FINAL AWARD ALLOWING COMPENSATION
(Modifying Award and Decision of Administrative Law Judge)

Injury No.: 99-070011

Employee: Marcia Rouse

Employer: Trans World Airlines

Insurer: Self-Insured

Additional Party: Treasurer of Missouri as Custodian of Second Injury Fund

The above-captioned workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have reviewed the evidence and considered the whole record. We have reviewed the parties' briefs. We find that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law, except as modified herein. Pursuant to § 286.090 RSMo, we issue this final award and decision modifying the January 8, 2010, award and decision of the administrative law judge. We adopt the findings, conclusions, decision, and award of the administrative law judge to the extent that they are not inconsistent with the findings, conclusions, decision, and modifications set forth below.

On January 8, 2010, the administrative law judge issued his award. On January 25, 2010, employee filed her Application for Review. Also, on January 25, 2010, the administrative law judge issued an Order Correcting Award on Hearing. If the Application for Review was filed before the Order Correcting, the administrative law judge had no jurisdiction to issue the Order Correcting. We do not know if the Application for Review or the Order Correcting was issued earlier. To eliminate any question regarding the efficacy of the attempted corrections, we make those corrections here. Corrected language is in italics.

We modify page 1, section 13 of the January 8, 2010, award to read:

> 13. Part(s) of body injured by accident or occupational disease: Neck and *left* shoulder

We modify page 23, paragraph 2, sentence 1, of the January 8, 2010, award to read:

> Dr. Wayne A. Stillings, a psychiatrist, testified by deposition on behalf of *Employee* on July 28, 2008.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

The award and decision of Administrative Law Judge, issued January 8, 2010, is attached and incorporated by this reference except to the extent modified herein.

Given at Jefferson City, State of Missouri, this 15th day of June 2010.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

_____
William F. Ringer, Chairman

_____
Alice A. Bartlett, Member

_____
John J. Hickey, Member

Attest:

_____
Secretary

Issued by DIVISION OF WORKERS' COMPENSATION

AWARD

Employee: Marcia Rouse

Injury No. 99-070011

Dependents: N/A

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Employer: Trans World Airlines

Additional Party: Second Injury Fund

Insurer: Self-insured

Hearing Date: September 15 & October 6, 2009

Checked by: JHP

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes

2. Was the injury or occupational disease compensable under Chapter 287? Yes

3. Was there an accident or incident of occupational disease under the Law? Yes

4. Date of accident or onset of occupational disease: June 20, 1999

5. State location where accident occurred or occupational disease was contracted St. Louis County, Missouri

6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes

7. Did employer receive proper notice? Yes

8. Did accident or occupational disease arise out of and in the course of the employment? Yes

9. Was claim for compensation filed within time required by Law? Yes

10. Was employer insured by above insurer? Yes

11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee, a flight attendant, was knocked to the floor of the airplane when the pilot unexpectedly applied the brakes during taxiing

12. Did accident or occupational disease cause death? No Date of death? N/A

13. Part(s) of body injured by accident or occupational disease: Neck and right shoulder

14. Nature and extent of any permanent disability: 15% permanent partial disability of the body due chronic pain referable to the neck and left shoulder; 7-1/2% permanent partial disability of the body due to exacerbation of somatoform disorder

15. Compensation paid to-date for temporary disability: $8,846.44

16. Value necessary medical aid paid to date by employer/insurer? $15,861.59

Employee: Marcia Rouse Injury No. 99-070011

17. Value necessary medical aid not furnished by employer/insurer? None claimed

18. Employee's average weekly wages: > $844.00

19. Weekly compensation rate: $562.67 PTD/TTD/ $294.73 PPD

20. Method wages computation: Stipulation

COMPENSATION PAYABLE

21. Amount of compensation payable:

Unpaid medical expenses None claimed	
Underpayment of temporary total disability	$ 1,120.86
90 weeks of permanent partial disability from Employer	$26,525.70

22. Second Injury Fund liability: No

TOTAL: $27,646,56

23. Future requirements awarded: None

Said payments to begin and to be payable Immediately and be subject to modification and review as provided by law.

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant:

Robert Flavin

FINDINGS OF FACT and RULINGS OF LAW:

Claimant:	Marcia Rouse	Injury No. 99-070011
Dependents:	N/A	Before the **Division of Workers' Compensation** Department of Labor and Industrial Relations of Missouri Jefferson City, Missouri
Employer:	Trans World Airlines	
Additional Party:	Second Injury Fund	
Insurer:	Self-insured	Checked by: JHP

A hearing in this proceeding was held on September 15. The record was left open for 30 days to allow Claimant to submit medical record. The record was closed on October 6, 2000. All parties submitted proposed awards, the last of which was received on November 5, 2009.

STIPULATIONS

The parties stipulated that on or about June 20, 1999:

1. the employer and employee were operating under and subject to the provisions of the Missouri Workers' Compensation Law;
2. the employer's liability was self-insured;
3. the employee's average weekly wage exceeded $844.00;
4. the rate of compensation for temporary total disability and permanent total disability was $562.67 and the rate of compensation for permanent partial disability was $294.73; and
5. the employee sustained an injury as a result of an accident arising out of and in the course of employee's employment occurring in St. Louis County, Missouri.

The parties further stipulated that:

1. the employer had notice of the injury and a claim for compensation was filed within the time prescribed by law;
2. compensation has been paid in the amount of $8,846.44 representing 18-1/7 weeks of benefits at the rate of $483.79 per week; and
3. the employer has paid $15,861.59 in medical expenses.

ISSUES

The issues to be resolved in this proceeding are:

1. whether the medical conditions in the employee's upper left extremity, cervical spine, and upper right thorax claimed by employee were caused or aggravated by the work-related accident of June 20, 1999;
2. whether the employee should be provided with any future medical treatment;

3. whether employee is entitled pursuant to Section 287.170 Mo. Rev. Stat. (2000) to any additional temporary total disability compensation;
4. the nature and extent of any permanent disability sustained by the employee as a result of the work-related injuries of June 20, 1999; and
5. whether and to what extent employee has sustained any additional permanent partial or permanent total disability for which the Second Injury Fund would be liable as a result of the combination of any preexisting disabilities with the primary injuries.

MEDICAL CAUSATION

Marcia Rouse, Employee herein, claims that the present condition of the "entire left side" of her body, including the left arm, shoulder, clavicle, axilla, left upper back and chest, neck, the changing of the color of her left hand and left foot to blue, and the development of a significant mood disorder and pain disorder were caused by the work-related accident of June 20, 1999.[1] Employer contends that some of these complaints were preexisting and some of these complaints were caused by a subsequent intervening incident.

The employee must establish a causal connection between the accident and the claimed injuries. Davies v. Carter Carburetor Div., 429 S.W.2d 738 (Mo. 1968); McGrath v. Satellite Sprinkler Systems, 877 S.W.2d 704, 708 (Mo. App. 1994); Blankenship v. Columbia Sportswear, 875 S.W.2d 937, 942 (Mo. App. 1994); Fisher v. Archdiocese of St. Louis, 793 S.W.2d 195, 198 (Mo. App. 1990); Cox v. General Motors Corp., 691 S.W.2d 294 (Mo. App. 1985); Griggs v. A.B. Chance Company, 503 S.W.2d 697, 703 (Mo. App. 1974); Smith v. Terminal Transfer Company, 372 S.W.2d 659, 664 (Mo. App. 1963).

Amendments made to Section 287.020.2 Mo. Rev. Stat. (2000) in 1993 require that the injury be "clearly work related" for it to be compensable. An injury is clearly work related "if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor." The Supreme Court held in Kasl v. Bristol Care, Inc., 984 S.W.2d 852 (Mo. 1999) that the foregoing language overruled the holdings in Wynn v. Navajo Freight Lines, Inc., 654 S.W.2d 87 (Mo. 1983), Bone v. Daniel Hamm Drayage Company, 449 S.W.2d 169 (Mo. 1970), and many other cases which had allowed an injury to be compensable so long as it was "triggered or precipitated" by work. Injuries which are triggered or precipitated by work may nevertheless be compensable if the work is found to be a "substantial factor" in causing the injury. Kasl, supra at 853. A substantial factor does not have to be the primary or most significant causative factor. Bloss v. Plastic Enterprises, 32 S.W.3d 666, 671 (Mo. App. 2000); Cahall v. Cahall, 963 S.W.2d 368, 372 (Mo. App. 1998). An accident may be both a triggering event and a substantial factor in causing an injury. Id. Subsection 2 also provides that an injury must be incidental and not independent of employment relationship and that "ordinary, gradual deterioration or progressive degeneration of the body caused by aging" is not compensable unless it "follows as an incident of employment." The extent to which the 1993 amendments have further modified prior caselaw will be determined by the appellate courts. See Cahall, supra at 372.

[1] As Employee's attorney failed to discuss the issue of medical causation in employee's Proposed award, this summary is based on Claimant's testimony at the hearing.

The quantum of proof is reasonable probability. Davies, supra at 749; Downing v. Willamette Industries, Inc., 895 S.W.2d 650, 655 (Mo. App. 1995); White v. Henderson Implement Co., 879 S.W.2d 575, 577 (Mo. App. 1994); Fischer at 199; Banner Iron Works v. Mordis, 664 S.W.2d 770, 773 (Mo. App. 1983); Griggs at 703. "Probable means founded on reason and experience which inclines the mind to believe but leaves room to doubt." Tate v. Southwestern Bell Telephone Co., 715 S.W.2d 326, 329 (Mo. App. 1986); Fischer at 198. Such proof is made only by competent and substantial evidence. It may not rest on speculation. Griggs v. A. B. Chance Company, 503 S.W.2d 697, 703 (Mo. App. 1974). Expert testimony may be required where there are complicated medical issues. Goleman v. MCI Transporters, 844 S.W.2d 463, 466 (Mo. App. 1993); Griggs at 704; Downs v. A.C.F. Industries, Incorporated, 460 S.W.2d 293, 295-96 (Mo. App. 1970). Expert testimony is required where the cause and effect relationship between the claimed injury or condition and the alleged cause is not within the realm of common knowledge or experience. Gordon v. City of Ellisville, 268 S.W.2d 454, 461 (Mo. App. 2008); McGrath v. Satellite Sprinkler Systems, 877 S.W.2d 704, 708 (Mo. App. 1994); Brundige v. Boehringer Ingelheim, 812 S.W.2d 200, 202 (Mo. App. 1991). Expert testimony is essential where the issue is whether a preexisting condition was aggravated by a subsequent injury. Modlin v. Sun Mark, Inc., 699 S.W.2d 5 (Mo. App. 1985).

The fact finder may accept only part of the testimony of a medical expert and reject the remainder of it. Cole v. Best Motor Lines, 303 S.W.2d 170, 174 (Mo. App. 1957). Where the opinions of medical experts are in conflict, the fact finding body determines whose opinion is the most credible. Hawkins v. Emerson Electric Co., 676 S.W.2d 872, 877 (Mo. App. 1984). Where there are conflicting medical opinions, the fact finder may reject all or part of one party's expert testimony which it does not consider credible and accept as true the contrary testimony given by the other litigant's expert. Webber v. Chrysler Corp., 826 S.W.2d 51, 54 (Mo. App. 1992); Hutchinson v. Tri-State Motor Transit Co., 721 S.W.2d 158, 163 (Mo. App. 1986). An administrative law judge may not constitute himself or herself as an expert witness and substitute his or her personal opinion of medical causation of a complicated medical question for the uncontradicted testimony of a qualified medical expert. Wright v. Sports Associated, Inc., 887 S.W.2d 596 (Mo. 1994); Bruflat v. Mister Guy, Inc., 933 S.W.2d 829, 835 (Mo. App. 1996); Eubanks v. Poindexter Mechanical, 901 S.W.2d 246, 249-50 (Mo. App. 1995). However, even uncontradicted medical evidence may be disbelieved. Massey v. Missouri Butcher & Cafe Supply, 890 S.W.2d 761, 763 (Mo. App. 1995); Jones v. Jefferson City School Dist., 801 S.W.2d 486, 490 (Mo. App. 1990).

On the other hand, where the facts are within the understanding of lay persons, the employee's testimony or that of other lay witnesses may constitute substantial and competent evidence of the nature, cause, and extent of disability. Silman v. William Montgomery & Associates, 891 S.W.2d 173, 175 (Mo. App. 1995). This is especially true where such testimony is supported by some medical evidence. Lawton v. Trans World Airlines, Inc., 885 S.W.2d 768 (Mo. App. 1994); Pruteanu v. Electro Core Inc., 847 S.W.2d 203 (Mo. App. 1993); Reiner v. Treasurer of State of Mo., 837 S.W.2d 363, 367 (Mo. App. 1992); Fisher v. Archdiocese of St. Louis, 793 S.W.2d 195, 199 (Mo. App. 1990); Ford v. Bi-State Development Agency, 677 S. W. 2d 899, 904 (Mo. App. 1984); Fogelsong v. Banquet Foods Corp, 526 S.W.2d 886, 892 (Mo. App. 1975). The trier of facts may even base its findings solely on the testimony of the employee. Fogelsong at 892. The trier of facts may also disbelieve the testimony of a witness even if no contradictory or impeaching testimony is given. Hutchinson v. Tri-State Motor Transit Co., supra

at 161-2; Barrett v. Bentzinger Brothers, Inc., 595 S.W.2d 441, 443 (Mo. App. 1980). The uncontradicted testimony of the employee may even be disbelieved. Weeks v. Maple Lawn Nursing Home, 848 S.W.2d 515, 516 (Mo. App. 1993); Montgomery v. Dept. of Corr. & Human Res., 849 S.W.2d 267, 269 (Mo. App. 1993).

Employer is liable for any aggravation of a preexisting asymptomatic condition caused by the primary injury. Gennari v. Norwood Hills Corporation, 322 S.W.2d 718, 722-23 (Mo. 1959); Miller v. Wefelmeyer, 890 S.W.2d 372, 376 (Mo. App. 1994); Weinbauer v. Gray Eagle Distributors, 661 S.W.2d 652, 654 (Mo. App. 1983); Johnson v. General Motors Assembly Division, 605 S.W.2d 511, 513 (Mo. App. 1980); Fogelsong v. Banquet Foods Corporation, 526 S.W.2d 886, 891 (Mo. App. 1975); Mashburn v. Chevrolet Kansas City Div., G.M. Corp., 397 S.W.2d 23 (Mo. App. 1965); Garrison v. Campbell "66" Express, 297 S.W.2d 22 (Mo. App. 1956); accord, Lawton v. Trans World Airlines, Inc., 885 S.W.2d 768, 771 (Mo. App. 1994); Terrell v. Board of Education, City of St. Louis, 871 S.W.2d 20 (Mo. App. 1993). In Weinbauer claimant had preexisting cervical osteoarthritis. In Johnson claimant had preexisting spondylolisthesis. In Miller, employer/insurer were held liable for the complete loss of the employee's right eye due to a work injury, even though he had been diagnosed with a preexisting, dormant condition in both eyes.

Employer is liable for any aggravation of a preexisting symptomatic condition caused by a work-related accident. Rector v. City of Springfield, 820 S.W.2d 639 (Mo. App. 1991); see also Sansone v. Joseph Sansone Const. Co., 764 S.W.2d 751 (Mo. App. 1989); Plaster v. Dayco Corp., 760 S.W.2d 639 (Mo. App. 1988).

