

2008

# Lex L. Brady v. Utah Labor Commission : Brief of Petitioner

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

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LEX L. BRADY,

Petitioner,

vs.

UTAH LABOR COMMISSION, and  
YOUNG ELECTRIC SIGN CO.,

Respondents,

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Appellate Case No. 20080976

Labor Comm. Case No. 2003948

BRIEF OF PETITIONER

This Appeal is from a final Order of the Utah Labor Commission dated October 28, 2008, and signed by Sherrie Hayashi, a Utah Labor Commissioner. The Order affirmed the decision of Administrative Law Judge Richard La Jeunesse to deny worker compensation benefits to the Petitioner.

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IN THE UTAH COURT OF APPEALS

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## **LIST OF PARTIES**

Petitioner: Lex L. Brady

Respondent: Utah Labor Commission

Respondent: Young Electric Sign Company (YESCO)

## **TABLE OF CONTENTS**

	Page
TABLE OF AUTHORITIES.....	iii
JURISDICTIONAL STATEMENT.....	1
STATEMENT OF ISSUES & STANDARD OF REVIEW.....	1
CONSTITUTIONAL OR STATUTORY PROVISIONS.....	2
STATEMENT OF CASE.....	2
STATEMENT OF FACTS.....	5
SUMMARY OF ARGUMENT.....	25
ARGUMENT.....	26
CONCLUSION.....	43
PROOF OF SERVICE.....	45
ADDENDUM.....	46

## **TABLE OF AUTHORITIES**

### **CASES CITED**

P.

*Martinez v. Media-Playmaster Plus, et al.*, 164 P. 3d 384 (UT 2007) . . . 3, 28

*Gardner v. Edward Gardner Plumbing and Heating, Inc.*, . . . . . 43

### **ADMINISTRATIVE RULES**

*Commission Rule 602-2-2(B)*..... 41

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Respondents.	:	

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**BRIEF OF PETITIONER**

**JURISDICTIONAL STATEMENT**

The Utah Court of Appeals has jurisdiction of this matter pursuant to Rule 14 of the Utah Rules of Appellate Procedure, and pursuant to Utah Code Ann. §63-46b-16.

**STATEMENT OF ISSUES AND STANDARD OF REVIEW**

**ISSUE NUMBER ONE**

Did the Utah Labor Commission err in affirming the administrative law judge's denial of worker compensation benefits to the Petitioner.

**Standard of review:**

The standard of review is substantial evidence, which exists when the factual findings support more than a scintilla of evidence . . . though something less than the weight of the evidence. An administrative law decision meets the substantial evidence test when a

reasonable mind might accept as adequate the evidence supporting the decision. In order to determine whether a decision is supported by substantial evidence, the reviewing court must consider the whole record before the lower court. Whole record review considers the evidence in support of the administrative finding, as well as evidence detracting from the finding. To aid the appellate court in conducting a whole record review, the party challenging the factual findings must marshal all of the evidence and demonstrate that, despite the facts supporting the decision, the findings are not supported by substantial evidence. See, *Martinez v. Media-Playmaster Plus et al.*, 164 P.3d 384, 394 (UT 2007).

### **ISSUE NUMBER TWO**

Did the Commission err in finding that a letter submitted by the Petitioner's treating physician after the medical panel's report, contained no new conflicting evidence, and in refusing to send to the medical panel for their further review.

#### **Standard of review:**

This is the same as for the first issue above.

In the Docketing Statement Petitioner had submitted that there was a third issue based on a denial of due process. That issue is withdrawn by the Petitioner at this time.

### **CONSTITUTIONAL OR STATUTORY PROVISIONS**

None

### **STATEMENT OF CASE**

In 1996, Petitioner was involved in an auto accident, and underwent a cervical fusion

of C5-7 in 1997. On December 8, 1998, during another surgery, Dr. Stephen J. Warner directly visualized the C5-7 fusion, and the fusion appeared solid. At this time Dr. Warner also performed a discectomy and fusion at C4-5. On January 12, 1999, Dr. Warner stated that films of the cervical spine showed that there was no motion at the relevant disc levels, and that the graft was in good position.

Prior to January 24, 2001 Petitioner did not have any significant problems with his low back or his left upper extremity.

In January of 2001, Petitioner worked as a sign installer for Young Electric Sign Company (YESCO). On January 24, 2001, Petitioner was involved in an industrial accident wherein a one-ton sign came loose while being removed, and hit Petitioner in the chest and pinned him at about a 90 degree angle against the frame of the lift he was in for about 30 seconds. After the accident Petitioner experienced problems in his cervical and lumbar regions, and his left shoulder, and breathing difficulties.

Due to a significant increase in neck pain, Dr. Warner took cervical x-rays in April of 2001, and concluded that Petitioner had experienced a fracture through the area of the fusion. Also, Dr. Warner concluded that the industrial accident precipitated symptoms of low back pain. Subsequent radiographic findings in 2001 showed a disc protrusion at L5-S1, and a fracture at L5.

Prior to the industrial accident Petitioner was not taking a substantial amount of pain medication. After the industrial accident, the amount of pain medication being taken increased significantly. Subsequent medical opinion was that the increase in pain medication



contributed to reduced pulmonary drive. Petitioner was diagnosed with a collapsed lung, which caused hypoxia. Also, Dr. Pearl, a pulmonologist, opined that the hypoxia may be caused by damaged to the nerve that leads from the neck to the muscles that move the lung.

In December of 2001, Petitioner was involved in another auto accident wherein his symptoms from the industrial accident were aggravated. Petitioner was able to continue working until June 6, 2003, when his pain in his neck, shoulders, and low back, and his hypoxia, became too severe, and he could no longer work.

The parties stipulated that Petitioner was permanently, totally disabled, but disagreed whether the medical impairments that left the Petitioner disabled were directly caused by the industrial accident. YESCO submitted a report from Dr. Jayne Clark wherein she opined that the injuries leading to Petitioner's disability were caused by the auto accidents either before or after the industrial accident. In her report, Dr. Clark made numerous misstatements concerning Petitioner's medical history.

Dr. Stephen J. Warner, the Chief of Surgery at LDS Hospital, made reference on several occasions that the injuries that forced Mr. Brady's permanent and total disability were a direct result of the industrial accident on January 24, 2001. Additionally, Dr. Scott Sheridan, Petitioner's primary care physician, and Dr. James Pearl, Petitioner's pulmonologist, also made reference repeatedly to substantial problems related to the industrial accident.

Petitioner filed an Application for Hearing with the Utah Labor Commission on September 24, 2003. Petitioner claimed entitlement to permanent total disability

compensation. A hearing on the application was held on April 19, 2004 before administrative law judge Richard M. La Jeunesse. Pursuant to a stipulation of the parties, the record was left open for 30 days so that YESCO could submit a report from Dr. Clark. On October 7, 2004, Judge La Jeunesse made and entered his Interim Findings of Fact, Conclusions of Law and Order. Due to the conflicting medical testimony, Judge La Jeunesse ordered that a medical panel review the medical record.

The medical panel report was not published until August 3, 2005. The medical panel concluded that the injuries that caused Petitioner's disability were not caused by the industrial accident in question. On August 17, 2005, counsel for Petitioner sent a letter to Judge La Jeunesse stating his objections to the medical panel report. Attached to the letter was a new letter from Dr. Pearl wherein he stated why he disagreed with the findings of the medical panel. Counsel requested that Judge La Jeunesse give the letter from Dr. Pearl to the medical panel so they could reconsider their opinion. Judge La Jeunesse refused to do so. Based on the opinion of the medical panel, Judge La Jeunesse denied workers compensation benefits to Petitioner.

Petitioner then asked the Utah Labor Commission to review the decision of Judge La Jeunesse. The Commission denied Petitioner's request for the medical panel to consider the letter from Dr. Pearl, and affirmed the decision of Judge La Jeunesse denying benefits.

### **STATEMENT OF FACTS**

#### **PRE-INDUSTRIAL ACCIDENT SURGICAL HISTORY**

1. In August of 1996, Petitioner was involved in an auto accident, after which he experienced neck and bilateral shoulder problems, with right shoulder greater than left. A CT myelogram taken on December 19, 1996, disclosed a bulging disk with possible protrusion at C4-5, C5-6, and C6-7. (R. 287).

2. On January 21, 1997, Dr. John MacFarlane diagnosed Petitioner with herniated disks at C5-6 and C6-7. The same day Dr. MacFarlane operated on Petitioner, and performed discectomy and fusion at C5-7. (R. 318).

3. After testing and examination on October 13, 1998, Dr. Stephen Warner concluded that the screws from the prior fusion were backing out, and that there was a disk bulge at C4-5 with some foraminal narrowing, and disk desiccation and collapse noted. (R. 32).

4. On November 30, 1998, Dr. Warner surgically removed the plate from the prior fusion, and performed a discectomy at C4-5. During this surgery Dr. Warner explored the fusion at C5-7, and noted that the fusion was solid. (R. 55).

#### **THE INDUSTRIAL ACCIDENT OF JANUARY 24, 2001**

1. Petitioner worked as a sign installer for Respondent, YESCO, from November 30, 1992, to June 6, 2003.

2. Petitioner was involved in an industrial accident on January 24, 2001, in which he was crushed by a 2,000 pound sign. The sign hit Petitioner's chest and bent him over backwards. Petitioner felt a pop in his neck as soon as the sign hit him. (R. 124, p. 58).

3. Petitioner tried to lift the sign off of him for about 30 seconds. He thought he was

going to die because he was in the lift-basket 80 feet in the air, and he was bent over backwards at almost a 90 degree angle. (Id.)

4. Petitioner did not miss time from work for any significant length of time after the industrial accident. (Id.)

5. The industrial accident happened soon after Petitioner's son was violently killed, and Petitioner did not want to take any time off work because the job worked as therapy for the emotional trauma that Petitioner experienced as a result of his son's death. (Id.)

6. As Petitioner's symptoms from the industrial accident increased in severity, Petitioner did miss time from work on a day-to-day basis. (R. 126, p. 25)

## **FACTS SUPPORTING DECISION OF COMMISSION**

### **RIGHT SHOULDER**

2. On June 30, 1994, Dr. Scott Sheridan M.D. recorded that Petitioner "... has a right shoulder problem ... dates back to about a month ago when he apparently dislocated the shoulder transiently while lifting a bale of hay." (R. 143).

3. On May 7, 1996 Dr. Sheridan confirmed the diagnosis that Petitioner suffered from "Right lateral epicondylitis." (R. 571)

4. On September 19, 1996 Dr. John Rizzi took an MRI of Mr. Brady's right shoulder that disclosed: "Thinning of the supraspinatus tendon suspicious for partial thickness tear." (R. 186)

5. On August 2, 1997 Dr. Warner evaluated Petitioner and concluded that "he has right rotator cuff tendonitis clearly seen on the MRI scan. He also has significant right AC

arthritis as well as a ganglion cyst sitting in the corner of the scapula.” (R. 48).

6. An MRI taken of Petitioner’s right shoulder on February 27, 1999, revealed postoperative metallic artifacts and “findings consistent with synovial inflammation of subacromialsubdeltoid bursa, and infraspinatus/supraspinatus tendonitis without full-thickness tendon tear....” (R. 65)

7. On March 1, 1999 Dr. Warner observed that Petitioner “[i]s going to have chronic problems with ... his right shoulder.” (R. 24)

8. On December 27, 2000 Dr. Sheridan confirmed that Petitioner suffered from chronic arm pain. (R. 82)

### **RESPIRATION PROBLEMS**

9. On June 30, 1994, Dr. Sheridan recorded that Petitioner suffered from "asthma with marginal control." (R. 143)

10. On June 21, 1999, Dr. Sheridan noted that Petitioner was then on oxygen. (R. 100). However, Petitioner did not accept the oxygen, and did not use any at that time.

11. On January 4, 2000, Dr. Sheridan noted that Petitioner had unusual nocturnal shortness of breath of unknown significance. However, chest x-rays showed the lungs to be clear and with no problems. (R. 145).

12. On June 14, 2000, Dr. Sheridan determined that Petitioner’s asthma lacked adequate control. (R. 89)

13. The industrial accident was on January 24, 2001, which was a Wednesday. Petitioner did not seek medical treatment until Monday, January 29<sup>th</sup>, when he saw Dr.

Sheridan, his primary care physician, at Granger Medical Clinic. Petitioner complained of neck pain, but did not mention low back pain, left shoulder pain, or breathing problems. (R. 545)

14. On January 30, 2001, Petitioner sought treatment at IHC WorkMed, where he complained of neck pain, low back pain, and left shoulder pain. He did not complain of breathing problems. (R. 609). X-rays taken at the time did not show any fractures. (R. 608)

15. Petitioner had a follow-up visit at IHC WorkMed on February 7, 2001, where it was noted that Petitioner had an increase in low back pain, but no mention of breathing problems. (R. 602).

16. On December 4, 2002, Dr. Sheridan noted that Petitioner was complaining of shortness of breath. Dr. Sheridan noted that when breathing problems have occurred in the past, it has always been the presumption that it was related to Petitioner's asthma. However, Dr. Sheridan noted that maybe Petitioner had chronic hypoxemia since chest x-rays did show an under expansion of at least one of the lungs. (R. 505).

17. On March 17, 2003, Dr. James Wilcox M.D. diagnosed Petitioner with: "Polycythemia almost assuredly secondary polycythemia. Probably due to both central sleep apnea and obstructive sleep apnea ...." (R. 407)

18. On June 26, 2003, Dr. Sheridan noted that Dr. Passey does not think that hypoventilation from methadone is responsible for Petitioner's hypoxemia. (R. 497).

19. On August 6, 2003, Dr. Andrew Colletti M.D., conducted a Color Doppler Echocardiogram on Petitioner that revealed a "Patent Foramen Ovale" referred elsewhere in

the medical records as a PFO. (R. 369)

20. On October 7, 2003, Dr. Warner noted that Petitioner had: “[b]een diagnosed with pulmonary hypertension and is on oxygen. He most likely has a ventricular septal defect with pulmonary hypertension.” (R. 324)

21. Then, on January 6, 2004, Dr. Cloward determined after testing:

I then had him perform a 100% F102 shunt study at LDS Hospital which revealed that he does have a significant shunt fraction measuring approximately 17% (normal less than 5%). He has a known PFO. DIAGNOSTIC IMPRESSION: Significant right to left shunt by physiological testing in the laboratory. His shunt fraction is approximately 17%. (R. 341)

22. In her evaluation of April 4, 2004, Dr. Clark opined:

The right hemidiaphragm paralysis or paresis was not diagnosed until 1/2004 by Dr. Pearl. But apparently review of x-rays even from 1997 note this problem. It possibly could have been a side effect of a cervical injections or surgeries, but also could be due to the presence of the syrinx causing dysfunction of the anterior horn cells at the C3-5 levels which innervate the vagus nerve to the diaphragm. It clearly was present long before the 1/24/01 incident. (R. 12)

23. In an alternative theory espoused by Dr. Clark on May 13, 2004 she postulated:

It is my conclusion from the statements of Mr. Brady and his treating physicians that the MVA of 12/01 was a much more disabling accident than (sic) the sign accident of 1/24/01. The change from 80.7% to 71.7% right lung height compared to left, is medically more likely related to the most severe and disabling accident, which was the 12/01 MVA.. (R. 16C).

