

THE STATE OF SOUTH CAROLINA  
In The Supreme Court

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APPEAL FROM THE S.C. WORKERS'  
COMPENSATION COMMISSION

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Opinion No. 2017-UP-443 (S.C. Ct. App. filed Nov. 29, 2017)

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Lettie Spencer, Respondent, S.C. SUPREME COURT

v.

NHC Parklane, Employer/Petitioner,

and

Premier Group Insurance Co., Inc. Carrier/Petitioner.

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APPENDIX - PART IV

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S.C. SUPREME COURT

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 1120778

**FILE**

LETTIE SPENCER,  
CLAIMANT,  
VS  
NHC PARKLANE,  
EMPLOYER,  
AND  
PREMIER GROUP INSURANCE  
COMPANY, INC.,  
CARRIER.

DEPOSITION OF WILLIAM LEHMAN, M.D.

ROCK HILL, SOUTH CAROLINA

JANUARY 9, 2013

REPORTER: KELLY REITER

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ROCK HILL, SOUTH CAROLINA

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Appearances:

For the Claimant -

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Elrod Pope Law Firm  
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For the Employer and Carrier -

Clarke W. McCants, III, Esquire  
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218 Newberry Street S.W.  
Post Office Box 2881 (29802)  
Aiken, South Carolina 29801

Also Present -

Ms. Lettie Spencer

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1 Deposition of William Lehman, M.D., taken before  
 2 me, Kelly Reiter, a Notary Public for the State of  
 3 South Carolina, at Carolina Orthopaedic Surgery  
 4 Associates, 134 Professional Park Drive, Rock Hill,  
 5 South Carolina, commencing at 6:39 p.m. on January  
 6 9, 2013, taken in the aforementioned cause now  
 7 pending before the South Carolina Workers'  
 8 Compensation Commission.

9 That the signing of the transcript of deposition by  
 10 the witness is waived:

11 \* \* \* \* \*

12 William Lehman, M.D., first being duly sworn, deposes  
 13 and says as follows:

14 E X A M I N A T I O N - (By Mr. McCants)

15 Q Doctor, I introduced myself to you before we went  
 16 on the record. I'm Clarke McCants. I'm an  
 17 attorney in Aiken, and I'm representing National  
 18 Healthcare Parklane in Ms. Spencer's workers'  
 19 compensation case.. I wanted the opportunity to  
 20 take your deposition to go over some of your notes  
 21 and discuss your care and treatment of Ms. Spencer.  
 22 I appreciate your willingness to do so. Your full  
 23 name is William Lehman. Is that correct?

24 A William Louis, L-o-u-i-s, Lehman, Junior.

25 Q And you're a practicing orthopaedic physician here

1 in Rock Hill, South Carolina. Is that correct?  
2 A Yes, sir.  
3 Q And are you an orthopaedic surgeon?  
4 A Yes, sir.  
5 Q Tell us a little bit about your educational  
6 background and training, if you would.  
7 A I graduated from Stanford University in 1972 with a  
8 B.S. in biological sciences. I then went to Case  
9 Western Reserve Medical School and received my  
10 degree in medicine in 1977. I then did an  
11 internship and residency program in family practice  
12 at the University of Colorado. I practiced about a  
13 year-and-a-half. I was an associate director of  
14 the program, but then decided to go back and do  
15 orthopaedic surgery. I completed an orthopaedic  
16 surgery training program at the University of  
17 Colorado in 1985. Then I came to Rock Hill, South  
18 Carolina and have been in private practice at this  
19 institution, this company, since that time.  
20 Q And what year would that have been?  
21 A I began in 1985 and up until present.  
22 Q All right, sir. We've had access to your chart and  
23 your records for Ms. Spencer.  
24 A Yes, sir.  
25 Q I appreciate you having provided documents in that

Deposition of William Lehman, M.D.

1 regard, and they'll be in front of the Commission,  
2 as you may be aware. According to my review of the  
3 chart that we have, you first saw her in April of  
4 2012. Is that correct?

5 A Yes, sir.

6 Q How was she referred to you?

7 A It states that her referring physician was Robert  
8 Bradley, M.D. He is an internal medicine doctor in  
9 Chester, South Carolina.

10 Q Now, I will tell you the last record I have from  
11 your office with regard to your having seen Ms.  
12 Spencer is November 26th of 2012.

13 A Yes, sir.

14 Q And I have - - - Is that the last time you visited  
15 with her?

16 A As far as I'm aware.

17 Q All right. And at any point, have you met with any  
18 of her attorneys regarding her care and treatment  
19 or this case that we're talking about today?

20 A No, not that I'm aware.

21 Q All right, sir. Let me go, if I can, to your first  
22 visit with Ms. Spencer. Again, the date that I've  
23 got - - - The date I have is April 4th, 2012.

24 A Yes, sir.

25 Q And she basically presented her history to you.

Deposition of William Lehman, M.D.

1 You went through her particular history, the  
2 history of her involvement with a work-related  
3 injury?

4 A Yes, sir.

5 Q And you made certain recommendations?

6 A (Indicating yes)

7 Q I'm going to talk to you a little bit about your  
8 care and treatment. I also want to talk to you  
9 about her statements to you and your  
10 recommendations with regard to her work status. In  
11 your report of April 4, 2012, it's toward the  
12 bottom. It's about the middle of that paragraph  
13 where it says, subjective transcription. It says,  
14 no specific light-duty is available. Do you see  
15 that?

16 A Under subjective trans - - -

17 Q Yes, sir.

18 A I'm sorry. Can you show me where?

19 Q Sure, I'll be happy to. My copy is a fax of a fax  
20 of a fax.

21 A Oh, in the middle, okay.

22 Q Yes, sir.

23 A Yes, sir. Got it.

24 Q And that, of course, is a sentence following some  
25 comments with regard to work status, and you

Deposition of William Lehman, M.D.

1 understood at the time you saw her in April of 2012  
2 that she was out of work. Is that correct?

3 A Yes.

4 Q And the sentence says, no specific light-duty is  
5 available. Do you remember today how you came to  
6 write that down in your report? In other words, is  
7 that something that she told you, or something you  
8 learned from somebody else?

9 A I believe that's something that Ms. Spencer told  
10 me.

11 Q And later on in that report, you did provide some  
12 recommendations. Let me back up a little bit. In  
13 that report, you mentioned, and this is on Page 3  
14 of 3, that you reviewed an MRI scan of her spine  
15 which had been taken at Chester Regional back in  
16 July of 2011. Is that correct?

17 A Yes, sir.

18 Q And you noted that the MRI scan showed hypertrophic  
19 facet arthropathy - - -

20 A Yes.

21 Q At, at least, one level and some facet changes at  
22 some other levels. Our Commission may very well  
23 know what arthropathy is, but what is it from a lay  
24 standpoint?

25 A Basically an arthritis of those joints, the facet

Deposition of William Lehman, M.D.

1 joints in the lower back, which connect one  
2 vertebrae to another.

3 Q Did ---

4 A And arthropathy simply means a degenerative process  
5 of those joints.

6 Q Again, typically then what you're talking about is  
7 the arthritic process, which is a degenerative  
8 process brought about over time. Is that correct?

9 A Yes.

10 Q And then you mentioned the ligamentum thickening  
11 and a disc bulge extending into one of the foramen,  
12 specifically at L-4/-5. Is that correct?

13 A Yes, sir.

14 Q All right. Convert that to lay terms, if you  
15 would.

16 A Well, that's also a property of the spine in the  
17 face of a lot of degenerative changes. The  
18 ligamentum flavum is a part of the covering of the  
19 spine, in the back part of it, and it thickens as  
20 part of a degenerative process.

21 Q And, of course, the record reflects when she first  
22 saw you, she was

23 A Yes, sir.

24 Q Back in the spring of 2012. Is that correct?

25 A Yes.

Deposition of William Lehman, M.D.

1 Q My question to you initially, based upon your  
2 review of the MRI scan when you saw her for the  
3 first time, did you see anything, Doctor, that  
4 looked like any type of acute change or anything  
5 that you thought was a product of any trauma to her  
6 spine?

7 A No.

8 Q Basically what you were looking at was the spine of  
9 a Is that fair?

10 A Yes.

11 Q All right, sir. And, of course, you recommended at  
12 that particular point in time that a CT myelogram  
13 be performed, and I would suspect that you wanted  
14 to take a closer look at the condition of her  
15 spine. Is that fair?

16 A Yes.

17 Q And your record speaks for itself with regard - - -  
18 Well, let me back up, Doctor. I do have to ask you  
19 this. In plain transcription, down at the bottom,  
20 you wrote, it does appear that she will be  
21 extremely limited in recurrent work and would have  
22 to include sedentary work only with the ability to  
23 change positions frequently. Then you noted that  
24 she will contact her attorney, Mr. Elrod - - -  
25 That's Luke Elrod. Is that correct?

Deposition of William Lehman, M.D.

1 A Yes.

2 Q Regarding her transfer of care, so you could look  
3 at her further. So basically what you were saying  
4 is, you gave us an opinion at that point that she  
5 was extremely limited with regard to return to  
6 work, and that you at least became aware that Mr.  
7 Elrod was assisting her. She told you she would  
8 talk to him about trying to get you to take over  
9 her care. Is that fair?

10 A Yes, sir.

11 Q All right. Then let me show you this document, and  
12 we've marked this as a deposition exhibit. I trust  
13 that's in your chart. This is Page 52 of my  
14 hearing documents. Is this a return-to-work slip  
15 that's in your chart?

16 A Yes, sir.

17 Q And this one reflects, at least at the time that  
18 you saw her on April 12th, 2012, you did indicate  
19 that she could perform sit-down work only with  
20 ability to change positions. Is that correct?

21 A Yes, sir.

22 Q And it was your understanding, at least from what  
23 she told you, that no such work was available with  
24 my client. Is that fair?

25 A Yes, sir.

Deposition of William Lehman, M.D.

1 Q All right. I'm going to try not to go through  
2 every note, Doctor, but I just have a couple of  
3 questions about some of them, if I could. Now, I  
4 do want to go to what I think is the next visit,  
5 September 17 of 2012. Is that the next visit?

6 A Yes, sir. In the interim, she had undergone the  
7 myelogram, the CT myelogram, at Springs Memorial  
8 Hospital.

9 Q That was performed, and I would take it that the  
10 radiologist's report for that is in your chart. Is  
11 that correct?

12 A Yes, sir.

13 Q In addition to the radiologist's report, may I  
14 trust that you also reviewed the films yourself?

15 A That's my general rule to see if there's anything  
16 controversial, but yes, I apparently did review  
17 that on - - - at the time of her follow-up visit on  
18 9-17-2012.

19 Q In fact, your note reflects you had a personal  
20 review of the CT myelogram. Is that correct?

21 A Yes.

22 Q Now, you used the words in your report, personal  
23 review of the CT myelogram of the lumbar spine did  
24 show interestingly no problem whatsoever, other  
25 than the L-4/-5 level, which did show mild central

Deposition of William Lehman, M.D.

1 stenosis. No abnormality otherwise. That may  
2 speak for itself, but help us understand a little  
3 bit further what you meant by that phrase or those  
4 sentences.

5 A I believe I was commenting on the fact that the  
6 prior testing, I think that was the MRI of the  
7 lumbar spine of 7-22-11, showed a lot of arthritis.  
8 Whereas, the CT myelogram done two months later did  
9 really not show that much arthritis, just the area  
10 of tightness. So in a sense, the findings on the  
11 CT myelogram were much less dramatic, much less  
12 severe, I guess you could say, in terms of  
13 arthritis than the CT myelogram.

14 Q What you're saying is, the CT didn't pick up some  
15 of the issues, if I could call them that, that  
16 perhaps the MRI had picked up, and that would have  
17 been one performed before you saw her. Is that  
18 correct?

19 A Yes.

20 Q Did you have any concerns about the validity of the  
21 CT scan, anything in that regard, when you looked  
22 at it in September of 2012?

23 A No, I don't believe so. I think it was - - - It  
24 was a reasonable test. Although, they had some  
25 trouble with the needle injection. So some of the

Deposition of William Lehman, M.D.

1 dye that was used in the test did not go into the  
2 area where it was supposed to go. So I think there  
3 was enough - - - You know, the CT part of it, which  
4 is the x-ray part of it, was sufficient, I guess  
5 you could say. Although, perhaps the test was not  
6 - - - or could have been better performed. Let's  
7 put it that way.

8 Q It certainly wasn't to the level of being  
9 unreliable enough to justify another CT. Is that  
10 fair?

11 A That's right.

12 Q It was enough for you to look at and to reach a  
13 conclusion based on that?

14 A Yes, sir.

15 Q All right, sir. And I can't remember if the MRI -  
16 - - and I don't know if it would pick up what's  
17 characterized as mild central stenosis. But would  
18 you tell us what that means?

19 A That would - - - Stenosis just means a tightness.  
20 In this particular case, it's a tightness in the  
21 canal. It's created by a combination of the  
22 thickening of that ligamentum that we talked about,  
23 the bone spurs on the facet joints, and the bulging  
24 discs, all of which create a relative tightness in  
25 the canal where the nerve roots are trying to get

Deposition of William Lehman, M.D.

1 through.

2 Q When you talk about the bone spurs, that's again  
3 kind of an arthritic process. Is that fair?

4 A Yes, sir.

5 Q Again, mostly degenerative-type issues. Is that  
6 fair?

7 A Yes, sir.

8 Q That would normally occur over time and certainly  
9 wouldn't be unusual in the spine of a  
10 year-old woman. Is that fair?

11 A Yes, sir.

12 Q You may even find them in the spine of a fifty-two-  
13 year-old like myself. Is that unreasonable?

14 A Yes, or sixty-two like mine.

15 Q Okay. And in your report of September 17, 2012,  
16 again if I understand correctly, you recommended  
17 sit-down work for Ms. Spencer only. Is that  
18 correct?