Employer is not liable for any post-accident worsening of an employee's preexisting disabilities which is not caused or aggravated by the last work-related injury. Kern v. General Installation, 740 S.W.2d 691, 692 (Mo. App. 1987).

Findings of Fact

Based on my observations of Claimant's demeanor during his testimony, I find that she is only partially credible. Based on that portion of Claimant's testimony which I find to be credible and on the medical records, I make the following findings of fact.

Description of Accident

On June 20, 1999 Marcia Rouse, a flight attendant For Trans World Airlines, who was standing near her jump seat during taxiing, was knocked to the floor of the airplane when the pilot unexpectedly applied the brakes. Employee's left shoulder and left face struck the side of the first class coat compartment.[2] Claimant was able to perform lighter duties during the flight from St. Louis to London. She put ice on her left shoulder during the flight. She stayed overnight in London and worked the return flight to St. Louis on June 23. She reported her injury to the pilot during the return flight. (Claimant's Testimony)

[2] Though she testified that she lost consciousness, I decline to make that finding as Claimant's statements to the treating physicians are conflicting as to whether she lost consciousness.

Medical Treatment

On June 24, 1999, Dr. Cindy Fortado-Clark at BarnesCare examined Ms. Rouse. The treatment record fails to include the findings on physical examination.[3] X-rays taken of her left shoulder were negative. X-rays taken of the cervical spine showed reversal of the normal lordosis. She was diagnosed with a cervical strain, a left shoulder strain, and a contusion to the left arm. Dr. Fortado-Clark prescribed Ibuprofen and allowed her to return to regular work without restrictions.

Claimant received massages from Barb Thomas at Vetter Chiropractic on June 29 and July 6. She was examined by Chiropractor Danny J. Vetter on July 9, 1999. He felt that Employee had decreased cervical range of motion in all directions with extreme pain radiating into the left arm and breast, reduced grip and deltoid strength, reduced cervical curve, positive Spurling's test bilaterally, tenderness and spasms of all muscles in the neck and shoulder girdle. He treated her with spinal manipulation, ultrasound, EMS, heat, hydrotherapy, and massage on July 9 and 10. (Claimant's Exhibit D)

Dr. Fortado-Clark reexamined Claimant on August 11, 2009. The treatment record fails to indicate the condition of Employee's neck and left shoulder. It shows only that Dr. Fortado-Clark advised her to apply warm compressed threes times a day to her neck and left shoulder and ordered an MRI of her cervical spine to rule out a herniated disc. (Claimant's Exhibit C)

An MRI of Employee's cervical spine was performed on August 20. According to the radiologist, it showed "cervical spondylosis, prominent osteophytes and uncovertebral hypertrophy of C4-5 and C5-6 with bilateral mild foraminal stenosis" and a "moderate size central disc herniation at C6-C7 with effacement of the anterior subarachnoid space, but no cord compression." (Claimant's Exhibit B) On receipt of the MRI report Dr. Fortado-Clark referred Claimant to Dr. Barry L. Samson, an orthopedic surgeon. (Claimant's Exhibit C)

Dr. Samson examined Ms. Rouse On September 2, 1999. She described the accident, told him that she felt the same as she had in June, and indicated that she had been working until August 20. On examination Dr. Samson found that her upper extremity reflexes were active and symmetric, that her muscles and grip strength were normal, that there was some left trapezius tenderness without spasm, and that neck extension and flexion caused a pulling on the left side of the neck. Dr. Samson reviewed the MRI report and diagnosed Claimant with cervical spondylosis and radiculitis. He recommended that employee wear a soft cervical collar at night and prescribed a Medrol dosepak and Darvocet, and kept her off work. (Claimant's Exhibit E)

Ms. Rouse returned to Dr. Samson on September 16. Claimant indicated that her symptoms markedly improved while she was taking the cortisone, but that she stopped taking it because she felt as though she was "'having a heart attack.'" Her physical examination was essentially normal except for some tenderness to palpation of the left trapezius and pain in the left trapezius on looking up. Dr. Samson reviewed the MRI film. Dr. Samson was not sure whether the mass effect at C6-7 was a herniated disc or an osteophyte. He recommended that she

[3] Though employee testified that her left shoulder became black and blue, there was no description of her left shoulder in the initial treatment record. (Claimant's Exhibit C)

walk for exercise, take Ibuprofen with food, wear the collar while sleeping, and remain off work. (Claimant's Exhibit E)

On October 15, 1999 Chiropractor Vetter performed manipulation with ultrasound on Employee. (Claimant's Exhibit B)

Dr. Samson reexamined Ms. Rouse on September 30. Employee told him that she tried stopping the Ibuprofen for a couple of days and her symptoms worsened. Her physical examination was normal. He kept her off work and advised her to increase her activity to see if she got better or worse. (Claimant's Exhibit E)

Ms. Rouse returned to Dr. Samson on October 25, 2009. As she was still having complaints of neck and left arm pain and as he was not able to determine the precise nature of the mass effect at C6-7, Dr. Samson ordered a cervical myelogram and CT myelogram. (Claimant's Exhibit E) They were performed at Barnes-Jewish West County Hospital on November 1, 1999. They showed a central and right lateral soft disc herniation at C6-7 and cervical spondylosis with osteophytes and mild bilateral foraminal stenosis at C4-5 and C5-6. (Claimant's Exhibits B and E)

On November 3, 1999, Dr. Samson reexamined Claimant and reviewed the report of the CT myelogram. She told him that she had vaginal pain and her left leg felt weak and shaky after the myelogram. She reported that her neck symptoms remained on the left side. Dr. Samson noted that she walked with a normal gait and had a normal arm swing. Her biceps, triceps, and grip strength were normal and her reflexes were symmetric. She complained of posterior neck pain with side bending and had decreased voluntary motion. He diagnosed her with cervical radicular syndrome with degenerative changes but no herniated disc to correlate with her symptoms. Dr. Samson kept her off work and recommended that she begin walking thirty to forty-five minutes a day. (Claimant’s Exhibit E)

Claimant returned to Dr. Samson on December 1, 1999. She complained that her left leg had “‘not been right’” since the myelogram, that she could not look up due to pain between her shoulder blades and neck, and that she was experiencing chills coming out of her spine. She also reported that she had experienced such severe neck pain when she tried to lift a turkey that she spent the next day in bed. Her physical examination was essentially negative, including straight leg raising. She complained of marked tenderness to skin touch pressure around the neck and trapezius muscles. Dr. Samson felt that her neck motion was voluntarily restricted. He diagnosed Employee with a cervical strain with degenerative changes of the cervical spine. He told Ms. Rouse that he could not explain her symptoms multiple complaints of left arm pain by the CT myelogram as the findings were on the right side. He recommended she see a neurologist for evaluation of her left leg pain. He opined that if the neurologist had no diagnosis related to her work, then Employee would be able to resume work. (Claimant's Exhibit E)

Dr. Daniel Phillips, a neurologist, examined Ms. Rouse on December 22, 1999. For the first time, Employee described experiencing a “whoosh” and “buzz” in her brain when she struck her left shoulder and the left side of face on the airplane. For the first time she also described experiencing a chilling of her cervical spine and out of body sensations on June 22, 1999. Subsequent to the accident she experienced pain starting in the left cervical thoracic region

spreading across the shoulder and down the left arm and intermittent numbness of the left arm, particularly of the last three fingers. She indicated that her average pain level was 7-1/2 over 10. (Employer's Exhibit 3, depo ex 2)

Dr. Phillips noted that Employee had variable self-limited cervical range of motion, agitation during the physical exam, diffuse giveaway weakness in testing the left upper and lower extremity and superficial jump responses in the cervicobrachial region without corresponding spasm. Fingertip palpation over the left lateral pelvis increased low back and left leg symptoms even though the palpation was nowhere near a nerve. Gentle palpation on the top of the head was reported to increase her symptoms in the left arm and less so in the low back and left leg. Dr. Phillips found no swelling, temperature change or color change of the upper extremities. Objective testing was essentially normal. Dr. Phillips started the nerve conduction study at a low level. Employee claimed she was feeling different and had never felt that way before. Even though Dr. Phillips noted that nerve conduction studies have no side effects, he stopped the study. The portion of the nerve conduction study that was completed was normal. (Employer's Exhibit 3, depo ex 2)

Dr. Phillips also reviewed the August 20, 1999 MRI and the November 1, 1999 CT myelogram. He noted that the C6-C7 central protruding disk was right paracentral without involvement of the nerve roots. He reported that all the nerve roots filled well and symmetrically. He concluded that the spinal cord was not involved and there was nothing to account for Employee's left upper extremity symptoms. Dr. Phillips stated that the objective components of her examination were unremarkable without evidence of intracranial injury, cervical myelopathy or radiculopathy, or thoracic or lumbar myelopathy or radiculopathy. (Employer's Exhibit 3, depo ex 2)

Chiropractor Vetter referred Ms. Rouse to Dr. Gregory J. Bailey, a neurosurgeon, who examined her on January 24, 2000. Employee described the airplane incident. Dr. Bailey noted that she had marked tenderness at the base of the neck as well as on the right and toward the shoulder as well as in the axilla, that movement of the left arm caused exacerbation of those symptoms, that she had slight giveaway weakness on motor strength testing due to pain. He felt that Employee had sustained an injury to "the support structure of the neck and toward the left shoulder" (i.e. that the muscles, tendons, ligaments, and joints were essentially stretched, torn, and compressed). He did not find any classic radicular symptoms. He did not note any symptoms of burning in her neck or left shoulder, any muscle atrophy, abnormal swelling, change of temperature or change of color of the arm. He felt that she was not capable of working and that she needed more treatment. He referred Employee to Dr. Phuong T. Nguyen, a physiatrist. (Claimant's Exhibit S, Pages 6-8, 11, 14 & 17-18)

On February 23, 2000 Chiropractor Vetter performed manipulation with ultrasound on Employee. (Claimant's Exhibit B)

Dr. Nguyen examined Ms. Rouse on February 29, 2000. She described her left shoulder and head hitting a wall in the airplane in June of 1999.[4] Employee complained of pain and

[4] She told Dr. Nguyen that she blacked out on the floor. This is the first time that any history of loss of consciousness appeared in the medical records.

swelling around her shoulder and neck and shortness of breath associated with her pain. She denied numbness, but she reported that her left arm changed in color. On physical examination Dr. Nguyen noted slight puffiness at the left SCM insertion, tenderness all over the left shoulder, and base of the skull, over the trapezius, along the pectoralis minor and pectoralis major, and along the cervical spine and upper thoracic spine. He diagnosed Claimant with left shoulder pain. He felt that she may have had an acute muscle strain with whiplash syndrome complicated with muscle spasm causing some feeling of swelling. He recommended that she continue with Voltaren. She discontinued Elavil herself. He ordered ultrasound and massage to the deltoid, trapezius and pectoralis minor muscles. (Claimant's Exhibit F)

On April 17, 2000 Dr. Nguyen indicated that Ms. Rouse had undergone ultrasound, massage and exercise of her neck and shoulder. She reported that the pain was improving, except that she continued to have severe radiating pain and a change of color of her left arm when driving back from Chicago. Dr. Nguyen noted that she seemed anxious and cried several times during conversation. He did not see any color change in her hands; he specifically noted that there was no change in color of Claimant's left hand compared to Claimant's right hand. He also noted that he could not differentiate swelling in the left chest or left axillary area compared to the right side, which Employee reported. He diagnosed Claimant with left-sided neck and shoulder pain. He continued her Darvocet and added Zoloft for her emotional instability and depression. (Claimant's Exhibit F)

Ms. Rouse returned to Dr. Nguyen on June 15, 2000. She told him that she had gone to Milan to visit her son. After pulling her luggage she developed severe pain in her neck and shoulder radiating up to the head and causing a headache. She was unable to open her eyes for three days because of the headache. She described having a different body with her left side achy most of the time and her right side feeling normal. On palpation Dr. Nguyen found tenderness along the left side of the neck, bicipital tendon, along the left costosternal joint, and along the whole spinal column. He noted discoloration of the left hand; he indicated that it might be a sympathetic reaction. Neck and left shoulder range of motion was limited due to pain. He diagnosed Ms. Rouse with chronic pain of the neck, shoulder and chest. He mentioned whiplash and Tietze's syndrome (costochondritis). He recommended massage, hot packs an ice packs and analgesics prescribed by her family doctor. He did not feel that Claimant could return to work because her job required much physical activities. (Claimant's Exhibit F)

On August 16, 2000 Chiropractor Vetter performed manipulation with ultrasound on Employee. (Claimant's Exhibit B)

On September 12, 2000, Claimant complained of swelling in her left breast and anterior chest and left neck, occasional blueness of the left hand, and aching and stiffness of the left upper quadrant of her body from the neck around the chest. Dr. Nguyen noted some puffiness of the left neck and the left anterior axillary area. With palpation claimant had pain all over from the neck, shoulder, arm, chest and axillary area. He noted discoloration of the left arm, where it was becoming red and bluish in color.[5] (Claimant's Exhibit F)

[5] Page 2 of this record was missing.

Ms. Rouse returned to Dr. Nguyen on November 8, 2000. She reported that Zoloft had helped with her moods, but her pain remained the same. She stated that it was sometimes so severe that she remained in bed and that her left hand turned pink when she was nervous or anxious. Use of her right arm also caused pain on the left side extending down the arm. She pointed to the inside of the shoulder joint and mid-upper trapezius area as the location of her pain. Dr. Nguyen noted that she had tender points in the upper trapezius area without radiating, the AC joint and back of the humeral glenoid joint. Range of motion of her neck and shoulder was limited with pain. Dr. Nguyen diagnosed Ms. Rouse with grade 1 complex regional pain syndrome affecting the upper left quadrant of the body from the neck down to the chest and left arm and whiplash syndrome. He prescribed Zoloft and Norgesic Forte and high frequency stimulation with a Matrix machine. He did not think she would be able to work as a flight attendant. (Claimant's Exhibit F)

Claimant returned to Chiropractor Vetter on January 16, 2001. She reported that her condition was still very painful. She received ultrasound to her neck and to upper left breast which remained swollen. (Claimant's Exhibit B)

Dr. Nguyen also reexamined Employee on January 16, 2001. She reported intermittent, severe pain in the left shoulder that referred to the whole arm and the left quadrant of the chest. She stated that her pain interfered with her daily activities of shopping and carrying things with the right arm. Dr. Nguyen noted puffiness in her left shoulder and left breast with change of color to red in the left arm and chest. Passive range of motion of the left shoulder motion was within normal limits with pain. Dr. Nguyen diagnosed claimant with reflex sympathetic dystrophy of the left shoulder, whiplash syndrome with neck pain, and anxiety. Matrix treatment was apparently not available in St. Louis. (Claimant's Exhibit F)

On March 9, 2001, Dr. Nguyen indicated to Employer's disability insurance carrier that Employee was unable to work. On May 7, 2001 claimant's disability claim was approved by Aetna Healthcare. (Claimant's Exhibit F)