24. Dr. David Ryser, M.D., subjected Petitioner to an Electromyography/Nerve conduction study on April 9, 2004, that revealed:

IMPRESSION: No electrodiagnostic evidence of acute phrenic denervation bilaterally. Morphology of early-recruited motor units in the right hemidiaphragm showed changes consistent with subacute to chronic

denervation, however, but this was neither marked nor unequivocal. (R. 656A)

Dr. Ryser's tests further demonstrated: "Phrenic nerve compound motor action potential amplitude on the right was almost twice those of the response on the left, but both were within normal limits. This finding is added assurance that no significant neuromuscular lesion is present on the right." (R. 656B)

### **CERVICAL SPINE**

25. On March 1, 1999, Dr. Warner observed that Petitioner, "[i]s going to have chronic problems with ... his cervical spine ...." (R. 24)

26. On January 29, 2001, Petitioner went to see Dr. Sheridan regarding his injuries from the industrial accident. Dr. Sheridan made a diagnosis of "acute neck pain on top of chronic problems." (R. 81)

27. On March 1, 2001, Dr. Terry Sawchuck examined Petitioner and concluded that as a result of the industrial accident, Petitioner suffered:

- a. Subacute cervical sprain/strain.
- b. Chronic cervicgia or neck pain.
- c. Status post cervical discectomy and anterior interbody fusion at C5-6 and C6-7 with anterior plating in January 1997.
- d. Status post anterior cervical discectomy at C4-5 with interbody fusion using allograft ... November 1998. (R. 173)

28. On December 26, 2001, Petitioner had another motor vehicle accident. Petitioner acknowledged that the December 26, 2001, automobile accident aggravated his neck pain. On January 24, 2002 Dr. Warner recounted that, "since the motor vehicle accident on December 26, 2001, the patient has had marked increase in neck pain...." (R. 477)



29. On February 21, 2002 Petitioner underwent another cervical spine MRI at the hands of Dr. Steven Hunt that demonstrated:

- a. anterior fusion C4-5, this appears solid.
- b. Postoperative changes C5-6 and C6-7, with degenerative changes. No central spinal stenosis at these levels.
- c. C7-T1 demonstrative mild degenerative change with broad-based grade I disc bulge. (R. 236)

30. On April 1, 2004 Dr. Jane Clark M.D., who was hired by Respondent YESCO to perform an IME, evaluated Petitioner and opined:

It appears that none of Mr. Brady's treating physicians have appreciated that he has had a small spinal cord syrinx, at least as early as 8/98. It is most likely that this Syrinx occurred just after the 1996 MVA or that it was congenital. This can account for the pain in his neck and upper back and scapular area, and the resolved sensory deficit that Dr. Warner noted in his upper thoracic region. It possibly could account for some of his shoulder pains as well, particularly when they couldn't really be influenced by Dr. Sawchuck's injections. (R. 11)

31. In her opinion, Dr. Clark found that the following problems to preexist Petitioner's industrial accident on January 24, 2001: "Cervical degenerative disc and facet disease with attempted fusions of C5-6 and C6-7 on 1/21/97." Subsequently, the screws loosened which caused more swallowing problems. They were removed in 11/98. Dr. Clark stated that Mr. Brady's January 24, 2001 industrial accident "[l]ikely strained his nonfusion levels of C5-6 and C6-7." (R. 13)

32. Dr. Clark also concluded that Petitioner's motor vehicle accident on December 26, 2001 "caused worse neck ... problems." (R. 14)

### **LUMBAR SPINE**

33. In her report of April 1, 2004, Dr. Clark assayed that Mr. Brady had "Lumbar degenerative disc disease" prior to his industrial accident on January 24, 2001. (R. 12)

### **LEFT SHOULDER**

34. On January 24, 2002, Dr. Warner commented: "Since the motor vehicle accident on December 26, 2001, the patient has had marked increase in ... shoulder pain especially on the left side ...." (R. 477)

35. Dr. Clark noted that prior to January 24, 2001, Petitioner had: Left shoulder problems due to a down slopping acromium and degenerative changes (R. 13)

36. On July 23, 2002, Dr. Sheridan noted that:

Lex experienced a car wreck in December 2001 which significantly aggravated his existing musculoskeletal problems. Prior to that, we were battling chronic pain with him, but we were seeing him on an every two-or-three month basis. Since then, I have been unable to get any significant control of his pain. I have recommended that he retire from his position at YESCO Sign Company, because his daily activities routinely aggravate his medical condition, but he is dedicated to working, and because of personal things in his life. He feels that he would be better off emotionally if he continues working. (R. 445)

37. Dr. Sheridan went on to observe that: "I think his overall condition has been aggravated by numerous issues, but this recent car wreck has really messed things up." (R. 446)

38. On February 5, 1996 Dr. Rigby diagnosed Petitioner with a "2-year history of bilateral epididymitis." (R. 571)

39. On August 10, 2000, Dr. Sheridan verified the diagnosis of left lateral epicondylitis. (R. 88)

### **OTHER FACTS**

40. On January 24, 2002, Dr. Warner noted that Petitioner had a marked increase in his symptoms since the auto accident of December 26, 2001. (R. 126, p. 63, 64).

41. In January of 2002, Dr. Sheridan noted that Petitioner's rib seems to be getting worse, and may now be a factor in inhibiting his ability to work. (R. 126, p. 61).

42. On March 25, 2002, Dr. Warner noted that Petitioner stated that since the auto accident of December 26, 2001, his general overall pain has been "significantly worse." (R. 329).

43. On July 23, 2002, Dr. Sheridan noted that Petitioner needed a letter indicating that the auto accident of December 26, 2001, really tipped him over the edge. Dr. Sheridan believed this was a prime factor in Petitioner's down turn. (R. 126, p. 61, 62).

### **FACTS WHICH DO NOT SUPPORT DECISION OF COMMISSION**

#### **LEFT SHOULDER**

1. On January 22, 1998, Dr. Warner operated on Petitioner's right shoulder and performed an open reduction and internal fixation of his acromium fracture followed by a subacromial decompression. (R. 66)

2. On May 19, 1998, Dr. Hugh West also operated on Petitioner's right shoulder performing a diagnostic arthroscopy, and a right distal clavicle resection. (R. 698)

3. On October 13, 1998 Dr. Warner determined that Petitioner's "[r]ight shoulder pain is secondary to the acromium fracture." (R. 32)

4. Prior to the industrial accident Petitioner's bilateral shoulder problems were mainly

limited to his right shoulder, without any significant symptoms in his left shoulder. (R. 124, p. 43)

5. On May 15, 2001, Dr. Warner noted that Petitioner was complaining of cervical, lumbar, left shoulder, and elbow problems. (R. 17).

6. On August 13, 2001, after several other visits where Petitioner did complain of neck pain, low back pain and shoulder pain, Dr. Sheridan noted that Petitioner's chronic pain was getting worse. There was a discussion as to whether Petitioner should make a worker's comp claim for permanent total disability. Petitioner did not want to make the application because he knew his employer would fight it. (R. 533).

7. On September 25, 2001, Dr. Sheridan noted that Petitioner's chronic pain was getting worse. In addition, Petitioner was experiencing his arms going completely numb at night, and that he could not grip very well to lift things. (R. 532).

8. On December 3, 2001, which was Petitioner's last visit with Dr. Sheridan before the auto accident of December 26, 2001, Dr. Sheridan noted that Petitioner's chronic pain was getting worse. Dr. Sheridan increased the prescription for Oxycontin to 40-80 mg. every 8 hours, and continued the prescription for Methadone.

9. On April 17, 2001, Dr. Warner observed that Petitioner: "[n]ow has significant complaints of left shoulder pain. His previous problems have been localized primarily to the right side." (R. 461)

10. On June 6, 2002, Dr. Hunt took an MRI of Petitioner's left shoulder that disclosed:

IMPRESSION:

1. No full thickness, complete rotator cuff tear identified.
2. There is moderate tendinopathy of the supraspinatus tendon and mild tendinopathy of the subscapularis tendon associated with a down-sloping type II acromion and AC joint hypertrophic change. (R. 229)

11. Dr. Clark acknowledged that Petitioner suffered an: "Aggravation of the left shoulder impingement syndrome and AC degeneration by the 1/24/01 incident." (Id.)

12. Nevertheless, Dr. Clark insisted that: "[i]t was the 12/26/01 MVA which really caused this to be problematic." (R. 14)

13. As of 2004, Petitioner's left shoulder was his main symptom, and the main reason why he was taking pain medication. (R. 126, p. 38)

### CERVICAL

14. On January 30, 2001, Petitioner went to see Dr. Tom Schuman M.D., at IHC WorkMed with respect to his industrial accident. Dr. Schuman recorded Petitioner's complaints of neck pain. (R. 609)

15. On March 10, 2001, Dr. William Halden, took an MRI scan of Petitioner's cervical spine that showed:

- a. Anterior fusion at the C4-5 level.
- b. A plate and screw fixation device across the C5-6 and C6-7 disc spaces seen has been removed. There is no definite bony fusion across these disc levels.
- c. There is some degenerative disc change at the C6-7 and to a milder degree C7-T1 levels. There is mild narrowing of the right C6-7 neural foramen. There is no central canal stenosis at any level. (R. 254)

16. On April 17, 2001, Dr. Warner evaluated Petitioner and determined:

The patient has had a significant increase in his neck pain since the industrial accident. When I look through the current cervical spine films compared to the previous cervical spine films, the patient now clearly has a

pseudoarthrosis at the C5-6 and C6-7 levels. When I performed removal of the loose plate and the C4-5 fusion, the patient had anterior bridging bone at both C5-6 and C6-7. I believe that the patient sustained a fracture through the fusion at C5-6 and C6-7 directly related to the industrial accident. He now has developed a large anterior callous at C5-6 which was not seen on previous x-rays. This suggests an attempt by Lex's body to heal the C5-6 level. Again, there is clear motion at C5-6 and C6-7. (R. 461)

17. On April 25, 2001, Dr. Sawchuck diagnosed Petitioner with a cervical disc protrusion and cervical radicular syndrome and status post cervical fusion. (R. 243)

18. On May 20, 2002, Dr. Sawchuck noted that a cervical MRI showed a fracture through the fusion at C5-6.

19. On October 7, 2003, Dr. Warner recorded: "I repeated a lateral x-ray of the cervical spine. Where he had the fracture through the fusion at C5-6 with a large amount of callous appears to have healed. This further supports the contention that he refractured the C5-6 level." (R. 324)

20. Dr. Warner provided a rebuttal to Dr. Clark's opinions wherein he opined:

I believe the patient's industrial accident caused a fracture of the patient's tenuous fusion at the C5-C6 and C6-C7 levels. This was enough stimulus to lead to the fusion of the C5-C6 level. The patient still has a failure of the fusion at the C6-C7 level ... It is my contention that the patient sustained a fracture through these fusions in the industrial accident of January 24, 2001. (R. 323A-B].

21. Dr. Warner went on to state that he reviewed Petitioner's cervical MRI's with two other neurosurgeons who all concluded that with respect to the variant observed as a syrinx by Dr. Clark "it is an insignificant finding." Dr. Warner determined that "[i]f this indeed represented a syrinx, it would be asymptomatic." (R. 323B)

22. On April 15, 2004, Dr. Warner noted that Petitioner had a fracture of the cervical fusion as a result of the industrial accident. Dr. Warner had directly visualized during surgery the fusion prior to the industrial accident, and there were no problems, and then he reviewed films of the fusion area after the industrial accident to reach his conclusion. (R. 323A).

### **LUMBAR**

23. Prior to the industrial accident on January 24, 2001, there is no documentation of any significant lumbar problems.

24. On March 1, 2001, Dr. Sawchuck diagnosed Petitioner in relevant part with:

- a. Myofascial type pain.
- b. Acute lumbar sprain/strain.
- c. lumbar radicular syndrome. (R. 173)

Dr. Sawchuck noted that the low back injury from the industrial accident was totally new. (R. 169).

25. On March 10, 2001, Dr. Holden took an MRI scan of Petitioner's lumbar spine that revealed:

#### **IMPRESSION:**

- 1. Grade I-II right posterolateral broad based disc protrusion at the L5-S1 level touching but not displacing the descending S1 root.
- 2. Some disc degenerative change at the L3-4, L2-3, and L1 -L2 levels ... no central canal stenosis or neural impingement at any level.
- 3. Mild facet degenerative arthritic change bilateral at the L4-5 and L5-S1 levels. (R. 177)

26. On April 2, 2001, Dr. Sawchuck assessed Petitioner with "Lumbar disc protrusion and lumbar radicular syndrome." (R. 248)

27. On April 17, 2001, Dr. Warner concluded that: "The industrial accident precipitated symptoms of low back pain." (R. 462)

28. Dr. Hunt did another MRI of Petitioner's lumbar spine on June 6, 2002 that showed:

**IMPRESSION:**

1. Multilevel degenerative disc and facet changes particularly at L4-5 on the right.
2. Unusual sclerotic appearing region in the right L5 pedicle. L5-S1 ... There is a grade I right posterolateral disc bulge with possible annular tear. No frank disc herniation. (R. 227)

29. On July 1, 2002, Dr. Jerry Handly conducted a bone scan on Petitioner's lumbar spine that disclosed: "IMPRESSION: 1. focal increased activity in the region of the right pedicle and facet at the L5 level consistent with an occult fracture at this site." (R. 225)

30. On July 31, 2002, Dr. Sawchuck reviewed the bone scan results and concurred that Petitioner had "[s]ome type of fracture at L5 on the right side in the pedicle region." (R. 223)

31. Dr. Clark conceded that: "The industrial accident of 1/24/02 is documented to have caused some ... lumbar pain, which is possibly due to the occult fracture of the L5 pedicle." (Id.)