19 A Yes, sir.

20 Q And, in fact, on the next page - - - This is Page 2  
21 of 2 of that report, September 17th, 2012. You  
22 indicate that she is able to work at light-duty.  
23 Although, such apparently is not available. That's  
24 in your report, and the same question as before.  
25 Is that information that she provided to you?

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1 A Yes.

2 Q Nobody else provided that information to you. Is  
3 that correct?

4 A I'm not exactly sure. She did have a case manager  
5 there, though, at that time, but I'm not sure if  
6 the case manager really knew exactly what her - - -  
7 what was available at her job.

8 Q Let me put the question to you then this way, if I  
9 could, and I'm not trying to interrupt you. Is it  
10 your best recollection that Ms. Spencer told you  
11 that light-duty was not available?

12 A Yes.

13 Q Is that your best recollection?

14 A Yes.

15 Q All right, sir. And I didn't mean to jump around.  
16 At that point, at least in September of 2012, what  
17 you recommended was a selective nerve root block on  
18 the left at L-5, and this - - - And it's because  
19 you really felt like that was most likely the nerve  
20 that is being irritated at the L-4/-5 level. Is  
21 that fair?

22 A Yes.

23 Q Now, if I could then, go back to the MRI and the CT  
24 that you talked about. Tell me what, on those two  
25 studies, indicated some irritation of the nerve or

Deposition of William Lehman, M.D.

1 a nerve at L-4/-5 is indicated.

2 A Well, the CT myelogram showed some mild stenosis at  
3 the L-4/-5 level, and that's just a relative  
4 tightness. So it doesn't tell me that the nerve is  
5 necessarily irritated. The patient had symptoms in  
6 the back, going down the left leg, and so that  
7 would imply that the nerve root is being irritated  
8 at the L-4/-5, or the fifth nerve root. That would  
9 be the - - - That would be the culprit, in a sense,  
10 for causing those left leg radicular symptoms. So  
11 that's why we would pop the needle in right at the  
12 L-5 level.

13 Q All right. I'm going to offer to translate this,  
14 but you interrupt me if I'm wrong. What you're  
15 saying is, the diagnostics did not show the  
16 irritation of that nerve root. What you did, based  
17 on what Ms. Spencer told you with regard to  
18 discomfort in her left leg, you thought it was  
19 likely and thought, at least at that point, that  
20 perhaps that nerve at L-4/-5 on the left was being  
21 irritated. Is that fair?

22 A Yes.

23 Q And at that point, you recommended a selective  
24 block, as you called it?

25 A Yes.

Deposition of William Lehman, M.D.

1 Q And I think we know a little bit about what the  
2 nerve root blocks are, but would you tell us a  
3 little bit about that from a lay standpoint?

4 A Well, under x-ray, I can draw generally - - - Well,  
5 almost exclusively when we do a selective nerve  
6 root block, basically I place a needle right in the  
7 area where that nerve root comes out of the spine,  
8 and then eventually, it does go down into the  
9 buttock and down into the leg. The needle is - - -  
10 I was using a little bit of sedation, or at least  
11 local anesthetic applied. Usually, there's a  
12 combination of an anesthetic and some cortisone  
13 basically that's put in that area, hoping to - - -  
14 well, relieve the irritation of the nerve and,  
15 therefore, relieve the leg pain.

16 Q Tell us about the needle itself. Physically, what  
17 are you doing?

18 A Well, basically placing a needle through the skin  
19 and - - -

20 Q How big a needle?

21 A Well, it's usually - - - It's about three-and-a-  
22 half inches long.

23 Q All right. And what gauge? It certainly wouldn't  
24 be the gauge of that pen, but give us an idea of  
25 how - - -

Deposition of William Lehman, M.D.

1 A No. It would be usually about a twenty-two gauge  
2 needle, which is about half the diameter of a  
3 typical pen, a ballpoint pen.

4 Q And that has an anesthetic attached to it, affixed  
5 to it, and you're going in there and you're trying  
6 to relieve some of the pressure around the root as  
7 it connects to the spinal cord. Is that correct?

8 A Yes.

9 Q Is that something you do?

10 A No, I - - - I generally - - - Well, I have done  
11 that, but generally, we send them to a pain  
12 specialist or an interventional radiologist or an  
13 anesthesiologist.

14 Q And, in fact, you recommended a Dr. Nandurkar here?

15 A Nandurkar is a physiatrist or - - - Well,  
16 basically, he's a pain specialist who does a lot of  
17 nerve blocks.

18 Q I apologize if I'm mispronouncing his name. Now,  
19 is he a local physician?

20 A He is. Actually, I think he lives in Charlotte,  
21 but I think he has an office in Lancaster, South  
22 Carolina, which is about thirty miles from here.  
23 He also has a - - - I think he has an office here  
24 in Rock Hill.

25 Q Do you know him?

Deposition of William Lehman, M.D.

- 1 A Yes.
- 2 Q And you trust him, and he's reliable?
- 3 A Yes.
- 4 Q And you have confidence in his ability to do what  
5 you think should be done?
- 6 A Yes, sir.
- 7 Q All right. Now, you saw where Ms. Spencer, I  
8 think, had been seen by at least one other pain  
9 management type provider - - -
- 10 A Yes, sir.
- 11 Q If I could characterize it?
- 12 A Yeah.
- 13 Q I'm talking about Tony Owens down in - - -
- 14 A Yes.
- 15 Q Maybe the Irmo area.
- 16 A Right.
- 17 Q Are you familiar with him, other than your  
18 involvement maybe in reviewing some of this  
19 records?
- 20 A No. I'm familiar with - - - more familiar with the  
21 - - - Well, the neurosurgeon, I can't remember his  
22 name.
- 23 Q That's Dr. Dyer.
- 24 A Dr. Dyer, I'm more familiar with him, and I think  
25 Dr. Dyer referred the patient to - - - Ms. Spencer

Deposition of William Lehman, M.D.

- 1 to him.
- 2 Q Let me take you on a sidetrack, and we can talk
- 3 about Dr. Dyer because I was going to ask you this
- 4 at some point. You do know Dr. Dyer?
- 5 A Well, I've dealt - - - Well, I guess I've talked to
- 6 him on the phone maybe once or twice over the
- 7 years, but basically just mutual patients.
- 8 Q He's a neurosurgeon?
- 9 A Yes, sir.
- 10 Q At Columbia Neurosurgical, I think?
- 11 A (Indicating yes)
- 12 Q A reputable provider - - -
- 13 A Yes, sir.
- 14 Q In your opinion?
- 15 A Yes, sir.
- 16 Q Do you have any reason to have any concerns about
- 17 his abilities and his ability to treat?
- 18 A No, he's excellent.
- 19 Q All right. Again, you just know Dr. Owens based
- 20 maybe perhaps on some review of the records. Is
- 21 that correct?
- 22 A Yes, sir.
- 23 Q You wouldn't have any problem with someone besides
- 24 Dr. Nandurkar doing this nerve block if that
- 25 situation were to present itself, would you?

Deposition of William Lehman, M.D.

1 A No.

2 Q You do trust Dr. Nandurkar. You've had experience  
3 with him. You think he would do a good job for Ms.  
4 Spencer if that's the course that should be taken.  
5 That's basically what you're saying?

6 A Yes, but - - -

7 Q All right.

8 A You know, all I would be asking him or Dr. Owens to  
9 do would be to do the nerve block.

10 Q Sure.

11 A It's a pretty straightforward procedure that one,  
12 certainly once properly trained, should be able to  
13 do that - - -

14 Q I couldn't do it.

15 A Adequately.

16 Q And I was going to ask you, in the concept of this  
17 field of medicine, it's a relatively routine type  
18 of procedure?

19 A Yes, sir.

20 Q In fact, is this one of the type of blocks, Doctor,  
21 when you do it and complete it, you're supposed to  
22 know then and there whether or not it works?

23 A Oftentimes, they do put the anesthetic in right  
24 away, and so they - - - The pain goes away, yes,  
25 right away. Now, sometimes they don't put as much

Deposition of William Lehman, M.D.

- 1           anesthetic in because then there would be a certain  
2           amount of weakness; so - - -
- 3   Q       All right.
- 4   A       But, yes, if they put some anesthetic in there  
5           along with the cortisone or the steroid, then  
6           oftentimes - - - You know, if that's really causing  
7           the pain, that's the area where the pain is  
8           generated, then you'll know right away.
- 9   Q       All right. And that's my point. If that's the  
10           problem, after you do that block, you should know  
11           pretty quickly?
- 12   A       Yes, sir.
- 13   Q       Is that fair?
- 14   A       Yes, sir.
- 15   Q       Now, this is what - - - Again, what you're doing is  
16           anesthetizing the nerve, correct?
- 17   A       Yes, sir.
- 18   Q       Obviously, that wears off?
- 19   A       Yes.
- 20   Q       How long do you typically see this type of block  
21           lasting?
- 22   A       Well, as far as the - - -
- 23   Q       The results of the block.
- 24   A       Yeah, I - - -
- 25   Q       I may have been unclear.

Deposition of William Lehman, M.D.

1 A It's very - - - It's extremely variable, I guess.  
2 Of course, the anesthetic wears off very quickly,  
3 within hours, but the cortisone then kicks in and  
4 ideally would give relief for - - - ideally gives  
5 relief for at least a couple of months. But  
6 oftentimes, these have to be repeated in a series  
7 of, say, three and then - - - before one gives up  
8 on it, I guess.

9 Q All right. And when you say a series, do you  
10 recommend a series, or do you wait after you've  
11 done the first one to see whether or not it works?

12 A Right, because it's - - - Generally, I like to see  
13 the response. If there's no response at all to the  
14 first block, I wouldn't repeat it. Obviously, if  
15 there's a hundred percent response, I wouldn't  
16 repeat it. Most people get - - - With a good  
17 result, they might get forty to fifty percent  
18 relief. So usually, a second shot is often  
19 provided.

20 Q You feel pretty good that if this nerve root block  
21 is the source or that - - - I should say that nerve  
22 is the source of Ms. Spencer's problem, then this  
23 nerve root block is going to have some level of  
24 success? You feel pretty good about that?

25 A Well, yeah. That was the only thing I had to go

Deposition of William Lehman, M.D.

1 on, I guess, based on the studies that had been  
2 done and the clinical examination. So, yes, that  
3 was my feeling to be the best course of action.

4 Q All right. You may understand these workers'  
5 compensation cases we deal with, what our  
6 Commission - - - And Drew will probably correct me  
7 if I'm developing the standard wrong here. But we  
8 look to medical treatment which is more likely than  
9 not most probably going to benefit somebody. So  
10 then the question I think technically and formally  
11 presented to you is, whether or not in your opinion  
12 and to this reasonable degree of medical certainty  
13 you think that nerve root block most probably is  
14 going to benefit Ms. Spencer?

15 A Yes. Yes, I would - - - I guess I will say that,  
16 at that point in time, that to me was the best  
17 possibility that would benefit her. Otherwise, I  
18 really wouldn't want to subject her to something  
19 that was sort of iffy. Although, sometimes what we  
20 do is, you always have options. So, I mean, of  
21 course you could surgically go in as an option and  
22 open up that nerve root and hope that might get it,  
23 but you have to look at the options. That  
24 certainly would be much preferably, to cure  
25 somebody with a nerve block than going through a

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1 surgery. So that was my - - - I guess the best  
2 option at that point.

3 Q That's fair, and I may have been wanting to jump  
4 ahead a little bit. Let me just raise the  
5 question. At least as of September 17 of 2012;  
6 that was your recommendation? And you thought, at  
7 that particular point in time, doing that nerve  
8 root block likely would assist Ms. Spencer. Is  
9 that a fair way of looking at it?

10 A Yes.

11 Q All right. Then let's keep going, if we can. The  
12 next visit I've got is October 25 of 2012. You  
13 talk a little bit about Dr. Dyer there. You  
14 mentioned that she had an ablation at some point.  
15 That was L-5/S-1/S-2. No relief. Physical therapy  
16 offered no relief, and I think you even mentioned  
17 that physical therapy, at least from Ms. Spencer's  
18 standpoint, may have made things worse. Do you  
19 remember saying that in your report?

20 A Yes, sir.

21 Q All right.

22 A Now, I think I'm just doing a little overview of  
23 her treatment prior to visiting with me.

24 Q Fair enough.

25 A This is all in 2011.

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1 Q That's correct. Yeah. Yeah, you were reviewing  
2 her care before she even saw you and began seeing  
3 you in the spring of 2012. Is that correct?

4 A Yes, sir.

5 Q Now, you wrote down at the bottom of that note in  
6 October of 2012, she continues to be out of work  
7 and is quite depressed. You noted she's lost a lot  
8 of weight because of the pain, the left leg pain.  
9 You note she's progressively becoming more  
10 debilitated and depressed. Now, her work status  
11 will speak for itself. But are you understanding  
12 that, at that particular point in time again and  
13 based on your conversation with her, that no work  
14 was being offered to Ms. Spencer? Is that your  
15 understanding?

16 A Yes. That was my understanding, that there was no  
17 light-duty available.

18 Q All right. Now, let's look at the second page of  
19 your note of October 25, 2012. The reason I asked  
20 about your impression of the CT scan back in  
21 September of 2012; in this note of October 2012,  
22 specifically October 25, 2012, you then expressed  
23 some concerns about the reliability of the CT scan.  
24 Is that correct?

25 A Right.

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1 Q Tell us a little bit about that, if you would.