On May 23, 2001 Dr. Timothy G. Lang, an orthopedic surgeon, examined Employee. She described the work injury in June of 1999 where she hit her left shoulder, then hit her neck, then fell to the floor of the airplane. She described a "'whooshing in her brain'" as she hit the floor. She told him that she had recently been fired from her job due to her inability to return to work. She told him that she did not have enough strength in her left arm to open and close doors. She reported that she had received some physical therapy and began using a TENS unit in May. Dr. Lang noted that Employee was quite thin and in obvious distress over her situation. On examination Dr. Lang noted obvious changes in vascular tone of the left arm in the ulnar distribution where she has some vascular congestion and a slight decrease in temperature in the same area. The neurological examination of the left upper extremity was normal. He noted good cervical range of motion that did not exacerbate her pain and no pain with palpation of the cervical paraspinous musculature or the spinous processes. She held the glenohumeral joint quite stiffly. Impingement testing was equivocal. She had difficulty getting flexion to 90 degrees. Dr. Lang diagnosed Claimant with ongoing pain following a fall at work in June of 1999 consistent with chronic regional pain syndrome and possible subacromial impingement with some mild crepitus and possible bursitis. Dr. Lang recommended that she have psychological assistance to deal with her pain. He opined that psychological pain management would be the best step in

dealing with her entire situation. He recommended that Dr. Nguyen continue to treat her chronic regional pain syndrome with medications. (Claimant's Exhibit G)

Dr. Craig Aubuchon, an orthopedic surgeon and colleague of Dr. Lang, examined Ms. Rouse on June 6, 2001.[6] He was informed of her June, 1999 injury at work where she fell and struck her left shoulder and neck. On examination Dr. Aubuchon felt that she had a positive impingement test of the left shoulder and a lot of weakness in supraspinatus testing. She also had a positive Tinel's over the anterior scalene muscle (in the cervical plexus). Dr. Lang indicated that Ms. Rouse had some evidence of thoracic outlet syndrome and some bursitis of her shoulder. He recommended that she undertake an exercise program and take anti-inflammatories. (Claimant's Exhibit G)

Dr. Nguyen reexamined Claimant on October 2, 2001. He noted that she had been medically stable and that her pain was improving with the electrical stimulation program. She felt that the change of color was improving. She remained unable to carry heavy objects and was unable to take care of her mother who was in seriously ill. Her physical examination was unchanged. He gave her exercises to perform to avoid contracture and again recommended use of a Matrix machine. (Claimant's Exhibit F)

Ms. Rouse returned to Dr. Nguyen on February 5, 2002. She reported that she had used the matrix machine three times. After the third treatment she developed nausea, tingling, foot drop, weakness on the left side, and urinary frequency. Treatment was stopped and those symptoms resolved. However, her left shoulder pain recurred. On physical examination Dr. Nguyen noted fullness of the soft tissue and change of color and multiple tender points around the neck and left shoulder and down the left side to T5. He diagnosed Claimant with reflex sympathetic dystrophy of the left shoulder and upper extremity and continued the Norgesic Forte. He recommended that she continue the electrical stimulation at home and continue to see the psychotherapist. (Claimant's Exhibit F)

On February 19, 2002 Dr. Anatoly Rozman, a neurologist, in Chicago, Illinois examined Employee at the request of Dr. Mahendra A. Patel[7] of Homewood, Illinois. Ms. Rouse told him that she fell on her left shoulder and twisted her neck when the TWA airplane made a sudden turn.[8] She complained of severe pain in her left upper thorax and above the collarbone area with swelling of the pectoralis muscle on the left side, swelling of the axilla and decreased range of motion in the left shoulder with severe pain. She reported discoloration of her left upper extremity. Dr. Rozman noted that she was very anxious about what was going on with her. Ms. Rouse told Dr. Rozman that she was diagnosed with depression but refused to take the medication because she did not feel depressed. She was very concerned about her health and had not worked for approximately two years due to pain in her neck and shoulder. She was taking only Tylenol for her pain. On examination Dr. Rozman noted pain with palpation of the left trapezius muscle and severe pain of the scalene muscle on the left side, mild pain with palpation

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[6] He had previously treated her for a recurrent Morton's neuroma in 1996. (Claimant's Exhibit G)

[7] Claimant had been seeking treatment from Dr. Patel while visiting her children in Chicago. His records were not offered into evidence.

[8] Ms. Rouse also told Dr. Rozman that she lost consciousness. This is the second medical record to document loss of consciousness.

of the pectoralis major muscle, pain with palpation of the cervical paraspinal muscles on the left side, mild swelling above the clavicle, and apparent bluish discoloration of the left hand with preserved radial pulse bilaterally. Adson's maneuver was positive on the left side. (Claimant's Exhibit H)

Dr. Rozman diagnosed Employee with persistent pain in the neck and left shoulder, left rotator cuff tendinitis with a possible partial tear, possible scalene syndrome on the left side (thoracic outlet syndrome). Dr. Rozman also stated he could not rule out possible mild reflex sympathetic dystrophy on the left side. He recommended nerve conduction studies and EMGs. Dr. Rozman performed the nerve conduction studies the same day. He noted that there was no strong electrodiagnostic evidence of cervical radiculopathy or peripheral neuropathy in the left upper extremity and left cervical spine. He recommended an MRI of the left upper thorax and left shoulder. He also recommended a bone scan to rule out reflex sympathetic dystrophy. (Claimant's Exhibit H)

On June 13, 2002 Employee underwent a bone scan at Ingalls Hospital. It showed no abnormal uptake in her cervical spine. There was a subtle increased uptake in a left lateral rib consistent with an old fracture and an increased uptake of the inferior right sacroiliac joint. (Claimant's Exhibit U)

An MRI of Employee's chest was performed for brachial plexus evaluation at Christian Hospital on July 27, 2002. It showed that the left brachial plexus was within normal limits. (Claimant's Exhibit I)

An MRI of Employee's left shoulder was performed at Christian Hospital on July 27, 2002. It showed a subtle intrasubstance tear involving the infraspinatus tendon at its attachment. There was no complete rotator cuff tear. There was minimal associated fluid in the subacromial-subdeltoid bursa. (Claimant's Exhibit I)

Ms. Rouse returned to Dr. Aubuchon on September 25, 2002. On examination Dr. Aubuchon noted that Employee had a lot of discomfort when she raised her arm to 45 degrees of abduction and a markedly positive impingement test. Dr. Aubuchon reviewed the MRI of the left shoulder and recommended an arthroscopic surgery with a possible open rotator cuff repair. (Claimant's Exhibit G)

On October 8, 2002 Dr. Aubuchon performed an arthroscopy of Employee's left shoulder. He did not find any tears of the rotator cuff, the superior labrum or the inferior labrum. He debrided the subacromial burrs, burred a spur on the undersurface of the acromion, and burred down the acromion. The postoperative diagnosis was impingement of the left shoulder. (Claimant's Exhibit M)

Following her left shoulder surgery employee was treated with Norgesic Forte and physical therapy. On November 13, 2002 Dr. Aubuchon noted that her range of motion was improving though she still had some limitation with abduction. He continued her physical therapy. (Claimant's Exhibit G)

Dr. Aubuchon reexamined Employee on December 19, 2002. She was able to abduct her arm to 100 degrees. She still had a lot of weakness when he tested her supraspinatus. He prescribed three additional weeks of physical therapy. He indicated that she should not lift overhead and not lift greater than 10 pounds with the left upper extremity. (Claimant's Exhibit G)

On January 7, 2003 Dr. Aubuchon noted that Employee was still have some discomfort and weakness in her left shoulder, but was getting more motion. He released Employee to return to work as far as her shoulder was concerned. She was to follow-up on an as needed basis. (Claimant's Exhibit G)

On February 26, 2003 Employee sought treatment from Dr. Fred G. Hicks, a psychiatrist, because Dr. Anthony Matteline, her primary medical doctor, told her to see him. Ms. Rouse told him that she had been distressed following a work-related injury in June of 1999 to her shoulder, side and face. She told him that she "felt all this energy to [her] brain and then it hurt and then [she] was out." She saw a number of physicians and eventually underwent shoulder surgery for impingement. She told him that during this period she had been involved with providing hospice care for her dying mother in Chicago. Both her mother and father died in December of 2001; her boyfriend and best friend also died in 2001. She reported that she had been fired from TWA for alleged malingering. She had been working with a lawyer. (Claimant's Exhibit J)

Employee told Dr. Hicks that her father was an alcoholic and her husband was a violent alcoholic. She also reported having been sexually abused as a child with some counseling for that and having been physically abused by her husband. She eventually divorced her husband, but they had been separated many times due to her husband's physical abuse. She had reconstructive surgery on her face after being struck by her husband. She had three grown children by this marriage. Ms. Rouse told Dr. Hicks that she did not feel like she was depressed. If she cried, she cried by herself. Dr. Hicks noted that she had sleep disturbance with initial insomnia with pain, crying spells, fatigue, poor motivation and interest, irritability, and self-deprecating thoughts, concentration problems, and obsessive thoughts about her injury. (Claimant's Exhibit J)

Dr. Hicks felt her treatment needs were to reduce pain complaints, improve her functional abilities, improve awareness of her personal needs, educate her regarding her current illness, educate her regarding medications and treatment options, and encourage compliance with treatment. He made an Axis I diagnosis of "pain disorder chronic associated with both psychological factors and a general medical condition". He indicated that major depression, recurrent, mild needed to be ruled out and that her occupational problem was a conflict over disability. He deferred making a diagnosis on Axis II though she might have dependent personality disorder. He indicated that obsessive-compulsive personality disorder needed to be ruled out. He made an Axis III diagnosis of shoulder injury and an Axis IV diagnosis of moderate ongoing pain and disability. Dr. Hicks indicated that she should continue Lexapro, consider resumption of Tegretol, and continue with physical therapy. (Claimant's Exhibit J)

On April 1, 2003 Dr. Hicks noted that Ms. Rouse had prominent mixed feelings about her job and her ability to work. She had been active with the recommended exercises. There was no change in the diagnosis. He continued the Lexapro and added Amitriptyline and continued physical therapy. (Claimant's Exhibit J)

On May 5, 2003 Ms. Rouse reported poor sleep due to pain in her left shoulder which she attributed to not taking the Norgesic Forte. Dr. Hicks described her as frustrated with the bureaucracy associated with her disability. He noted that Employee was intermittently tearful. She had been staying with her children. There was no change in the diagnosis. He continued the Lexapro, Amitriptyline and physical therapy. (Claimant's Exhibit J)

On June 10, 2003 Dr. Hicks noted a telephone conversation with Dr. Matteline, Claimant's personal physician, who stated that Ms. Rouse was an anxious personality, did not have sympathetic dystrophy, and was physically capable of returning to work. (Claimant's Exhibit J)

On July 24, 2003 Employee told Dr. Hicks that she had been residing in Chicago. He indicated that Employee continued to struggle with her physical problems worsening with her physical exertion. She was angry about being furloughed by American Airlines[9] after 35 years of employment with Trans World Airlines. Dr. Hicks indicated that she continued to struggle with limited ability to garden or to be active. The only change in diagnosis was the addition to Axis IV of "ambivalent about retirement". He continued the Lexapro, Amitriptyline, added Seroquel and physical therapy. (Claimant's Exhibit J)

On September 23, 2003 Dr. Hicks noted that Employee was struggling with her injuries and ongoing pain and had tried yoga with fair benefit, and had fair sleep when taking her medication. He noted that she struggled with accepting the use of medication and continued to have prominent ambivalence about possible retirement. She was tearful intermittently. There was no change in the diagnosis. He continued the Lexapro, Amitriptyline, Seroquel and physical therapy. (Claimant's Exhibit J)

On December 4, 2003 Dr. Hicks noted that Employee was feeling downcast with thoughts of having to make a decision about settling her case and retirement. She had been sleeping better. There was no change in the diagnosis. He continued the Lexapro, Amitriptyline, Seroquel and physical therapy. (Claimant's Exhibit J)

On January 9, 2004 Dr. Hicks noted that Employee was distressed with ongoing pain and frustration about the pain. She had stopped taking her medications to see where she was without medication. She was tearful intermittently. There was no change in the diagnosis. He continued the Lexapro, Amitriptyline, Seroquel and physical therapy. (Claimant's Exhibit J)

On February 20, 2004 Dr. Hicks noted that Employee was feeling downcast and that she continued to have marginal compliance with the medication. She was tearful intermittently. There was no change in the diagnosis. He discontinued the Lexapro and Seroquel, prescribed Lamictal, continued the Amitriptyline and physical therapy. (Claimant's Exhibit J)

On May 18, 2004 Dr. Hicks noted that Ms. Rouse was distressed with ongoing physical problems and had ongoing pain with even very limited physical exertion. She indicated that there was no doubt that she could not carry her suitcase. She indicated that Dr. Matteline had retired. She was tearful intermittently. The only change in diagnosis was the deletion from Axis IV of

[9] American Airlines purchased all of the assets of Trans World Airlines on April 9, 2001.

"ambivalent about retirement". He prescribed Lamictal, continued the Amitriptyline and physical therapy. (Claimant's Exhibit J)

On July 7, 2004 Dr. Hicks noted that Employee had been feeling stressed with her physical problems. She tried Yoga again, but was not able to do it with her left arm. She indicated that she was distressed with business development in her neighborhood (a lumbar yard). There was a problem with the neighborhood lumbar yard. She was tearful intermittently. There was no change in the diagnosis. He increased the dosage of Lamictal, continued the Amitriptyline, added Abilify, and continued physical therapy. (Claimant's Exhibit J)

On September 27, 2004 Dr. Hicks noted that Employee was avoiding coming to her appointments and was struggling with the expansion of the lumber yard in her neighborhood. She told him that American Airlines was starting to call people back. She was tearful intermittently. The only change in diagnosis was the addition to Axis IV of "lumbar yard next door". He continued the Lamictal and Amitriptyline, added Abilify, and continued physical therapy. (Claimant's Exhibit J)

On February 18, 2005 Dr. Hicks noted that Ms. Rouse was distressed with the lumbar yard expansion next door. She continued with involvement with the lawsuit over her work and disability. She indicated that she wanted her job. She told him that her family urged her to retire. She was tearful. There was no change in the diagnosis. He increased the Lamictal and continued the Amitriptyline and physical therapy. (Claimant's Exhibit J)

On April 5, 2005 Dr. Hicks noted that employee was feeling downcast and continued to struggle with legal matters regarding the lumbar yard and her work disability. She was tearful. There was no change in the diagnosis. He discontinued the Lamictal due to expense, prescribed carbamezepine, continued Amitriptyline, prescribed Abilify, and continued massage therapy. She was to return in four weeks. She did not return to Dr. Hicks. (Claimant's Exhibit J)

On May 17, 2005 employee sought treatment from Dr. Anthony Guarino, a pain management specialist at Barnes-Jewish West County Hospital. She complained of pain in the neck, clavicle, left shoulder, shaking at random, nausea, cold and blue left hand and foot, and low back pain. Dr. Guarino diagnosed her with diffuse left-sided myalgias, chronic fatigue syndrome, chronic depression and anxiety and recommended that she be referred to the STEPP program at Barnes-Jewish Hospital.[10]

Dr. Guarino asked Dr. Juan C. Escandon, a neurologist, to perform a neurological examination. Dr. Escandon felt that the examination he performed on August 5, 2005 was within normal limits.[11]

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[10] As Dr. Guarino's records were not offered into evidence, these findings were made from the medical reports of Dr. David T. Volarich, who evaluated Claimant on June 15, 2006 at the request of her attorney, and Dr. Timothy T. Farley, who evaluated Claimant on July 24, 2007 at the request of Employer's attorney. (Claimant's Exhibit N, depo ex 2, p. 4 and Employer's Exhibit 2, depo ex 2, p.6)