### **RESPIRATION PROBLEMS**

32. Before the industrial accident in question Petitioner was taking about 30 milligrams of Oxycontin twice a day. After the accident, this increased to 100 milligrams twice a day. (R. 124, p. 48, 49); and he takes 20 milligrams of Lortab three times a day for breakthrough pain (R. 126, p. 34)



33. Prior to the accident, Dr. Sheridan had prescribed Methadone of 90 milligrams, twice a day, along with Amitriptyline of 50 mg, at bedtime. After the industrial accident, Dr. Sheridan also prescribed Ibuprofen at 800 mg, three times a day. (R. 609).

34. On April 23, 2001, due to continuing severe pain, Dr. Sheridan prescribed Morphine of 15045 mg, every 4-6 hours. (R. 541)

35. On May 3, 2001, due to continuing severe pain, Dr. Sheridan changed the prescription to MScontin at 60 mg, every 12 hours. (R. 540).

36. On May 16, 2001, due to continuing severe pain, Dr. Sheridan changed the prescription to Methadone at 30 mg, every 6-8 hours, and increased the MScontin to 90 mg, every 12 hours. (R. 539).

37. On May 29, 2001, due to continuing severe pain, Dr. Sheridan discontinued the MScontin, but started Oxycontin again at 40-80 mg, every 12 hours, and continued the Methadone and the Amitriptyline.

38. On June 18, 2001, due to continuing severe pain, Dr. Sheridan increased the prescription for Oxycontin to 80 mg, every 12 hours. At this same visit, Dr. Sheridan noted that Petitioner's asthma was "well controlled." (R. 537).

39. Petitioner didn't begin having significant breathing problems and redness in his face until after the industrial accident. (R. 126, p. 51) Petitioner noticed soon after the industrial accident that he couldn't catch his breath when he would carry items up stairs. (R. 126, p. 52)

40. Petitioner did not initially see any medical personnel about his breathing problems

because he believed, based on what other people had told him, it was related to his son's tragic death. (Id.)

41. On March 14, 2003, Dr. Tom Cloward, M.D., assessed Petitioner with:

DIAGNOSTIC IMPRESSION:

1. I think that he has obesity-hyperventilation syndrome complicated by obstructive sleep apnea. In addition, he has airway obstruction on pulmonary function tests. This is consistent with "Mixed Syndrome." The above problems are exacerbated by narcotic pain medication, benzodiazepines and muscle relaxants. I think a majority of his sleep apnea can be explained by concomitant use of these medications. (R. 400)

42. On June 3, 2003, Dr. C. Gregory Elliot, a pulmonologist weighed in on the nature of Petitioner's respiratory problems:

ASSESSMENT:

1. Arterial hypoxemia associated with alveolar hypotension in the absence of significant abnormalities of the respiratory mechanics suggests that this is on the basis of depressed respiratory drive related to his chronic requirement for methadone and analgesics.
2. Chronic asthma and chronic obstructive pulmonary disease.
3. History of obstructive sleep apnea.
4. Episodic dyspnea, etiology remains unclear. (R. 390)

43. On June 6, 2003, Dr. Elliot elaborated on his prior assessment of Petitioner's respiratory problems:

"[M]y impression is that Mr. Brady has multiple cardiorespiratory problems compounded by his chronic pain syndrome, depression and anxiety. Mr. Brady does have polycythemia which I believe is most likely related to his chronic hypoxemia. The etiologies for his chronic hypoxemia include chronic obstructive pulmonary disease (asthma) in combination with alveolar hypoventilation caused by his dependence upon methadone and other analgesics for relief of chronic musculo-skeletal pain." (R. 387)

44. Dr. Mark Passey, M.D., another pulmonologist, concluded on July 22, 2003:

Based on the level of hypoxemia and the patient's exam it would seem apparent that he has intrinsic lung disease at this time. (R. 213)

45. Dr. Cloward, on December 15, 2003, updated his assessment of Petitioner:

IMPRESSION:

1. Persistent hypoxemia. The most likely etiology of his hypoxemia is due to chronic hypoventilation due to his large narcotic doses.
2. He also has evidence of underlying lung disease, consistent with chronic obstructive pulmonary disease.

46. However, on March 29, 2004 Dr. Sherman Sorensen determined that: "He does not have a significant PFO." (R. 488B)

47. Yet, on December 17, 2003, Dr. Wayne Adams found: "No evidence of right to left shunt." (R. 346)

48. On January 8, 2004 Dr. Robert Famey examined Petitioner and concluded he had:

IMPRESSION:

1. Sleep disorder breathing...
2. Persistent hypoxemia secondary to hypoventilation secondary to narcotics.
3. Polycythemia secondary to above.
4. Patent Foramen Ovale with shunt.
5. Chronic obstructive pulmonary disease. (R. 661)

49. On January 22, 2004, a pulmonary specialist, Dr. James Pearl, diagnosed Petitioner with: "IMPRESSION: 1. Mr. Brady has hypoxemia of unclear etiology. He does have atelectosis 2 at the right base which may relate to a paralyzed right hemidiaphragm. It is possible that this occurred with his traumatic chest injury and that would seem to be a likely etiology." (R. 339)

50. On January 29, 2004, Dr. Margaret Ensign M.D., performed a thoracic

fluoroscopy on Petitioner that revealed: "Findings most consistent with eventration<sup>3</sup> right hemidiaphragm." (R. 337)

51. On April 8, 2004, Petitioner's treating physician, Dr. Sheridan, provided a rebuttal to some of the conclusions reached by Dr. Clark:

A statement was made that Mr. Brady was first found to be hypoxemic on January 4, 2000. In fact, Mr. Brady was hypoxemic at that time, but my estimation is that the source of his hypoxemia was bronchitic with a flare of asthma, since he had a considerable period of time after that where he was not complaining of difficulty breathing. He responded well to Biaxin and turning of his asthma medication. A second statement which I believe to be an error, is that one of the reasons for Mr. Brady's hypoxemia is his long-term steroid use and his asthma. To my knowledge, long-term steroid use does not create hypoxemia. Secondly, none of specialists whom Mr. Brady has seen recently to evaluate his hypoxemia believes that Mr. Brady's low oxygen saturations can be explained by reactive airway disease. I think that Mr. Brady's hypoxemia is due to paralysis of part of his diaphragm muscle. (R. 488A)

52. On April 15, 2004, Dr. Warner also challenged Dr. Clark's analysis that causally linked Mr. Brady's respiration problems with the syrinx observed by Dr. Clark. Dr. Warner stated that he reviewed Mr. Brady's cervical MRI's with two other neurosurgeons who all concluded that with respect to the variant observed as a syrinx by Dr. Clark "[i]t is an insignificant finding." (R. 323B)

53. Dr. Warner determined that "[i]f this indeed represented a syrinx, it would be asymptomatic." (Id.)

**FACTS RELEVANT TO ISSUE OF WHETHER DR. PEARL'S LETTER OF AUGUST 15, 2005, SHOULD HAVE BEEN CONSIDERED BY THE MEDICAL PANEL**

1. Due to the conflicting evidence on many of the medical issues, the administrative law judge requested a medical panel to review the case. (R. 44, 76)

2. The medical panel concluded that the Petitioner's total disability was not caused by any injuries that he may have suffered in the industrial accident in question. (R. 82)

3. On April 8, 2004, Dr. Pearl opined that Petitioner's hypoxemia was most likely caused by his paralyzed hemidiaphragm. (R. 624A).

4. On or about August 17, 2005, counsel for the Petitioner submitted a letter to the administrative law judge stating certain objections to the findings of the medical panel. Counsel also requested the judge to have the medical panel review an accompanying letter from Dr. Pearl, the pulmonologist, where he theorized that the hypoxemia was actually caused by the neck injuries suffered in the industrial accident in that the nerve that controls the hemidiaphragm, which makes the lung move, comes from the cervical region injured in the industrial accident. Dr. Pearl also attempted to rebut Dr. Jarvis (a member of the medical panel), by showing that Dr. Jarvis' claim that there had been no damage to the phrenic nerve (the nerve from the cervical spine to the hemidiaphragm), was not correct, as shown by radiographic findings. (R. 85-87)

5. The administrative law judge refused to submit the new letter from Dr. Pearl to the medical panel for their review.

6. The Petitioner filed a Motion for Review to the Labor Commission on December 29, 2005. (R. 110).

7. After a hearing, the Labor Commission upheld the findings of the administrative

law judge, and also concluded that in their opinion the letter from Dr. Pearl did not present any new conflicting medical evidence, and thus, it was appropriately within the discretion of the ALJ to not submit the letter to the medical panel for review. (R. 120)

### **OTHER FACTS**

8. Petitioner had been back to work at YESCO for about two years prior to the industrial accident in question. (R. 124, p. 33)

9. It was a combination of the respiratory problems along with the neck, low back and left shoulder problems that led Petitioner to not be able to work any more. (R. 124, p. 56)

10. Petitioner did not have any new symptoms after the auto accident of December 26, 2001. He just suffered aggravation of his old symptoms. (R. 126, p. 30)

11. Dr. Warner stated on October 7, 2003, that he thought Petitioner was totally disabled “due to his multiple medical problems as well as the severe degeneration of his cervical as well as his lumbar spine.” (R. 491).

### **SUMMARY OF ARGUMENT**

The Labor Commission erred in upholding the decision of the ALJ to deny benefits because even more than the simple weight of the evidence was contrary to that decision. In particular, even though Petitioner had cervical pain before the industrial accident, it was significantly aggravated as a result of the accident. In addition, the accident caused a fracture through the fusion at C5-7, with resulting instability. This is a very significant injury from the industrial accident. Furthermore, prior to the industrial accident there was no history of any significant problems with Petitioner’s lumbar spine, but after the

accident there was diagnosed a fracture at L5, and a bulging disk at L5-S1, with radicular symptoms. Also, prior to the industrial accident there was not any significant problems with the left shoulder, but after the accident there were severe problems. In regards to the hypoxemia, there are several doctors, including pulmonary specialists, that have diagnosed that the hypoxemia was either caused by the crush injury itself, or by an increase in pain medication after the industrial accident, or by an injury to the nerve that controls the muscle that makes the lung move. Most important, is that all three theories are related to the industrial accident. Even though Petitioner continued to work after the industrial accident, there were several occasions where he discussed with his primary care doctor submitting for workers comp permanent total disability. However, even though there was medical justification to do so, Petitioner declined to do so at that time because he found that working was the best therapy for dealing with the tragic loss of his son, and because he had seen that his employer had fought other employee' workers comp claims. Furthermore, due to many medical history mistakes and unsupported opinions, the report of Dr. Jayne Clark should not be given much weight, if any. And last, the Labor Commission also erred in finding that a letter written by Dr. Pearl, which proffered new and conflicting evidence, should not be submitted to the medical panel for consideration. It should have submitted for review because it showed how the test that Dr. Jarvis, one of the doctors on the medical panel, was relying upon was, in the words of the radiologists, equivocal, or not clear, and could not support the position of Dr. Jarvis.

### **ARGUMENT**

## **FIRST ISSUE**

### **DID THE UTAH LABOR COMMISSION ERR IN AFFIRMING THE ADMINISTRATIVE LAW JUDGE'S DENIAL OF COMPENSATION BENEFITS TO THE PETITIONER**

The standard of review in determining whether the Utah Labor Commission erred in affirming the administrative law judge's denial of benefits is “. . . substantial evidence, which exists when the factual findings support more than a scintilla of evidence, though something less than the weight of the evidence.” See, *Martinez v. Media-Playmaster Plus et al.*, 164 P. 3d 384, 394 (UT 2007). The Utah Supreme Court further stated in *Martinez* that,

An administrative law decision meets the substantial evidence test when a reasonable mind might accept as adequate the evidence supporting the decision. In order to determine whether a decision is supported by substantial evidence, the reviewing court must consider the whole record before the lower court. Whole record review considers the evidence in support of the administrative finding, as well as evidence detracting from the finding. To aid the appellate court in conducting a whole record review, the party challenging the factual findings must marshal all of the evidence and demonstrate that, despite the facts supporting the decision, the findings are not supported by substantial evidence. *Id.*

As set forth in the section above entitled “Facts Which Support the Commission Decision,” Petitioner has attempted to fulfill his responsibility to marshal the evidence in support of the administrative decision. The Petitioner will now analyze the facts which purportedly support the decision of the Commission to deny benefits, and show that in spite of those facts the Commission decision should be overturned.

The ALJ's order adopted the medical panel report in making his order wherein he found that the injuries sustained in the January 24, 2001 industrial accident did not result in



his becoming termed permanently and totally disabled. He concluded that the medical problems sustained and caused by the industrial accident "resulted in no physical or functional restrictions above and beyond those he already endured." It is respectfully submitted that the greater weight of the record supports contrary conclusions such that it should be found that Petitioner is permanently and totally disabled due to the effects of the January 24, 2001 industrial injury, and should be termed as being permanently and totally disabled. The key is to look at all of the injuries and symptoms that Petitioner suffered as a result of the industrial accident. It is submitted that the ultimate reason for Petitioner not being able to work is due to a combination of physical problems, and not just one item, such as the respiratory problems.

### **CERVICAL**

The medical panel stated it found evidence that Mr. Brady had post-operative cervical spine problems (non-union) before the industrial accident and no evidence of a fracture due to the industrial accident. The medical record shows, however, that prior to the industrial accident, the surgeon, Dr. Stephen J. Warner, on November 30, 1998 (R. 28) performed a surgery where he explored the sight of the prior fusion, and the fusion appeared solid. It was explored with both a Cobb elevator, as well as with a micro curette. Also, on January 12, 1999 (R. 26), Dr. Warner stated that a flexion and extension lateral film of the cervical spine was obtained in which he could see no motion at that level and found the graft to be in good position. Thus, before the industrial accident there were no fractures in the fusion.

It was only after the industrial accident of January 24, 2001 that Dr. Warner found a

fracture through the fusion at C5-C6 with a large amount of callus. By October 2003, it appeared to be healed. There is no callus noted in the films prior to the industrial accident. This also supports the conclusion that there was no pre-existing non-union. Dr. Warner specifically stated that,

The patient has had significant increase in neck pain since the industrial accident. When I look through the current cervical spine films compared to the previous cervical spine films, the patient now clearly has a pseudoarthrosis at the C5-6 and C6-7 levels. When I performed removal of the loose plate and the C4-5 fusion, the Patient had anterior bridging bone at both C5-6 and C6-7. I believe that the patient Sustained a fracture through the fusion at C5-6 and C6-7 directly related to the Industrial accident. He now has developed a large anterior callus at C5-6 which was not seen on previous x-rays. This suggests an attempt by Lex's body to heal the C5-6 level. (R. 458-462).