2 A Well, as I mentioned before, some of the dye that  
3 they inject in order to see the nerve roots more  
4 effectively really had not gone inside the sac and  
5 mixed with the spinal fluid. Some of it had. Some  
6 of it hadn't. So the - - - I guess, the quality of  
7 the test was not ideal. I, of course, stated that  
8 it was a poor study on that basis. I guess what  
9 I'm saying here is that I felt it was unlikely to  
10 be completely accurate, but that there were some  
11 changes of stenosis at -4/-5, L-4/-5. Of course,  
12 that's what we discussed previously.

13 Q Then, in fact, you note down at the bottom in plan  
14 transcription - - - This is Page 2 of 3 of your  
15 reports. My page, APA Page 59. You said, listen,  
16 I don't even think the CT is particularly useful in  
17 terms of evaluating Ms. Spencer's condition. Is  
18 that a fair statement?

19 A Yes.

20 Q Now, at this point if I understand your note  
21 correctly - - - Well, let's back up. In this note  
22 of October 25, 2012, you wrote - - - And again,  
23 this is plan transcription, down towards the  
24 bottom, the middle paragraph. You mentioned that  
25 you met with Patti Chambers, the case manager. You

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1 noted that the leg symptoms - - - And I trust  
2 you're talking about the left. Is that correct?

3 A Yes, sir.

4 Q Was there any concern about the right at that  
5 point?

6 A I don't believe so.

7 Q All right. So you're focused on the left. You  
8 wrote, the leg symptoms are now seemingly more  
9 prominent, and I would recommend a trial of  
10 epidural steroid injections or selective nerve root  
11 blocks at L-5. Then you make the comment the CT  
12 really didn't help you, which is consistent with  
13 what you said before. Based upon what Ms. Spencer  
14 had told you and specifically about having pain  
15 down the left leg, you felt like it was an  
16 irritation of a root at L-5. Is that fair?

17 A Yes, sir.

18 Q And at this point, if I understand your note  
19 correctly, you're saying, I think the block is  
20 still an appropriate course here. Is that fair?

21 A Yes. I don't think she had received the block. We  
22 finally had gotten the approval for the myelogram -  
23 - - or we had gotten it approved, but I don't think  
24 she'd had a nerve block at that point.

25 Q I think that's true.

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- 1 A Yeah.
- 2 Q I think that's true.
- 3 A Yeah, okay. So I would - - - As it's still stated,  
4 my recommendation would be to do the nerve block on  
5 a trial basis.
- 6 Q All right.
- 7 A And if that didn't help, of course, other issues,  
8 other approaches to treatment would be pain  
9 management. I didn't feel that surgery would  
10 necessarily be helpful.
- 11 Q I'm going to talk to you about that in a second.
- 12 A All right.
- 13 Q What I do want to ask you about is the epidural  
14 steroid injection. That's different than a nerve  
15 root block. Is that fair?
- 16 A Yes, but it's basically - - - It's - - - Instead of  
17 coming from the side and specifically getting the  
18 nerve root, they just put it directly in the back.  
19 I guess it's just a more - - - It has a better  
20 spread, so that especially if you have - - - Well,  
21 and it's - - - It's easier to do, so it's - - -
- 22 Q It's what we call an ESI?
- 23 A Right, yeah.
- 24 Q It's more broader in effect than a selective nerve  
25 root block. Is that fair?

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1 A Yes, sir.

2 Q So at least as of this October visit, you were  
3 saying, listen, I think the left leg is growing  
4 more prominent. I'm suggesting a broader-based  
5 injection, or you can consider doing the selective  
6 block that you mentioned before. Is that a fair  
7 characterization of your plan?

8 A Yes, sir.

9 Q All right. Now, then in the last paragraph on  
10 that, you said, listen, she didn't respond to these  
11 treatments. And I will trust that you're talking  
12 about either the selective block or the ESI. What  
13 you are considering is a spinal cord dorsal column  
14 stimulator, and in that context, that might be  
15 considered. All right. Talk to us a little bit  
16 about that.

17 A Well, basically, I like to think of this as simply  
18 a pacemaker type of apparatus that, instead of the  
19 lead going into the heart, the lead goes in along  
20 the spinal cord. It's just a reasonable treatment  
21 approach. It's sort of down the line when you've  
22 really failed with everything else, but a  
23 reasonable type of treatment that seems to relieve  
24 the pain, especially when it shoots down the leg.  
25 It's often used in chronic pain management. You

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1 always use a trial first to make sure it's going to  
2 do some work. So they put in just a little  
3 temporary deal first, but the - - - But that really  
4 - - - I'm mentioning that, but really, that would  
5 be - - - The decision about that would probably be  
6 more from the pain management guy than it would be  
7 from me.

8 Q Do you implant stimulators or the trials? Do you  
9 do that?

10 A I don't do the trials. I've done the actual  
11 implantation, but now, the pain guys do that. They  
12 do it all, so - - -

13 Q All right.

14 A Yeah. So I really am not the guy who would be  
15 doing it.

16 Q It's pretty premature in her case to be looking at  
17 that, though, don't you agree?

18 A Yes. So that would be sort of down the road,  
19 especially since she hadn't even had a - - - you  
20 know, pain management of any sort, I guess, and no  
21 nerve blocks.

22 Q Well, and I'm not trying to interrupt you or argue  
23 with you, but she has had pain management to some  
24 degree.

25 A Oh, sorry. She's had - - - She's seen Dr. Owens,

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1           yeah. Yeah.

2 Q    What she has not had, that you've recommended  
3           specifically, is either the selective block or the  
4           ESI?

5 A    Right.

6 Q    Is that fair?

7 A    That's correct.

8 Q    And again based on what you've told me, you said,  
9           Clarke, that's a reasonable course of action based  
10          on the subjective complaints presented by Ms.  
11          Spencer. - - -

12 A    Yes, sir.

13 Q    To see what was going on. Is that fair?

14 A    Yes, sir.

15 Q    And if those don't work, then it's time to  
16          reevaluate it again. Is that fair?

17 A    Yes, sir. Yes.

18 Q    But it's premature to decide what to do after you  
19          consider these, either one of these injections or  
20          blocks. Is that fair?

21 A    That's fair.

22 Q    All right. Now, but it's your opinion today, Dr.  
23          Lehman, as we sit here and talk, that it's your  
24          opinion that the blocks will likely work in her  
25          case. Is that your opinion?

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1 A But that - - - that - - -

2 Mr. McCants - Let's go off the record for a  
3 second.

4 Whereupon - A brief discussion was held off  
5 the record which was not reported.

6 FURTHER EXAMINATION - (By Mr. McCants)

7 Q All right. We'll go back on the record after  
8 you've cogitated, I guess.

9 A Okay. I've cogitated. Yes. At that point in time  
10 or during the time of the - - - What I've read in  
11 here is, that my hope is that most probably and to  
12 a reasonable degree of medical certainty, the nerve  
13 block will work or will be - - - at least relieve  
14 some of the patient's pain.

15 Q All right.

16 A And potentially lessen the level of disability and  
17 hopefully get her back to a more - - - back to  
18 work.

19 Q All right. And again; and I don't mean to beat  
20 this horse, but that's based on your acceptance of  
21 the subjective complaints presented by Ms. Spencer  
22 as opposed to diagnostic evidence of an  
23 abnormality. Is that fair?

24 A Yes.

25 Q And let's jump ahead. I'll be careful here because

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1 I've heard people characterize this in different  
2 ways. Some people have told me that sticking a  
3 needle in someone is a surgical procedure. I don't  
4 know if you share that thought, but you made the  
5 comment you don't think she's a surgical candidate.  
6 Okay. Excluding the injections, the blocks, things  
7 of that nature, do you foresee that Ms. Spencer is  
8 a candidate for any type of invasive surgical  
9 procedure to, as you call it, relieve the  
10 irritation on that nerve at the L-5 or L-4 level  
11 that you're picking up with regard to her  
12 subjective complaints?

13 A My general impression is no.

14 Q All right, sir. If the block doesn't work or an  
15 ESI doesn't work, and let's say you were looking at  
16 a stimulator, do you think it would be unreasonable  
17 to maybe look at a second opinion at that point to  
18 determine whether or not a stimulator would be  
19 appropriate? Not to offend you or anything, but -

20 - -  
21 A Oh, no, no. Absolutely. As I said, I'm not really  
22 the one who puts them in. I know they are  
23 sometimes effective, but certainly, I think these -  
24 - - When I was doing them, the studies showed that  
25 even after successful implantation of the real

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1 thing, still at three years, fifty percent were not  
2 being used. So it's not really the total answer,  
3 but it - - - You know, so you definitely want to do  
4 a trial first. Then I always welcome second  
5 opinions on these issues, especially in a difficult  
6 situation like this.

7 Q Yes, sir. And I was going to ask you what your  
8 thoughts were as to the success rate of the  
9 stimulators, and what do you understand to be the  
10 current thinking in terms of success rates of ones  
11 that have been implanted following a trial?

12 A As I mentioned, it's been only moderately  
13 successful in the past. I just threw out the, you  
14 know, fifty percent in three years, but I think  
15 they're improved now since they have multiple  
16 sensors and electrodes. But still - - - Still,  
17 it's not the - - - It's not a miracle cure, should  
18 I say. It is an option in treatment sort of  
19 towards the end of the road. It's a salvage  
20 procedure, I guess you could say.

21 Q And that is a somewhat invasive procedure. Is that  
22 correct?

23 A Yes.

24 Q That is the - - - Not the trial, but the implant of  
25 a permanent stimulator?

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1 A Yes, sir.

2 Q In other words, you're actually going into the back  
3 and you're actually attaching electrodes, wires,  
4 and whatnot to the actual nerves connecting to the  
5 spinal cord. Is that correct?

6 A Yes.

7 Q And attendant with that are any number of risks  
8 associated with that procedure. Is that correct?

9 A Yes, sir.

10 Q Paralysis being one?

11 A Yes.

12 Q Do you agree?

13 A Yes.

14 Q Have you heard of most unfortunate implantation  
15 procedures where there's been some degree of  
16 paralysis?

17 A Some degree, yes. I don't remember a - - -  
18 reasonably anyway, total paralysis. But yes, there  
19 can be some nerve damage, and of course, it often  
20 requires a general anesthetic. So there are  
21 inherent risks of that procedure as well.

22 Q All right. Thank you, Doctor. Then finally in  
23 your last note, I think you've told us November  
24 26th of 2012, she saw you. It was a follow up.  
25 You indicate she's still depressed. I appreciate

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1 any physician is charged with monitoring the  
2 emotional state of their patients; You certainly  
3 have been trained to recognize depression and the  
4 emotional affect of your patients. Is that  
5 correct?

6 A Yes. Certainly not as much as a psychologist or  
7 psychiatrist, but - - -

8 Q But you can tell when somebody's depressed?

9 A Yes.

10 Q And in your opinion, she is depressed, or was at  
11 the time she saw you in November of 2012. Is that  
12 correct?

13 A Yes.

14 Q Was the depression, Doctor, more linked to her work  
15 status, or was it linked to a combination of  
16 things, or can you tell us?

17 A I really wouldn't be the - - - I really shouldn't  
18 comment really. I - - - I can recognize  
19 depression, but - - - It is probably  
20 multifactorial, the fact that she was out of work,  
21 but - - - the pain level and so forth, but I would  
22 not be qualified to really comment on that.

23 Q Fair enough. You just don't have an opinion, one  
24 way or the other, as to the cause of any depression  
25 that you observed. Is that a true statement?

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1 A Yes.

2 Q All right. Now, then you talk about your physical  
3 findings. You indicate she still has mainly back  
4 pain, but occasionally does have symptoms that  
5 extend into the left calf. Now, I have to ask you  
6 about that. Okay. The back pain is that old  
7 standard discomfort right there in the lower back.  
8 Is that correct?

9 A Yes.

10 Q And then you're talking about the leg pain. That's  
11 the shooting pain or the radicular pain that you  
12 refer to. Is that correct?

13 A Yes.

14 Q And that's the pain that is into the left calf that  
15 gave rise to your thought, well, let's try a nerve  
16 block or try an ESI. Is that correct?

17 A Yes.

18 Q All right. You used the term in this note of  
19 November 26th of 2012 that she occasionally does  
20 have symptoms that extend into the left calf. Now,  
21 that tells me that - - - and by using the word  
22 occasionally, that they come and go. That is,  
23 they're intermittent. Is that your - - - Was that  
24 your intention there?

25 A Yeah. That would imply that it is not a constant

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1 symptom, but it does either wax and wane or is not  
2 always - - - or constantly there in the left leg.

3 Q. So at least as of November 2012, she presented to  
4 you with back pain and also occasional pain, which  
5 extended into her left leg all the way down to her  
6 calf. Is that correct?

7 A Yes.

8 Q Now, then let's get back to your recommendations.  
9 You wrote, I had recommended a left L-5 selective  
10 nerve root block versus a spinal cord stimulator,  
11 but the referral has not been authorized as yet.  
12 Now - - - And I don't mean to pick out words at  
13 all. I don't see the ESI in this recommendation.  
14 What I see here is, let's try the selective nerve  
15 root block as opposed to a stimulator. All right.  
16 Was that intentional on your part, or what was the  
17 course? What were you planning at that point?

18 A No, I just think that an ESI, I think, would be  
19 basically an equivalent thing. You're using the  
20 same medication. You're just approaching the area  
21 from a different - - - a slightly different  
22 direction. But I do like the - - - I do prefer the  
23 selective nerve root block because it's more  
24 specific to the area where the abnormality shows up  
25 on the myelogram.

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1 Q Fair enough. So at least as of this visit,  
2 November - - - the end of November of last year,  
3 certainly within the realm of consideration was an  
4 ESI or a selective block? Just the notion that you  
5 think, we ought to go in there and anesthetize that  
6 nerve to see how - - - if it produces a result?

7 A Yes, sir.

8 Q And again, your opinion at least at that point is,  
9 that would likely provide her with some assistance.  
10 Is that correct?