[11] As Dr. Escandon's records were not offered into evidence, these findings were made from the medical reports of Dr. David T. Volarich, who evaluated Claimant on June 15, 2006 at the request of her attorney, and Dr. Timothy T. Farley, who evaluated Claimant on July 24, 2007 at the request of Employer's attorney. (Claimant's Exhibit N, depo ex 2, p. 4 and Employer's Exhibit 2, depo ex 2, p.6)

Ms. Rouse sought treatment from Dr. Bud P. Chomhirun, a physiatrist, in Wood River, Illinois, who evaluated her on August 30, 2005. She described the June 20, 1999 incident on the TWA airplane when she struck her left shoulder and face and fell to the floor. She added that she struck her right shoulder before hitting the floor. She complained of left-sided neck pain, left hand and foot blueness, heart palpitation, sweating, difficulty sleeping, and shaking inside. Dr. Chomhirun reviewed most of the foregoing medical records. On physical examination Dr. Chomhirun noted slight loss of flexion, extension, and bilateral rotation of the neck, moderate tenderness with positive trigger point tests[12] of the left sternocleidomastoideus and rhomboideus, severe tenderness in the left trapezius with muscle spasm, severe tenderness in and swelling of the left supraclavicular fossa or thoracic outlet area, and mild tenderness at the mid thoracic paraspinal area. Adson's test was positive on the left, but the radial pulse was still palpable with discoloration. He also noted multiple positive trigger point tests for the muscles along the left anterior chest wall including pectoral muscle and latissimus dorsi. Left shoulder abduction was limited to 150 degrees. (Claimant's Exhibit Q, depo ex A, pp 1 & 4-5)

Dr. Chomhirun diagnosed Claimant with persistent neck and upper back pain due to chronic cervical and upper thoracic myofascial sprain syndrome, left scalene syndrome (thoracic outlet syndrome), mild left upper extremity reflex sympathetic dystrophy, herniated C6-C7 disk toward the right side, cervical spondylosis and spondylitis, and chronic pain syndrome including symptom of depression. Dr. Chomhirun opined that Claimant had not reached maximum medical improvement for her June 20, 1999 injuries. He recommended treatment for Claimant's thoracic outlet syndrome, including injection therapy, physical therapy, electrical stimulation, and exercises to modify her activity of daily living, primarily the use of the left posture. (Claimant's Exhibit Q, depo ex A, pp 6-7)

On September 14, 2005 Dr. Chomhirun administered physical therapy consisting of inferential electrical stimulation to the cervical, upper thoracic area followed by spray and stretch manipulative treatment to all muscle groups. He advised her to continue taking Amitriptyline, carbazepine, and Norgesic Forte. On September 29, 2005 Dr. Chomhirun administered multiple scalene trigger point injections and a left thoracic brachioplexus nerve block and advised her to rest for two days. On September 30, 2005 Dr. Chomhirun administered three trigger point injections to the upper left quadrant muscles followed by physical therapy. (Claimant's Exhibit Q, depo ex D)

On October 3, 2005 Claimant reported that she was feeling a lot better regarding the pain in the left side of the neck, shoulder and other areas. Dr. Chomhirun administered two trigger point injections to left trapezius muscle followed by physical therapy. On October 4 Ms. Rouse reported that her pain had improved in the left shoulder, neck and upper back. She appeared less depressed and had been taking her medications and doing stretching exercises. Dr. Chomhirun administered physical therapy and 20 minutes of hot packs. On October 5, Dr. Chomhirun reported that Employee was continuing to improve. He administered a trigger point injection at the left T7 paraspinal area, followed by physical therapy and hot packs. On October 6, Dr. Chomhirun administered physical therapy and hot packs. He noted that her improvement

[12] Dr. Chomhirun testified that a trigger point is a positive physical finding on physical examination of a certain location of a muscle that is very tender when pressure is applied to that location. (Claimant's Exhibit Q, Pages 19-20)

following multiple injections confirmed his diagnosis of left thoracic outlet syndrome as well as the other diagnoses. On October 7 Claimant reported that her pain had returned in the left thoracic outlet along with swelling. She received physical therapy and hot packs. (Claimant's Exhibit Q, depo ex D)

On October 10, 2005 Dr. Chomhirun noted that she had a recurrence of left thoracic outlet area pain and shoulder pain and pain radiating to the left arm, that her Adson's test was positive, and that she had multiple positive trigger points. Dr. Chomhirun administered a left brachioplexus nerve block and three trigger point injections of the scalene muscles, followed by physical therapy. He advised her to continue taking her medications. On October 12 Ms. Rouse reported that she was feeling much better. She was given physical therapy. On October 13 Employee reported that she was better, though she occasionally experienced left arm coldness and changes of color resembling RSD symptoms of the left upper extremity. She was given physical therapy and hot packs. On October 14 Ms. Rouse reported that she was doing better. Her left thoracic outlet area tenderness had improved. She received physical therapy and hot packs. (Claimant's Exhibit Q, depo ex D)

On October 19, 2005 Ms. Rouse reported that she was doing better and improved in activities. She appeared to be less depressed. She had been taking medication and doing gentle exercises. She received physical therapy and hot packs. On October 20 Employee reported that she had continued to improve, but still had occasional pain in the left shoulder and arm. Dr. Chomhirun prescribed a TENS unit for the neck and upper back area, particularly on the left side. On October 24 Ms. Rouse reported that she continued to improve in all areas. She received physical therapy and hot packs. On October 25 Ms. Rouse reported that she was doing better in all areas. She received physical therapy and hot packs and was advised to continue using the TENS unit. On November 7 Employee reported that her left thoracic area pain had recurred, along with coldness and change in color of the left hand. She had a positive scalene cramp test. He prescribed Restoril and Lyrica. On November 8 Dr. Chomhirun administered a left brachioplexus nerve block for her recurrent left shoulder pain radiating to the left arm. On November 9 Ms. Rouse reported that she was doing a lot better. She received physical therapy and hot packs. (Claimant's Exhibit Q, depo ex D)

On November 16, 2005 Ms. Rouse told Dr. Chomhirun that she had traveled to Los Angeles and that she experienced recurrent left shoulder pain and upper back pain on her return. She had carried only light hand bags. She was given physical therapy and hot packs. On November 17 she reported that she felt much better. She received physical therapy and hot packs. On November 18 Ms. Rouse reported that she continued to feel better. She was given physical therapy and hot packs. On November 28 Employee reported that she had traveled to New York and came back feeling better. She had less pain in the left shoulder and felt less nervous and less depressed. She was given physical therapy and hot packs. She was advised to continue to limit lifting to not more than 10 pounds. On November 29 and 30 Ms. Rouse reported that she felt better and was exercising at home. She was given physical therapy and hot packs. On December 1 she reported occasional dizziness. Dr. Chomhirun reduced the dose of Lyrica. She was given physical therapy and hot packs. (Claimant's Exhibit Q, depo ex D)

On December 2, 5 and 6, 2005 Ms. Rouse received physical therapy and hot packs. She was also diagnosed with hypertension. On December 6 she was prescribed Wellbutrin because

she appeared to be more depressed; Lyrica was discontinued. On December 7 Dr. Chomhirun discontinued the Norgesic and prescribed Celebrex because she had been taking Norgesic for a long time. She was given physical therapy and hot packs. On December 8 Ms. Rouse reported that she was feeling better on Celebrex and Wellbutrin. Amitriptyline was discontinued. She was given physical therapy and hot packs. On December 9, 12, and 13 Employee received physical therapy and hot packs. She reported doing better regarding the pain in her neck and shoulder area. (Claimant's Exhibit Q, depo ex D)

On January 12, 2006 Dr. Chomhirun noted that Claimant was continuing to improve in her overall pain problem in the neck and shoulder and radiating pain to her left arm and hand. He advised her to use the TENS unit as needed at home. On January 18, Dr. Chomhirun noted that Employee remained nervous and depressed. He prescribed Xanax. On January 24 Claimant reported that her pain in the left shoulder, thoracic outlet area and left shoulder blade had recently increased. Dr. Chomhirun found trigger points in the left trapezius and left rhomboideus and a positive Adson's test on the left. He administered a left brachioplexus nerve block and trigger point injections to those muscles followed by physical therapy to all muscle groups. On January 25 Dr. Chomhirun noted a trigger point in the right trapezius. He administered a trigger point injection in the muscle. (Claimant's Exhibit Q, depo ex D)

On March 3, 2006 Employee reported that she was doing better and had been doing exercises, taking medication, and using the TENS unit. Dr. Chomhirun noted that she appeared to be less depressed. He reminded her not to lift more than 10 pounds. On April 6 Ms. Rouse told Dr. Chomhirun that a week earlier she had experienced a return of some pain in the left thoracic outlet area radiating to the left arm with occasional numbness of the ulnar innervated area. He noted a positive Adson's test, scalene cramp test, and positive trigger points in the left trapezius and left rhomboideus. He administered trigger point injections to those muscles. On April 7 Dr. Chomhirun administered a trigger point injection to the trapezius muscle followed by physical therapy. (Claimant's Exhibit Q, depo ex D)

On May 3, 2006 Dr. Chomhirun noted that her physical examination showed less tenderness and that she appeared to be less depressed. He thought she was approaching a state of maximum medical improvement. On June 14 Claimant reported that she was doing better regarding the pain in her neck and shoulder area from thoracic outlet syndrome, but was still occasionally nervous and worried. He advised her to continue taking Wellbutrin, Xanax and Norgesic Forte. On August 4 Dr. Chomhirun noted that she continued to be occasionally nervous and had developed trembling, palpitation and shortness of breath. On examination he noted that there was remaining tenderness in the left thoracic area and that Adson's test and scalene cramp tests were only questionably positive. He advised her to resume taking Lyrica. On August 23 Dr. Dr. Chomhirun noted that Employee appeared to be less depressed and less nervous. He increased the dosage of Lyrica. On August 29 Dr Chomhirun noted on physical examination of Employee that there was less tenderness in the left thoracic outlet area and that there was no longer discoloration of the left hand or radiating pain to the left arm or hand. (Claimant's Exhibit Q, depo ex D)

On September 19, 2006 Dr. Chomhirun noted that Employee's pain in the left shoulder and neck continued to improve and that she appeared less depressed. She was told to continue with her medications. On October 13 and December 19 Dr. Chomhirun noted that Employee's

overall pain continued to improve. She was told to continue with her medications. (Claimant's Exhibit Q, depo ex D)

On February 28, 2007 Dr. Chomhirun noted that Employee continued to feel better and was having less pain in all areas and was also less depressed. She was taking her medication, doing exercises, and using the TENS unit. On May 14, 2007 employee told Dr. Chomhirun that she had recently stopped taking her Lyrica, Wellbutrin, and Xanax and was a bit more nervous. On July 24 Claimant told Dr. Chomhirun that she had to resume taking her medications and that she had been doing better in terms of her overall pain since the resumption of her medications. On July 24 and August 13 Dr. Chomhirun noted slight tenderness at the left thoracic outlet area. (Claimant's Exhibit Q, depo ex D)

On August 14, 2007 Claimant underwent a functional capacity evaluation at Gateway Rehabilitation Company. The therapist noted that Ms. Rouse demonstrated the ability to meet the job demands of walking and climbing stairs. She declined to carry 10 pounds. He concluded that she performed work in the light work demand level by lifting 13 pounds on an occasional basis. He noted that she was very focused on her subjective reports of pain which limited her overall performance during the evaluation. (Claimant's Exhibit Q, depo ex D)

On August 20, 2007 Ms. Rouse complained to Dr. Chomhirun of pain in the left thoracic outlet area during the previous week. She appeared to be depressed and nervous and the scalene cramp test was positive with tenderness in he left thoracic outlet area along with the return of two trigger points. He administered two trigger point injections in the left scalene muscle, followed by physical therapy and hot packs. He advised her to continue taking her medications. On September 11 Dr. Chomhirun noted that there was remaining mild tenderness of the thoracic area. In an October 5, medical report Dr. Chomhirun summarized Ms. Rouse's condition and his treatment. He added a diagnosis of arthroscopic surgery of the left shoulder on October 8, 2002 for partial tear of the rotator cuff.[13] (Claimant's Exhibit Q, depo ex D)

On October 30, 2007 Ms. Rouse reported occasional left-sided neck pain and shoulder pain and that she remained slightly depressed and nervous. She reported that every time she engaged in prolonged repetitive movement or heavy lifting, she experienced pain in the left shoulder area radiating to the left upper extremity. On physical examination Dr. Chomhirun noted only slight tenderness in the left thoracic outlet area. Other tests were negative. On December 12 and 20 Ms. Rouse reported left thoracic outlet pain and that she remained slightly depressed and nervous. On physical examination Dr. Chomhirun noted only slight tenderness in the left thoracic outlet area. Other tests were negative. (Claimant's Exhibit Q, depo ex D)

On February 19, 2008 Ms. Rouse appeared to be less depressed and less anxious. On physical examination Dr. Chomhirun noted less tenderness in the left thoracic outlet area and increased range of motion of the cervical spine and left shoulder. He advised her to reduce the dosage of Xanax and Lyric. On March 25 Ms. Rouse reported that she had experienced neck and shoulder pain for the previous 1-1/2 months along with insomnia and occasional depression. Dr. Chomhirun noted trigger points in the left trapezius and left rhomboideus. He administered three

[13] This diagnosis was a mistake as the operative report indicated that Dr. Aubuchon found only impingement, but no tear of the rotator cuff. See finding on Page 13 supra.

trigger point injections in those muscles. On April 15 Ms. Rouse reported that she had traveled to two places with increased activities, but she continued to have pain in the left shoulder blade area. Dr. Chomhirun found a positive trigger point in the left rhomboideus and injected that muscle. (Claimant's Exhibit Q, depo ex D)

On May 6, 2008 Dr. Chomhirun noted that Employee's overall pain continued to improve, and that she appeared to be less depressed and nervous and that she had been able to travel and visit children. On June 3 Dr. Chomhirun noted that there was remaining tenderness of Employee's left thoracic outlet area, less tenderness and muscle spasm of the left trapezius muscle. Trigger point test was still positive. On July 21 Dr. Chomhirun noted that there was less tenderness in Employee's left thoracic outlet area, left paracervical muscle and left trapezius muscle. On September 11 Dr. Chomhirun noted that Employee had experienced recurrent left shoulder pain. On physical examination there was severe tenderness with positive trigger point test of the left rhomboideus. He administered a trigger point injection to that muscle. On September 19 Employee reported that she had been more nervous and weak. Dr. Chomhirun noted tenderness of the left trapezius muscle. He prescribed Zocor and Xanax. (Claimant's Exhibit Q, depo ex E)

On November 4, 2008 Ms. Rouse reported that she was still experiencing some muscle cramps and muscle spasm all over. Dr. Chomhirun noted that Employee had very low Vitamin D. He added up to 50000 units of Vitamin D for six weeks. On November 25 Ms. Rouse reported that she was doing better, was less nervous and depressed, and had less pain in the left side of her neck and shoulder. On December 17, 2008 Dr. Chomhirun noted that Employee was doing better in all areas though she experienced occasional muscle spasm and pain that made her nervous. She was still taking vitamin D and other medications. (Claimant's Exhibit Q, depo ex E)