This opinion of Dr. Warner is certainly consistent with Petitioner hearing a pop in his neck when the sign fell on him, and then immediately feeling intense pain in his neck. It is also significant that Dr. Warner rendered this opinion on April 17, 2001, which was after the industrial accident, but before the auto accident of December 26, 2001.

Further, with respect to the cervical spine, the medical record shows no documentation of severe chronic neck pain within a period of time before the accident. For example, during visits with Dr. Warner during the year before the industrial accident, despite pain complaints, there are no significant indications of continuing neck problems.

In addition, on March 1, 2001, Dr. Sawchuck diagnosed a sub acute cervical sprain/strain, and then on April 25, 2001, Dr. Sawchuck diagnosed a cervical disk protrusion and cervical radicular syndrome. Once again, these diagnoses were made after the industrial accident, but before the auto accident.

Following the industrial accident, there is clear documentation that Petitioner suffered a significant increase in neck pain as a result of the fracture in the prior fusion, and due to the cervical sprain/strain, and the new protruding disk and radicular syndrome. These are definitely physical and/or functional restrictions above and beyond what Petitioner experienced prior to the industrial accident.

### **LUMBAR**

Prior to the industrial accident of January 24, 2001, there is no documentation of any significant problem with Petitioner's lumbar spine. In contrast, after the industrial accident the medical record shows new injuries of the lumbar spine, which contribute to Petitioner's disability.

On March 1, 2001, Dr. Sawchuck diagnosed Petitioner with myofascial type pain; Acute lumbar sprain / strain; and Lumbar radicular syndrome. These were new injuries that had not been diagnosed previously.

On March 10, 2001, Dr. Holden diagnosed Petitioner with a grade I-II, right posterolateral broad based disc protrusion at the L5-S1 level touching but not displacing the descending S1 root. This is another new diagnosis. On April 2, 2001, Dr. Sawchuck confirmed the lumbar disk protrusion, and added lumbar radicular syndrome. This is another new diagnosis that had not been made prior to the industrial accident.

On April 17, 2001 Dr. Warner concluded that: "The industrial accident precipitated symptoms of low back pain. The patient has a difficult time straightening and bending due to lower back pain." (R. 462). Once again, these diagnoses and opinions were rendered

before the auto accident of December 26, 2001.

On July 31, 2002 Dr. Sawchuck reviewed the bone scan results and diagnosed "some type of fracture at L5 on the right side in the pedicle region."

On April 1, 2004 Dr. Clark, the doctor hired by YESCO, conceded that: "The industrial accident of 1/24/2001 is documented to have caused some....lumbar pain, which is possibly due to the occult fracture of the L5 pedicle."

The Medical panel concurred that the industrial accident caused a "fracture of the L5 pedicle with disc protrusion at L5-S1."

Thus, in regards the lumbar back, the physical problems caused by the industrial accident, that went above and beyond what already existed, were an aggravation of prior low back pain, a fracture at L5, a disk protrusion at L5-S1, lumbar sprain/strain, and lumbar radicular syndrome. These are not insignificant problems, and have contributed significantly to Petitioner's inability to work.

### **RESPIRATION PROBLEMS**

The medical panel also concluded that Petitioner's hypoxia was not caused or aggravated by the industrial injury. The main facts that would seemingly support that conclusion are that prior to the industrial accident Petitioner did have some mild problems controlling his asthma, there was one note of shortness of breath at night, and after the industrial accident there is seemingly no documentation of breathing problems until well after the auto accident of December 26, 2001. However, the pulmonologists who have examined

this case have offered at least three different theories as to how the industrial accident actually did cause Petitioner's hypoxia. Before examining those theories it should be noted that the Petitioner has testified that he actually did have breathing problems after the industrial accident and before the auto accident. Petitioner noticed soon after the industrial accident that he couldn't catch his breath when he would carry items up stairs. (R. 126, p. 52). Petitioner had not experienced this prior to the industrial accident. However, Petitioner did not immediately see any medical provider about these breathing problems because he believed, based on what others had told him, that it was caused by stress and anxiety related to the tragic and violent death of his son.

**1. Crush injury significantly aggravated prior mild eventration.**

Dr. James Pearl has stated that,

Lex brought in x-rays from 1997, 1999 and 2000 for review of his chest. It was noted that he did have what looked like a mild eventration of his right hemidiaphragm, but radiographically it appears much worse on his more recent x-rays. I suspect that with his history, that when he was crushed, he strained very hard and made the eventration much worse, thus contributing to loss of diaphragmatic movement and atelectases on the right lung which has caused his hypoxemia. I can say this with reasonable medical certainty. (R. 625).

This conclusion would certainly be consistent with the undisputed facts of a 2,000 pound sign pushing on Petitioner's chest.

**2. Significant increase in pain medication causing hypoxia.**

Further, in consideration of the statement made by the medical panel regarding pre-existing opioid medication, and it likely leading to reduced pulmonary drive, it is significant,

as shown by the records, that Petitioner was not taking a substantial amount of pain medication prior to the industrial accident. However, directly following the industrial accident Petitioner's medication dosages, including Methadone and Oxycontin, gradually but significantly increased. This increase is documented and occurred prior to the December 2001 auto accident (See R. 124, p. 48, 49; 126, p. 34; 609; 541; 540; 539; 538; and 537). Following the auto accident there was no increase in medication, in fact after the auto accident Petitioner's medication slightly decreased.

On June 3, 2003, Dr. C. Gregory Elliot, another pulmonologist, gave his opinion as follows: "ASSESSMENT: 1. Arterial hypoxemia associated with alveolar hypertension in the absence of significant abnormalities of the respiratory mechanics suggests that this is on the basis of depressed respiratory drive related to his chronic requirement for methadone and analgesics." (R. 390).

Furthermore, on December 15, 2003, Dr. Tom Cloward opined that Petitioner had "persistent hypoxemia," and that "the most likely etiology of his hypoxemia is due to chronic hypoventilation due to his large narcotic doses." The fact that the breathing problems gradually developed during the period between the industrial accident and the auto accident would seem to coincide with the gradual increase in pain medication during this period.

### **3. Hypoxia caused by damage to nerve in cervical region which controls the hemidiaphragm.**

Finally, there is the letter of August 15, 2005, from Dr. Pearl where he states that, "It

is most likely that Mr. Brady's injury of January 2001 caused his neck injury which affected the nerves which innervate the diaphragm #'s 3, 4, and C3-C4 and C4-C5. This is the cause of his hypoxemia as his other workup has been completely negative." (R. 87). It is also significant that Dr. Pearl noted that there were x-rays taken the day of the auto accident on December 26, 2001, and those films showed that there was no change in the neck, but that the hemidiaphragm was elevated. According to Dr. Pearl, this demonstrated that the collapse of the lung occurred before the auto accident, and probably occurred as a result of the industrial accident. (Id.). This may be the most significant objective evidence regarding the issue of the etiology of the hypoxemia.

In any event, there are at least three plausible theories as to the cause of the hypoxemia, all of which relate to the industrial accident as the root of the problem.

Dr. Clark postulated in her report that Petitioner was actually hypoxemic in January of 2000 – about one year prior to the industrial accident. In response to this assertion, Dr. Sheridan stated,

A statement was made that Mr. Brady was first found to be hypoxemic on January 4, 2000. In fact, Mr. Brady was hypoxemic at that time, but my estimation is that the source of his hypoxemia was bronchitic with a flare of asthma, since he had a considerable period of time after that where he was not complaining of difficulty breathing. He responded well to Biaxin turning of his asthma medication. A second statement, which I believe to be an error, is that one of the reasons for Mr. Brady's hypoxemia is his long-term steroid use and his asthma. To my knowledge, Long-term steroid use does not create hypoxemia. Secondly, none of the specialists whom Mr. Brady has seen recently to evaluate his hypoxemia believes that Mr. Brady's low oxygen saturations can be explained by reactive airway disease. I think that Mr. Brady's hypoxemia is due to paralysis of part of his diaphragm muscle. (R. 488A).

Dr. Clark also postulated that Petitioner's breathing problems may be linked to syrinx that she supposedly observed in the relevant radiographic evidence. In response to this assertion, Dr. Warner, stated that he reviewed Petitioner's MRI's with two other neurosurgeons, and they all concluded that if there is a syrinx, "it is an insignificant finding, " and that if there was a syrinx ". . . it would be asymptomatic." (R. 323B).

### **LEFT SHOULDER**

There is medical evidence that Petitioner did have some problems with his left shoulder prior to the industrial accident, but it is also clear that those problems were minimal when compared to the problems with the right shoulder. There were two surgeries on the right shoulder, and none on the left shoulder. It is also clear that after the industrial accident, and before the auto accident, there were complaints of severe pain in the left shoulder.

When Petitioner saw Dr Schuman at IHC WorkMed a few days after the industrial accident he complained of left shoulder pain. (R. 609). On subsequent visits with Dr. Sheridan, Petitioner complained of left shoulder pain (R. 531-544). It is significant to note that on one of those visits Dr. Sheridan noted that Petitioner's chronic pain was getting worse, and there was a discussion at that time as to whether Petitioner should make a worker's comp claim for permanent total disability. However, Petitioner did not want to do so because he knew his employer would fight it because Petitioner had seen his employer fight such claims by other employees. (R. 533). This fact is critical in that well before the auto accident, there was, in the estimation of the Dr. Sheridan, the doctor that knew



Petitioner the best, sufficient medical evidence to support a claim for permanent total disability.

On September 25, 2001, Dr. Sheridan noted that Petitioner's chronic pain was getting worse, and that his arms were going completely numb at night, and that he could not grip very well to lift things. (R. 532).

On April 17, 2001, Dr. Warner observed Petitioner “. . . now has significant complaints of left shoulder pain. His previous problems have been localized primarily to the right side.” (R. 461).

Even Dr. Clark admitted that Petitioner had, at a minimum, suffered an aggravation of the left shoulder impingement syndrome and AC degeneration due to the industrial accident. (R. 229). And finally, Petitioner testified that as of 2004, his left shoulder was his main problem, and the main reason why he was continuing to take so much pain medication. (R. 126, p. 38).

In sum, as a result of the industrial accident, Petitioner experienced:

1. A fracture at L5, and bulging disk at L5-S1, and lumbar sprain/strain that has developed in to a chronic condition; and
2. Completely new musculoskeletal injury to his left shoulder, or at least a significant aggravation of pre-existing condition; and
3. Severe breathing problems due to a collapsed lung, which is either a completely new problem, or, at a minimum, a significant aggravation of a pre-existing problem; and
4. A significant aggravation of prior chronic neck pain; and

5. A fracture of the prior cervical fusion, which is a completely new injury.

After viewing this list, how can it reasonably be said that these injuries “resulted in no physical or functional restrictions above and beyond those he already endured.” Such is not the case. Dr. Warner, the Chief of Surgery at LDS Hospital, made reference on several occasions that these injuries, which are the ones that forced Petitioner’s permanent and total disability, were a direct result of the industrial accident on January 24, 2001. Additionally, Dr. Scott Sheridan, Petitioner’s primary care physician, and Dr. James Pearl, Petitioner’s pulmonologist, also made reference repeatedly to substantial problems related to the industrial accident. As mentioned, Dr. Sheridan's records indicate on multiple occasions that disability retirement was discussed immediately following the accident. Obviously, if these discussions did indeed take place, the question then is why didn’t Petitioner proceed at that time to file for workers comp disability. As previously cited, there were at least two reasons: first, Petitioner did not believe he would be successful in doing so due to YESCO fighting other employees who had filed other workers comp claims, and second, because Petitioner wanted to continue working as he found that it was the best therapy for him to deal with the tragic loss of his son. Consequently, Petitioner did continue to work even though he was suffering significant pain in multiple locations, and even though he had medical justification at that time to apply for permanent total disability.

It is apparent from the findings of the ALJ and the Commission, that to some degree they relied on the report of Dr. Jayne Clark in support of their decision. It is respectfully submitted that Dr. Clark’s report is not reliable and lacks credibility for the following

reasons:

1. On page 15 of her report (R. 15), Dr. Clark responded to question number 7, which was: Does Mr. Brady's impairment or combination of impairments limit his ability to do basic work? From a medical perspective is Mr. Brady permanently and totally disabled? Please explain.

Dr. Clark responded by stating: "Yes, Mr. Brady is permanently and totally disabled due to medical conditions. It is the syrinx and degenerative spinal disease, and traumatic shoulder problems, that are causing his pain and hypoxia."

As noted previously, the finding of a syrinx by Dr. Clark is totally inconsistent with any of the findings by any of the other doctors, including three neurosurgeons. The three neurosurgeons stated that even if there were a syrinx, it would be an insignificant finding, and that it would have been asymptomatic. If you through out the syrinx from Dr. Clark's opinion, you are left with degenerative spinal disease and traumatic shoulder problems as the cause of Petitioner's disability. As also shown previously, Petitioner suffered a significant cervical injury, a fracture of the fusion, as well as a significant aggravation of chronic pain in the cervical region. In addition, the main shoulder problem since the industrial accident has been the traumatic injury to the left shoulder which was caused by the industrial accident. Consequently, the cause of Petitioner's disability is the industrial accident.

2. On page 6 of her report (R. 6), Dr. Clark notes under item number 18 that, "12/26/01 a radiologist at PVH interpreted cervical x-rays to show a 'remote fracture of C5 and C6. It cannot be determined whether or not he knew of the prior fusion of C5-C7.'"

However, if you look at the radiologist's report, it clearly states that the radiologist spoke with the Petitioner's orthopedic surgeon, and they discussed the prior fusion.

3. On page 11 of her report (R. 11), Dr. Clark states in item number 1 under "Discussion and Notations," that,

This syrxn can account for the pain in his neck and upper back and scapula area, and the resolved sensory deficit that Dr. Warner noted in his upper thoracic region. It possibly could account for some of his shoulder pains as well, particularly when they couldn't really be influenced by Dr. Sawchuck's injections. (emphasis added).

First, it was Dr. Warner who gave injections in the shoulder, and not Dr. Sawchuck. Next, the injections actually did provide pain relief for a period of time. Next, it is significant to note that Dr. Clark does not actually state that the syrxn definitely did cause the other symptoms. All she is saying is that it "can" happen, or that it "possibly" could happen. Almost anything is "possible." But what is definite is that three surgeons, one being the chief of surgery at LDS Hospital, have said that there is no syrxn, and that if there is one it would be an insignificant finding, and it would be asymptomatic.

4. On page 14 of her report (R. 14), in item number 4, under "Onset After and Unrelated to the Industrial Injury Incidents," Dr. Clark states that "it was not until 4/1/02 that rib pain was documented." However, on page 12 of her own report (R. 12), Dr. Clark states that "the industrial accident of 1/24/01 is documented to have caused some left rib pain." Dr. Clark contradicts herself in her own report.