11 A Yes.

12 Q All right. Have you seen Dr. Dyer's note that  
13 she's not a surgical candidate?

14 A Yes.

15 Q And again, you concur with that?

16 A Yes.

17 Q And within the concept of an invasive surgical  
18 procedure?

19 A Yes.

20 Q You agree with that?

21 A Yes.

22 Q All right. And again, in November of 2012, you  
23 mentioned the spinal cord stimulator, but is your  
24 opinion at that point really the same as it was  
25 before? That's really premature, and we'll

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1 evaluate that at some point in the future after a  
2 block of some type is done. Is that fair?

3 A Yes.

4 Q All right, sir. And again, talking about her work  
5 status, at least as of November 26th of 2012, it  
6 was your understanding that she was not working.  
7 Is that correct?

8 A Yes.

9 Q Because you made the note, she's been out of work  
10 since November of 2011. Of course, that would have  
11 been about a year prior to this visit. Is that  
12 correct?

13 A Yes.

14 Q But if you'd look at your Page 2 of the visit in  
15 November of 2012, you recommended sit-down work  
16 only. Is that correct?

17 A Yes.

18 Q And then you wanted to see her in six weeks which,  
19 heck, I guess we're coming up on?

20 A Yes.

21 Q Is that right?

22 A Yes, I guess so. Or as needed, you know,  
23 basically.

24 Q Okay. Your opinion as of November 26th, 2012 is  
25 that Ms. Spencer is capable of performing what you

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1 call sit-down work only, which sounds like work at  
2 a sedentary level. Is that fair?

3 A Yes.

4 Q And is that your opinion within a reasonable degree  
5 of medical certainty?

6 A Yes.

7 Q When you say sit-down work, I have to explore that  
8 a little bit with you. Because it seems to me I  
9 saw something in a previous note, sit-down work but  
10 the ability to get up and down?

11 A Yes, sir.

12 Q You do want your patients moving to some degree,  
13 don't you?

14 A Yes, sir.

15 Q In other words, an administrative desk type job,  
16 something where she has the ability to move and  
17 make herself comfortable. Is that fair?

18 A Yes, sir.

19 Q You don't want her lifting anything of any  
20 significant weight?

21 A I wouldn't think so. Of course, some physical  
22 therapy or a functional capacity evaluation would  
23 be helpful to make a more specific recommendation  
24 in that regard.

25 Q Okay.

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1 A But basically sedentary work, yes.

2 Q All right. I may talk to you about the FEC in just  
3 a second. I'm getting close to finishing. To  
4 explore that work recommendation, an  
5 administrative, sit-down, sedentary type position.  
6 She certainly should be getting up and down with  
7 regard to her work opportunities, just for general  
8 mobility. Is that correct?

9 A Yes.

10 Q How about walking? Are you okay with her walking  
11 about, for example, in a nursing facility or  
12 residential care facility?

13 A Well, I guess it - - - I guess, you know, some - -  
14 - Some walking certainly seems reasonable, would be  
15 reasonable, but I guess again, you know, it's hard  
16 to say. She's depressed. She's lost a tremendous  
17 amount of weight. Although, I think it's  
18 stabilized at this point. So the amount of  
19 ambulation, I'd have to - - - I'd have to look at  
20 that more carefully.

21 Q How about, as tolerated, at least for now? Are you  
22 okay with that? In other words, if she can do it,  
23 is it okay with you, or would you say don't do it?

24 A Oh, sure. I don't see any reason why she couldn't  
25 do something within the - - - Well, as tolerated,

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1           yes. That makes sense.

2   Q    If some of her emotional issues - - - And I know  
3        you say you don't have an opinion as to the cause.  
4        But if some of her emotional issues have been  
5        linked to this non-work status, is it your opinion  
6        that maybe some degree of work, maybe even a  
7        limited number of hours to start off with, is going  
8        to assist her with improving her emotional state?

9   A    It's - - - That has happened, yes.

10   Q    I mean, is that an unreasonable thought?

11   A    That's a - - - No, that is reasonable.

12   Q    I mean, I've heard some people say that work is  
13        sometimes the best physical and emotional therapy  
14        you can find. Do you share that opinion?

15   A    Sure. I think that that's often the reason why we  
16        - - - Well, we're basically, in these such  
17        situations, we're asked to provide restrictions and  
18        not strictly out of work, just so that hopefully  
19        they can get them back to at least something, but  
20        they - - - people do recover quicker.

21   Q    All right. An FCE, do you think it's appropriate  
22        at this point to look at an FCE? And the reason I  
23        - - - And I'm sorry. I didn't mean to throw you  
24        multiple questions. In light of your opinion,  
25        listen, I don't think she is an invasive surgical

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1 candidate. We're looking at really a limited  
2 number of options at this point, nerve blocks,  
3 maybe a stimulator. If blocks don't work, we'll  
4 deal with that. But in light of that, do you think  
5 we're at the point where an FCE would be  
6 appropriate?

7 A Well, usually, I reserve that for someone once  
8 they've reached maximum medical improvement. At  
9 least as of the last visit, I really was still  
10 interested in getting at least a trial of the nerve  
11 blocks. So in a sense, I guess I would say I would  
12 wait until we've pretty much explored all treatment  
13 options, and if they really have not been  
14 effective, then an FCE makes sense.

15 Q All right. Fair enough, and I guess I should have  
16 asked this question. At least from your  
17 standpoint, from a medical standpoint, she really  
18 hasn't reached that plateau, that MMI, with regard  
19 to her treatment because you recommend some other  
20 options. Is that correct?

21 A That's correct.

22 Q And specifically, the blocks that you've talked  
23 about. But you don't agree - - - You don't  
24 disagree that we're approaching that point, do you?  
25 We're going to know pretty quickly if the blocks

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1 are approved or an ESI is approved, whatever you  
2 do. That's going to answer a lot of questions in  
3 your mind, don't you think?

4 A Yes, sir. Yes, sir.

5 Q All right. Okay.

6 A Really, other than a trial of the nerve block and  
7 the - - - of course, the continued pain management  
8 of medications, so forth, maybe some physical  
9 therapy, there really isn't much else to offer.

10 So, yeah, I think we're getting towards the end of  
11 the road here.

12 Q Fair enough. I'm not asking you to pull out your  
13 crystal ball. I'm just going to ask you most  
14 probably, more likely than not, but in - - - And  
15 you've been doing this how long?

16 A Oh, a good twenty-five or more years, I guess.

17 Q All right. You've seen a lot of patients coming  
18 through, certainly patients in Ms. Spencer's  
19 condition. Is that correct?

20 A Yes.

21 Q Look ahead a little bit. The block works. That's  
22 the source of the problem, that nerve root. That  
23 relieves the pain. You say, all right, we've got  
24 to follow that for a period of time, but I do think  
25 she's reached a level of MMI. You got any opinion

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1           whatsoever as to the degree of permanent physical  
2           impairment Ms. Spencer has sustained?

3   A    I guess I'd have to look at that, but I do believe  
4           most probably that there is some impairment but it  
5           - - - Assuming a response to the nerve block, there  
6           will still be the back pain and the depression. So  
7           there will be at least some element of permanent  
8           impairment.

9   Q    Yeah. If you get rid of the pain, get back to  
10           work, it's likely that depression is going to start  
11           to attenuate, don't you agree?

12   A    I think that will get better, yes.

13   Q    All right, sir. So in that regard, we are  
14           premature in determining MMI, impairment, things of  
15           that nature. We've got to wait and see. But I'm  
16           just wondering whether or not you've got any  
17           thoughts with regard to impairment.

18   A    (No response)

19   Q    And whether you're saying that's premature?

20   A    Well, I - - - I could - - - Like you said, I could  
21           crystal ball it a little bit and, I guess, base an  
22           impairment generally. - - - Well, I'm really not  
23           qualified to provide an impairment rating for the  
24           depression. I don't even know if that will  
25           continue. Assuming the leg pain is gone, there's

Deposition of William Lehman, M.D.

1 still going to be back pain and - - - Well, the AMA  
2 Guides, you know, provide five to eight percent  
3 whole person based on this kind of situation.

4 Q. All right. Well, I appreciate your answer then,  
5 and I will put an asterisk beside it saying, we've  
6 got to look at certain things. But if the block  
7 works and you're not going to give an opinion as to  
8 the depression issue, but based on your experience,  
9 you're looking at five to eight percent permanent  
10 physical impairment from a whole percent  
11 standpoint, but related to the spine. Is that  
12 fair?

13 A Yes, sir.

14 Q Okay. I hate to jump back and forth. Are you okay  
15 with Ms. Spencer working in a receptionist type  
16 position at the present time? There's not a bunch  
17 of lifting, working at a desk, doing paperwork,  
18 having the opportunity to get up and down. Are you  
19 okay with that?

20 A I think that would be a reasonable approach, yes,  
21 something at least to - - - on a trial basis to see  
22 if she could go back to that kind of work.

23 Q You certainly wouldn't tell her not to do it?

24 A That's correct.

25 Q And, in fact, in many ways, you might even

Deposition of William Lehman, M.D.

1 recommend it. Is that fair? Or at least a trial  
2 basis to see how it works out?

3 A Yes.

4 Mr. McCants - Okay. That's all I've got.

5 Thank you for your answers this evening,

6 Doctor. I appreciate your time.

7 Mr. Creech - I have a few small things.

8 EXAMINATION - (By Mr. Creech)

9 Q This work accident decrement has been admitted and  
10 provided by the carrier, but Mr. McCants has asked  
11 you kind of about what the diagnostics showed. I  
12 think we've talked about the facet arthritis or the  
13 stenosis in her back. If she was asymptomatic and  
14 really didn't have any back problems before this  
15 work accident, and then she testified that she felt  
16 a pop in her back when pushing this cart and all of  
17 her back pain started after that, is it probable  
18 and most likely within a reasonable degree of  
19 medical certainty that the work accident aggravated  
20 those degenerative conditions, causing her back  
21 pain and radicular symptoms?

22 A Yes.

23 Q Okay. And I think you've been crystal clear about  
24 it, but at this point as we sit here today, you  
25 believe Ms. Spencer needs to have a nerve root

Deposition of William Lehman, M.D.

1 block?

2 A Yes. She still has radicular symptoms in her leg,  
3 and that seems consistent with, well, the CT  
4 myelogram and the MRIs. That seems to be the  
5 source of the predominant share of her symptoms, so  
6 yes.

7 Q Okay. And so she's not at MMI yet, as we sit here  
8 today?

9 A That's correct.

10 Q We talked about her depression, and I certainly  
11 understand you're not a psychiatrist. But as you  
12 stated a few minutes ago, since her work accident,  
13 Ms. Spencer has lost a considerable amount of  
14 weight. I think maybe around thirty pounds maybe  
15 in the last year. She had no depression symptoms  
16 before her work injury. Do you think it's likely  
17 that her chronic pain has at least contributed to  
18 her depression, if not directly caused it?

19 A Yes.

20 Q Do you believe that it would benefit her to at  
21 least be evaluated by some type of psychiatric  
22 professional who could hopefully treat her  
23 depression and get it under control?

24 A Yes.

25 Q Okay. We talked a little bit about functional

Deposition of William Lehman, M.D.

1 capacity evaluations. Do you normally prefer Eric  
2 Schmidt or somebody over at Catawba Rehab perform  
3 those, or do you have a preference on who does  
4 them?

5 A They do a good job. Select Physical Therapy here  
6 in town does a good job. HealthSouth, they also do  
7 them. So in general, yes, I think Catawba is a  
8 reasonable place to have that done.

9 Q Okay. And just so we are clear, right now, is it  
10 your opinion that sedentary work is appropriate  
11 with kind of standing and walking as tolerated?

12 A Yeah. I think Mr. McCants' statement that, you  
13 know, as tolerated with - - - you know, at least on  
14 a trial basis to see what she can tolerate. That  
15 makes very good sense.

16 Mr. Creech - Okay. No further questions.

17 Mr. McCants - No further questions. Thank  
18 you, Doctor. It was a pleasure to meet you.

19 Mr. Creech - Thank you.

20 A Thank you.

Deposition of William Lehman, M.D.



THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS'  
COMPENSATION COMMISSION

SCWCC FILE NO. 112078


Lettie Spencer,.....Appellant,

v.

NHC Parklane,.....Respondents.

**CERTIFICATE OF COUNSEL**

The undersigned certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



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ROA 681

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APPEAL

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM THE SOUTH CAROLINA  
WORKERS' COMPENSATION COMMISSION

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Appellate Case No. 2015-002112

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Lettie Spencer,

Employee, Appellant,

v.

NHC Parklane,

Employer,

and

Premier Group Insurance Co., Inc.,

Carrier, Respondents.

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FINAL BRIEF OF APPELLANT

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STATEMENT OF ISSUES ON APPEAL

- I. DID THE COMMISSION ERR IN FAILING TO FIND THAT MS. SPENCER IS PERMANENTLY AND TOTALLY DISABLED?
- II. IN THE EVENT THAT MS. SPENCER IS NOT PERMANENTLY AND TOTALLY DISABLED, DID THE COMMISSION ERR IN FAILING TO ADDRESS MS. SPENCER'S WAGE LOSS CLAIM?

## STATEMENT OF THE CASE

Claimant/Appellant Lettie Spencer suffered admitted work-related injuries to her low back and psyche while pushing a medical cart on June 22, 2011. On February 28, 2014, she filed a Form 50 seeking permanent and total disability pursuant to § 42-9-10 or § 42-9-30, or, in the alternative, seeking a partial wage loss award under § 42-9-20. (R. p. 22). Respondents filed a Form 51 denying permanent and total disability and seeking a determination of compensation pursuant to § 42-9-30. (R. p. 24).

