DONNA LASH, Employee/Appellant, v. WALKER SOUTHVIEW NURSING HOME and LUMBERMENS UNDERWRITING ALL., Employer-Insurer, and FAIRVIEW SOUTHDALE HOSP., Intervenor/Cross-Appellant, and JEFFREY GRONER, M.D., SUBURBAN RADIOLOGIC CONSULTANTS, LTD. and MED. ADVANCED PAIN SPECIALISTS, Intervenors.

WORKERS' COMPENSATION COURT OF APPEALS
MAY 3, 1999

No. [REDACTED SSN]

HEADNOTES

PRACTICE & PROCEDURE - REMAND; EVIDENCE. The appellant and cross-appellant established that the compensation judge may have overlooked certain material evidence which may have affected the resolution of the finding from which appeal was taken. Under these circumstances, a remand is required for reconsideration.

Remanded.

Determined by Johnson, J., Wilson, J., and Wheeler, C.J.
Compensation Judge: Jeanne E. Knight

OPINION

STEVEN D. WHEELER, Judge

The appellant employee and cross-appellant intervenor Fairview Southdale Hospital appeal from the compensation judge's determination that the employee failed to prove that she sustained a work-related Gillette injury[1] on or about May 27, 1997. We remand.

BACKGROUND

The employee, Donna Lash, was born in January 1948 and is currently 51 years old. She is right-handed. In about 1973, the employee injured her right hand while hang gliding, and fractured two fingers. This injury was treated by surgery and post-surgical splinting of the right hand. (T. 12, 21, 65-66.)

The employee's initial work history included work as a motel housekeeper, waitress and janitor. In February 1978 the employee had an acute onset of numbness and tingling in the median distribution of her right hand. She was then working as a janitor for Lutheran

[1] Gillette v. Harold, Inc., 257 Minn. 313, 101 N.W.2d 200, 21 W.C.D. 105 (1960).

Brotherhood. She was medically diagnosed with carpal tunnel syndrome. The condition failed to respond to conservative therapy, and on June 7, 1978 the employee underwent surgery in the form of a right median nerve release and right ulnar nerve release at the wrist. (T. 12-16, 21; Exh. 1.)

The employee testified that, after recovery from the surgery, her symptoms resolved and she did not require further treatment. The employee did not return to janitorial work following the surgery. Instead, she attended Minneapolis Community College and studied accounting and computers. After this, she worked for a time performing accounting work. In about 1990, the employee began studying to become a licensed practical nurse. She started working as a nurse for Bryn Mawr Nursing Home in March 1992. While working for Bryn Mawr, the employee developed a ganglion on her left wrist which was surgically removed. She testified that she had no permanent restrictions or ongoing problems with her left wrist after this surgery and returned to work in her job for Bryn Mawr. She next worked as a full-time nurse for the Crystal Lake nursing home, but after one year went on an on-call status and began working part time at North Memorial Hospital, using the on-call work at Crystal Lake to make up a full-time job. She testified that she had no difficulties with either her left or right hand in performing the duties of these jobs. (T. 13-19, 63.)

On March 19, 1997 the employee began working for the employer, Walker Southview Nursing Home. Her duties were very similar to those she had previously been performing, particularly to those performed at the Bryn Mawr and Crystal Lake nursing homes. One of the employee's duties was to stock a medication cart and then push it along the hallway on her floor of the nursing home and dispense medications to the residents. The employee testified that the cart weighed about 140 to 160 pounds. Customarily, the employee was responsible for providing medications for the patients in 10 to 12 rooms, although at times when the staff was shorthanded she had to dispense medications to as many as sixty residents. (T. 19-24.)