5. On page 3 of her report (R. 3), Dr Clark states next to the date of "1/30/01," that,

"Cervical spine x-rays from IHC Work Med which shows a C4-5 solid

fusion and C5-6 and C6-7 degenerative changes and possible non-unions are present with near obliteration of the discs.

The problem with this observation is that in January of 1997, the procedure that was done was a discectomy and fusion at C5-7” (R. 707).

In other words, the disks were removed. How could Dr. Clark see an obliterated disk if there was no disk to see?

6. On page 2 of her report (R. 2), Dr. Clark states next to the date “3/31/97,” that cervical x-rays from LDS Hospital of that date show that “C4-5 appears to have a solid fusion.” The problem is that the fusion at C4-5 was not done until 11/30/98 (R. 691). This shows that Dr. Clark is not only inaccurate in her recording of medical history, but also quite inaccurate at reading x-rays that supposedly show a fusion before it was actually performed.

7. On page 3 of her report (R. 3), Dr. Clark states next to the date 1/30/01, that “left shoulder x-rays from IHC Work Med showed some acromioclavicular degenerative changes.” However, on page 4 (R. 4), Dr. Clark states that “left shoulder x-rays from Granger Medical Clinic – appear normal to me, but I would defer to the interpreting radiologists.” If the degenerative changes were there previously, they would still be there in subsequent x-rays. Once again, this calls in to question Dr. Clark’s ability to accurately read x-rays.

8. On page 4 of her report (R. 4), Dr. Clark states next to the date 1/24/02, that “. . . C4-6 fusion with C6-7 degenerative disc changes and anterior spurs.” Once again, the first fusion was from C5 through C7, so there would be no disk at C6-7 to show degenerative changes. Dr. Clark’s ability to accurately read an x-ray and render an opinion is quite

questionable in this case. Dr. Clark makes the same mistake on the same page next to the date of 2/21/02.

9. On page 2 of her report (R. 2), Dr. Clark states that a lumbar myelogram was performed on 12/19/96. No such myelogram was performed. Petitioner does not remember having a lumbar myelogram at that time, and none could be found in the medical record. Dr. Clark is either not thorough in documenting the medical history, or she is pulling stuff out of thin air to support her erroneous opinions.

### **SECOND ISSUE**

#### **DID THE COMMISSION ERR IN FINDING THAT A LETTER SUBMITTED BY THE PETITIONER'S TREATING PHYSICIAN AFTER THE MEDICAL PANEL'S REPORT, CONTAINED NO NEW CONFLICTING EVIDENCE.**

Accompanying Petitioner's objections to the medical panel report was a letter from Dr. James Pearl dated August 15, 2005. In light of Dr. Pearl's letter, the medical panel should have been asked to review the matter again concerning the relationship between the aggravation of the neck problem in the industrial accident and the innervation of the diaphragm # 3, 4 and disk level C3-C4 and C4-C5. In its decision the Commission cited R602-2-2(b), which permits the ALJ, at his discretion, to submit new medical evidence to the panel "where there is a proffer of new written conflicting medical evidence." (R. 120).

The evidence from Dr. Pearl was in writing, so that element was satisfied. In addition, what Dr. Pearl offered was certainly conflicting in that the panel had concluded that the hypoxemia either pre or post dated the industrial accident, and Dr. Pearl opined that it was a result of the industrial accident. The only element possibly questionable is whether the

evidence was “new.” It is respectfully submitted that it was new. In his letter Dr. Pearl stated that due to the damage done to the cervical region in the industrial accident, this affected the nerve that controlled the diaphragm, which in turn lifts the lung. Theretofore, the two previous theories that Petitioner’s medical providers had espoused were either the crush from the sign directly damaged the diaphragm, or the hypoxemia was caused by the significant amounts of pain medication that Petitioner was taking. So, the theory of a relationship between the cervical injury and breathing problems, as set forth by Dr. Pearl, was a new theory. Furthermore, Dr. Pearl, noted that Dr. Jarvis, one of the panel members, had opined that the phrenic nerve (the nerve that goes to the diaphragm), was functionally in tact. However, Dr. Pearl noted that the EMG test that Dr. Jarvis was basing his opinion on, was equivocal, making it unclear as to whether function of the nerve was in tact or not. This is something that the medical panel had not previously addressed, and it should have been incumbent upon the ALJ and the Commission to allow the medical panel to address these issues. Thus, the Commission did err in finding that the letter presented no new evidence, and thus, not allow the medical panel to address Dr. Pearl’s letter.

In the case of *Gardner v. Edward Gardner Plumbing and Heating, Inc.*, 693 P.2d 678 (Utah 1984), the Plaintiff wanted to present additional testimony at his second hearing before the ALJ. As in the present case, the additional evidence was from the plaintiff’s doctors, who were to testify as to their objections to the medical panel’s report. The ALJ refused to allow them to testify, and subsequently denied workers comp benefits. In overturning this decision, the Utah Supreme Court stated that “we find that at the second hearing the administrative law

judge erred in limiting the evidence that could be presented by plaintiff to attack the panel's finding." Id. at 681. More specifically, the Court stated that, ". . . the administrative law judge refused to allow plaintiff's doctor to comment on the specific points in the medical panel's report with which he disagreed. The administrative law judge abused his discretion in making these evidentiary rulings." Id. The Court went on to note that,

. . . plaintiff's doctor should have been allowed to comment on his specific points of disagreement with the medical panel's report. That was the reason for his testifying at the hearing. He was familiar with plaintiff's condition, and he could have focused the attention of the administrative law judge on the precise points of the report concerning which he had different information or conclusions. Id. at 682.

Similarly, although not in hearing form, Petitioner in the present case proffered testimony from Dr. Pearl on specific points of disagreement with the medical panel's report. This should have been allowed, and it was error for the Commission to uphold the ALJ's decision to suppress the evidence.

We submit the medical record supports a finding that the industrial injury aggravated the previously corrected neck problem, caused the lower back, and either caused or aggravated the hypoxemia from which Mr. Brady currently suffers. Because of this, a finding of disabled due to the effects of the industrial injury should be made, or in the alternative, in light of Dr. Pearl's letter, we ask the matter first be sent back to medical panel to determine if the panel's opinion is changed in light of Dr. Pearl's discussion.


### **CONCLUSION**

Based upon the evidence cited above, it is respectfully submitted that not only does



the great weight of the evidence support a finding that Petitioner is permanently and totally disabled due to the industrial accident of January 24, 2001, it also shows that the Respondents can not even show that the evidence in their favor is more than a scintilla but less than the weight of the evidence. In other words, there is no substantial evidence that the decision of the Labor Commission should be upheld. Consequently, the decision should be reversed, and benefits should be awarded. At a minimum, the case should be sent back to the Labor Commission with the instruction that the last letter from Dr. Pearl be sent to the medical panel for their review.

Dated this 12 day of August 2009.

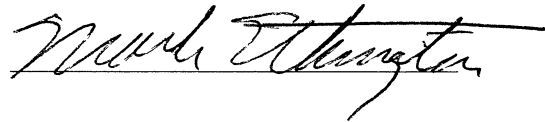
  
Mark T. Ethington  
Attorney for Petitioner

### **PROOF OF SERVICE**

I hereby certify that a true and correct copy of the foregoing Brief of Petitioner was mailed August 2, 2009 first class postage prepaid to the following:

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A handwritten signature in black ink, appearing to read "Mark E. Hingston", written over a horizontal line.

# **ADDENDUM**

UTAH LABOR COMMISSION  
ADJUDICATION DIVISION  
PO Box 146615  
Salt Lake City, Utah 84114-6615  
801-530-6800

<b>LEX L. BRADY,</b>  <b>Petitioner,</b>  <b>vs.</b>  <b>YOUNG ELECTRIC SIGN CO.,</b>  <b>Respondent,</b>	<b>FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER</b>  <b>Case No. 2003948</b>  <b>Judge Richard M. La Jeunesse</b>
---	--

**HEARING:** Room 334 Labor Commission, 160 East 300 South, Salt Lake City, Utah,  
on April 19, 2004 at 1:00 p.m. Said Hearing was pursuant to Order and  
Notice of the Commission.

**BEFORE:** Richard M. La Jeunesse, Administrative Law Judge.

**APPEARANCES:** The petitioner, Lex L Brady, was present and represented by his attorney  
Phillip Shell Esq.

The respondent, Young Electric Sign Co. (YESCO), was represented by  
attorney James R. Black Esq.

**I. STATEMENT OF THE CASE.**

The petitioner, Lex L. Brady, filed an Application for Hearing with the Utah Labor Commission on September 24, 2003, and claimed entitlement to permanent total disability compensation. Mr. Brady's claim for workers' compensation benefits arose out of an industrial accident that occurred on January 24, 2001.

The respondents stipulated that Mr. Brady was permanently and totally disabled. However, the respondents denied that Mr. Brady's industrial accident on January 24, 2001 medically caused the injuries that left him permanently and totally disabled. The respondents argued that Mr. Brady suffered preexisting or subsequent medical problems unrelated to his industrial accident of January 24, 2001 that directly caused his permanent and total disability.

## **II. ISSUE.**

Did the industrial accident of January 24, 2001 cause the medical problems that in turn left Lex Brady permanently and totally disabled?

## **III. COURSE OF PROCEEDINGS.**

Mr. Brady filed his Application for Hearing with the Utah Labor Commission on September 24, 2003. I held an evidentiary hearing in this matter on April 19, 2004. At the request of the parties I left the evidentiary record open for 30 days in order to receive some additional records from Dr. Jane Clark M.D.

On October 7, 2004 I issued my Interim Findings of Fact, Conclusions of Law and Order. Also on October 7, 2003 I sent the parties my proposed Medical Panel Referral and allowed them 15 days to file objections to the form of the letter. November 3, 2004 I sent the Medical Panel Referral to the appointed Medical Panel..

The Medical Panel filed a report on August 2, 2005. I sent the Medical Panel Report to the parties on August 3, 2005 and allowed them 15 days to file objections to the admissibility of the report. Mr. Brady filed his objections to the Medical Panel Report on August 18, 2005.

## **IV. FINDINGS OF FACT.**

### **A. Employment.**

Young Electric Sign Co. employed Mr. Brady from November 30, 1992, to June 6, 2003.

### **B. Compensation Rate.**

At the time of the accident in issue, Mr. Brady was married, but had no dependent children less than 18 years of age. Mr. Brady's testimony provided the unrefuted evidence concerning his wages with YESCO. Mr. Brady's compensation with YESCO at the time of the accident in issue equaled \$18.00 per hour, 40 hours per week average, for the maximum permanent total disability compensation rate of \$450.00 per week. [ $\$18.00/\text{hour} \times 40 \text{ hours/week} = \$720.00/\text{week} \times 2/3 = \$480.00/\text{week} + \$5.00/\text{week} = \$485.00/\text{week}$ ].

### **C. January 24, 2001 Industrial Accident.**

Mr. Brady's testimony provided the lone, un rebutted, evidentiary account of his January 24, 2001 industrial accident. Mr. Brady worked as a sign installer for YESCO. Mr. Brady routinely worked on crews that installed building signs, billboards, and other outdoor signs.  
Findings of Fact, Conclusions of Law and Order

Lex L Brady vs. Young Electric Sign Co.

On January 24, 2004 Mi. Brady worked for YESCO removing a sign from a Conoco station in Orem, Utah. The sign being removed by Mr. Brady and his crew at the Conoco station measured 30' x 10' and weighed one ton.

Mr. Brady located in the basket of a man-lift supervised the sign removal. The crew first hooked the sign to the rigging of a crane. The crew then cut the pole supporting the sign. The sign did not immediately break loose. Mr. Brady still in the basket of the man-lift approached the center of the pole and began to hit it with a 5 lb. Sledge hammer. The one ton sign swung loose from the pole and hit Mr. Brady in the chest. The sign bent Mr. Brady backward in the basket and pinned him for 30 seconds. Mr. Brady estimated that he supported 500 pounds of the sign's weight on his chest while pinned in the basket.

Mr. Brady complained that during the incident on January 24, 2001, his whole body felt numb. Mr. Brady then experienced pain in his neck, shoulders, and low back. Mr. Brady missed no work immediately following his January 24, 2001 industrial accident. But, as time progressed Mr. Brady's pain increased, and he experienced breathing difficulties to the point that he could no longer work as of June 6, 2003.

**B. Lex Brady's Medical Problems Prior to January 24, 2001.**

**I. Cervical Spine Problems.**

While Mr. Brady drove his 3/4 ton Ford pick-up truck in August of 1996 a Jeep CJ hit him head on at about 20 miles per hour. Mr. Brady sustained neck and bi-lateral shoulder problems after the 1996 motor vehicle collision. A CT scan of Mr. Brady's cervical spine taken on December 19, 1996 disclosed:

Broad disk bulging with possible protrusion seen centrally and to the left at C4-CS and centrally and to the right at C5-C6 and C6-C7 as above. [Exhibit "J-1" at 287].

On January 21, 1997 Dr. John MacFarlane M.D. diagnosed Mr. Brady with: "C5-C6, C6-C7 herniated nucleus pulposes." [id. At 318]. The same day Dr. MacFarlane operated on Mr. Brady and performed an:

[a]nterior cervical disectomy and fusion with bank bone grafting and Synthes Plating at C5-C6 and C6-C7. [id.].

On October 12, 1998 Dr. Duane Blatter M.D. conducted an MIRI scan of Mr. Brady's cervical spine that revealed in addition to his fusion from C5 to C7:

Degenerative disc disease at C4-5. No definite disc herniation is appreciated although there is a superior margin osteophyte on the left side at C5 does slightly indent the central surface of the cord. [id. At 62].

On October 13, 1998 Dr. Stephen Warner M.D. examined Mr. Brady and observed that:

His plain films demonstrate backing out of the lower screws of his anterior cervical plate.

At C4-C5 there is a diffuse intervertebral disc bulge without significant central canal stenosis ... There is some foraminal narrowing noted. The disc is desiccated and collapsed. [Id. At 32].

On November 30, 1998 Dr. Warner surgically addressed Mr. Brady's cervical problems with:

PROCEDURE PERFORMED: 1. Removal of anterior cervical plate C-5 to C-7.  
2. Exploration of anterior cervical fusion C-5 to C-7, with solid arthrodesis found at the time of exploration.  
3. Anterior cervical discectomy at C-4/C-5.  
4. Harvesting right tricortical iliac crest graft.  
5. Anterior cervical fusion C-4/C-5 using tricortical iliac crest graft. [id. at 55].