A hearing was held before Commissioner R. Michael Campbell, II on September 3, 2014. Prior to the hearing, counsel for Ms. Spencer made an oral motion clarifying his alternative positions, requesting that if Ms. Spencer was not found permanently and totally disabled under §§ 42-9-10 and 42-9-30, she be entitled to an award for wage loss under § 42-9-20. (R. p. 35, lines 11-14). Counsel for Defendants/Respondents consented to the motion. (R. p. 35, line 15). In an order filed on March 12, 2015, Commissioner Campbell found that Ms. Spencer “sustained permanent partial disability to the back in the amount of 21%.” (R. p. 12, par. 15). The commissioner made no findings with regard to Ms. Spencer’s wage loss claim under § 42-9-20. Ms. Spencer timely filed a Form 30 request for appellate review. (R. p. 26).

On June 15, 2015, oral argument was presented before an Appellate Panel of the South Carolina Workers’ Compensation Commission consisting of Commissioners Avery B. Wilkerson, Jr.; Aisha Taylor; and Susan S. Barden. In its order of September 11, 2015, the Commission acknowledged seven issues were properly before the panel; five of these related to whether Ms. Spencer was permanently and totally disabled, while one pertained to alleged overpayment of temporary total compensation. (R. pp. 17-18). The remaining issue was

whether “the Single Commissioner err[ed] in failing to make a finding under 42-9-20 regarding the extent of the Claimant’s wage loss.” (R. p. 18, par. 6).

The Commission simply re-affirmed the findings of the Single Commissioner verbatim, finding that Ms. Spencer sustained only a 21% permanent partial disability to her back and that Defendants/Respondents were not entitled to a credit for overpayment of temporary compensation. (R. p. 5). However, the Full Commission also failed to enter any rulings whatsoever concerning Ms. Spencer’s wage loss. Neither their Findings of Fact nor their Conclusions of Law so much as mention wage loss or § 42-9-20. The terms never appear again after being listed as an issue on appeal. (R. pp. 17-21).

On October 9, 2015, Ms. Spencer filed a Notice of Appeal with the South Carolina Court of Appeals. (R. p. 28).

## FACTS

Ms. Spencer is a woman. She completed the 8<sup>th</sup> grade, but later obtained a GED. (R. pp. 40-41, lines 25-2). In 1982, Ms. Spencer was accepted into nursing school in Orlando, where she received a degree as a licensed practical nurse (LPN). (R. p. 41, lines 2-10). She has worked as an LPN for the last 33 years; she has not performed any other type of work. (R. p. 42, lines 11-17). In 1997, Ms. Spencer joined National Health Care (NHC) as an LPN. (R. p. 42, lines 18-25). Her primary job duties included looking after Alzheimer's patients, which became a passion for her. (R. p. 43, lines 7-11). Ms. Spencer worked for NHC for approximately 15 years. (R. p. 42, lines 18-25).

On June 22, 2011, Ms. Spencer suffered an admitted lower back injury when the wheels locked up on a medical cart she was pushing. (R. pp. 44-45, lines 13-8; p. 24). She was initially evaluated by neurosurgeon Dr. Randall Drye, who determined that she was not a surgical candidate and instead recommended physical therapy and potentially pain management. (R. p. 181).

Ms. Spencer treated with pain management physician Dr. Tony Owens. (R. p. 190). Dr. Owens performed an SI injection for her in November 2011, and a radiofrequency ablation in December 2011. (R. pp. 192, 197). Unfortunately, this conservative treatment failed. (R. p. 200). In April 2012, Dr. Owens diagnosed Ms. Spencer with chronic pain syndrome, SI joint pain, and low back pain. (R. pp. 211-212). He then referred her for a second opinion from an orthopedist. (R. p. 212).

Ms. Spencer accordingly saw orthopedic surgeon Dr. William Lehman of Carolina Orthopaedic Surgery Associates. (R. p. 228). Dr. Lehman recommended a series of L4-5 nerve root blocks for Ms. Spencer's radiating left leg pain, as well as epidural steroid injections. (R. p.

234). Initially, the root blocks were effective in treating Ms. Spencer's leg pain. (R. p. 246). Her back pain, however, remained. (R. p. 246). On April 2, 2013, Dr. Lehman diagnosed her as suffering from chronic back pain with resolved left leg symptoms per nerve root block, severe depression with resulting severe weight loss. (R. p. 246). Records from this time indicate that Ms. Spencer weighed only 103 pounds, a 35-pound loss from her pre-injury weight of 138. (R. p. 246). On that same day, Dr. Lehman found that Ms. Spencer had reached MMI from an orthopedic standpoint, stating in his records that, "It is obvious Ms. Spencer is functioning at a less than sedentary level, not only to her back difficulties requiring independent recumbency, but also chronic pain syndrome as well as major depression." (R. p. 247). Dr. Lehman noted that these restrictions were permanent in nature. (R. p. 248). He also stated that Ms. Spencer would need ongoing medication both for pain management and for her severe depression. (R. p. 247). Dr. Lehman assigned her a 7% whole person impairment to her back. (R. p. 247).

In August of 2013, Ms. Spencer was referred by Respondents to a "comprehensive rehabilitation program" at The Rehab Center Incorporated in Charlotte, North Carolina. (R. p. 300). At the conclusion of this program, Dr. Kern Carlton released Ms. Spencer with an 8% impairment rating to her back and permanent restrictions of "sedentary work." (R. p. 408). These assessments were based primarily on a functional capacity examination performed on October 2, 2013. (R. p. 403).

A closer look at this FCE reveals that Ms. Spencer put forth "excellent effort" and "full effort." (R. p. 403). The specific restrictions actually enumerated in the APA include "Sitting for 60 minutes; Standing for 10 minutes; Lift 6 lbs frequently; Lift 7 lbs occasionally; Avoid twisting at the waist." (R. p. 404). These restrictions indicate that Ms. Spencer is not capable of sedentary work pursuant to the DOT physical classifications. Ms. Spencer is not capable of

occasionally lifting up to 10 pounds, and is not able to sit constantly for 6 to 8 hours, both of which are minimum requirements for the sedentary work classification listed in 20 CFR § 404.1567.

After her stint at The Rehab Center Incorporated, Ms. Spencer was referred to an authorized treating pain management doctor, Dr. Sanjay Nandurkar of Piedmont Interventional Spine and Pain Care. (R. p. 259). By this time, Ms. Spencer's left leg radiculopathy had returned. (R. p. 259). Dr. Nandurkar made a diagnosis of lumbar radiculopathy, lumbar disc bulges, chronic pain syndrome, and lumbosacral spondylosis. (R. p. 283). For her pain, Ms. Spencer was prescribed 75 milligrams of Nucynta every 8 hours, 300 milligrams of Gabapentin three times a day, and 4 milligrams of Zanaflex as needed. (R. p. 286). In December of 2013, Dr. Nandurkar recommended that Ms. Spencer consider a spinal cord stimulator. (R. p. 283). However, after discussing this procedure with a friend who underwent the same operation, Ms. Spencer decided against the stimulator. She was therefore declared by Dr. Nandurkar to have reached maximum medical improvement, and assigned a 13% whole person impairment for "injury to the low back affecting the leg," with permanent restrictions of "less than sedentary work." (R. p. 288).

In January of 2014, Ms. Spencer underwent a second FCE, this time at Columbia Rehabilitation Clinic. (R. p. 416). This second FCE noted "full and consistent effort" and again concluded that Ms. Spencer was limited to "less than sedentary work." (R. p. 417).

Ms. Spencer's psychological injury, her severe depression, has also been admitted by Respondents to be compensable. (R. p. 37, lines 7-11). Treatment for this injury has been provided. On February 28, 2014, Ms. Spencer was sent for a psychiatric IME with Dr. Patrick Mullen. (R. p. 443). After the examination, Dr. Mullen concluded that "Ms. Spencer is not a

candidate in the active work force in any capacity. Her depression and her pain make her more than 50% to 60% disabled, but even that may be a low estimate.” (R. p. 447). He added that, “Ms. Spencer cannot work and she will remain permanently disabled for the rest of her life. She could not maintain the persistence and pace necessary for any kind of gainful employment and her depression prevents her from learning anything new, plus her chronic pain is just worse and worse and prevents her from doing any kind of work at all.” (R. p. 447). Ms. Spencer continues to require anti-depressants as prescribed by her family physician. (R. p. 51, lines 14-21). She will require those medications indefinitely. (R. p. 52, lines 5-8).

Finally, Ms. Spencer was evaluated by vocational expert Leanna Hollenbeck on March 8, 2014. (R. p. 449). Ms. Hollenbeck concluded that “Ms. Spencer cannot work at all and will remain permanently disabled for the rest of her life.” (R. p. 456). Additionally, Ms. Hollenbeck opined that even if Ms. Spencer were able to return to work, it would be in an unskilled entry-level position earning \$7.50 per hour. (R. p. 456). However, given Ms. Spencer’s less-than-sedentary work restrictions, age, chronic pain, emotional and cognitive disabilities, and lack of transferrable skills, it was Ms. Hollenbeck’s opinion that Ms. Spencer sustained a 100% wage loss. (R. p. 456).

At hearing, Ms. Spencer testified that her back pain is constant, but worse at night. (R. p. 56, lines 5-6). She stated that, on average, this pain is a 6 out of 10. (R. p. 56, lines 17-23). The pain can be helped by sitting in a recliner. (R. p. 57, lines 2-9). Ms. Spencer testified that she is unable to lift more than 10 pounds. (R. p. 57, lines 13-15). She can sometimes sit for long periods of time if she is in a comfortable chair, and she can drive, but not continuously for more than an hour or two. (R. pp. 57-58, lines 19-4). She has problems standing in one place, but does better if she walks. (R. p. 58, lines 7-10). She also has difficulty with going up and down

stairs, and issues with balance due to the weakness and pain in her legs. (R. p. 60, lines 20-23). This pain is in both legs, but worse in the left. (R. p. 60, lines 20-22). Ms. Spencer is able to dust and clean the kitchen, but cannot vacuum. (R. p. 61, lines 22-23). She can run errands and shop for groceries, but has to make sure that no one bag is too heavy. (R. p. 62, lines 10-11). Normally when she shops, she uses a grocery cart she can lean on to relieve the pressure on her back. (R. p. 62, lines 18-20). Ms. Spencer stated that she can still squat to weed a flower bed, but only for a short period of time. (R. p. 63, lines 1-9). Likewise, she can ride a lawnmower over certain places in her yard, so long as they are level and she turns her TENS unit all the way up. (R. p. 63, lines 13-15).

At the hearing, Respondents did not introduce any evidence to contradict the medical testimony finding Ms. Spencer to be permanently and totally disabled. Instead, they relied on copious amounts of surveillance footage. This footage, however, served to confirm rather than contradict Ms. Spencer's testimony. It shows her driving; grocery shopping; putting small bags of groceries into her car; walking; often with difficulty; and standing and sitting at her son's place of business. All of these activities accord with Ms. Spencer's testimony regarding her physical limitations.

Respondents put special emphasis on the time Ms. Spencer spent at her son's business, Car Toys. The evidence in the record indicated that Ms. Spencer would occasionally visit Car Toys. (R. p. 65, lines 22-25). These visits occurred during a time when she was very depressed, and her son asked her to come to his office so she would not be alone. (R. p. 65, lines 16-20). Ms. Spencer testified that some weeks, she would visit the business daily, while during others she would not go at all. (R. p. 65, lines 22-25). She never worked there and was never paid any wages. (R. p. 65, lines 4-10).

This testimony was confirmed by Ms. Spencer's son, Terry Sartin. He stated that he would ask his mother to come to the shop to get out of the house, and that she came and went as she pleased. (R. p. 111, lines 5-9). Mr. Sartin testified that Ms. Spencer never worked for the business and was never paid any wages; he was happy simply to see her. (R. p. 111, lines 10-12). While she was there, Mr. Sartin said that his mother mostly sat on the couch in the office, watched TV, or talked to the customers as they came in. (R. p. 111, lines 17-22).

## STANDARD OF REVIEW

An appellate court's review of factual findings in a workers' compensation case is governed and controlled by the substantial evidence rule. Houston v. Deloach & Deloach, 378 S.C. 543 (Ct. App. 2008). This rule dictates that the Court review factual findings to determine whether there is competent evidence to sustain them. Wynn v. Peoples Natural Gas Co., 238 S.C. 1 (1961). The Commission's findings "may not be based upon surmise, conjecture, or speculation, but must be founded on evidence of sufficient substance to afford a reasonable basis for it." Edwards v. Pettit Constr. Co., Inc., 273 S.C. 576, 579 (1979). "Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action." Houston v. Deloach & Deloach, 378 S.C. at 543.

## ARGUMENT

### **I. THE FULL COMMISSION'S FINDING THAT MS. SPENCER SUFFERED ONLY A 21% PARTIAL DISABILITY TO HER LOWER BACK IS NOT SUPPORTED BY SUBSTANTIAL EVIDENCE.**

The Single Commissioner lacked substantial evidence to support his finding that Ms. Spencer suffered a 21% impairment to her back and was not totally disabled.

Generally, an injured claimant may proceed under either the general disability statutes, (§§ 42-9-10 and 42-9-20) or under the scheduled member statute (§ 42-9-30) to maximize recovery. Colonna v. Marlboro Park Hosp., 404 S.C. 537, 548 (Ct. App. 2013). The scheduled recovery is exclusive only when a scheduled loss is not accompanied by additional complications affecting another part of the body. Id. As with all workers' compensation statutes, these provisions must be "construed liberally in favor of coverage." Peay v. United States Silica Co., 313 S.C. 91, 94 (1993). Ms. Spencer is entitled to pursue recovery under the general disability statutes because she suffered admitted injuries to two distinct body parts—her back and her psyche—and because her back pain is affecting into her left leg. Accordingly, Ms. Spencer is seeking recovery under § 42-9-10 on the ground that she is totally disabled.