According to the employee's testimony, by mid-May 1997, a few months after starting work for the employer, she began to experience difficulty with her right wrist, especially at the base of the thumb. The soreness increased as she used her right hand more, and she found pushing the medication cart at work particularly uncomfortable. Other duties which bothered her hand were twisting caps on medicine bottles, pushing with the palm, reaching into bottom drawers of the medication cart and trying to lift and hold large containers. (T. 31-32.) The employee testified that her symptoms were different than those experienced in connection with her earlier carpal tunnel syndrome. (T. 32-33.)

On May 27, 1997 the employee went to the employer's physical therapy department asking for a wrist brace. She was told to report her injury to management. After the alleged injury was reported, the employer sent the employee to see Dr. William Isaksen, M.D., at the Airport Medical Clinic. Dr. Isaksen saw the employee that same day, May 27, 1997. The employee described symptoms of right wrist pain and of numbness and tingling extending along the ulnar margin of the right forearm from the elbow to the fourth and fifth digits. She related these problems to pushing the medication cart at work and stated that she thought she had strained

her arm performing this activity. Dr. Isaksen noted in the employee's medical chart that "assuming the history provided by the employee is correct, this is a work-related injury." Dr. Isaksen diagnosed right wrist tendinitis and right ulnar neuropraxia. He prescribed a thumb splint, an elbow pad, Tylenol and a course of physical therapy, and placed the employee on temporary restrictions on lifting, grasping, torquing or crimping and operating power tools. (T. 32-34; Exh. G: 5/27/97 Physician's First Report of Injury, 5/28/97 restrictions.)

The employee returned to Dr. Isaksen on June 6, 1997 for a recheck. She remained symptomatic and she was experiencing acute pain especially over the volar surface of the wrist. There was acute tenderness to palpation about the ulnar groove and over the flexor surface of the right wrist. Dr. Isaksen noted a soft tissue mass on the volar surface of the wrist with a consistency suggestive of a ganglion cyst. He referred the employee to Dr. Jeffrey P. Groner, M.D., for a hand specialty consultation. (Exh. G: 6/6/97.)

Dr. Groner saw the employee for examination on June 9, 1997. He recorded that the employee described a five-year history of right wrist and thumb pain, occasionally accompanied by thenar swelling, with the pain becoming very severe recently and with fullness developing at the radial volar aspect of the wrist over the past two to three months. The employee described this swelling as similar to that which she experienced when she developed a ganglion at the opposite wrist several years earlier. Based upon his examination findings, Dr. Groner diagnosed osteoarthritis of the first carpometacarpal (CMC) joint, DeQuervain's tenosynovitis and a possible radial volar wrist ganglion. (Exh. B: 6/9/97.)

Over the next several months, the employee's right hand was treated with splinting and steroid injections. These treatments initially provided significant improvement, but on several occasions the employee experienced acute flareups of her symptoms which she related to pushing the medication cart or opening pill bottles at work. By late fall 1997 the employee was reporting that her symptoms continued to worsen. During this period, the diagnosis of osteoarthritis of the first CMC joint remained the primary diagnosis. On examination by Dr. Groner no mass or other evidence of a ganglion was present and an MRI scan on October 29, 1997 showed no evidence of a ganglion or tendinous abnormality. As of December 22, 1997, Dr. Groner characterized the employee's condition as first CMC joint osteoarthritis and noted that in addition there was some evidence of very mild irritation about the ulnar nerve at the elbow and the median nerve at the wrist. He further noted that there might be a component of first dorsal compartment tenosynovitis which he believed might be splint related. Radiography of the carpal metacarpal junction of the right hand revealed prior resection of the greater multangular at the base of the thumb, consistent with prior ligament reconstruction by history. (Exh. B: 6/11/97 - 1/14/98, 10/29/97 & 1/20/98 radiology reports.) As early as July 10, 1997, Dr. Groner suggested surgery in the form of a first CMC joint trapezium resection arthroplasty.