On March 1, 1999 Dr. Warner observed that Mr. Brady "[i]s going to have chronic problems with ... his cervical spine . . ." [id. at 24]. The undisputed medical evidence in this case verified significant cervical spine problems suffered by Mr. Brady prior to January 24, 2001 that resulted in cervical spinal fusions from C4 to C7.

## **2. Low Back Problems.**

On November 3, 1998 Dr. Warner noted:

I reviewed the Mill scan as well as plain films. He has progressive disc space collapse at the L4-5 level. [Exhibit "J-1" at 30].

Accordingly, the medical evidence in this confirmed problems with Mr. Brady's lumbar spine at the L4-5 level prior to January 24, 2001.

## **3. Right Upper Extremity Problems.**

On June 30, 1994 Dr. Scott Sheridan M.D. recorded that Mr. Brady:

[h]is right shoulder problem ... dates back to about a month ago when he apparently dislocated the shoulder transiently while lifting a bale of hay. [Exhibit

"J-1" at 143].

On February 5, 1996 Dr. Odell Rigby M.D. diagnosed Mr. Brady with a "2-year history of bilateral epicondylitis." [id. at 571]. On May 7, 1996 Dr. Sheridan confirmed the diagnosis that Mr. Brady suffered from "Right lateral epicondylitis."

On September 19, 1996 Dr. John Rizzi M.D. took an MRI of Mr. Brady's right shoulder that disclosed: "Thinning of the supraspinatus tendon suspicious for partial thickness tear. [id. at 186]." On August 2, 1997 Dr. Warner evaluated Mr. Brady and concluded:

He has right rotator cuff tendonitis clearly seen on the MRI scan. He also has significant right AC arthritis as well as a ganglion cyst sitting in the corner of the scapula. [id. at 48].

On January 22, 1998 Dr. Warner approached Mr. Brady's right shoulder surgically who:

[u]nderwent an open reduction and internal fixation of his acromium fracture

followed by a subacromial decompression. [id. at 66].

Dr. Warner postoperatively diagnosed Mr. Brady's right shoulder with:

1. Impingement syndrome.
2. Intact rotator cuff
3. Right acromium fracture nonunion. [id. at 703].

On May 19, 1998 Dr. Hugh West also operated on Mr. Brady's right shoulder performing:

1. Diagnostic arthroscopy.
2. Right distal clavicle resection. [id. at 698].

Dr. West postoperatively diagnosed Mr. Brady with:

1. Right AC joint arthritis.
2. Right Acromium nonunion. [id.].

On October 13, 1998 Dr. Warner determined that Mr. Brady's "[r]ight shoulder pain is secondary to the acromium fracture." [id. at 32]. An MRI taken of Mr. Brady's right shoulder on February 27, 1999 revealed postoperative metallic artifacts and:

Findings consistent with synovial inflammation of subacromial/subdeltoid bursa. Infrapinatus/supraspinatus tendonitis without full-thickness tendon tear.... [id. at 65].

On March 1, 1999 Dr. Warner observed that Mr. Brady "[i]s going to have chronic problems with ... his right shoulder." [id. at 24]. On December 27, 2000 Dr. Sheridan confirmed that Mr.



Brady suffered from chronic arm pain. [id. at 82].

The uniform medical evidence in this case established that prior to January 24, 2001 Mr. Brady suffered chronic right arm and shoulder pain resultant from: (1) right lateral epicondylitis; (2) right rotator cuff tendonitis; (3) right AC arthritis, and a right acromium fracture nonunion.

#### **4. Left Upper Extremity Problems.**

On February 5, 1996 Dr. Rigby diagnosed Mr. Brady with a "2-year history of bilateral epicondylitis." [Exhibit "J-1" at 571]. On August 10, 2000 Dr. Sheridan verified the diagnosis of left lateral epicondylitis."

O September 14, 2000 Dr. Warner annotated an event where Mr. Brady:

[f]ell out of his basket at work approximately 1 month ago sustaining an injury to his left wrist and elbow.

\* \* \* \* \*

IMPRESSION: 1. Left wrist pain. He is tender over the first dorsal compartment and this most likely represents de Quervain's disease: however, I cannot rule out intercalary instability of the left wrist following traumatic injury.

2. Left extension tendonitis. [id. at 18].

The uncontradicted medical evidence in this case substantiated the fact that Mr. Brady had left lateral epicondylitis prior to January 24, 2001.

#### **5. Respiration Problems.**

On June 30, 1994 Dr. Sheridan recorded that Mr. Brady suffered from "asthma with marginal control." [Exhibit "J-1" at 143]. On June 21, 1999 Dr. Sheridan noted that Mr. Brady was then on oxygen. [id. at 100]. On January 4, 2000 Dr. Sheridan assessed Mr. Brady with:

1. URI with unusual nocturnal shortness of breath of unknown significance.
2. Asthma.

Lab Data: Pulse oximetry on room air is 89 to 91%. [id. at 94].

On June 14, 2000 Dr. Sheridan determined that Mr. Brady's asthma lacked adequate control. [id. at 89]. In sum, the medical records established that prior to January 24, 2001 Mr. Brady suffered from poorly controlled asthma and nocturnal shortness of breath that required the use of oxygen.

### **E. Lex Brady's Medical Problems Caused by the January 24, 2001 Industrial Accident.**

#### **1. Cervical Spine Problems.**

On January 24, 2001 Mr. Brady went to see Dr. Tom Schuman M.D. with respect to his

industrial accident that day. Dr. Schuman recorded Mr. Brady's complaints of neck pain. On February 12, 2001 Mr. Brady went back to his regular treating physician Dr. Sheridan who diagnosed him with: "Chronic neck and shoulder pain with recent injury." [Exhibit J-t" at 80].

On March 1, 2001 Dr. Terry Sawchuck examined Mr. Brady and concluded:

[w]ork related accident, which occurred on approximately January 24, 2001.

IMPRESSION: 1. Subacute cervical sprain/strain.

2. Chronic cervicgia or neck pain.

3. Status post cervical discectomy and anterior interbody fusion at C5-5 and C6-7 with anterior plating in January 1977.

4. Status post anterior cervical discectomy at C4-5 with interbody fusion using allograft ... November 1998. [id. at 173].

On March 10, 2001 Dr. William Halden M.D. took an MRI scan of Mr. Brady's cervical spine that showed:

1. Anterior fusion at the C4-5 level.

2. A plate and screw fixation device across the C5-6 and C6-7 disc spaces seen has been removed. There is no definite bony fusion across these disc levels.

3. There is some degenerative disc change at the C6-7 and to a milder degree C7-T1 levels. There is mild narrowing of the right C6-7 neural foramen. There is no central canal stenosis at any level. [id. at 254].

On April 17, 2001 Dr. Warner evaluated Mr. Brady and determined:

The patient has had a significant increase in his neck pain since the industrial accident.

When I look through the current cervical spine films compared to the previous cervical spine films, the patient now clearly has a pseudoarthrosis at the C5-6 and C6-7 levels.

When I performed removal of the loose plate and the C4-5 fusion, the patient had anterior bridging bone at both C5-6 and C6-7. I believe that the patient sustained a fracture through the fusion at C5-6 and C6-7 directly related to the industrial accident. He now has developed a large anterior callous at C5-6 which was not seen on previous x-rays. This suggests an attempt by Lex's body to heal the C5-6 level. Again there is clear motion at C5-6 and C6-7. [id. at 461].

On April 25, 2001 Dr. Sawchuck diagnosed Mr. Brady with a:

Cervical disc protrusion and cervical radicular syndrome and status post cervical fusion. [id. at 243].

On December 26, 2001 Mr. Brady had another motor vehicle accident when a car ran a red light and hit Mr. Brady's ¾ ton Ford pick-up truck. Mr. Brady wore no seat belt and hit his head on the truck cab interior roof Mr. Brady acknowledged that the December 26, 2001 automobile accident aggravated his neck pain. On January 24, 2002 Dr. Warner recounted that: "Since the

motor vehicle accident on December 26, 2001, the patient has had marked increase in neck pain...[id. at 477].

On February 21, 2002 Mr. Brady underwent another cervical spine MRI at the hands of Dr. Steven Hunt M.D. that demonstrated:

IMPRESSION: 1. Anterior fusion C4-5, this appears solid.  
2. Postoperative changes C5-6 and C6-7, with degenerative changes. No central spinal stenosis at these levels.  
3. C7-T 1 demonstrative mild degenerative change with broad-based grade I disc bulge. [id. at 236].

On October 7, 2003 Dr. Warner recorded:

I repeated a lateral x-ray of the cervical spine. Where he had the fracture through the fusion at C5-6 with a large amount of callous appears to have healed. This further supports the contention that he refractured the C5-6 level. [id. at 324].

On April 1, 2004 Dr. Jane Clark M.D. evaluated Mr. Brady and opined:

It appears that none of Mr. Brady's treating physicians have appreciated that he has had a small spinal cord syrinx, at least as early as 8/98. It is most likely that this syrinx occurred just after the 1996 MVA or that it was congenital. This syrinx can account for the pain in his neck and upper back and scapular area, and the resolved sensory deficit that Dr. Warner noted in his upper thoracic region. It possibly could account for some of his shoulder pains as well, particularly when they couldn't really be influenced by Dr. Sawchuck's injections. [id. at 11].

Dr. Clark found that the following problems preexisted Mr. Brady's industrial accident on January 24, 2001:

Cervical degenerative disc and facet disease with attempted fusions of C5-6 and C6-7 on 1/21/97. subsequently the screws loosened which caused more swallowing problems. They were removed in 11/98.

Dr. Clark stated that Mr. Brady's January 24, 2001 industrial accident "[I]likely strained his nonfusion levels of C5-6 and C6-7." [id. at 13]. Dr. Clark also concluded that Mr. Brady's motor vehicle accident on December 26, 2001 "caused worse neck ... problems." [id. at 14].

Dr. Warner provided a rebuttal to Dr. Clark's opinions wherein he opined:

I believe the patient's industrial accident caused a fracture of the patient's tenuous fusion at the C5-C6 and C6-C7 levels. This was enough stimulus to lead to the fusion of the C5-C6 level. The patient still has a failure of the fusion at the C6-C7 level ... It is my contention that the patient sustained a fracture through these

fusions in the industrial accident of January 24, 2001. [id. at 323A-B].

Dr. Warner went on to state that he reviewed Mr. Brady's cervical MRI's with two other neurosurgeons who all concluded that with respect to the variant observed as a syrinx by Dr. Clark "[i]t is an insignificant finding." [id. at 323B]. Dr. Warner determined that "[i]f this indeed represented a syrinx, it would be asymptomatic." [id.].

On August 2, 2005 the Medical Panel filed a report. The Medical Panel consisted of the chair, Dr. Joseph Jarvis M.D. an occupational medicine specialist, and Dr. Dennis Gordon M.D., an orthopedic surgeon. The Medical Panel determined that Mr. Brady's industrial accident on January 24, 2001 caused an:

Aggravation of pre-existing lower cervical spine (C5-T1) problems, magnifying pain related to muscle spasm and degenerative disease. [Medical Panel Report p. 111].

I found the Medical Panel Report well considered and supported by other medical evidence in the record. Consequently, the preponderance of the medical evidence in this case established that Mr. Brady's industrial accident on January 24, 2001 caused an:

Aggravation of pre-existing lower cervical spine (C5-T1) problems, magnifying pain related to muscle spasm and degenerative disease.

## **2. Low Back problems.**

On March 1, 2001 Dr. Sawchuck diagnosed Mr. Brady in relevant part with:

6. Myofascial type pain.
7. Acute lumbar sprain/strain.
8. lumbar radicular syndrome. [id. at 173].

On March 10, 2001 Dr. Holden took an MRI scan of Mr. Brady's lumbar spine that revealed:

IMPRESSION: 1. Grade I-II right posterolateral broad based disc protrusion at the L5-S1 level touching but not displacing the descending S1 root.  
2. Some disc degenerative change at the L3-4, L2-3, and L1-L2 levels ... no central canal stenosis or neural impingement at any level.  
3. Mild facet degenerative arthritic change bilateral at the L4-5 and L5-S1 levels.  
[id. at 177].

On April 2, 2001 Dr. Sawchuck assessed Mr. Brady with "Lumbar disc protrusion and lumbar radicular syndrome." [id. at 248]. On April 17, 2001 Dr. Warner concluded that: "The industrial accident precipitated symptoms of low back pain." [id. at 462]. Dr. Hunt did another MRI of Mr. Brady's lumbar spine on June 6, 2002 that showed:

IMPRESSION: 1. Multilevel degenerative disc and facet changes particularly at L4-5 on the right.

2. Unusual sclerotic appearing region in the right L5 pedicle.

\* \* \* \* \*

L5-S1 ... There is a grade I right posterolateral disc bulge with possible annular tear. No frank disc herniation. [id. at 227].

On July 1, 2002 Dr. Jerry Handly M.D. conducted a bone scan on Mr. Brady's lumbar spine that disclosed:

IMPRESSION: 1. focal increased activity in the region of the right pedicle and facet at the L5 level consistent with an occult fracture at this site. [id. at 225].

On July 31, 2002 Dr. Sawchuck reviewed the bone scan results and concurred that Mr. Brady had "[s]ome type of fracture at L5 on the right side in the pedicle region." [id. at 223]. In her report of April 1, 2004 Dr. Clark assayed that Mr. Brady had "Lumbar degenerative disc disease" prior to his industrial accident on January 24, 2001. [id. at 12]. However, Dr. Clark conceded that: "The industrial accident of 1/24/02 is documented to have caused some ... lumbar pain, which is possibly due to the occult fracture of the L5 pedicle." [id].

The Medical panel concurred that Mr. Brady's industrial accident on January 24, 2001 caused a "Fracture of the L5 pedicle with disc protrusion at L5-S1." [Medical Panel Report p. 1 ¶ 1.a.]. The preponderance of the medical evidence in this case confirmed that Mr. Brady's industrial accident on January 24, 2001 caused a "Fracture of the L5 pedicle with disc protrusion at L5-S1."

### **3. Right Upper Extremity Problems.**

February 12, 2001 Mr. Brady saw his regular treating physician Dr. Sheridan who diagnosed him with: "Chronic neck and shoulder pain with recent injury." [Exhibit J~ 1" at 80]. On April 1, 2004 Dr. Jane Clark M.D. evaluated Mr. Brady and opined:

It appears that none of Mr. Brady's treating physicians have appreciated that he has had a small spinal cord syrinx, at least as early as 8/98. It is most likely that this syrinx occurred just after the 1996 MVA or that it was congenital. This syrinx can account for the pain in his neck and upper back and scapular area, and the resolved sensory deficit that Dr. Warner noted in his upper thoracic region. It possibly could account for some of his shoulder pains as well, particularly when they couldn't really be influenced by Dr. Sawchuck's injections. [id. at 11].