To support her claims, Ms. Spencer introduced the testimony of the following six medical professionals:

William Lehman, M.D.: "It is obvious that Ms. Spencer is functioning at a less than sedentary level." (R. p. 247).

Kern Carlton, M.D.: "She was placed in a sedentary work category." (R. p. 408).

Sanjay Nandurkar, M.D.: "The claimant is unable to return to work at his or her current employment. Less than sedentary restriction." (R. p. 288).

Tracy Hill, PT: "She qualifies for limited sedentary (less than sedentary) work." (R. p. 417).

Patrick B. Mullen, M.D.: "She cannot work at all and she will remain permanently disabled for the rest of her life." (R. p. 447).

Leanna Hollenbeck, M.S., C.L.C.P., C.R.C.: "Ms. Spencer is not employable now, nor will her employability increase in the future....Given her less than sedentary work restriction, combined with her age, chronic pain level, emotional and cognitive instability, and her lack of transferrable skills, it is my professional opinion that she has experienced a 100% loss". (R. p. 456).

Medical testimony such as this is entitled to great respect in Workers' Compensation hearings. Potter v. Spartanburg Sch. Dist. 7, 395 S.C. 17, 23 (Ct. App. 2011). The Commission may only disregard such evidence in favor of other competent evidence in the record. Id. When an opinion does not originate from a medical provider, but is instead the medical opinion of the single commissioner, adopted by the Commission, any findings based on that opinion should be overruled. See Burnette v. City of Greenville, 401 S.C. 417, 428 (Ct. App. 2012).

What occurred in this case is exactly the situation described in Burnette—the single commissioner entered his own medical opinion, which was then adopted by the Full Commission. The idea that Ms. Spencer suffered a 21% impairment to her back does not originate with any medical provider. No provider lends any substantial support or evidence for that finding. Only one witness, Dr. Carlton, provided any evidence that Ms. Spencer was capable of performing some level of work – releasing her with sedentary work restrictions. However, Dr. Carlton's opinion was internally inconsistent and contradictory. When one moves beyond the substance of his discharge summary and examines the actual results of his FCE, it is

clear that he should have found Ms. Spencer incapable of performing sedentary work. Under the Social Security regulations, a sedentary job "involves lifting no more than 10 pounds at a time" as well as sitting for the better part of a 6-8 hour workday. 20 CFR § 404.1567. Yet Dr. Carlton only measured that Ms. Spencer was capable of lifting "7 lbs occasionally" and was "observed sitting for 60 minutes at a time," despite putting forth excellent effort. (R. pp. 403-404). This is clearly and unequivocally less than what is required to qualify for sedentary work. Dr. Carlton's opinion is thus of no value, and fails to provide substantial evidence for the Commissioner's finding.

The only other evidence Respondents presented at the hearing was the surveillance footage. As previously stated, this footage in no way contradicts Ms. Spencer's testimony. Rather, it shows her performing the exact same tasks that she testified, both at her deposition and at hearing, she was able to do. In any event, carrying small bags of groceries, slowly walking about a store, and driving short distances are not equivalent to the demands of working a full-time sedentary job. Yet the video shows no more than this. It does not form a sufficient basis for finding that Ms. Spencer is capable of gainful employment in a competitive market.

Ms. Spencer's orthopedist, pain management physician, psychiatrist, physical therapist, and vocational expert all found that Ms. Spencer was permanently and totally disabled. The actual findings and observations of Dr. Carlton's report indicated the same. The Single Commissioner, however, decided to disregard this evidence and substitute his own medical opinion for that of the providers. There was no sufficient basis for his conclusion that Ms. Spencer suffered a mere 21% permanent partial disability to her back, and this finding must therefore be overturned.

**II. THE FULL COMMISSION ERRED IN FAILING TO ADDRESS MS. SPENCER'S WAGE LOSS CLAIM UNDER § 42-9-20.**

It is Ms. Spencer's position that she suffered permanent and total disability to her back as a result of her admitted workplace injury. In the alternative, if Ms. Spencer did sustain only partial disability, she is entitled to compensation for wage loss. However, neither the Single Commissioner nor Full Commission ever entered any finding of fact or law concerning Ms. Spencer's wage loss.

As set forth above, Ms. Spencer is entitled to seek recovery under either of the general disability statutes, § 42-9-10 or § 42-9-20. Like § 42-9-10, § 42-9-20 is based on the economic model, which defines disability and incapacity in terms of the claimant's loss of earning capacity. Wigfall v. Tideland Utils., 354 S.C. 100, 103 (2003). Disabilities under § 42-9-20 are to be measured by the claimant's capacity or incapacity to earn the wages which he was receiving at the time of his injury. Owens v. Herndon, 252 S.C. 166, 169 (1969). Loss of earning capacity is the criterion. Outlaw v. Johnson Service Co., 254 S.C. 486, 489 (1970). Under the statute, she is entitled to receive "weekly compensation equal to sixty-six and two-thirds percent of the difference between [her] average weekly wages before the injury and the average weekly wages which [s]he is able to earn thereafter, but not more than the average weekly wage in this State for the preceding fiscal year." As with all workers' compensation statutes, § 42-9-20 must be "construed liberally in favor of coverage." Peay v. United States Silica Co., 313 S.C. at 94.

The uncontroverted testimony at the hearing was that Ms. Spencer did suffer a diminishment in her earning capacity. It is not disputed that Ms. Spencer is physically unable to return to her former job. At the time of her workplace injury, she was working as a licensed practical nurse. This job falls under medium-level work under the Social Security

classifications. 20 CFR § 404.1567. Even the most optimistic of medical evaluations in this case placed her only “in the sedentary work category.” Clearly, then, she is not able to return to her former job. Leanna Hollenbeck, an expert in vocational rehabilitation, opined in the unlikely event Ms. Spencer were able to return to work, it would be in an entry-level position earning \$7.50/hour. This would represent a wage loss of 70%. Respondents did not present any evidence to rebut this testimony.

Neither the Commissioner nor the Full Commission entered any finding concerning wage loss, “the criterion” for a claim under § 42-9-20. In his Order, Commissioner Campbell states, “I am not persuaded that Claimant’s disability to her back, combined with the impairment to her psyche, diminishes her earning capacity to such an extent as to result in a total incapacity for work.” (R. p. 12, par 14). The implication of this statement is Ms. Spencer did in fact suffer some diminishment of her earning capacity. However, the extent of that reduction was never addressed, calculated, or ruled upon. This was error on the part of the Single Commissioner, and should be reversed by this Court.

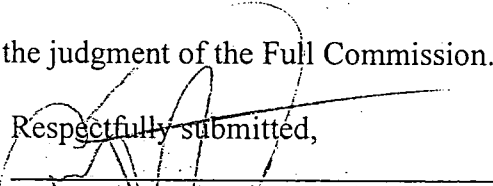
CONCLUSION

Ms. Spencer is totally and permanently disabled as a result of her workplace injury. Even if she were physically capable of performing sedentary work, the only vocational expert opinion in the record states that—based on her age, education, lack of work experience and transferrable skills, chronic pain, and emotional instability—Mrs. Spencer would not be able to work in any capacity. This was the unanimous opinion of Dr. Lehman, Dr. Nandurkar, Dr. Mullen, and the Columbia Rehabilitation Clinic. Even the Respondents' hand-picked physical therapist returned the same results, if not the same opinion, in his FCE. However, the Single Commissioner disregarded this evidence and entered his own medical opinion that Ms. Spencer sustained a 21% permanent partial disability to her back.

In the alternative, if the Court determines Ms. Spencer is able to work in some capacity, the only evidence of record states she has suffered a wage loss of 70%. Her old duties as a licensed practical nurse constitute medium work under the Social Security regulations. There is no dispute that Ms. Spencer is unable to return to this work, and the only evidence on the record concerning wage loss establishes that Ms. Spencer would be paid \$7.50 for performing sedentary work. This would constitute a wage loss of 70%, for which she is entitled to compensation under § 42-9-20.

For these reasons, this Court should reverse the judgment of the Full Commission.

Respectfully submitted,

  
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March 15, 2016

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

APPEAL FROM THE  
SOUTH CAROLINA WORKERS COMPENSATION COMMISSION  
APPELLATE PANEL  
Commissioner Campbell, II, Chair

Case No. 2015-002112


Lettie Spencer, Employee, ..... Claimant/Appellant,

v.

NHC Parklane and  
Premier Group Insurance Co. Inc., Appellants ..... Defendants/Respondents

CERTIFICATE OF COUNSEL

The undersigned certifies that this **FINAL BRIEF OF APPELLANT**  
complies with Rule 211 (b), SCACR.



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March 15, 2016

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM THE S.C. WORKERS'  
COMPENSATION COMMISSION

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Appellate Case No. 2015-002112

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Lettie Spencer, Employee, Appellant,

v.

NHC Parklane, Employer, and Premier Group Insurance Co., Inc., Carrier,  
Respondents.

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FINAL BRIEF OF RESPONDENTS

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## STATEMENT OF ISSUES ON APPEAL

1. DID THE COMMISSION ERR IN FAILING TO FIND THAT MRS. SPENCER IS PERMANENTLY AND TOTALLY DISABLED?
2. IN THE EVENT THAT MS. SPENCER IS NOT PERMANENTLY AND TOTALLY DISABLED, DID THE COMMISSION ERR IN FAILING TO ADDRESS MS. SPENCER'S WAGE LOSS CLAIM?

## STATEMENT OF THE CASE

This is a workers' compensation case. The Appellant, Lettie Spencer, sustained injuries to her lower back and psyche on June 22, 2011 as a result of an accident arising out of and in the course of her employment as a nurse with the Respondent Employer. (R. pp. 16 - 21). Following this accident, the Respondents paid for certain medical treatment rendered to Mrs. Spencer for these injuries, and also paid temporary total compensation to her. (Id.).

The Claimant contends that she is permanently and totally disabled as a result of the accident which forms the basis for this case. (R. pp. 22 - 23). She contends that she is entitled to an award of compensation for such permanent and total disability, as well as provision and payment for causally related medical care for the remainder of her life. (Id.). In the alternative she contends that she is entitled to benefits for a diminution in her ability to earn wages and pursuant to S.C. Code Ann. § 42-9-20 (1976).

The Respondents agree that Mrs. Spencer has sustained some degree of permanent partial disability as a result of the accident here, but deny that she is permanently and totally disabled. (R. pp. 24 - 25). They further deny that Mrs. Spencer is entitled to wage loss benefits. (Id.). The Respondents further agree that Mrs. Spencer is entitled to ongoing authorized, causally related and reasonable and necessary medical care which tends to lessen any disability sustained by her. (Id.).

A hearing to consider the issues set forth in the Parties' Forms 50 and 51 was conducted before Commissioner Michael Campbell on September 3, 2014. Following that hearing he issued his Decision and Order setting forth his findings of fact and conclusions of law. (R. pp. 1 - 15). Mrs. Spencer then requested Full Commission Review of Commissioner Campbell's decision. (R. pp. 26 - 27). A hearing was then held before an Appellate Panel of the Commission which affirmed Commissioner Campbell's decision for this case. (R. pp. 16 - 21).

Mrs. Spencer then filed a Notice of Appeal of the Commission's Decision and Order for this case. (R. pp. 28 - 29).

## ARGUMENTS

### I. THE FULL COMMISSION'S FINDING THAT MRS. SPENCER SUFFERED A 21% PARTIAL DISABILITY TO HER LOWER BACK IS SUPPORTED BY THE SUBSTANTIAL EVIDENCE.

Upon review in South Carolina, a decision of an administrative agency should be affirmed unless that decision is clearly erroneous in view of the reliable, probative and substantial evidence on the record as a whole. S.C. Code Ann. Section 1-23-380(g)(6) (1976); Lark v. Bi-lo, Inc., 276 S.C. 130, 276 S.E. 2d 304 (1981). The court reviewing the agency's decision should not substitute its own findings of fact for those of the agency nor should the court substitute its judgment for that of the agency as to the weight of the evidence. Tobey v. L & P Construction Company, 296 S.C. 122, 370 S.E. 2d 897 (Ct. App. 1988).

Substantial evidence is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the agency involved reached to justify its decision. Harrell v. Pacific Columbia Mills, 291 S.C. 469, 471, 354 S.E. 2d 384, 385 (1987). The substantial evidence rule means that the court will not overturn findings of fact by an administrative

agency unless there is no reasonable probability that the fact could be as related by the witness upon whose testimony the finding was based. Lark v. Bi-Lo, Inc., *infra*. When factual findings are supported by substantial evidence, analogous to a jury's finding of fact on disputed issues, the agency's conclusions should be affirmed. Hunter v. Patrick Construction Company, 289 S.C. 46, 344 S.E. 2d 613 (1986).

The thrust of Mrs. Spencer's argument in this case is that there is overwhelming expert and medical evidence to establish that she is either permanently or totally disabled or entitled to a substantial award of a compensation based upon an alleged diminution of her ability to earn wages as a result of the injuries she sustained. The Respondents do not deny that there is such evidence contained in the record for this case.

The question, however, is whether that expert medical evidence is reliable or credible, and especially when viewed alongside the vast and overwhelming lay and other evidence presented at the hearing for this case.