On December 10, 1997, Dr. Chris Tountas, M.D., examined the employee on behalf of the employer and insurer. Dr. Tountas concluded that the employee had not sustained any indentifiable injury to the right wrist from pushing a medication cart at work. He did not agree with the recommendation for trapezial resection arthroplasty. He further suggested that

intermittent immobilization be done to objectively identify any significant pathology at the wrist or thumb and that a bone scan of the upper extremities be done. He stated that any focal increase in uptake detected in the scan would be good evidence of an inflammatory process requiring further investigation or imaging. (Exh. B: 7/10/97; Exh. 2.)

A bone scan was done of the employee's right wrist on January 14, 1998 and demonstrated significantly increased uptake at the right first CMC joint. Dr. Groner considered this finding to be consistent with basilar joint osteoarthritis. The employee underwent a "first CMC joint arthroplasty with trapezium excision and placement of a palmaris longus interposition anchovy" on January 20, 1998. During the surgery, dense adhesions were found to be present between the wrist capsule and the trapezium. Some CMC joint synovitis was present and there were several small osteophytes at the radial volar aspect of the joint. (Exh. B: 1/20/98 surgical report, 1/14/98 bone scan report.)

In two letters apparently written in response to questions from counsel in this case, Dr. Groner offered opinions as to the employee's restrictions and permanent partial disability. In these letters he also indirectly addressed whether the right hand symptoms were causally related to the employee's work activities for the employer. In the first of these letters, dated February 23, 1998, Dr. Groner stated:

> [The employee] developed symptoms of first CMC arthritis while working at the Walker Southview Convalescent facility. She states that she had not experienced any symptoms of pain involving the right thumb prior to her work at Walker Southview and that she began to experience pain at this site approximately 2 months after she began working there. She attributes the development of pain at this joint to her job activities there. (The patient states that the office note of 06-09-97 is in error and that this relates to left wrist pain - s/p left wrist ganglionectomy about 5 years ago). She states that activities which, in particular, caused pain at the basilar thumb joint were twisting open medication vials and pushing a heavy medication cart (approximately 140-160 pounds).

In the second letter, dated May 29, 1998, Dr. Groner similarly stated:

> Ms. Lash states her symptoms developed in direct response primarily to use of a medication cart. Ms. Lash states use of the cart precipitated the onset of symptoms and that persistent cart use exacerbated symptoms.

(Exh. B: 2/23/98; Exh. A.)

The employee was reexamined by Dr. Tountas on June 10, 1998 on behalf of the employer and insurer. In his report, Dr. Tountas opined that

> [b]ased on the bone scan which indicates that there are degenerative changes at the CMC joint of the thumb, and a pre-operative diagnosis of CMC joint osteoarthritis, it is my opinion again that the TMA activities at Walker City View and most notably the cart pushing was not a substantially contributing, accelerating or aggravation of the diagnosed arthritis on a permanent basis. In my opinion, the work at [b]est was a temporary aggravation of the diagnosed arthritis on a permanent basis. The arthritis, in my opinion, did not begin two months after employment at Walker City View.

(Exh. 3 at p. 5.)

The employee filed a claim petition on March 12, 1998 seeking payment of her medical expenses and compensation for various periods of temporary partial and total disability associated with her right hand condition. The employer and insurer's answer denied primary liability. Several medical providers, including cross-appellant Fairview Southdale Hospital, motioned for and were granted intervention interests in the matter. (Judgment Roll.)

The matter came on for hearing before a compensation judge of the Office of Administrative Hearings on August 18, 1998. Following the hearing, the judge determined, among other things, that the employee had failed to prove by a preponderance of the evidence that she had sustained a Gillette injury on or about May 27, 1997. (Findings 17, 18.) The employee appeals from this determination, joined by the intervenor Fairview Southdale Hospital on cross-appeal.

STANDARD OF REVIEW

On appeal, this court must determine whether the compensation judge's findings and order are "clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1(3) (1992). Substantial evidence supports the findings if, in the context of the record as a whole, they "are supported by evidence that a reasonable mind might accept as adequate." Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where the evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings must be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, "[f]actfindings are clearly erroneous only if the reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). Factfindings may not be disturbed, even though this court might disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." Id.