Dr. Clark concluded that all of Mr. Brady's right upper extremity problems preexisted his industrial accident on January 24, 2001. [id. pp. 12-14].

Dr. Warner examined Mr. Brady's cervical MRI's with two other neurosurgeons who all concluded that with respect to the variant observed as a syrinx by Dr. Clark "[i]t is an

insignificant finding." [id. at 323B]. Dr. Warner determined that "[i]f this indeed represented a syrx, it would be asymptomatic." [id.].

Dr. Warner disputed Dr. Clark's theory about a syrx causally contributing to Mr. Brady's right shoulder problems. Nevertheless, none of the medical experts attempted to causally relate Mr. Brady's ongoing right upper extremity problems to his industrial accident of January 24, 2001. To the contrary, the medical evidence in this case fairly established that prior to January 24, 2001 Mr. Brady suffered chronic right arm and shoulder pain resultant from: (1) right lateral epicondylitis; (2) right rotator cuff tendonitis; (3) right AC arthritis, and a right acromium fracture nonunion.

#### 4. Left Upper Extremity Problems.

On April 17, 2001 Dr. Warner observed that Mr. Brady: "[n]ow has significant complaints of left shoulder pain. His previous problems have been localized primarily to the right side. [Exhibit "J-1" at 461]. On January 24, 2002 Dr. Warner commented:

Since the motor vehicle accident on December 26, 2001, the patient has had marked increase in ... shoulder pain especially on the left side .... [id. at 477].

On June 6, 2002 Dr. Hunt took an MRI of Mr. Brady's left shoulder that disclosed:

IMPRESSION: 1. No full thickness! complete rotator cuff tear identified.  
2. There is moderate tendinopathy of the supraspinatus tendon and mild tendinopathy of the subscapularis tendon associated with a down-sloping type II acromium and AC joint hypertrophic change. [id. at 229].

Dr. Clark noted that prior to January 24, 2001 Mr. Brady had:

Left shoulder problems due to a down sloping acromium and degenerative changes and trauma from a MVA of 12/26/01. [id. at 13].

Dr. Clarke acknowledged that Mr. Brady suffered an:

Aggravation of the left shoulder impingement syndrome and AC degeneration by the 1/24/01 incident. [id.].

Nevertheless, Dr. Clark insisted that: "[i]t was the 12/26/01 MVA which really caused this to be problematic." [id. at 14]. The Medical Panel refuted any causal connection between Mr. Brady's left shoulder problems and his industrial accident on January 24, 2001. [Medical Panel Report p. I ¶ 1.a.]. Accordingly, the preponderance of the evidence in this case verified that none of Mr. Brady's left shoulder problems causally resulted from his industrial accident on January 24, 2001.

#### 5. Respiratory Problems.

On March 17, 2003 Dr. James Wilcox M.D. diagnosed Mr. Brady with:

Polycythemia almost assuredly secondary polycythemia. Probably due to both central sleep apnea and obstructive sleep apnea .... [Exhibit "J-1" at 407].

On March 14, 2003 Dr. Tom Cloward M.D. assessed Mr. Brady with:

DIAGNOSTIC IMPRESSION: 1. I think that he has obesity-hyperventilation syndrome complicated by obstructive sleep apnea. In addition he has airway obstruction on pulmonary function tests. This is consistent with "Mixed Syndrome." The above problems are exacerbated by narcotic pain medication, benzodiazepines and muscle relaxants. I think a majority of his sleep apnea can be explained by concomitant use of these medications. [Id. at 400].

On June 3, 2003 Dr. C. Gregory Elliot weighed in on the nature of Mr. Brady's respiratory problems:

ASSESSMENT: 1. Arterial hypoxemia associated with alveolar hypotension in the absence of significant abnormalities of the respiratory mechanics suggests that this is on the basis of depressed respiratory drive related to his chronic requirement for methadone and analgesics.  
2. Chronic asthma and chronic obstructive pulmonary disease.  
3. History of obstructive sleep apnea.  
4. Episodic dyspnea, etiology remains unclear. [id. at 390].

On June 6, 2003 Dr. Elliot elaborated on his prior assessment of Mr. Brady's respiratory problems:

[M]y impression is that Mr. Brady has multiple cardiorespiratory problems compounded by his chronic pain syndrome, depression and anxiety.

Mr. Brady does have polycythemia which I believe is most likely related to his chronic hypoxemia. The etiologies for his chronic hypoxemia include chronic obstructive pulmonary disease (asthma) in combination with alveolar hypoventilation caused by his dependence upon methadone and other analgesics for relief of chronic musculo-skeletal pain. [id. 387].

Dr. Mark Passey M.D. concluded on July 22, 2003:

Based on the level of hypoxemia and the patient's exam it would seem apparent that he has intrinsic lung disease at this time. [id. at 213].

On August 6, 2003 Dr. Andrew Colletti M.D. conducted a Color Doppler Echocardiogram on Mr. Brady that revealed a "Patent Foramen Ovale" referred elsewhere in the medical records as a PFO. [id. at 369]. On October 7, 2003 Dr. Warner noted that Mr. Brady had:

[b]een diagnosed with pulmonary hypertension and is on oxygen. He most likely has a ventricular septal defect with pulmonary hypertension. [id. at 324].

Dr. Cloward on December 15, 2003 updated his assessment of Mr. Brady:

IMPRESSION: 1. Persistent hypoxemia. The most likely etiology of his hypoxemia is due to chronic hypoventilation due to his large narcotic doses.

However, on March 29, 2004 Dr. Sherman Sorensen M.D. determined that: "He does not have a significant PFO." [id. at 488B].

2. he also has evidence of underlying lung disease, consistent with chronic obstructive pulmonary disease.

3. There may be some element of right to left shunting.... [id. at 344-345].

Yet, on December 17, 2003 Dr. Wayne Adams M.D. found: "No evidence of right to left shunt." [id. at 346J. Then, on January 6, 2004 Dr. Cloward determined after testing:

I then had him perform a 100% F102 shunt study at LDS Hospital which revealed that he does have a significant shunt fraction measuring approximately 17% (normal less than 5%). He has a known PFO.

DIAGNOSTIC IMPRESSION: Significant right to left shunt by physiological testing in the laboratory. His shunt fraction is approximately 17%. [id. at 341].

On January 8, 2004 Dr. Robert Farney M.D. examined Mr. Brady and concluded he had:

IMPRESSION: 1. Sleep disorder breathing...  
2. Persistent hypoxemia secondary to hypoventilation secondary to narcotics.  
3. Polycythemia secondary to above.  
4. Patent Foramen Ovale with shunt.  
5. Chronic obstructive pulmonary disease. [id. at 661].

On January 22, 2004 a pulmonary specialist, Dr. James Pearl M.D., diagnosed Mr. Brady with:

IMPRESSION: 1. Mr. Brady has hypoxemia of unclear etiology. He does have atelectasis<sup>2</sup> at the right base which may relate to a paralyzed right hemidiaphragm. It is possible that this occurred with his traumatic chest injury and that would seem to be a likely etiology. [id. at 339].

On January 29, 2004 Dr. Margaret Ensign M.D. performed a thoracic fluoroscopy on Mr. Brady that revealed: "Findings most consistent with eventration<sup>3</sup> right hemidiaphragm." [id. at 337]. In her evaluation of April 4, 2004 Dr. Clark opined:



The right hemidiaphragm paralysis or paresis was not diagnosed until 1/2004 by Dr. Pearl. But apparently review of x-rays even from 1997 note this problem. It possibly could have been a side effect of a cervical injections or surgeries, but also could be due to the presence of the syrinx causing dysfunction of the anterior

2 Partial or complete collapse of the lung.  
Wound of large extent.

horn cells at the C3-5 levels which innervate the vagus nerve to the diaphragm. It clearly was present long before the 1/24/01 incident. [id. at 12].

In an alternative theory espoused by Dr. Clark on May 13, 2004 she postulated:

It is my conclusion from the statements of Mr. Brady and his treating physicians that the MVA of 12/01 was a much more disabling accident than (sic) the sign accident of 1/24/01. The change from 80.7% to 71.7% right lung height compared to left, is medically more likely related to the most severe and disabling accident, which was the 12/01 MVA. [id. at 16C}.

On April 8, 2004 Mr. Brady's treating physician Dr. Sheridan provided a rebuttal to some of the conclusions reached by Dr. Clark:

A statement was made that Mr. Brady was first found to be hypoxemic on January 4, 2000. In fact Mr. Brady was hypoxemic at that time, but my estimation is that the source of his hypoxemia was bronchitic with a flare of asthma, since he had a considerable period of time after that where he was not complaining of difficulty breathing. He responded well to Biaxin and turning of his asthma medication.

A second statement which I believe to be an error, is that one of the reasons for Mr. Brady's hypoxemia is his long-term steroid use and his asthma. To my knowledge, long-term steroid use does not create hypoxemia. Secondly, none of specialists whom Mr. Brady has seen recently to evaluate his hypoxemia believes that Mr. Brady's low oxygen saturations can be explained by reactive airway disease. I think that Mr. Brady's hypoxemia is due to paralysis of part of his diaphragm muscle. [id. at 488A].

Dr. David Ryser M.D. subjected Mr. Brady to an Electromyography/Nerve conduction study on April 9, 2004 that revealed:

IMPRESSION: No electrodiagnostic evidence of acute phrenic denervation bilaterally. Morphology of early-recruited motor units in the right hemidiaphragm showed changes consistent with subacute to chronic denervation, however, but this was neither marked nor unequivocal. [id. at 656A].

Dr. Ryser's tests further demonstrated:

Phrenic nerve compound motor action potential amplitude on the right was almost - twice that of the response on the left but both were in normal limits. This finding is added assurance that no significant neuromuscular lesion is present on the right. [id. 656B].

Findings of Fact, Conclusions of Law and Order

Lex L Brady vs. Young Electric Sign Co.

On April 15, 2004 Dr. Warner also challenged Dr. Clark's analysis that causally linked Mr. Brady's respiration problems with the syrinx observed by Dr. Clark. Dr. Warner stated that he reviewed Mr. Brady's cervical MRI's with two other neurosurgeons who all concluded that with respect to the variant observed as a syrinx by Dr. Clark "[i]t is an insignificant finding." [id. at 323B]. Dr. Warner determined that "[i]f this indeed represented a syrinx, it would be asymptomatic." [id.].

The Medical Panel Report stated:

The medical panel finds no evidence that Mr. Brady's hypoxia should be considered a consequence of the accident on 1/24/01. The right hemi-diaphragm is clearly elevated well before 2001. There is evidence that phrenic nerve function is intact. Mr. Brady does have obstructive pulmonary disease of longstanding (Asthma). He has been using opioid medication for some time, which likely leads to reduced pulmonary drive (at least one measure of hypoventilation is the pCO<sub>2</sub>, which has been elevated at 48 in Mr. Brady's case). While it is true that the incident on 1/24/01 did likely increase pain problems for Mr. Brady, the clinical records in this case indicate that difficulties in management of the overall pain problems and onset of the hypoxia occurred after the auto accident of 12/01. Therefore, the medical panel finds it likely that Mr. Brady would not have encountered hypoxia absent the auto accident in December 2001. [Medical Panel Report pp.1-2 ¶ 1].

Again, I found the Medical Panel Report well considered. Accordingly, the preponderance of the medical evidence in this case verified that Mr. Brady's industrial accident on January 24, 2001 did not cause his respiratory problems and more specifically his hypoxia.

## **F. Permanent Total Disability.**

### **1. Permanent Total Disability.**

As found *infra*, the parties stipulated that Mr. Brady became permanently and totally disabled on June 6, 2003. However, the parties disagreed over the direct cause of Mr. Brady's permanent total disability.

### **2. The Direct Cause of Lex Brady's Permanent Total Disability.**

On July 23, 2002 Dr. Sheridan noted that:

Lex experienced a car wreck in December 2001 which significantly aggravated his existing musculoskeletal problems. Prior to that we were battling chronic pain with him, but we were seeing him on an every two-or-three month basis. Since then, I have been unable to get any significant control of his pain. I have recommended that he retire from his position at YESCO Sign Company, because his daily activities routinely aggravate his medical condition, but he is dedicated to working, and because of personal things in his life. He feels that he would be better off emotionally if he continues working. [id. at 445].

Dr. Sheridan went on to observe that:

I think his overall condition has been aggravated by numerous issues, but this

recent car wreck has really messed things up. [id. at 446].

On October 7, 2003 Dr. Warner concluded that:

At this point, it is my opinion that the patient is totally disabled for the performance of work related activities due to his multiple medical problems as well as the severe degeneration of his cervical as well as lumbar spine. I do not feel that the patient will be able to be gainfully employed in any manner. [id. at 324].

On October 15, 2003 Dr. Sheridan determined that Mr. Brady's "[p]ain level is pretty much out of control." [id. at 490].

On April 1, 2004 Dr. Clark opined that: "It really is Mr. Brady's hypoxia which ultimately caused his quitting work." [id. at 12]. Dr. Clark within her same opinion elaborated:

It is my opinion that because of his slowly progressive symptoms from the cervical syrinx and the degenerative problems with his cervical, thoracic, and lumbar spine, including the hypoxia, he is no longer able to work or be gainfully employed. But none of this disability causing him to be unable to work is due, in any significant part, to any of the industrial injury incidents. [id. at 14].

The Medical Panel declared that:

[M]r. Brady likely had no significant physical and functional restrictions caused by the incident of 1/24/01 over and above those he had experienced prior thereto. [Medical Panel Report p.2 ¶ 2].

Once more, I found the Medical panel Report determinative on this issue. Therefore, the preponderance of the evidence in this case established that Mr. Brady's medical problems caused by his January 24, 2001 industrial accident resulted in no physical or functional restrictions above and beyond those he already endured. Consequently, the medical problems caused by Mr.

Brady's industrial accident on January 24, 2001 did not serve as the direct cause of his permanent total disability.

### **3. Conclusion.**

Mr. Brady's industrial accident on January 24, 2001, and the medical problems resultant there from, did not serve as the direct cause of his permanent total disability. Consequently, Mr. Brady's claim for permanent total disability compensation must be denied.

## **V. CONCLUSIONS OF LAW**

### **A. Employment.**

YIESCO employed Mr. Brady from November 30, 1992, to June 6, 2003.