Medical Opinions

Dr. Gregory J. Bailey testified by deposition on behalf of Claimant on May 4, 2001. He opined that a significant amount of force was exerted when Employee was thrown against the airplane wall. (Claimant's Exhibit S, Pages 8-9) He opined that, assuming that Employee was thrown into a luggage storage compartment and experienced pain in her neck and shoulder and that she had no other significant trauma or injury to her neck or shoulder, her symptoms were likely related to the traumatic event of June of 1999. (Claimant's Exhibit S, Pages 10-11)

On August 24, 2000 Dr. Nguyen wrote to Claimant's prior attorney and stated that he could not confirm or rule out that her chronic left neck and shoulder pain, whiplash, and Tietz's syndrome were caused by the work-related accident on June 20, 1999. (Claimant's Exhibit F)

Dr. Chomhirun testified by deposition on behalf of Claimant on January 15, 2009. He opined that all of his clinical findings as of August 30, 2005 related to the injury sustained on June 20, 1999. He also opined that the treatment which he had recommended at that time was for injuries she sustained while on the airplane on June 20, 1999. (Claimant's Exhibit Q, Pages 11-12) Dr. Chomhirun testified that the treatment which he provided between August 30, 2005 and October 5, 2007 for chronic cervical and upper thoracic myofascial sprain syndrome, left scalene syndrome, mild left upper extremity reflex sympathetic dystrophy, herniated disc at C6-C7, and chronic pain syndrome with depression confirmed his diagnoses. (Claimant's Exhibit Q, Pages

13-14 & depo ex B) Dr. Chomhirun testified that the main problem related to thoracic outlet syndrome would continue to require treatment from time to time. He noted that following October 5, 2007 Employee continued to have multiple recurrences of the problem and required additional treatment through December of 2008. (Claimant's Exhibit Q, Pages 14-15) Dr. Chomhirun opined that the complaints which Employee made to him and for which he provided treatment through October of 2007 were caused by the accident of June of 1999. (Claimant's Exhibit Q, Pages 15-16)

Dr. David T. Volarich testified by deposition on behalf of Claimant on March 2, 2008. He examined Ms. Rouse on June 16, 2006. Dr. Volarich indicated that Employee told him that on June 20, 1999 she was standing near her jump seat and was thrown to her left when the pilot applied the brakes of the airplane. She struck her left shoulder and the left side of her face on the wall and was thrown to the coat compartment on the right and fell to the floor. After losing consciousness, she woke up with a buzzing and whooshing sensation in her head. (Claimant's Exhibit N, depo ex 2, pp 1-2) Dr. Volarich reviewed the pertinent records of medical treatment. (Claimant's Exhibit N, depo ex 2, pp 2-4)

Dr. Volarich testified that she told him that she experienced constant left shoulder pain that radiated into her chest wall area.[14] She was able to raise her upper left extremity overhead but it fatigued easily and became painful. Employee told him that if she used her left upper extremity it turned to a bluish color as did the arm and fingers.[15] Claimant told Dr. Volarich that range of motion in the neck was difficult. She stated that she occasionally experienced a severe headache when she had to shut her eyes and lay down.[16] (Claimant's Exhibit N, depo ex 2, p. 5)

Dr. Volarich testified that Ms. Rouse appeared to be depressed and she dwelt considerably on her pain syndrome. He noted considerably loss of motion in her neck. He said that pain occurred in her neck with all motions.[17] Palpation elicited pain in the left shoulder girdle posteriorly and anteriorly. Multiple trigger points were noted throughout the left anterior and posterior thorax about the shoulder girdle. (Claimant's Exhibit N, depo ex 2, p. 9)

Dr. Volarich diagnosed Claimant with cervical syndrome secondary to disc herniation at C6-C7 as well as aggravation of cervical degenerative disc disease at C4-5 and C5-6 without radiculopathy, left shoulder impingement with rotator cuff tendonitis, and left shoulder girdle and upper extremity myofascial pain syndrome. He opined that the June 20, 1999 accident was the substantial contributing factor causing the C6-7 disc herniation, the left shoulder internal derangement in the form of impingement, and rotator cuff tendonitis that required surgical repair, as well as causing the development of her severe myofascial pain syndrome of the left upper extremity and upper torso. (Claimant's Exhibit N, Pages 10-12 & depo ex 2, pp 9-10)

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[14] This statement is inconsistent with what she told Dr. Chomhirun in June of 2006. See finding on Page 19 supra.

[15] On August 29, 2006 she told Dr. Chomhirun that her left hand no longer turned blue. See finding on Page 19 supra.

[16] The last time that Claimant described a severe headache to a doctor was to Dr. Nguyen on June 15, 2000. See finding on Page 10 supra.

[17] This is in contrast to reports of Dr. Chomhirun who in June of 2006 reported that she was going better regarding pain in her neck and shoulder. See finding on Page 19 supra.

Dr. Volarich noted that there no signs of reflex sympathetic dystrophy and no chronic atrophic changes distally such as dry skin, tightness of the skin, or clawing of the hand. On cross examination Dr. Volarich stated that he did not believe that she had reflex sympathetic dystrophy or thoracic outlet syndrome. (Claimant's Exhibit N, Page 25 depo ex 2, p. 9)

Dr. Wayne A. Stillings, a psychiatrist, testified by deposition on behalf of Employer on July 28, 2008. He evaluated Claimant on October 16, 2006. He stated that Claimant told him that she injured her left shoulder in a fall to the floor and injured her neck and left upper extremity when airplane made an abrupt stop. (Claimant's Exhibit O, Page 7) Dr. Stillings testified that Claimant's first lifetime mental health care occurred around 1967 when she and her husband had marriage counseling. They were divorced in 1987 because of his physical abusiveness. Her next lifetime psychiatric contact was post injury. (Claimant's Exhibit O, Page 8) Dr. Stillings felt that she was distraught and anxious. Her speech was disjointed and circumstantial. Overall her affect was labile (unstable). Her mood was clinically depressed. Concentration was impaired by her clinical depression. Comprehension was only fair. She displayed mild psychological distress regarding her work injury and ongoing work-related symptoms. (Claimant's Exhibit O Pages 9-10)

Dr. Stillings diagnosed Employee's psychiatric condition on Axis I: mood disorder due to general medical condition (injuries to neck with herniation at C6-C7, aggravation of cervical DDD from C4-C6, left shoulder impingement with rotator cuff tendinitis, and left shoulder myofascial pain syndrome) and pain disorder associated with psychological factors and general medical condition. He did not give her an Axis II diagnosis. Axis III: per record review. Axis IV: disabled from employment and interaction with legal system. Axis V: GAF (global assessment of functioning) was 55 (moderate systems, impairment). (Claimant's Exhibit O, Pages 10-12 & depo ex B, p. 8)

On cross examination Dr. Stillings admitted his mistake in failing to diagnose Employee with preexisting partner-relational problems with a vicious marital situation where she had been repeatedly beaten and injured. Dr. Stillings stated that Employee did not believe she was having psychological problems. She viewed her problems as physical. Her MMPI-2 profile indicated that she will express her psychological problems as some degree of physical symptoms. He stated that this abuse must have been so severe that she actually sought joint marriage counseling and after her divorce sought individual counseling. He also indicated that she was the victim of sexual abuse at an early age. He testified that her partner-relational problems and childhood sexual abuse were two clearly preexisting psychiatric conditions. (Claimant's Exhibit O, Pages 24-25) Dr. Stillings stated that Claimant missed time from work during her hospitalizations for two fractured noses and the concomitant emotional distress and marital abuse. (Claimant's Exhibit O, Page 31) The childhood abuse was continued by choosing an abusive husband. Employee was functionally incapacitated as a result her prior abuse; it then got in the way of her marriage and an appropriate partner. (Claimant's Exhibit O, Page 32)

Dr. Stillings stated that on Axis II he could not find anything that rose to the level of a diagnosis of a personality disorder. He indicated that the MMPI-2 documented chronic psychological problems. She is immature and dependent. She has some maladaptive preexisting personality traits. He explained that maladaptive personality traits are fixed and enduring and pervasive as of late adolescence and early adulthood. (Claimant's Exhibit O, Page 26)

Dr. Stillings opined that the June 20, 1999 work injury was the substantial factor in causing Ms. Rouse to develop a significant mood disorder and pain disorder. (Claimant's Exhibit O, Page 13 & depo ex B, pp 8-9) On cross examination he stated that these were separate disorders from her preexisting problems. (Claimant's Exhibit O, Page 33)

Dr. Stillings agreed that he had not seen any medical records from Gateway Rehabilitation for a functional capacity evaluation and the medical reports from Dr. Farley, Dr. Smith or James England. (Claimant's Exhibit O, Page 27)

On November 30, 1999, Dr. Samson opined that, based upon Employee's description of the accident and his review of the myelogram films, the June 20, 1999 accident did not cause the arthritis in her neck or the herniated disc. He noted that the findings of the CT myelogram did not correlate with Employee's symptoms. He opined that all of Employee's complaints were basically a strain of her neck and not a specific structural injury to any of the underlying bony discs or neurologic structures in the neck. He concluded that the June, 1999 accident resulted in a neck strain. (Claimant's Exhibit E)

Dr. Daniel Phillips testified by deposition on behalf of Employer on July 11, 2001. He performed a neurological examination of Ms. Rouse on December 22, 1999.[18] He testified that the objective components of her examination were unremarkable without evidence of intracranial injury, cervical myelopathy or radiculopathy, or thoracic or lumbar myelopathy or radiculopathy. He opined that Claimant had no disability because her exam was normal; there was no organic injury. (Employer's Exhibit 3, Page 10)

On cross examination Dr. Phillips testified that he also reviewed the MRI films and the myelogram. He opined that at C6-7 there was a small right paracentral bulge at C6-7. He stated the disc pathology at C6-7 was irrelevant because the bulge was to the right and all of Claimant's symptoms were on the left. On cross examination Dr. Phillips testified that he thought that there was a small spur with a bulge at C6-7 which can look like a herniation, even though it is not one. (Employer's Exhibit 3, Pages 12-13)

Dr. Timothy Farley, an orthopedic surgeon, testified by deposition on behalf of Employer on April 21, 2009. He examined Ms. Rouse on July 24, 2007. Dr. Farley stated that Employee told him that on June 20, 1999 during taxing the airplane came to a sudden braking and she fell forward with direct impact of her left shoulder and neck on a wall, stumbled to the right and impacted the right side of her body. She told him that she lost consciousness, but she awakened before take-off. She told Dr. Farley that she continued to have left shoulder and neck pain, stiffness, instability, and loss of motion.[19] Employee told him that stress and physical activity exacerbate her symptoms. She also told Dr. Farley that the pain leads to shaking and sensations of heat, that she has headaches, finds herself crying, has chilling sensation and out-of-body episodes. (Employer's Exhibit 2, depo ex 2, p. 1) On cross examination Dr. Farley explained that

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[18] My findings regarding his examination are contained on Page 8 supra.

[19] On that same date Ms. Rouse told Dr. Chomhirun that she had to resume taking her medication, that she experienced pain from time to time, and that since taking the medication her left shoulder and neck pain were improved. (Claimant's Exhibit Q, depo ex D)

he felt that the work-related injury with its lack of any real organic findings of pathology within the neck or shoulder would not be consistent with causing significant psychiatric or personality issues when Employee had experienced fairly traumatic evidence in the past that had not caused significant psychiatric issues. (Employer's Exhibit 2, Pages 21-22)

Dr. Farley reviewed all of the medical records through the initial report by Dr. Chomhirun; he did not have any of Dr. Chomhirun's treating records. He also reviewed the medical evaluations by Drs. Volarich and Stillings. (Employer's Exhibit 2, Page 16 & depo ex 2, pp 2-6) Employee told him that she was taking Lyrica, Norgesic Forte and Xanax. On physical examination Dr. Farley noted significant tenderness along the spinous processes of her cervical spine and within the paraspinal musculature bilaterally, tenderness over her trapezius muscle bellies bilaterally, discomfort with palpation around the left coracoid process, grimacing with cervical spine motion, significant pain with neck extension along the left paraspinal region posteriorly. He found fairly symmetric range motion of the shoulder with the left moving very slowly. Special tests around the left shoulder or arm were universally positive when trying to elicit discomfort. There was no evidence of atrophy around the shoulder with regards to her rotator cuff. He did not find any discoloration or skin temperature changes of the left hand. Her Adson's test was completely normal. Dr. Farley diagnosed Claimant with left shoulder and neck chronic pain syndrome, symptom magnification and possible malingering and prior psychiatric diagnosis of depression as well as possible Axis II personality disorder. (Employer's Exhibit 2, depo ex 2, pp 7-8)

Dr. Farley opined that while Employee had demonstrated mild degenerative changes within her cervical spine and a potential disk protrusion, they had not yet demonstrated central or foraminal stenosis. He added that the disk protrusion was more related to asymptomatic right side rather than to her symptomatic left side. He indicated that she told him that she had some improvement in her left shoulder pain following the surgery by Dr. Aubuchon, yet his postoperative notes showed that she complained of ongoing pain, weakness, and loss of motion. He said that the MRI suggested a small tear of the infraspinatus which would not have accounted for her significant weakness in abduction preoperatively. (Employer's Exhibit 2, depo ex 2, p 8)

Dr. Farley opined that Employee did not have findings consistent with reflex sympathetic dystrophy or complex regional pain syndrome. He pointed out that she underwent a triple phase whole body scan that did not demonstrate increase signal or increase perfusion with her left upper extremity. Dr. Farley indicated that thoracic outlet syndrome can have two causes: neurologic and vascular. He indicated that Claimant had a normal EMG/nerve conduction test which would assist in ruling out a neurologic cause and a normal Adson's test which would assist in ruling out a vascular cause. He indicated that an arteriography would better rule out a potential vascular form. (Employer's Exhibit 2, depo ex 2, p 9)

Dr. Farley opined that the incident onboard an international flight in 1999 was not the root cause for her subsequent psychiatric diagnoses. He stated that while the incident in 1999 could lead to significant bruising, he did not understand how it could lead to a significant downward spiral following that incident but not after several earlier more significant injuries which required surgeries. They included being struck in the face by an abusive husband in 1984 which caused maxilla and zygomatic fractures and the crushing of an intraorbital nerve after which she underwent maxillofacial surgery which further caused a trigeminal neuralgia and foot surgeries in

1992 and 1996. In 1991 she kicked a liquor cabinet and developed a Morton's neuroma that failed conservative treatment. She underwent surgical removal in September of 1992. Her symptoms returned and she underwent a second surgery in 1996. One month after that surgery she suffered a Lisfranc injury when she dropped a toilet on her left foot. This required open reduction and fixation.[20] (Employer's Exhibit 2, depo ex 2, p 9) On cross examination Dr. Farley stated that he did not know whether he had all of the records from Dr. Hicks. (Employer's Exhibit 2, Pages 14)

Dr. Farley stated that he did not think that any particular injury to her cervical spine which occurred would account for her symptoms. He opined that Claimant developed symptoms of chronic pain secondary to what was likely a significant anterior shoulder contusion and myofascial strain of her cervical spine. (Employer's Exhibit 2, depo ex 2, p 9)

Dr. Stacey L. Smith, a psychiatrist, testified by deposition on behalf of Employer on February 10, 2009. She evaluated Employee on July 26, 2007. Dr. Smith stated that Employee told her that on June 20, 1999 she was standing on an airplane during taxiing. When the pilot slammed on the brakes, Employee was slammed into her seat and hit the wall with her cheek and was thrown to the floor and knocked out. She worked the flight to London with her right arm. (Employer's Exhibit 4 depo ex 2, p. 3) Employee complained of pain on the left side of her neck, front and back of the left shoulder and front of the chest from the shoulder to middle of the sternum and also of swelling in the area of the clavicle and sternum and neck.[21] (Employer's Exhibit 4 depo ex 2, p. 7)

Dr. Smith noted that her father was an alcoholic which caused family problems. She recalled being fondled on four or five occasions at the age of nine by a non-family member. (Employer's Exhibit 4, Pages 8-9) Dr. Smith summarized all of the medical records on Pages 13 to 33 of her report. (Employer's Exhibit 4, Page 9) She also reviewed the report from Dr. Stillings. She criticized him for failing to give a diagnosis on Axis II. Dr. Smith indicated that with Claimant's underlying personality issues, there is a high degree of certainty that she does have a personality disorder. Dr. Smith diagnosed Claimant on Axis I - somatoform disorder not otherwise specified, preexisting, but exacerbated by the events of June 20, 1999. She also noted that Employee had occupational problems unrelated to those events. Axis II - dependent and histrionic personality disorder. Axis III - degenerative disc disease, preexisting, a resolved musculoskeletal strain, left shoulder surgery, a panoply of varied physical complaints. Axis IV Death of mother, death of father, death of best fried and boyfriend, labor relations conflicts between former TWA flight attendants and American Airlines, ongoing litigation, ambivalence regarding retirement, living next to expanding lumbar yard, fighting expansion of lumbar yard, and remote physical and sexual abuse. Axis V GAF 67. (Employer's Exhibit 4, Pages 15-16 & depo ex 2, pp 33-34)

Dr. Smith explained that the psychiatric importance of the event of June 20, 1999, which resulted in a muscular strain of her neck, played into the preexisting somatoform predilection and

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[20] The details were contained in the history taken by Dr. Volarich and described in his June 15, 2006 report and are contained in Claimant's Exhibits G, I, K, and L.

