establish her job involved rapid and repetitive motion. In this regard, the majority cites a failure to offer testimony as to how often the claimant pressed down on the foot pedal during the course of her work day. I believe this point is fallacious in that the claimant testified she was continually pressing on the pedal during the entire day. That is, in order to activate the dictation machine she was listening to, she had to press down on the pedal. Obviously, this required a constant motion of her foot by either pressing down on the pedal to play it forward or pushing it to the side to go back.

The Appellate Courts in assessing the Commission's role in making factual determinations, has often cited the Commission's unique position as having experience and knowledge regarding industrial and vocational settings. In this regard, this Commission is very familiar with the type

of device being used by the claimant. While the scope of our review is certainly limited to the evidence presented at the hearing, we are not forbidden from using our own common sense or accumulated knowledge in making these decisions. In fact, I believe we are required to make use of our expertise in the occupational setting. Obviously, a transcriptionist such as the claimant is going to be using her foot to mash on a dictation pedal constantly. She is going to be either holding the pedal down to hear the dictation, or moving her foot to the side to replay a passage to listen to again. As any member of this Commission is aware, this type of activity is continuous throughout the time any person is transcribing dictation.

In the claimant's case, this activity consumed her entire work day. The testimony of the claimant and the supervisory personnel called by the respondent established the claimant was expected to arrive at her work place by 8:00 AM and promptly begin work. She was further expected to continue transcribing medical dictation throughout her work day. Testimony was also offered showing the employer

was short handed for a substantial period of time during the claimant's employment, and she was forced to work a considerable amount of overtime. The claimant's activities using her right foot to operate the dictation foot pedal required her to make near continuous movements of that part of her body over and over again, for long periods of time. I have no difficulty finding this action was rapid and repetitive, and I cannot fathom why the majority failed to reach this obvious conclusion.

I also believe the movement of the claimant's knee in performing her job duties is the major cause of her injury. The claimant testified she was not suffering from any problems with her knee prior to September 2007. Her past medical records bear this out. (In this regard, I note the respondent, for reasons not entirely clear, offered into evidence numerous medical reports about an unrelated thumb ailment. Had the claimant suffered from prior knee problems, I am certain the respondent would have made us aware of that fact).

The claimant's medical records establish her knee problems began in association with her job related activities. As quoted in the majority's Opinion, the first orthopedic physician the claimant saw for treatment of her knee was Dr. James Bryan on January 18, 2008. In his report of that date, Dr. Bryan noted the claimant's knee pain had been worsening, and associated the injury with the use of the foot pedal at work. Later, the claimant saw Dr. Eric Gordon, the orthopedist who operated on her knee to correct her problem. In Dr. Gordon's office note of June 9, 2008, he stated the pathology of the claimant's condition was, "likely due to overuse or twisting of the knee." In a later report dated June 23, 2008, Dr. Gordon further elaborated on the etiology of the claimant's problem. He began by stating meniscus tears, the type suffered by the claimant, were often caused by a twisting injury. As he noted, in younger people, these type of injuries were usually traumatically induced by playing sports or engaging in similar activities. But, the doctor explained, as people age, their cartilage becomes more prone to injuries from a simple twisting and he

concluded the claimant's condition, "may have very well been caused by the repetitive twisting you were doing with your leg while doing transcription."

I find Dr. Gordon's opinion to be persuasive. He obviously is a talented and capable orthopedic surgeon who is experienced in treating the type of injuries suffered by the claimant. He also explained his rationale clearly and based it on both facts and his examination of the claimant. Further, being the claimant's treating physician gives him a unique perspective on the nature and extent of the claimant's problems and I believe his opinions regarding the nature of the claimant's condition and the pathology of her injury, is entitled to great weight.

In rejecting Dr. Gordon's conclusion, the Majority relies upon the opinion of Dr. Earl Peeples. This Commission is familiar with Dr. Peeples in that we see his reports in many of the cases presented to us for determination. In these cases, Dr. Peeples rarely provides any actual treatment to injured workers. Rather, his opinions are generally sought by the respondents who wish to

develop some medical opinion in contradiction of the claimant's treating physician. Dr. Peeples is apparently obliging in this regard in that his opinions almost invariably state the claimant's condition is not associated with their job related injury and that no particular treatment option is available for them to improve their condition. In this case, Dr. Peeples did not even see the claimant. Rather, his evaluation, such as it was, consisted solely of his review of the claimant's medical records. Given the predictable nature of Dr. Peeples' opinions, and the fact he did not ever physically touch or manipulate the claimant's knee or actually observe the torn cartilage during the surgery, as Dr. Gordon had the opportunity to do, I am at a loss as to how his opinion could be given greater weight than that of Dr. Gordon. I believe the majority has erred in placing any weight whatsoever on Dr. Peeples' opinion.

I find the claimant has established she sustained an injury to her right knee as a result of the rapid and repetitive motion performed at her place of employment. I

also believe she has established by a preponderance of the evidence she is entitled to the temporary total disability benefits associated with this injury. These benefits include reasonable and necessary medical treatment provided to her by her treating physician as well as temporary disability benefits beginning on or about January 17, 2008, the date she began missing work through June 23, 2008, when Dr. Gordon completed his treatment of her. Since the majority failed to reach that conclusion, I must respectfully dissent from their decision.

PHILIP A. HOOD, Commissioner