### **B. Compensation Rate.**

At the time of the accident in issue, Mr. Brady was married, but had no dependent children less than 18 years of age. Mr. Brady's compensation with YESCO at the time of the accident in issue equaled \$18.00 per hour, 40 hours per week average, for the maximum permanent total disability compensation rate of \$450.00 per week. [ $\$18.00/\text{hour} \times 40 \text{ hours/week} = \$720.00/\text{week} \times 2/3 = \$480.00/\text{week} + \$5.00/\text{week} = \$485.00/\text{week}$ ].

### **C. January 24, 2001 Industrial Accident.**

Mr. Brady worked as a sign installer for YESCO. Mr. Brady routinely worked on crews that installed building signs, billboards, and other outdoor signs.

On January 24, 2004 Mr. Brady worked for YESCO removing a sign from a Conoco station in Orem, Utah. The sign being removed by Mr. Brady and his crew at the Conoco station measured 30' x 10' and weighed one ton.

Mr. Brady located in the basket of a man-lift supervised the sign removal. The crew first hooked the sign to the rigging of a crane. The crew then cut the pole supporting the sign. The sign did not immediately break loose. Mr. Brady still in the basket of the man-lift approached the center of the pole and began to hit it with a 5 lb. Sledge hammer. The one ton sign swung loose from the pole and hit Mr. Brady in the chest. The sign bent Mr. Brady backward in the basket and pinned him for 30 seconds. Mr. Brady estimated that he supported 500 pounds of the sign's weight on his chest while pinned in the basket.

Mr. Brady complained that during the incident on January 24, 2001, his whole body felt numb. Mr. Brady then experienced pain in his neck, shoulders, and low back. Mr. Brady missed no work immediately following his January 24, 2001 industrial accident. But, as time progressed Mr. Brady's pain increased, and he experienced breathing difficulties to the point that he could no longer work as of June 6, 2003.

**D. Lex Brady's Medical Problems Prior to January 24, 2001.**

**1. Cervical Spine Problems.**

Mr. Brady suffered significant cervical spine problems prior to January 24, 2001 that resulted in cervical spinal fusions from C4 to C7.

**2. Low Back Problems.**

Mr. Brady had problems with his lumbar spine at the L4-5 level prior to January 24, 2001.

**3. Right Upper Extremity Problems.**

Prior to January 24, 2001 Mr. Brady suffered chronic right arm and shoulder pain resultant from: (1) right lateral epicondylitis; (2) right rotator cuff tendonitis; (3) right AC arthritis, and a right acromion fracture nonunion.

**4. Left Upper Extremity Problems.**

Mr. Brady had left lateral epicondylitis prior to January 24, 2001.

**5. Respiration Problems.**

Before January 24, 2001 Mr. Brady suffered from poorly controlled asthma and nocturnal shortness of breath that required the use of oxygen.

**E. Lex Brady's Medical Problems Caused by the January 24, 2001 Industrial Accident.**

**I. Cervical Spine Problems.**

Mr. Brady's industrial accident on January 24, 2001 caused an:

Aggravation of pre-existing lower cervical spine (C5-T1) problems, magnifying pain related to muscle spasm and degenerative disease.

**2. Low Back problems.**

Mr. Brady's industrial accident on January 24, 2001 caused a "Fracture of the L5 pedicle with disc protrusion at L5-S 1."

**3. Right Upper Extremity Problems.**

Dr. Warner disputed Dr. Clark's theory about a syrinx causally contributing to Mr. Brady's right shoulder problems. Nonetheless, none of the medical experts attempted to causally relate Mr.

Brady's ongoing right upper extremity problems to his industrial accident of January 24, 2001. To the contrary, the medical evidence in this case fairly established that prior to January 24, 2001 Mr. Brady suffered chronic right arm and shoulder pain resultant from: (1) right lateral epicondylitis; (2) right rotator cuff tendonitis; (3) right AC arthritis, and a right acromium fracture nonunion.

#### **4. Left Upper Extremity Problems.**

none of Mr. Brady's left shoulder problems causally resulted from his industrial accident on January 24, 2001.

#### **5. Respiratory Problems.**

Mr. Brady's industrial accident on January 24, 2001 did not cause his respiratory problems and more specifically his hypoxia.

### **F. Permanent Total Disability.**

#### **1. Permanent Total Disability.**

Mr. Brady became permanently and totally disabled on June 6, 2003. However, the parties disagreed over the direct cause of Mr. Brady's permanent total disability.

#### **2. The Direct Cause of Lex Brady's Permanent Total Disability.**

Utah Code Ann. §34A-21-413(1) (1995) provides in pertinent part:

(b) To establish entitlement to permanent total disability compensation, the employee has the burden of proof to show by a preponderance of the evidence that:

(iii) the industrial accident or occupational disease was the direct cause of the employee's permanent total disability.

Mr. Brady's medical problems caused by his January 24, 2001 industrial accident resulted in no physical or functional restrictions above and beyond those he already endured. Consequently, the medical problems caused by Mr. Brady's industrial accident on January 24, 2001 did not serve as the direct cause of his permanent total disability.

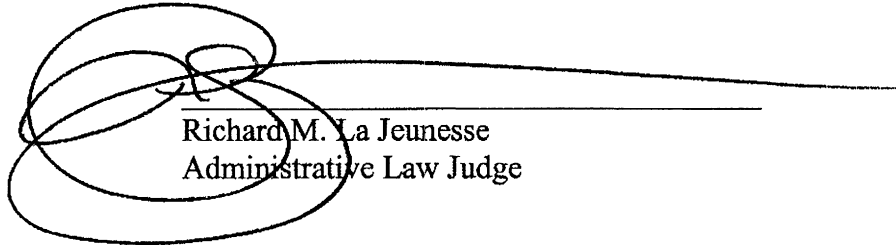
#### **3. Conclusion.**

Mr. Brady's industrial accident on January 24, 2001, and the medical problems resultant there from, did not serve as the direct cause of his permanent total disability. Consequently, Mr. Brady's claim for permanent total disability compensation must be denied.

## **VI. ORDER**

**IT IS THEREFORE ORDERED** that Lex Brady's claim for permanent total disability compensation against Young Electric Sign Co. is hereby dismissed with prejudice.

**DATED** November 29, 2005.



Richard M. La Jeunesse  
Administrative Law Judge

## **NOTICE OF APPEAL RIGHTS**

A party aggrieved by the decision may file a Motion for Review with the Adjudication Division of the Utah Labor Commission. The Motion for Review must set forth the specific basis for review and must be received by the Commission within 30 days from the date this decision is signed. Other parties may then submit their responses to the Motion for Review within 20 days of the date of the Motion for Review.

Any party may request that the Appeals Board of the Utah Labor Commission conduct the foregoing review. Such request must be included in the party's Motion for Review or its response. If none of the parties specifically request review by the Appeals Board, the review will be conducted by the Utah Labor Commission.

## **CERTIFICATE OF MAILING**

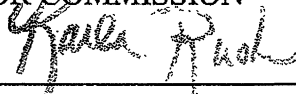
I hereby certify that a true and correct copy of the attached Findings of Fact, Conclusions of Law, and Order, was mailed by prepaid U.S. postage on November 29, 2005, to the persons/parties at the following addresses:

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UTAH LABOR COMMISSION

A handwritten signature in cursive script, appearing to read "Kara Rush", is written over a horizontal line.

Clerk, Adjudication Division  
PO Box 146615  
Salt Lake City, UT 84114-6615



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**UTAH LABOR COMMISSION**

**LEX L. BRADY,**

**Petitioner,**

**vs.**

**YOUNG ELECTRIC SIGN CO.,**

**Respondent.**

**ORDER AFFIRMING  
ALJ'S DECISION**

**Case No. 2003948**

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Lex L. Brady asks the Utah Labor Commission to review Administrative Law Judge La Jeunesse's denial of Mr. Brady's claim for benefits under the Utah Workers' Compensation Act, Title 34A, Chapter 2, Utah Code Annotated.

The Labor Commission exercises jurisdiction over this motion for review pursuant to Utah Code Annotated § 630-4-301 and § 34A-2-801(3).

**BACKGROUND AND ISSUE PRESENTED**

Mr. Brady filed a claim for workers' compensation benefits from Young Electric Sign Co. ("YESCO") for a work accident that occurred on January 24, 2001. Mr. Brady sought permanent total disability benefits and YESCO stipulated that Mr. Brady was permanently totally disabled, but disputed that the work injuries were the direct cause of his disability. Judge La Jeunesse held an evidentiary hearing and then, due to conflicts in the medical opinions, referred the medical aspects of the case to a medical panel. After adopting the panel's report, Judge La Jeunesse denied benefits.

In his motion for review, Mr. Brady argues that the panel's opinion was contrary to other, more persuasive medical evidence. Alternatively, Mr. Brady argues that a new letter from one of his medical providers should have been submitted to the medical panel for further consideration.

**FINDINGS OF FACT**

The Commission adopts Judge La Jeunesse's findings of fact. The facts relevant to the motion for review are as follows:

In 1996, Mr. Brady was involved in an auto accident and underwent a cervical spinal fusion. Prior to his work accident, Mr. Brady had a history of medical problems related to his lower back, right and left upper extremities, and asthma.

On January 24, 2001, Mr. Brady was assisting in the removal of a one-ton sign at work when the sign swung loose and hit him in the chest, pinning him for about 30 seconds. He reported neck,

shoulder, low back pain, and, later, breathing difficulties. Over the next several months, he

**ORDER AFFIRMING ALJ'S DECISION**

**LEX L. BRADY**

**PAGE 2 OF 4**

continued to receive medical care for his complaints. Then, on December 26, 2001, Mr. Brady was involved in another car accident. Mr. Brady was able to continue working, however, until June 6, 2003, when his hypoxia (respiratory condition) became too severe and he could no longer work.

The parties stipulated that Mr. Brady was permanently totally disabled; however, they disputed whether the medical impairments that left Mr. Brady disabled were directly caused by the work accident. There were multiple medical opinions that indicated either the work accident caused Mr. Brady's injuries or that the injuries were caused by preexisting conditions and subsequent injuries, particularly the second car accident. Dr. Pearl, Mr. Brady's pulmonologist, provided three reports regarding Mr. Brady's hypoxia. Dr. Pearl's March 10, 2004, report stated:

I suspect that with his history, that when he was crushed, he strained very hard and made the eventration much worse, thus contributing to loss of diaphragmatic movement and atelectases' on the right lung which has caused his hypoxemia. I can say this with reasonable medical certainty.

Therefore, Judge La Jeunesse appointed a medical panel to review issues of medical causation. The panel concluded that Mr. Brady's injuries from the January 24, 2001, work accident did not directly cause his disability. Specifically, the panel opined:

The medical panel finds no evidence that Mr. Brady's hypoxia should be considered a consequence of the accident on 1/24/01. . . . While it is true that the incident on 1/24/01 did likely increase pain problems for Mr. Brady, the clinical records in this case indicate that difficulties in management of the overall pain problems and onset of the hypoxia occurred after the auto accident of 12/01. Therefore, the medical panel finds it likely that Mr. Brady would not have encountered hypoxia absent the auto accident in December 2001.

After receiving the medical panel's report, Mr. Brady submitted another letter from Dr. Pearl, dated August 15, 2005, for additional consideration from the medical panel. The letter disagreed with the panel's opinion and summarized Dr. Pearl's opinion of the medical evidence, stating:

It is most likely that Mr. Brady's injury of January 2001 caused his neck injury which affected the nerves which innervate the diaphragm #'s 3, 4, and C3-C4 and C4-C5. This is the cause of his hypoxia as his other workup has been completely negative.

**DISCUSSION AND CONCLUSIONS OF LAW**

The Commission first notes Mr. Brady's request to submit a new letter from one of his physicians to the medical panel for consideration. Commission Rule R602-2-2(b) permits the

(1) Collapse of all or part of a lung.  
**ORDER AFFIRMING ALJ'S DECISION**  
**LEX L. BRADY**  
**PAGE 3 OF 4**

ALJ's, at their discretion, to submit new medical evidence to the panel "[w]here there is a proffer of new written conflicting medical evidence." The Commission has reviewed the medical records exhibit, previously submitted to the medical panel, and Dr. Pearl's letter and finds that the letter does not provide any new written conflicting evidence that was not previously available to the medical panel for consideration.

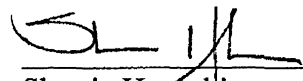
Mr. Brady's primary argument, in his motion for review, is that the evidence shows his January 24, 2001, work injury is the direct cause of his permanent and total disability. Both Mr. Brady and YESCO submitted various medical opinions supporting their respective arguments on direct causation. In light of these conflicting opinions, the Commission appointed an impartial medical panel to evaluate Mr. Brady's claim. The panelists reviewed Mr. Brady's entire relevant medical history, personally examined Mr. Brady, and reviewed the opinions of both parties' medical consultants and treating physicians. Based on all this information, it was the panel's opinion that the onset of Mr. Brady's hypoxia and pain management difficulties occurred after the December 2001 auto accident, and thus it was the auto accident that was the direct cause of Mr. Brady's permanent and total disability-not the January 2001 work accident. Given the panel's expertise and independence, the Commission finds the panel's opinion persuasive.

In summary, the Commission denies Mr. Brady's request for the medical panel to consider further evidence. The Commission concurs with Judge La Jeunesse's denial of benefits based on a determination that Mr. Brady's permanent total disability was not directly caused by his work injury.

**ORDER**

The Commission affirms Judge La Jeunesse's decision. It is so ordered.

Dated this 28<sup>th</sup> day of October, 2008.

  
\_\_\_\_\_  
Sherrie Hayashi  
Utah Labor Commissioner

**NOTICE OF APPEAL RIGHTS**

Any party may ask the Labor Commission to reconsider this Order. Any such request for reconsideration must be received by the Labor Commission within 20 days of the date of this order. Alternatively, any party may appeal this order to the Utah Court of Appeals by filing a petition for review with the court. Any such petition for review must be received by the court

within 30 days of the date of this order.

**ORDER AFFIRMING ALJ'S DECISION**  
**LEX L. BRADY**  
**PAGE 4 OF 4**

**CERTIFICATE OF MAILING**

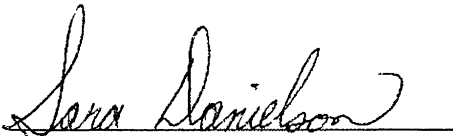
I certify that a copy of the foregoing Order Affirming ALJ's Decision the matter of Lex L. Brady, Case No. 2003948, was mailed first class postage prepaid this 28<sup>th</sup> day of October, 2008, to the following:

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