[21] This description is inconsistent with her report to Dr. Chomhirun on July 24, 2007. See findings on Page 20 supra.

created a significant flaring of her complaints. She stated that somatization is a pathologic psychological defense mechanism. When an individual with somatoform disorder experiences an unpleasant mental state, it is expressed in various physical symptoms. These individuals have many different physical complaints which often do not make any medical sense. These individuals frequently see many doctors, collect many diagnoses along the way, and often have unnecessary procedures. Dr. Smith explained that somatoform not otherwise specified means that the somatization is not limited to one part of the body. Claimant has a more generalized condition. Dr. Smith testified that her past medical records demonstrated that Employee had a litany of physical complaints in various parts of the body and many of them did not add up anatomically. The complaints did not make sense as a result of the events of June 20, 1999. Dr. Smith opined that there has to be a large, overarching problem to explain the pattern of physical symptoms that she presented over time. (Employer's Exhibit 4, Pages 17-19) Dr. Smith stated that Claimant saw about fifteen doctors following June 20, 1999 including some whose records were not offered into evidence, and was given about 20 different diagnoses.[22] Dr. Smith stated that these are red flags for somatoform disorder. (Employer's Exhibit 4, Pages 19-21) Examples of complaints which made no sense were “shaking inside” and “vaginal numbness”. She said that the first is not a symptom of any know disorder. The second, which was made in 1996 and 1997, is almost pathognomonic of a somatoform spectrum syndrome. (Employer's Exhibit 4, Pages 42 & 45) Subsequent to the initial evaluation Dr. Smith received pre-June of 1999 medical records.[23] She stated in a supplemental report that those records only served to reinforce her original diagnostic impression. (Employer's Exhibit 4, depo ex 3, p. 7)

Dr. Smith reiterated that Ms. Rouse’s primary problem is somatoform condition that she had prior to June of 1999. She added that Employee’s beliefs about what happened represented a substantial factor in the exacerbation or flaring of this preexisting condition. Dr. Smith testified that psychiatric treatment is not going to lead to any significant diminishment of Employee’s condition. However, she said that some persons with this condition do a little better if they take an anti-depressant. One of the problems for Ms. Rouse is that she rejects that she has a psychological problem and she has become completely invested in the fact that she has a bad physical problem. (Employer's Exhibit 4, Page 22)

On cross examination Dr. Smith testified that she did not think that Employee was faking all of her complaints. Dr. Smith stated that with her histrionic personally disorder, Ms. Rouse has a heightened emotional tone; all of her complaints were presented in an exaggerated fashion. Dr. Smith felt that some of it was real to Employee; however she cautioned that we should not ignore the temporal setting with the complicated setup of American Airlines buying Trans World Airlines and the medical clock versus the furlough clock. Dr. Smith opined that Claimant was looking at these various clocks and trying to figure out what was best for her; it kept her from trying to go back to work. (Employer's Exhibit 4, Pages 32-33)

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[22] According to Dr. Smith, Dr. Juan Escandon, a neurologist, stated on August 2, 2005 that Employee’s symptoms did “‘not follow an anatomical pattern’” and were “‘highly suggestive of an anxiety disorder.’” (Employer's Exhibit 4, depo ex 2, p. 27) According to Dr. Smith, on a patient questionnaire completed for Dr. Guarino on May 17, 2005 Ms. Rouse reported that “‘heart shakes, dysphagia, lose balance, drop things, eyes shake, spine shakes … electrical jolts though body.’” (Employer's Exhibit 4, depo ex 2, p. 29)

[23] See Claimant’s Exhibits G, I, K, and L.

On cross examination Dr. Smith stated that somatoform disorder is a chronic condition which tends to wax and wane with various stressors. (Employer's Exhibit 4, Page 45)

Additional Findings

I find that Ms. Rouse embellished the details of the June 20, 1999 incident in a manner consistent with Dr. Smith's diagnosis of a histrionic personality. She added that she was knocked unconscious and that she felt a "whooshing in her brain". I find that, in describing her current symptoms to Drs. Volarich, Farley, and Smith, she mentioned symptoms that had bothered her in the past, but that she had not mentioned to Dr. Chomhirun. Based on the medical records, I find that Ms. Rouse described symptoms which did not make anatomical sense.

In comparing the medical experts, I find the opinions of Drs. Samson, Phillips and Farley are far more persuasive than the opinions of Drs. Volarich and Chomhirun and Bailey. Dr. Volarich examined Claimant on June 16, 2006. Claimant misled him concerning her current symptoms. In addition, Claimant's condition dramatically improved by the end of 2008 according to the records of Dr. Chomhirun. Although Dr. Chomhirun diagnosed Claimant with reflex sympathetic dystrophy and thoracic outlet syndrome, Dr. Volarich found that Claimant did not have those conditions. Dr. Farley explained why objective testing performed on Claimant was inconsistent with those diagnoses. I find the opinions of Drs. Samson and Farley, both orthopedic surgeons and the opinion of Dr. Phillips, a neurologist, more persuasive that the opinions of Drs. Volarich and Dr. Chomhirun on causation regarding the cervical disk pathology. Claimant's symptoms were always on the left side while the disk pathology at C6-C7 was more to the right side; her right arm was mostly asymptomatic.

Based on the credible opinions of Drs. Samson, Phillips, and Farley, I find that the June 20, 1999 accident did not cause a herniated disc at C6-7 and did not aggravate her preexisting cervical arthritis. Based on the credible opinions of Drs. Volarich and Farley, I find that Employee does not have reflex sympathetic dystrophy or thoracic outlet syndrome. Dr. Samson felt that Employee had sustained a strain as a result of the June 20, 1999 accident. His opinion was rendered in November of 1999. Dr. Farley's opinion was rendered in July of 2007. By July of 2007 Dr. Farley had reviewed all of the treatment records. Dr. Samson was not asked to review those records. So while Dr. Samson's opinion may have been correct at that time, it was superseded by subsequent events.

Based on the credible opinions of Dr. Farley, I find that Claimant developed chronic pain secondary to a significant anterior left shoulder contusion and myofascial strain of Employee's cervical spine as a result of the work-related accident of June 20, 1999.

Regarding Employee's psychiatric condition, I find the opinions of Dr. Smith are far more persuasive than the opinions of Dr. Stillings. She convincing explained that Employee's nine years of medical treatment from many medical providers was primarily the product of her somatoform disorder and histrionic personality disorder. Dr. Stillings' failure to diagnose preexisting conditions demonstrates his superficial analysis of Ms. Rouse's condition compared to Dr. Smith's more thorough analysis. Dr. Smith carefully reviewed all of the treating records and showed how they demonstrated that Claimant had somatoform disorder and a histrionic personality disorder. While Dr. Stillings felt that June 20, 1999 accident was the substantial

factor in causing Claimant's psychiatric condition, Dr. Smith opined that Employee's somatoform condition preexisted the June 20, 1999 accident, as demonstrated by substantial medical treatment prior to June 20, 1999, and that it was exacerbated by the events of June 20, 1999. Dr. Farley also convincing argued that the June 20, 1999 accident, which was far less traumatic than several other incidents in Claimant's life, did not cause her present psychiatric condition.

Based on the credible opinions of Dr. Smith, I find that Claimant had somatoform disorder and a histrionic personality disorder prior to the events of June 20, 1999 and that the events of June 20, 1999 exacerbated the symptoms of her somatoform disorder.

FUTURE MEDICAL CARE

Employee is requesting an award of future medical care for her left shoulder and neck and her psychiatric condition.

Section 287.140 Mo. Rev. Stat. (2000) requires that the employer/insurer provide "such medical, surgical, chiropractic, and hospital treatment ... as may reasonably be required ... to cure and relieve [the employee] from the effects of the injury." Future medical care can be awarded even though claimant has reached maximum medical improvement. Mathia v. Contract Freighters, Inc., 929 S.W.2d 271, 278 (Mo. App. 1996). It can be awarded even where permanent partial disability is determined. The employee must prove beyond speculation and by competent and substantial evidence that his or her work-related injury is in need of treatment. Williams v. A.B. Chance Co., 676 S.W.2d 1 (Mo. App. 1984). Conclusive evidence is not required. However, evidence which shows only a mere possibility of the need for future treatment will not support an award. It is sufficient if claimant shows by reasonable probability that he or she will need future medical treatment. Dean v. St. Luke's Hospital, 936 S.W.2d 601, 603 (Mo. App. 1997); Mathia v. Contract Freighters, Inc., 929 S.W.2d 271, 277 (Mo. App. 1996); Sifferman v. Sears, Roebuck and Co., 906 S.W.2d 823, 828 (Mo. App. 1995). "Probable means founded on reason and experience which inclines the mind to believe but leaves room to doubt." Tate v. Southwestern Bell Telephone Co., 715 S.W.2d 326, 329 (Mo. App. 1986); Sifferman at 828.

Where the sole medical expert believes that it is "very likely" that the claimant will need future medical treatment, but is unable to say whether it is more likely than not that the claimant will need such treatment, that opinion, when combined with credible testimony from the claimant and the medical records in evidence, can be sufficient to support an award which leaves the future treatment issue open. This is particularly true where the medical expert states that the need for treatment will depend largely on the claimant's pain level in the future and how well the claimant tolerates that pain. Dean, supra at 604-06.

The amount of the award for future medical expenses may be indefinite. Section 287.140.1 does not require that the medical evidence identify particular procedures or treatments to be performed or administered. Dean, supra at 604; Talley v. Runny Meade Estates, Ltd., 831 S.W.2d 692, 695 (Mo. App. 1992); Bradshaw v. Brown Shoe Co., 660 S.W.2d 390, 393-394 (Mo. App. 1983). The award may extend for the duration of an employee's life. P.M. v. Metromedia Steakhouses Co., Inc., 931 S.W.2d 846, 849 (Mo. App. 1996). The award may

require the employer to provide future medical treatment which the claimant may require to relieve the effects of an injury or occupational disease. Polavarapu v. General Motors Corporation, 897 S.W.2d 63 (Mo. App. 1995). It is not necessary that such treatment has been prescribed or recommended as of the date of the hearing. Mathia v. Contract Freighters, Inc., 929 S.W.2d 271, 277 (Mo. App. 1996). Where future medical care and treatment is awarded, such care and treatment "must flow from the accident before the employer is to be held responsible." Modlin v. Sun Mark, Inc., 699 S.W.2d 5, 7 (Mo. App. 1985); Talley v. Runny Meade Estates, Ltd. at 694. The employer/insurer may be ordered to provide medical and hospital treatment to cure and relieve the employee from the effects of the injury even though some of such treatment may also give relief from pain caused by a preexisting condition. Hall v. Spot Martin, 304 S.W.2d 844, 854-55 (Mo. 1957). However, where preexisting conditions also require future medical care, the medical experts must testify to a reasonable medical certainty as to what treatment is required for the injuries attributable to the last accident. O'Donnell v. Guarantee Elec. Co., 690 S.W.2d 190, 191 (Mo. App. 1985).

Medical Opinions

Dr. Volarich opined that Ms. Rouse had reached maximum medical improvement as of June 15, 2006, (Claimant's Exhibit N, Page 12) However, he also opined that Employee required daily medical treatment and the use of a TENS unit for her severe myofascial pain and that she also needed to lie down periodically to rest to relieve her pain syndrome. (Claimant's Exhibit N, depo ex 2, p. 13)

Dr. Chomhirun testified that as of December 2008 employee had not reached the state of maximum medical improvement. During the prior year she had experienced multiple recurrences of her thoracic outlet syndrome and would probably require additional treatment. (Claimant's Exhibit Q, Page 15)

Dr. Farley testified that Claimant did not have thoracic outlet syndrome and that there was evidence of symptom magnification. He felt that she had reached maximum medical improvement. (Employer's Exhibit 2, Pages 7 & 9)

Dr. Smith testified that psychiatric treatment was not going to lead to any significant diminishment of Employee's somatoform condition. However, she said that some persons with this condition do a little better if they take an anti-depressant. One of the problems for Ms. Rouse is that she rejects that she has a psychological problem and she has become completely invested in the fact that she has a bad physical problem. Dr. Smith opined that Employee was at maximum medical improvement. (Employer's Exhibit 4, Page 22)

Additional Findings

As I have previously found that Claimant does not have thoracic outlet syndrome, I find that Dr. Chomhirun's opinion that she will need additional treatment for it is not persuasive. As I have found Dr. Farley's diagnosis of Claimant's orthopedic injury is more persuasive than Dr. Volarich's diagnosis of employee's work-related injury, I find Dr. Volarich's opinion regarding additional medical treatment is not persuasive. As I have found Dr. Smith's diagnosis as more persuasive than Dr. Stillings diagnosis, I find Dr. Smith's opinions on treatment credible.

Based on the credible opinions of Drs. Farley and Smith, I find that Claimant will not require any future medical care.

TEMPORARY TOTAL DISABILITY

Employee is seeking temporary total disability compensation for the period from December 25, 1999 through June 15, 2006.

Section 287.170 Mo. Rev. Stat. (2000) provides that an injured employee is entitled to be paid compensation during the continuance of temporary total disability up to a maximum of 400 weeks. Total disability is defined in Section 287.020.7 as the "inability to return to any employment and not merely ... [the] inability to return to the employment in which the employee was engaged at the time of the accident." Compensation is payable until the employee is able to find any reasonable or normal employment or until his medical condition has reached the point where further improvement is not anticipated. Vinson v. Curators of Un. of Missouri, 822 S.W.2d 504 (Mo. App. 1991); Phelps vs. Jeff Wolk Const. Co., 803 S.W.2d 641, 645 (Mo. App. 1991); Williams v. Pillsbury Co., 694 S.W.2d 488 (Mo. App. 1985).