DECISION

Causation

In her memorandum, the compensation judge briefly summarized her reasoning in concluding that the employee had failed to prove the occurrence of a work-related Gillette injury. Noting that, pursuant to Steffen v. Target Stores, 517 N.W.2d 579 (1994), proof of a Gillette injury primarily depends upon medical evidence, the judge points out that the only opinion of Dr. Groner regarding causation was, in essence, a statement that "the employee said work caused it." The compensation judge, further noting that the primary diagnosis was one of arthritis, a condition which "takes time to develop," found that this was insufficient evidence to prove causation, reasoning that "the fact that her symptoms became manifest during her short duration of employment [for the employer] does not constitute causation." She stated, "[t]he so-called causation opinion by Dr. Groner is simply an inadequate basis upon which to find causation. Therefore the claim of a work injury must be denied in its entirety." (Mem. at 6.)

In the appeal and cross-appeal, the employee and intervenor Fairview Southdale Hospital contend that the compensation judge's determination is flawed because she made a factual error when she stated that certain evidence did not exist. The employee argues that the compensation judge was simply wrong concerning the existence of the evidence. Since this stated lack of evidence was one of the primary bases for denial of the employee's claim, the employee contends the compensation judge's decision should be reversed.

Specifically, they emphasize the following language in the compensation judge's memorandum:

> In this case, despite the introduction of extensive medical records into evidence, the only support for causation is found in Dr. Groner's narrative report of May 29, 1998 (Petitioner's Exhibit A) . . . Careful review of the records reveals no other causation opinion.

(Mem. at 6, emphasis added.)

The appellant and cross-appellant allege that the underlined language is clearly erroneous. They argue that the compensation judge failed to consider several statements by Dr. Isaksen, the physician selected by the employer at the Airport Medical Clinic, on the issue of causation: (1) the May 27, 1997 Physician's First Report of Injury in which Dr. Isaksen recorded that the employee related the development of her symptoms to pushing the medication cart at work, and then stated "[a]ssuming the history provided by the employee is correct, this is a work-related injury," and (2) a Work/Medical Status Report signed by Dr. Isaksen on June 6, 1996 in which the doctor checked "yes" in a box under the heading "Work-related Illness/Injury." (Exh. G.) In conjunction with this argument the employee points out that the compensation judge did not specifically indicate her reliance on any medical opinion in finding no causation but dismissed the employee's case for lack of persuasive proof. Given that the compensation judge framed the disposition of the case on this basis and was in error about the existence of evidence which clearly supported the employee's position, she contends that the compensation judge's decision should

be reversed.

Generally, we will assume that the compensation judge has considered all material evidence which has been offered and received in a case. We will not assume that evidence has been overlooked or ignored absent a clear indication to the contrary. A compensation judge is not required to relate or discuss every piece of evidence introduced at trial. See Braun v. St. John's Univ., slip op. (W.C.C.A. July 20, 1992). However, when a compensation judge erroneously states that certain material evidence, which would support the losing party's case, does not exist, returning the matter to the compensation judge for reconsideration should be seriously considered.

We agree that the compensation judge's statement that there was "no other causation opinion" suggests that she overlooked Dr. Isaksen's May 17, 1997 "Physician's First Report of Injury" and the June 6, 1997 Work/Medical Status Report. There are, however, other inferences which might be drawn from the compensation judge's statement, including the possibility that the compensation judge was aware of the reports but found them unpersuasive. It is unclear whether the compensation judge was unaware of these reports or simply chose to not consider them as material "opinions" concerning causation. It is not this court's function to resolve the competing inferences. As a result, we believe the compensation judge needs to revisit this matter and clarify her findings. She may take additional evidence and argument on remand, at her sole discretion.