The South Carolina Supreme Court, on numerous occasions, has addressed the requirement that all types of evidence, both lay and expert, be considered in reaching a decision in a workers' compensation case. In Tiller v. National Health Care Center of Sumter, 334 S.C. 333, 513 S.E.2d 843, (1999) the Supreme Court reached a seminal decision in this regard, by stating:

The Commission is given discretion to weigh and consider all the evidence, both lay and expert, when deciding whether causation has been established. See Ballenger v. Southern Worsted Corp., 209 S.C. 463, 40 S.E.2d 681 (1946) (despite doctor's testimony that there was not a connection with the accident that caused almost boiling dye to fly in claimant's face and eyes and his subsequent eye problems, lay testimony of claimant's good vision before the accident was sufficient to support an award); Poston v. Southeastern Construction Co., 208 S.C. 35, 36 S.E.2d 858 (1946) (lay/testimony that claimant's eyes became runny and inflamed after some construction material blew into them and that claimant lost vision in eyes subsequent

to the accident was sufficient to support an award, even though doctor testified vision loss was not related to job injuries).

Granted, in Tiller, and the cases cited by the Supreme Court awards of benefits and compensation were made to injured workers in the absence of clear, expert medical evidence establishing causation or a particular finding or conclusion, the rule of law established clearly flows in both directions.<sup>1</sup>

Thus, while medical testimony is entitled to great respect, the Commission as the ultimate fact finder may disregard it if there is other competent evidence in the record. Ballenger, supra. As stated by the Supreme Court, "indeed, medical testimony should not be held conclusive irrespective of other evidence." Ballenger, 209 S.C. at 467, 40 S.E.2d at 682-83. Expert medical testimony is designed to aid the Commission in coming to the correct conclusion; therefore, the Commission determines the weight and credit to be given to the expert testimony. Poston, supra; Hines v. Pacific Mills, 214 S.C. 125, 51 S.E.2d 383 (1949).

Finally, and perhaps most importantly, expert testimony, once admitted, is to be considered just like any other testimony. Smith v. Southern Builders, 202 S.C. 88, 24 S.E.2d 109 (1943).

The reason and basis for this well-established precedent is clear - just because an expert offers an opinion, does not mean that it is not subject to being challenged. Such is especially the case when an expert's opinion is built upon an unstable foundation. That is, facts which are not accurate. Otherwise, the opinion rests on nothing but shifting sand and is not reliable.

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<sup>1</sup> Of course, the ruling in Tiller was subsequently modified by legislation enacted by the General Assembly in 2007. However, that legislation did not abrogate the requirement that the Commission consider all types of evidence in reaching its decisions.

Commissioner Campbell and three other Commissioners, sitting as an Appellate Panel, reviewed the evidence contained in the record for this case and chose to decide that the principle expert opinions offered by Mrs. Spencer in this case did not reach the level of such reliability as to support the foundation upon which she builds her case. As part of the summary of the evidence presented in this case, Commissioner Campbell noted the following:

“Counsel for the Claimant offered reports prepared by Patrick Mullen, M.D. and Leanna Hollenbeck, MS, CLCP, CRC in support of his position that the Claimant suffers from major depressive symptoms and is incapable of engaging in gainful employment at the present time.

“Upon cross examination by Counsel for the Defendants, Mrs. Spencer admitted that as a health care professional it is very important that a provider obtain an accurate history from a patient before reaching a diagnosis and assessing that patient’s condition and needs. She agreed that medical professionals must have accurate information in order to reach the opinions that they offer.

“Mrs. Spencer agreed that Dr. Mullen’s report for this matter indicates that she experienced minor medical problems until the accident in this matter, after which she began experiencing chronic pain and depression. She also agreed that Dr. Mullen’s report included in her history that she had never received any psychiatric care.

“The Defendants introduced records documenting medical treatment received by the Claimant prior to the accident involved in this case. Included in that evidence are records documenting treatment for Mrs. Spencer at Chester Regional Medical Center in January 2009. In those records it is noted that she reported a past medical history of chronic pain and depression. The Claimant testified that she did not recall providing that information to providers at Chester Regional, but does not have information to demonstrate that the referenced medical report is inaccurate.

“Prior medical records for Mrs. Spencer show that she underwent neck surgery in 2004. Medical records produced by Amy Dorn, M.D. demonstrate that in 2006 the Claimant reported symptoms of “hyperlipidemia, hypertension, chronic back pain, chronic neck pain status post surgery, carpal tunnel syndrome, restless leg syndrome, smoking and anxiety.” An insurance claim form prepared by the Claimant in 2005 reflects that she experiences neck pain and lower back pain.

“The Claimant also admitted that she provided a history to Dr. Mullen to the

effect that following the accident in this case, she had "to stay in her bed and the pain has grown worse." Upon questioning she stated that her problems have improved to the point where she does not "stay in bed all the time anymore."

"Mrs. Spencer further admitted that she did not provide an accurate history to Dr. Mullen regarding her marital status. Dr. Mullen's report indicates that the Claimant resides with her husband, who is a truck driver and is not home on a regular basis. The evidence for this matter shows that Mrs. Spencer separated from her husband following a domestic dispute, and during which she was assaulted by him. When asked, she agreed that it is important for a mental health provider to fully understand the circumstances surrounding the stability of a patient's family life before reaching a medical opinion.

"Dr. Mullen also set forth in his report that Mrs. Spencer "raised beautiful flowers, but has not done any gardening since the accident." The Claimant testified that she does perform some yard work from time to time. She further agreed that Dr. Mullen's statement that she is "completely dysfunctional" is not accurate.

"Mrs. Spencer agreed that Ms. Hollenbeck set forth in her report for this matter that she "reports being in agony by 5:00 p.m. after a day at home with little or no physical activity during the day." She also agreed that Ms. Hollenbeck understood that she "uses a cane when she leaves her home." The video evidence presented in this matter reflects no use of a cane by the Claimant. Further, she testified that she uses a cane only while outside and actually at her house.

"Upon cross examination the Claimant also testified that she planned to work until she reached the age of sixty-years of age and then work part-time. She also testified that she wants to perform volunteer work to assist individuals suffering from Alzheimer's Disease.

"The Parties stipulate that the Claimant is shown in the video sequences and segments offered into evidence in this case. The Claimant agrees that the video does show her outside of her home, driving by herself, shopping and performing errands at any given times of the day, including the morning, afternoon and into the evening and night. She further agrees that portions of the video sequences show that she walks on occasion without difficulty. She, however, contends that this is only for short distances.

"With respect to the business known as Car Toys, Mrs. Spencer agrees that it was placed in her name, her name was on the lease, the power bill, water bill and the business checkbook. She also testified that she applied for the necessary permits to operate the business. She also stated that she paid the bills incurred by the business. When asked, she related that she did not inform either Dr. Mullen or Ms.

Hollenbeck that she was engaging in such business activities. She contends, however, that she never received any wages or compensation from Car Toys.

“After Car Toys ceased operations, the evidence shows that Mrs. Spencer participated in winding-up its affairs. Segments of the video offered into evidence shows Mrs. Spencer assisting with clearing debris from the garage where the business was located.

“Other video segments offered by the Defendants show the Claimant shopping. Specifically, she is shown emptying the contents of her shopping cart into her automobile.

“One segment of video shows the Claimant operating her John Deere lawn tractor at 2:00 p.m. on July 29, 2014. Mrs. Spencer agrees that the outside temperature on that date, and at that time, was approximately ninety-seven degrees. A review of the videotape shows that the Claimant spent an extended period of time operating the tractor and cutting her large lawn. Additional video evidence shows the Claimant filling gasoline cans on other dates, which she agrees are used to supply gasoline to her tractor. Mrs. Spencer also testified that she is able to perform a number of these physical tasks with the assistance of her TENS Unit.

“Terry Sartin, the Claimant’s son, testified as part of this matter. He stated that he actually operated the business known as Car Toys, which was financed by his Mother. He also testified that his Mother was depressed following her accident, and he encouraged her to get out of the bed and attempt to “do something.” Upon cross examination, he admitted that his Mother did perform some tasks for the business, including sweeping the floor areas and paying bills.

(R. pp. 7 - 11).

The video evidence in this case, visually depicting Mrs. Spencer in daily activities and spanning a wide period of time, is compelling. (Defendants’ APA Submissions and Exhibits). The summary of the evidence outlined above, including the video evidence, was used by Commissioner Campbell in crafting the findings of fact and conclusions of law set forth in his Decision and Order. (R. pp. 1 - 15). They further served as the foundation for the Appellate Panel’s Decision and Order for this case. (R. pp. 16 - 21). Obviously, the Panel deferred greatly to Commissioner Campbell’s opportunity to personally observe and hear Mrs. Spencer at the hearing

held before him.

There is clearly reliable and substantial evidence to support the Commission's decision in this case, not only with respect to whether or not she is permanently and totally disabled but also as to the award of permanent partial disability to her. As such the Respondents respectfully submit that it should be affirmed.

## II. THE FULL COMMISSION DID NOT ERR WITH RESPECT TO MRS. SPENCER'S CLAIM FOR A WAGE LOSS UNDER § 42-9-20

The Respondents do not dispute that the Commission did not specifically make findings of fact or conclusions of law with regard to Mrs. Spencer's claim for wage-loss benefits under S.C. Code Ann. § 42-9-20 (1976). The Respondents contend, however, that such ruling is not necessary in this case given the evidence presented to the Commission, and the manner in which Mrs. Spencer presented her case below.

As noted, Mrs. Spencer's principle argument and theme in this case is that she is permanently and totally disabled as a result of her job-related accident in June 2011. Indeed, she relies upon the numerous expert opinions submitted to the Commission in this regard. The Commission, however, found and concluded that those opinions were undercut and outweighed by the other credible evidence in the record for this case.

In the face of such assertions the Respondents submit that it is difficult for Mrs. Spencer to argue an alternative theory here and ask the Court to accept it. In one breath Mrs. Spencer states that she is not able to engage in any meaningful work activity whatsoever, but in the next breath says she is capable of earning wages to some degree. From the Respondents' perspective such contentions are necessarily mutually exclusive, and given the manner in which the evidence has

been presented by her in this case.

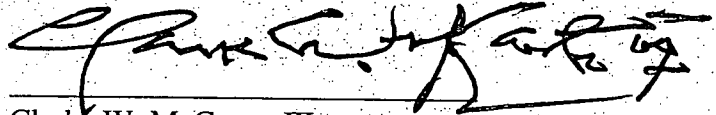
That said, and while the Respondents submit that the Commission's decision should be affirmed, to the extent that this Court accepts Mrs. Spencer's argument that a wage-loss claim should be addressed by the Commission more specifically, the Respondents welcome this Court's decision to remand this matter to the Commission solely for that purpose.

#### CONCLUSION

The Commission's decision in this matter is supported by substantial evidence and should be affirmed.

March 15, 2016

Respectfully Submitted,



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THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM THE S.C. WORKERS'  
COMPENSATION COMMISSION

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Appellate Case No. 2015-002112

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Lettie Spencer, Employee, Appellant,

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NHC Parklane, Employer, and Premier Group Insurance Co., Inc., Carrier,  
Respondents.

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CERTIFICATE OF COUNSEL

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I hereby certify that the Final Brief of the Respondents complies with Rule 211(b) SCACR.

NANCE, MCCANTS & MASSEY

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March 15, 2016

THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE  
CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING  
EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

Lettie Spencer, Employee, Appellant,

v.

NHC Parklane, Employer, and Premier Group Insurance  
Co., Inc., Carrier, Respondents.

Appellate Case No. 2015-002112

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Appeal From The Workers' Compensation Commission

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Unpublished Opinion No. 2017-UP-443  
Heard October 3, 2017 – Filed November 29, 2017

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**REVERSED AND REMANDED**

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Andrew Wade Creech and Garrett Brendan Johnson, both  
of Elrod Pope Law Firm, of Rock Hill, for Appellant.

Clarke W. McCants, III, and Amy Patterson Shumpert,  
both of Nance, McCants & Massey, of Aiken, for  
Respondents.

---

**PER CURIAM:** Lettie Spencer, a former employee of NHC Parklane, appeals the decision of the Appellate Panel of the Workers' Compensation Commission (Appellate Panel) awarding Spencer 21% partial disability of the lower back sustained from an admitted workplace injury on June 22, 2011. Spencer argues (1)

the Appellate Panel's decision is not supported by substantial evidence and (2) the Appellate Panel erred in failing to address her wage loss claim pursuant to section 42-9-20 of the South Carolina Code (2015). We reverse and remand.

### FACTS/PROCEDURAL HISTORY

On June 22, 2011, Spencer suffered an admitted lower back injury, affecting her left leg, with a resulting psyche injury while working for NHC Parklane as a Licensed Practical Nurse. Since her injuries, Spencer has been evaluated by a plethora of physicians.

She was initially evaluated by Dr. Randall Drye, who recommended physical therapy and pain management. For pain management, Spencer was treated by Dr. Tony Owens. Dr. Owens diagnosed Spencer with chronic pain syndrome, sacroiliac (SI joint) pain, and lower back pain in April 2012.

Spencer was then treated by Dr. William Lehman, an orthopedic surgeon. In April 2013, Dr. Lehman diagnosed Spencer with chronic lower back pain and severe depression with corresponding weight loss. At this time, Spencer weighed 103 pounds, 35 pounds less than her pre-injury weight. Dr. Lehman determined Spencer had reached Maximum Medical Improvement (MMI) and assigned her a 7% whole person impairment rating to her back, translating to a 9% regional lumbar spine impairment. Dr. Lehman also noted Spencer would need ongoing medication for pain management and severe depression.

In August 2013, at the behest of NHC, Spencer was referred to The Rehab Center Incorporated in Charlotte, North Carolina. At the conclusion of the comprehensive rehabilitation program, Dr. Kern Carlton released Spencer with "a rating of 8% of her back" and sedentary work restrictions. Dr. Carlton's finding was based off on functional capacity examination performed on October 2, 2013.