With respect to possible employment, the test is "whether any employer, in the usual course of business, would reasonably be expected to employ the claimant in his present physical condition." Brookman v. Henry Transp., 924 S.W.2d 286, 290 (Mo. App. 1996). The refusal of an employer to allow an employee, who has been released by the treating physician to return to light duty work, to return to such work is some evidence that the employee could not find any reasonable or normal employment. Herring v. Yellow Freight System, Inc., 914 S.W.2d 816, 821 (Mo. App. 1995). However, an employer is not required to either provide light duty or pay temporary total disability compensation solely because the employee is still receiving medical treatment for a condition which is reasonably expected to improve. Cooper v. Medical Center of Independence, 955 S.W.2d 570, 575 (Mo. App. 1997).

An employee's unsuccessful attempts to perform some of the activities connected with his or her job do not in and of themselves constitute conclusive evidence that the employee was capable of working after the accident. Reeves v. Midwestern Mortg. Co., 929 S.W.2d 293, 296-96 (Mo. App. 1996). The failure of an employee who is released to light duty to seek sporadic or light duty work in the open labor market would not automatically disqualify the employee from receiving temporary total disability compensation. Cooper, supra at 575. While the ability of the employee to physically perform some work is relevant, it is not dispositive. Idem. An employee's ability to engage in occasional or light duty work in a protected environment where the employee is able to work at his or her own pace or with the help of friends or family members, does not necessarily disqualify employee from receiving temporary and total disability compensation. Minnick v. South Metro Fire Prot. Dist., 926 S.W.2d 906, 910-11 (Mo. App. 1996). Employee's performance of some work during the period of temporary disability is not controlling on whether employee was temporarily and totally disabled. Other factors, such as economic necessity, the expected period of time until claimant's medical condition reaches maximum medical improvement, the nature of the continuing course of treatment, whether there is a reasonable expectation that claimant will return to his or her former job, the nature of the work, and whether such work should not have been performed from a medical standpoint are important in deciding that issue. Cooper, supra at 576; Brookman, supra.

The employee has the burden of proving that he or she is unable to return to any employment. Such proof is made only by competent and substantial evidence. It may not rest on speculation. Griggs v. A.B. Chance Company, 503 S.W.2d 697, 703 (Mo. App. 1974). The employee's testimony alone can constitute substantial evidence to support an award of temporary total disability. Unlike proof of permanency, evidence of temporary disability given by the employee is not necessarily beyond the realm of understanding by lay persons. Riggs v. Daniel Intern., 771 S.W.2d 850, 851 (Mo. App. 1989).

Temporary disability payments are intended to cover a healing period. Temporary total disability is to be granted only for the time prior to when the employee can return to work. Temporary total disability is not expected to encompass disability after the condition has reached the point where further improvement is not expected. Where further improvement of employee's is not likely, employee is no longer temporarily and totally disabled. Bruflat v. Mister Guy, Inc., 933 S.W.2d 829, 835 (Mo. App. 1996); Williams v. Pillsbury, 694 S.W.2d 488, 489 (Mo. App. 1985). Employer is entitled to a credit for any temporary total disability payments made with respect to any period after employee is no longer temporarily totally disabled. Parker v. Mueller Pipeline, Inc., 807 S.W.2d 518, 522 (Mo. App. 1991).

Medical Opinions

Dr. Volarich opined that Ms. Rouse had reached maximum medical improvement as of June 15, 2006. (Claimant's Exhibit N, Page 12)

Dr. Chomhirun testified that as of December of 2008 employee had not reached the state of maximum medical improvement. (Claimant's Exhibit Q, Page 15)

Dr. Samson opined that Employee would be at maximum medical improvement if the neurologist who evaluated Employee had no diagnosis, then Employee would be able to resume work. (Claimant's Exhibit E) Dr. Phillips testified that he found no organic injury as of December 22, 1999. (Employer's Exhibit 3, Page 10)

Dr. Farley stated that Employee had reached maximum medical improvement by the time of his examination. He was not asked whether she reached that state on an earlier date. (Employer's Exhibit 3, depo ex 2, p. 9)

Additional Findings

Based on the credible opinions of Drs. Samson and Phillips, I find that Claimant reached maximum medical improvement on December 22, 1999.

The parties stipulated that Employer paid $8,846.44 in temporary disability compensation. Claimant was temporarily and totally disabled form August 20 to December 22, 1999, a period of 17-5/7 weeks. She should have been paid the sum of $9,967.30 for this period. I find that claimant is owed $1,120.86 for an underpayment of temporary disability compensation.

ALLEGED PERMANENT TOTAL DISABILITY

Employee claims that she is permanently and totally disabled as a result of the work-related injury of June 20, 1999, or, alternatively, as a result of the combination of the work-related injury with employee's alleged preexisting disabilities to her left foot. The claim of total disability against the employer must be considered first. Where the disability caused solely by the primary injury is total disability, there can be no liability for the Second Injury Fund. Hughey v. Chrysler Corp., 34 S.W.3d 845, 847 (Mo. App. 2000); Vaught v. Vaughts, Inc., 938 S.W.2d 931, 939 (Mo. App. 1997); Roller v. Treasurer of State of Mo., 935 S.W.2d 739, 740 (Mo. App. 1996).

Section 287.020.7 Mo. Rev. Stat. (2000) defines total disability as the "inability to return to any employment and not merely...[the] inability to return to the employment in which the employee was engaged at the time of the accident." The words "inability to return to any employment" mean "that the employee is unable to perform the usual duties of the employment under consideration in the manner that such duties are customarily performed by the average person engaged in such employment." Kowalski v. M-G Metals and Sales, Inc., 631 S.W.2d 919, 922 (Mo. App. 1982). The words "any employment" mean "any reasonable or normal employment or occupation; it is not necessary that the employee be completely inactive or inert in order to meet this statutory definition." Id. at 922; Brown v. Treasurer of Missouri, 795 S.W.2d 479, 483 (Mo. App. 1990); Crum v. Sachs Elec., 769 S.W.2d 131, 133 (Mo. App. 1989). "[W]orking very limited hours at rudimentary tasks [is not] reasonable or normal employment." Grgic v. P & G Const., 904 S.W.2d 464, 466 (Mo. App. 1995). The primary determination with respect to the issue of total disability is whether, in the ordinary course of business, any employer would reasonably be expected to employ the claimant in his or her present physical condition and reasonably expect him or her to perform the work for which he or she is hired. Reiner v. Treasurer of State of Mo., 837 S.W.2d 363, 367 (Mo. App. 1992); Talley v. Runny Mead Estates, Ltd., 831 S.W.2d. 692, 694 (Mo. App. 1992); Brown v. Treasurer of Missouri, at 483; Fischer v. Archdiocese of St. Louis, 793 S.W.2d 195, 199 (Mo. App. 1990); Sellers v. Trans World Airlines, Inc., 776 S.W.2d 502, 504 (Mo. App. 1989). The test for permanent and total disability is whether given the employee's condition, he or she would be able to compete in the open labor market; the test measures the employee's prospects for obtaining employment. Reiner at 367; Brown at 483; Fischer at 199. A claimant who is "only able to work very limited hours at rudimentary tasks is a totally disabled worker." Grgic v. P & G Const., 904 S.W.2d 464, 466 (Mo. App. 1995).

The employee must prove the nature and extent of any disability by a reasonable degree of certainty. Downing v. Willamette Industries, Inc., 895 S.W.2d 650, 655 (Mo. App. 1995); Griggs v. A. B. Chance Company, 503 S.W.2d 697, 703 (Mo. App. 1974). Such proof is made only by competent and substantial evidence. It may not rest on speculation. Idem. Expert testimony may be required where there are complicated medical issues. Goleman v. MCI Transporters, 844 S.W.2d 463, 466 (Mo. App. 1993); Griggs at 704; Downs v. A.C.F. Industries, Incorporated, 460 S.W.2d 293, 295-96 (Mo. App. 1970). The fact finder may accept only part of the testimony of a medical expert and reject the remainder of it. Cole v. Best Motor Lines, 303 S.W.2d 170, 174 (Mo. App. 1957). Where the opinions of medical experts are in conflict, the fact finding body determines whose opinion is the most credible. Hawkins v. Emerson Electric Co., 676 S.W.2d 872, 877 (Mo. App. 1984). Where there are conflicting medical opinions, the fact

finder may reject all or part of one party's expert testimony which it does not consider credible and accept as true the contrary testimony given by the other litigant's expert. Webber v. Chrysler Corp., 826 S.W.2d 51, 54 (Mo. App. 1992); Hutchinson v. Tri-State Motor Transit Co., 721 S.W.2d 158, 163 (Mo. App. 1986).

However, where the facts are within the understanding of lay persons, the employee's testimony or that of other lay witnesses may constitute substantial and competent evidence. This is especially true where such testimony is supported by some medical evidence. Pruteanu v. Electro Core Inc., 847 S.W.2d 203 (Mo. App. 1993); Reiner v. Treasurer of State of Mo., 837 S.W.2d 363, 367 (Mo. App. 1992); Fisher v. Archdiocese of St. Louis, 793 S.W.2d 195, 199 (Mo. App. 1990); Ford v. Bi-State Development Agency, 677 S.W.2d 899, 904 (Mo. App. 1984); Fogelsong v. Banquet Foods Corp, 526 S.W.2d 886, 892 (Mo. App. 1975). The trier of facts may even base its findings solely on the testimony of the employee. Fogelsong at 892. The trier of facts may also disbelieve the testimony of a witness even if no contradictory or impeaching testimony is given. Hutchinson v. Tri-State Motor Transit Co., supra at 161-2; Barrett v. Bentzinger Brothers, Inc., 595 S.W.2d 441, 443 (Mo. App. 1980). The uncontradicted testimony of the employee may even be disbelieved. Weeks v. Maple Lawn Nursing Home, 848 S.W.2d 515, 516 (Mo. App. 1993); Montgomery v. Dept. of Corr. & Human Res., 849 S.W.2d 267, 269 (Mo. App. 1993).

The determination of the degree of disability sustained by an injured employee is not strictly a medical question. While the nature of the injury and its severity and permanence are medical questions, the impact that the injury has upon the employee's ability to work involves factors which are both medical and nonmedical. Accordingly, the Courts have repeatedly held that the extent and percentage of disability sustained by an injured employee is a finding of fact within the special province of the Commission. Sellers v. Trans World Airlines, Inc., 776 S.W.2d 502 (Mo. App. 1989); Quinlan v. Incarnate Word Hospital, 714 S.W.2d 237, 238 (Mo. App. 1986); Banner Iron Works v. Mordis, 663 S.W.2d 770, 773 (Mo. App. 1983); Barrett v. Bentzinger Brothers, Inc., 595 S.W.2d 441, 443 (Mo. App. 1980); McAdams v. Seven-Up Bottling Works, 429 S.W.2d 284, 289 (Mo. App. 1968). The fact finding body is not bound by or restricted to the specific percentages of disability suggested or stated by the medical experts. It may also consider the testimony of the employee and other lay witnesses and draw reasonable inferences from such testimony. Fogelsong v. Banquet Foods Corporation, 526 S.W.2d 886, 892 (Mo. App. 1975). The finding of disability may exceed the percentage testified to by the medical experts. Quinlan v. Incarnate Word Hospital, at 238; Barrett v. Bentzinger Brothers, Inc., at 443; McAdams v. Seven-Up Bottling Works, at 289. The uncontradicted testimony of a medical expert concerning the extent of disability may even be disbelieved. Gilley v. Raskas Dairy, 903 S.W.2d 656, 658 (Mo. App. 1995); Jones v. Jefferson City School Dist., 801 S.W.2d 486 (Mo. App. 1990). The fact finding body may reject the uncontradicted opinion of a vocational expert. Searcy v. McDonnell Douglas Aircraft Co., 894 S.W.2d 173, 177-78 (Mo. App. 1995).

CLAIM AGAINST EMPLOYER

An employer is liable for permanent total disability compensation under Section 287.200 Mo. Rev. Stat. (2000) only where there is evidence in the record that the primary accident alone caused employee to be permanently and totally disabled. Mathia v. Contract Freighters, Inc., 929 S.W.2d 271, 276 (Mo. App. 1996); Feldman v. Sterling Properties, 910 S.W.2d 808, 810 (Mo.

App. 1995); Moorehead v. Lismark Distributing Co., 884 S.W.2d 416, 419 (Mo. App. 1994); Kern v. General Installation, 740 S.W.2d 691, 692 (Mo. App. 1987); accord, Terrell v. Board of Education, City of St. Louis, 871 S.W.2d 20, 23 (Mo. App. 1993); Roby v. Tarlton Corp., 728 S.W.2d 586, 589 (Mo. App. 1987).

Employer is liable for any aggravation of a preexisting symptomatic condition caused by a work-related accident. Rector v. City of Springfield, 820 S.W.2d 639 (Mo. App. 1991); see also Sansone v. Joseph Sansone Const. Co., 764 S.W.2d 751 (Mo. App. 1989); Plaster v. Dayco Corp., 760 S.W.2d 639 (Mo. App. 1988).

Findings of Fact

Educational and Employment History

Employee was born on August 3, 1948. She attended college at Southern Illinois University and received her undergraduate degree in biological medical sciences. She also completed one year of dental school. (Claimant's Testimony)

Employee worked at TWA for 31 years as a flight attendant. She began working for TWA in 1968. She worked for TWA consistently, unless there was a strike or she was on leave for a pregnancy. (Claimant's Testimony)

Employee is currently not working. She has not worked since August 1999. When American Airlines bought out TWA, Employee was furloughed, along with many other flight attendants who had been TWA employees. (Claimant's Testimony)

Employee's Testimony

Ms. Rouse testified that her pain continues to be in different degrees, but her other symptoms come and go, and she could not say how often they would go on. She testified that when her symptoms would "kick in" she would lay down and rest for days and that she could not do anything. She testified that she hurt all the time.

Claimant testified that, other than spending time at home, she travels to the homes of her two children. One lived in Chicago and one lived in New York. When she is staying with her children, she testified that she watches their cats and dogs, but otherwise does not do anything else. However, Dr. Smith noted that Employee reported that she helped her daughter in the garden and was able to do household chores.

Medical Opinions

Dr. Chomhirun opined that due solely to the injuries sustained in June of 1999, Employee was not able to return to her former employment as an airline fight attendant or any other gainful employment. (Claimant's Exhibit Q, Page 16 & depo ex B)

On cross examination Dr. Chomhirun testified that from time to time Employee had and did not have muscle spasm and trigger points. Her condition was better at times, particularly

following injection therapy, and worse at times, particularly after her trip to Los Angeles. (Claimant's Exhibit Q, Pages 20-21) He testified that the therapist who conducted the functional capacity evaluation in August of 2007 concluded that Employee was able to perform work in the light work demand level and that, although employee had not performed all of the assignments due to her subjective complaints of pain, she performed enough of them to not fall into the category of being a malinger. (Claimant's Exhibit Q, Pages 22-23) He agreed that his treatment had resulted in an increase in Employee's activity level at times. (Claimant's Exhibit Q, Page 25) Dr. Chomhirun testified that Claimant was living by herself and that she was able to perform essential activities of daily living, including getting dressed, feeding herself, walking around, and going to the bathroom. (Claimant's Exhibit Q, Page 2)

Dr. Chomhirun agreed that Employee had symptoms of a psychiatric diagnosis of depression in August of 2005. (Claimant's Exhibit Q, Pages 29-30) Dr. Chomhirun testified that he prescribed anti-depressants because of her chronic pain syndrome rather than her psychiatric diagnosis of major depressive disorder. (Claimant's Exhibit Q, Page 32)

Dr. Volarich opined that Claimant night be able to perform some work activities on a limited basis with a number of restrictions, including not handling of any weight greater than 15 pounds, limiting all bending, twisting, pulling, carrying, climbing to an as needed basis, not remaining in a fixed position for more than 30 minutes including both sitting and standing, not using her left arm overhead or away from the body above the chest level, minimal pushing, pulling and traction maneuvers with the left upper extremity, and not handling weights greater than 1 pound with the left arm extended away from the body or overhead or 5 pounds with the left arm dependent. (Claimant's Exhibit N, depo ex 2, p. 13)

Dr. Volarich opined that Employee had sustained 25% permanent partial disability of the body as a whole referable to the cervical spine due to the disc herniation at C6-C7 and aggravation of degenerative disc disease at C4-C5 and C5-C6, 35% permanent partial disability of the left upper extremity at the shoulder due to the impingement and rotator cuff tendinitis that required surgical repair, and 20% permanent partial disability to the body as a whole due to the severe myofascial pain of the upper torso and left shoulder girdle. (Claimant's Exhibit N, Page 13)

Dr. Volarich noted that he felt that Claimant had considerable disability from depression, but he deferred to psychiatric evaluation for that assessment. (Claimant's Exhibit N, Page 14)

Dr. Volarich opined that the combination of her disabilities created a substantial greater disability than the simple sum or total of each separate injury and a loading factor should be added. He further opined that Employee was unable to engage in substantial gainful activity, nor could she be expected to perform in an on-going working capacity in the future of eight hours per day, five days a week, throughout the work year. He further stated that Ms. Rouse was permanently and totally disabled as a result of the June 20, 1999 work-related injury combined with her psychiatric disability. He noted that she was 57 years old and that he education included graduation from high school and a half year studying dental hygiene school and worked as a flight attendant her entire work career.[24] (Claimant's Exhibit N, Pages 15-16 & 26)

[24] Dr. Volarich failed to mention that Employee was a graduate of Southern Illinois University.

Dr. Stillings opined that the combination of her mood and pain disorders caused Employee to become permanently and totally disabled from a psychiatric standpoint. (Claimant's Exhibit O, Page 13 & depo ex B, p. 9) He agreed on cross examination that her preexisting problems could contribute to her total disability. (Claimant's Exhibit O, Page 28) On redirect examination Dr. Stillings restated his opinion that Employee was currently and totally disabled from a psychiatric standpoint due to the injury of June 20, 1999. (Claimant's Exhibit O, Page 34)

Dr. Phillips opined that Claimant had no disability because her exam was normal; there was no organic injury. (Employer's Exhibit 3, Page 10)

On cross examination Dr. Phillips testified that he also reviewed the MRI films and the myelogram. He opined that at C6-7 there was a small right paracentral bulge at C6-7. He stated the disc pathology at C6-7 was irrelevant because the bulge was to the right and all of Claimant's symptoms were on the left. On cross examination Dr. Phillips testified that he thought that there was a small spur with a bulge at C6-7 which can look like a herniation, when it was not one. (Employer's Exhibit 3, Pages 12-13)

Dr. Farley opined that Claimant had not sustained any injury to her cervical spine and had not sustained any permanent disability regarding her cervical spine. He did note that Employee had a significant anterior shoulder contusion. Therefore, he opined that there was no long term disability to the left shoulder. He assessed her with 3% permanent partial disability of the left shoulder secondary to pain. (Employer's Exhibit 2, Page 9 & depo ex 2, p. 9)

Dr. Farley recommend that Employee avoid lifting, pushing, and pulling objects with the left upper extremity of greater than 30 pounds.

Dr. Smith opined that employee had psychiatric impairment of 15% with half preexisting and half due to exacerbation. Dr. Smith explained that Ms. Rouse has minimal physical impairment because all of her impairment is based on her subjective beliefs about her situation. Dr. Smith was not sure about the need for physical restrictions. She stated that physical restrictions should be based on objective findings on exam and not based on her subjective complaints. She felt that Ms. Rouse probably needs barely any physical restrictions; more physical activity would probably be beneficial. (Employer's Exhibit 4, Pages 23-24) On cross examination Dr. Stacey testified that she did not believe that Ms. Rouse had a significant physical problem. However she has some psychic impairment; what she is capable of doing is considerably diminished over what she actually is capable of doing based on her diagnosis. She opined that it would be therapeutic for her to be doing some type of work. On the other hand, it would be difficult for her to find a type of position that she would find psychologically acceptable. (Employer's Exhibit 4, Page 30)

Dr. Smith opined that claimant was capable of working based on her reports about how she actually was spending her time as mentioned in the report. She predicted that she would have more physical complaints if she returned to work. Dr. Smith mentioned that she was able to do light housework, go shopping with her relatives, travel to visits her relatives. She visited her son in Europe and made numerous 300 mile drives to Chicago. (Employer's Exhibit 4, Pages 23-24)

Vocational Opinions

On August 14, 2007 Claimant underwent a functional capacity evaluation at Gateway Rehabilitation Company. The therapist noted that Ms. Rouse demonstrated the ability to meet the job demands of walking and climbing stairs. She declined to carry 10 pounds. He concluded that she performed work in the light work demand level by lifting 13 pounds on an occasional basis. He noted that she was very focused on her subjective reports of pain which limited her overall performance during the evaluation. (Claimant's Exhibit Q, depo ex D)

Mr. James Israel, a vocational rehabilitation counselor, testified by deposition on behalf of Claimant on September 25, 2008. He evaluated Ms. Rouse on June 13, 2007. He opined that Employee was unable to return to her past job as a flight attendant and was unable to perform any type of work in the open labor market. The reason for this disability from employment is her physical and mental condition, advanced age, education, work background and special work site accommodations place her at an insurmountable disadvantage in seeking employment. His opinion was that Employee is unable to compete in the open labor market due to the injuries she sustained and psychiatric disabilities which were caused by the incident of June 20, 1999 on the airplane. (Claimant's Exhibit P, Pages 17-18).

Mr. James England, a rehabilitation counselor, testified by deposition on behalf of Employer on February 23, 2009. He evaluated Ms. Rouse on December 19, 2007. Mr. England opined that whether or not Employee could work would depend on which doctor he believed. If he believed Drs. Sampson, Farley and Smith, then Mr. England believed Employee could work as a flight attendant and at many other jobs. If he believed Dr. Volarich, then Employee could not work as a flight attendant but could do some sedentary jobs. If he believed Dr. Stillings, then Employee could not work. He admitted that Employee does not believe she can work and this would affect her ability to get a job. In addition, he admitted that a person with all the physical and psychiatric complaints of Ms. Rouse and that she has been out of the work force for 10 years would affect her ability to get a job. (Employer's Exhibit 1)

Additional Findings

I find that based on the medical records of Dr. Chomhirun that Claimant's medical and psychiatric condition dramatically improved during 2007 and 2008 and that Dr. Volarich was not aware of this improvement. I previously found Dr. Volarich's opinions concerning Employee's work-related conditions was not persuasive. Accordingly, I find that Dr. Volarich's opinion regarding permanent disability is not credible. I further find his restrictions on Claimant's activities are not credible.

As I have previously found that Claimant did not have thoracic outlet syndrome or reflex sympathetic dystrophy, I find Dr. Chomhirun's opinion regarding Claimant's permanent disability is not credible.

I find that based on the medical records of Dr. Chomhirun that claimant's medical and psychiatric condition dramatically improved during 2007 and 2008 and that Dr. Stillings was not aware of this improvement. In addition, I previously found that his diagnosis of Claimant's

psychiatric condition was not credible. For those reason, I find his opinion regarding permanent disability is not credible.

Though I found Dr. Farley's diagnosis of Claimant's work-related orthopedic injury was credible, I find that his assessment of her permanent disability is too conservative.

I find Dr. Smith's opinion regarding permanent disability is completely credible.

As Mr. Israel relied on Dr. Volarich's permanent restrictions, which I have found are not credible, and as Mr. Israel was not aware of the dramatic improvement of Claimant's condition during 2007 and 2008, I find Mr. Israel's opinions regarding permanent disability are not credible.

As Mr. England has been able to take into account Claimant's improved medical condition during 2007 and as he relied on the opinions of Drs. Farley and Smith, I find that his opinion regarding permanent disability is credible.

Taking into account all of the evidence, I find that employee sustained 15% of the body as a whole due to her chronic pain secondary to a significant anterior shoulder contusion and myofascial strain and that she sustained 7-1/2% permanent partial disability of the body as a whole due to the exacerbation of her preexisting somatoform disorder as a result of the June 20, 1999 accident. Based on the credible opinions of Drs. Farley and Smith and Mr. England, I further find that Claimant is not totally disabled and is capable of working in the open labor market.

CLAIM AGAINST SECOND INJURY FUND

As there was no evidence that Claimant's preexisting disability in her left foot combined with the chronic pain in her left shoulder and neck and the exacerbation of her somatoform disorder to cause additional permanent partial disability, the alternative claim against the Second Injury Fund for permanent partial disability is denied.

ATTORNEY'S FEES

This award is subject to a lien in the amount of 25% of the additional payments hereunder in favor of the employee's attorney, Robert Flavin, for necessary legal services rendered to the employee.

Date: _____ Made by: _____

JOHN HOWARD PERCY
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

_____
NAOMI PEARSON
Division of Workers' Compensation

BEFORE THE
DIVISION OF WORKERS' COMPENSATION
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Injury No:	99-070011
Employee:	Marcia Rouse
Employer:	Trans World Airlines
Additional Party	Second Injury Fund
Insurer:	Self-insured

ORDER CORRECTING AWARD ON HEARING

On Pages 1 and 23 of the Award typing errors were made by this ALJ which he failed to correct in proofreading the award. Copies of the corrected pages are attached. The changes have been highlighted for the benefit of the parties.

In all other respects the award on hearing remains in full force and effect as originally written.

Given at St. Louis, State of Missouri, this 21st day of January, 2010.

Date: _____ Made by: _____

JOHN HOWARD PERCY
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

_____
NAOMI PEARSON
Division of Workers' Compensation

Issued by DIVISION OF WORKERS' COMPENSATION

AWARD

Employee: Marcia Rouse

Injury No. 99-070011

Dependents: N/A

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Employer: Trans World Airlines

Additional Party: Second Injury Fund

Insurer: Self-insured

Hearing Date: September 15 & October 6, 2009

Checked by: JHP

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes

2. Was the injury or occupational disease compensable under Chapter 287? Yes

3. Was there an accident or incident of occupational disease under the Law? Yes

4. Date of accident or onset of occupational disease: June 20, 1999

5. State location where accident occurred or occupational disease was contracted St. Louis County, Missouri

6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes

7. Did employer receive proper notice? Yes

8. Did accident or occupational disease arise out of and in the course of the employment? Yes

9. Was claim for compensation filed within time required by Law? Yes

10. Was employer insured by above insurer? Yes

11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee, a flight attendant, was knocked to the floor of the airplane when the pilot unexpectedly applied the brakes during taxiing

12. Did accident or occupational disease cause death? No Date of death? N/A

13. Part(s) of body injured by accident or occupational disease: Neck and left shoulder

14. Nature and extent of any permanent disability: 15% permanent partial disability of the body due chronic pain referable to the neck and left shoulder; 7-1/2% permanent partial disability of the body due to exacerbation of somatoform disorder

15. Compensation paid to-date for temporary disability: $8,846.44

16. Value necessary medical aid paid to date by employer/insurer? $15,861.59

Dr. Volarich noted that there no signs of reflex sympathetic dystrophy and no chronic atrophic changes distally such as dry skin, tightness of the skin, or clawing of the hand. On cross examination Dr. Volarich stated that he did not believe that she had reflex sympathetic dystrophy or thoracic outlet syndrome. (Claimant's Exhibit N, Page 25 depo ex 2, p. 9)

Dr. Wayne A. Stillings, a psychiatrist, testified by deposition on behalf of Employee on July 28, 2008. He evaluated Claimant on October 16, 2006. He stated that Claimant told him that she injured her left shoulder in a fall to the floor and injured her neck and left upper extremity when airplane made an abrupt stop. (Claimant's Exhibit O, Page 7) Dr. Stillings testified that Claimant's first lifetime mental health care occurred around 1967 when she and her husband had marriage counseling. They were divorced in 1987 because of his physical abusiveness. Her next lifetime psychiatric contact was post injury. (Claimant's Exhibit O, Page 8) Dr. Stillings felt that she was distraught and anxious. Her speech was disjointed and circumstantial. Overall her affect was labile (unstable). Her mood was clinically depressed. Concentration was impaired by her clinical depression. Comprehension was only fair. She displayed mild psychological distress regarding her work injury and ongoing work-related symptoms. (Claimant's Exhibit O Pages 9-10)

Dr. Stillings diagnosed Employee's psychiatric condition on Axis I: mood disorder due to general medical condition (injuries to neck with herniation at C6-C7, aggravation of cervical DDD from C4-C6, left shoulder impingement with rotator cuff tendinitis, and left shoulder myofascial pain syndrome) and pain disorder associated with psychological factors and general medical condition. He did not give her an Axis II diagnosis. Axis III: per record review. Axis IV: disabled from employment and interaction with legal system. Axis V: GAF (global assessment of functioning) was 55 (moderate systems, impairment). (Claimant's Exhibit O, Pages 10-12 & depo ex B, p. 8)

On cross examination Dr. Stillings admitted his mistake in failing to diagnose Employee with preexisting partner-relational problems with a vicious marital situation where she had been repeatedly beaten and injured. Dr. Stillings stated that Employee did not believe she was having psychological problems. She viewed her problems as physical. Her MMPI-2 profile indicated that she will express her psychological problems as some degree of physical symptoms. He stated that this abuse must have been so severe that she actually sought joint marriage counseling and after her divorce sought individual counseling. He also indicated that she was the victim of sexual abuse at an early age. He testified that her partner-relational problems and childhood sexual abuse were two clearly preexisting psychiatric conditions. (Claimant's Exhibit O, Pages 24-25) Dr. Stillings stated that Claimant missed time from work during her hospitalizations for two fractured noses and the concomitant emotional distress and marital abuse. (Claimant's Exhibit O, Page 31) The childhood abuse was continued by choosing an abusive husband. Employee was functionally incapacitated as a result her prior abuse; it then got in the way of her marriage and an appropriate partner. (Claimant's Exhibit O, Page 32)

Dr. Stillings stated that on Axis II he could not find anything that rose to the level of a diagnosis of a personality disorder. He indicated that the MMPI-2 documented chronic psychological problems. She is immature and dependent. She has some maladaptive preexisting personality traits. He explained that maladaptive personality traits are fixed and enduring and pervasive as of late adolescence and early adulthood. (Claimant's Exhibit O, Page 26)