Dr. Sanjay Nandurkar, a pain management doctor, began treating Spencer in early 2013. In December 2013, Dr. Nandurkar determined Spencer had reached MMI and assigned a 13% whole person impairment resulting from her lower back injury affecting her left leg. Dr. Nandurkar diagnosed Spencer with lumbar radiculopathy, lumbar disc bulges, chronic pain syndrome, and lumbrosacral spondylosis. Additionally, Dr. Nandurkar recommended less than sedentary work.

In January 2014, Spencer underwent a second functional capacity evaluation, this time at the Columbia Rehabilitation Clinic. This evaluation concluded Spencer was limited to less than sedentary work.

In February 2014, Spencer was examined by Leanna Hollenbeck, a Vocational Rehabilitation Counselor. Hollenbeck concluded Spencer could not work at all and "will remain permanently disabled for the rest of her life." Hollenbeck believed Spencer had sustained a 70% loss of wage. However, Hollenbeck opined Spencer had suffered a 100% loss based on Spencer's "less than sedentary work restriction, combined with her age, chronic high pain level, emotion and cognitive instability and her lack of transferable skills."

Dr. Patrick Mullen performed an Independent Medical Evaluation to assess Spencer's psychiatric condition in February 2014. Dr. Mullen concluded that Spencer's depression and pain "make her more than 50% or 60% disabled[—]but even that may be a low estimate." However, Dr. Mullen further stated, "if you want to measure it, she cannot work at all and she will remain permanently disabled for the rest of her life."

Spencer filed a Form 50 seeking permanent and total disability pursuant to section 42-9-10 (general disability) or section 42-9-30 (scheduled member disability) of the South Carolina Code (2015). In the alternative, Spencer sought partial wage loss under section 42-9-20 (partial disability) of the South Carolina Code (2015). NHC filed a Form 51 denying permanent and total disability and seeking a determination of compensation for partial disability pursuant to section 42-9-30.

At the hearing in September 2014, the single commissioner found Spencer had "sustained permanent partial disability to the back in the amount of 21%" under section 42-9-30. The single commissioner did not make any findings of fact regarding Spencer's alternative wage loss claim. Spencer appealed to the Appellate Panel, who affirmed the ruling of the single commissioner. This appeal followed.

### ISSUES ON APPEAL

1. Is the Appellate Panel's finding that Spencer suffered only a 21% partial disability to her lower back supported by substantial evidence?
2. Did the Appellate Panel err in failing to address Spencer's wage loss claim under section 42-9-20?

In January 2014, Spencer underwent a second functional capacity evaluation, this time at the Columbia Rehabilitation Clinic. This evaluation concluded Spencer was limited to less than sedentary work.

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### ISSUES ON APPEAL

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2. Did the Appellate Panel err in failing to address Spencer's wage loss claim under section 42-9-20?

(2015); and alternatively, (3) scheduled disability under section 42-9-30 of the South Carolina Code (2015). *Colonna v. Marlboro Park Hosp.*, 404 S.C. 537, 544, 745 S.E.2d 128, 132 (Ct. App. 2013). An employee with one scheduled injury is limited to recovery under the scheduled member statute. *Id.* at 545, 745 S.E.2d at 133.

However, an employee "is not limited to scheduled benefits . . . if he or she can show additional injuries beyond a lone scheduled injury." *Id.* This rule is based on the common-sense notion "that, when two or more scheduled injuries [or a scheduled and non-scheduled injury] occur together, the disabling effect may be far greater than the arithmetical total of the schedule allowances added together." *Id.* (alteration in original) (quoting *Wigfall v. Tideland Utils., Inc.*, 354 S.C. 100, 106–07, 580 S.E.2d 100, 103 (2003)). An award of compensation under the general disability statutes, rather than the scheduled member statute, is appropriate when an employee has suffered an injury to a scheduled member with a resulting mental injury, such as depression.<sup>1</sup> See *Bass v. Kenco Grp.*, 366 S.C. 450, 462–64, 622 S.E.2d 577, 583–84 (Ct. App. 2005).

We find the Appellate Panel's award of compensation under the scheduled member statute was an error of law. The Appellate Panel awarded disability pursuant to the scheduled member statute despite NHC's admission, and the Appellate Panel's finding, that Spencer had suffered "injuries to her lower back and psyche." Pursuant to *Colonna* and *Bass*, an award under the general disability statutes is proper when an employee suffers a physical injury with a resulting mental injury. Because the undisputed facts show Spencer injured her lower back, affecting her left leg, with resulting depression, we find the Appellate Panel's award of compensation under the scheduled member statute was an error of law. See *Davaut*, 418 S.C. at 632, 795 S.E.2d at 681 (deciding a workers' compensation case as a matter of law because the facts were not in dispute).

Additionally, we find the Appellate Panel's decision that Spencer is not totally disabled is unsupported by substantial evidence because, examining the record as a whole, including the overwhelming medical evidence, no reasonable mind could have reached the conclusion that Spencer is anything but permanently and totally disabled. See *Lark*, 276 S.C. at 135, 276 S.E.2d at 306 (holding "substantial

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<sup>1</sup> See 4 Lex K. Larson, *Larson's Workers' Compensation* § 56.03[1] (Matthew Bender, Rev. Ed.) ("[W]hen there had been a physical accident or trauma, and claimant's disability is increased or prolonged by traumatic neurosis . . . it is now uniformly held that the full disability[,] including the effects of the neurosis[,] is compensable.").

(2015); and alternatively, (3) scheduled disability under section 42-9-30 of the South Carolina Code (2015). *Colonna v. Marlboro Park Hosp.*, 404 S.C. 537, 544, 745 S.E.2d 128, 132 (Ct. App. 2013). An employee with one scheduled injury is limited to recovery under the scheduled member statute. *Id.* at 545, 745 S.E.2d at 133.

However, an employee "is not limited to scheduled benefits . . . if he or she can show additional injuries beyond a lone scheduled injury." *Id.* This rule is based on the common-sense notion "that, when two or more scheduled injuries [or a scheduled and non-scheduled injury] occur together, the disabling effect may be far greater than the arithmetical total of the schedule allowances added together." *Id.* (alteration in original) (quoting *Wigfall v. Tideland Utils., Inc.*, 354 S.C. 100, 106-07, 580 S.E.2d 100, 103 (2003)). An award of compensation under the general disability statutes, rather than the scheduled member statute, is appropriate when an employee has suffered an injury to a scheduled member with a resulting mental injury, such as depression.<sup>1</sup> See *Bass v. Kenco Grp.*, 366 S.C. 450, 462-64, 622 S.E.2d 577, 583-84 (Ct. App. 2005).

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inferences, conclusions, or decisions are . . . arbitrary or capricious . . . or [a] clearly unwarranted exercise of discretion.").

Furthermore, the Appellate Panel reached its decision by discrediting the opinions of Dr. Mullen and Hollenbeck, reasoning the opinions should be given less evidentiary weight due to the inaccurate information Spencer provided. Dr. Mullen's report contained an inaccurate marital status for Spencer and stated Spencer had experienced only minor medical problems and had never received psychiatric care. However, NHC introduced Spencer's medical records pre-dating her workplace injury indicating Spencer had previously suffered from depression and chronic pain. Additionally, Spencer reported to Hollenbeck she is in agony by 5:00 p.m. after little physical activity and uses a cane when she leaves her home. However, NHC introduced video surveillance of Spencer not using a cane in one instance while outside of her house.

The Appellate Panel's reliance on Spencer withholding her pre-existing conditions from Dr. Mullen to discredit his assessment of Spencer's psychiatric condition ignores a cornerstone of workers' compensation law—an employee is entitled to compensation as long as there is a greater disability than otherwise would have existed simply due to the combined effects of an injury and pre-existing condition. *See Bartley v. Allendale Cty. Sch. Dist.*, 392 S.C. 300, 309, 709 S.E.2d 619, 623 (2011) ("There is no requirement that the pre-existing condition aggravated the injury, or that the injury aggravated the pre-existing condition so long as there is a greater disability [than otherwise would have existed] simply from the 'combined effects' of the injury and the pre-existing condition." (quoting *Ellison v. Frigidaire Home Prods.*, 371 S.C. 159, 164, 638 S.E.2d 664, 666 (2006))). Considering Spencer's uncontroverted ability to perform her job uninhibited with her pre-existing impairments prior to the workplace injury, the fact that Spencer provided certain inaccurate information does not wholly deprive Dr. Mullen's opinion of probative value.

## II. Wage Loss Claim

Spencer argues the Appellate Panel erred in failing to address her wage loss claim. However, in light of this court's disposition on the previous issue, it is not necessary to address Spencer's remaining assignment of error. *See Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) ("[An] appellate court need not address remaining issues when [resolution] of prior issue is dispositive.").

We reverse and remand for a determination of Spencer's compensation consistent with this opinion.

**REVERSED AND REMANDED.**

**SHORT, KONDUROS, and GEATHERS, JJ., concur.**



CITATION OF AUTHORITIES

Cases

Harrell v. Pacific Columbia Mills, 291 S.C. 469, 471, 354 S.E. 2d 384, 385 (1987) ..... 2

Hunter v. Patrick Construction Company, 289 S.C. 46, 344 S.E. 2d 613 (1986) ..... 2

Lark v. Bi-lo, Inc., 276 S.C. 130, 276 S.E. 2d 304 (1981) ..... 2

Tobey v. L & P Construction Company, 296 S.C. 122, 370 S.E. 2d 897 (Ct. App. 1988) ..... 2

Statute

S.C. Code Ann. Section 1-23-380(g)(6) (1976) ..... 2

MEMORANDUM IN SUPPORT OF  
PETITION FOR REHEARING

I. THE COMMISSION'S FINDINGS AND CONCLUSIONS ARE SUPPORTED BY THE SUBSTANTIAL EVIDENCE CONSIDERING THE RECORD FOR THIS MATTER AS A WHOLE.

The law in this State is well-settled. A decision of an administrative agency should be affirmed unless that decision is clearly erroneous in view of the reliable, probative and substantial evidence on the record as a whole. S.C. Code Ann. Section 1-23-380(g)(6) (1976); Lark v. Bi-lo, Inc., 276 S.C. 130, 276 S.E. 2d 304 (1981). The court reviewing the agency's decision should not substitute its own findings of fact for those of the agency nor should the court substitute its judgment for that of the agency as to the weight of the evidence. Tobey v. L & P Construction Company, 296 S.C. 122, 370 S.E. 2d 897 (Ct. App. 1988).

Substantial evidence is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the agency involved reached to justify its decision. Harrell v. Pacific Columbia Mills, 291 S.C. 469, 471, 354 S.E. 2d 384, 385 (1987). The substantial evidence rule means that the court will not overturn findings of fact by an administrative agency unless there is no reasonable probability that the fact could be as related by the witness upon whose testimony the finding was based. Lark v. Bi-Lo, Inc., *infra*. When factual findings are supported by substantial evidence, analogous to a jury's finding of fact on disputed issues, the agency's conclusions should be affirmed. Hunter v. Patrick Construction Company, 289 S.C. 46, 344 S.E. 2d 613 (1986).

In its decision for this case this Court determined that the Commission's decision that

the Appellant is not totally disabled is unsupported by substantial evidence on the basis that when the record is examined as a whole, including the medical evidence, no reasonable mind could have reached the conclusion that she is anything but permanently and totally disabled. Using the standard outlined above, the Court necessarily finds that there is no reasonable probability that four members of the South Carolina Workers Compensation Commission could have reached the decision they made in this case. The Respondents respectfully submit that a reasonable mind could certainly reach the decision made by the Commission in this case.

Without any question there is a great deal of medical evidence in this case. From the Respondents' perspective the threshold question is whether or not the medical evidence presented by the Appellant, and upon which she bases her claim for benefits for a permanent and total disability, is reliable and credible.

Medical and other expert opinions must rest on a firm foundation. That foundation is built on an accurate history provided by the person for whom the opinion is offered. It follows that absent an accurate history the opinion is not reliable.

As outlined in the Respondents' Brief for this case, there are multiple examples and instances where the Appellant did not provide an accurate history to her medical providers and her vocational expert. For example, and as cited in this Court's decision, the Appellant did not accurately state her marital status to Dr. Mullen. The Respondents did not offer this single inaccuracy to the Commission just to show whether or not the Appellant was married, but rather to show that Dr. Mullen did not have an accurate view of her family life. The Appellant herself admits that her marital status was important for purposes of enabling Dr. Mullen to provide a reliable opinion. As the Commission noted:

Mrs. Spencer further admitted that she did not provide an accurate history to Dr. Mullen regarding her marital status. Dr. Mullen's report indicates that the Claimant resides with her husband, who is a truck driver and is not home on a regular basis. The evidence for this matter shows that Mrs. Spencer separated from her husband following a domestic dispute, and during which she was assaulted by him. When asked, she agreed that it is important for a mental health provider to fully understand the circumstances surrounding the stability of a patient's family life before reaching a medical opinion.

It is further without dispute in this case that the Appellant withheld from her providers significant information regarding her pre-existing physical and psychiatric problems. A fair reading of the medical opinions upon which the Appellant relies in this case is to the effect that the work-related injury sustained by her in June 2011 directly caused the physical and mental problems which have created her alleged total disability.

Those opinions are obviously inaccurate. At best, the Appellant suffered aggravations of pre-existing problems and conditions. If such is the case, then the providers involved in this case should state their opinions in that regard. And once they do, the next question is to what extent has the Appellant's pre-existing condition been so aggravated and to what degree have any increased problems contributed to the Appellant's disability. One cannot evaluate the combined effects of an injury and a pre-existing condition, unless they fully know and understand the nature and extent of that pre-existing condition.

The video evidence submitted by the Respondents in this case overwhelmingly shows that the Appellant is physically active to a significant degree. The Commission found that this evidence, factually and legally, demonstrates that the Appellant is not totally disabled. This Court agrees that the Commission has discretion to weigh the evidence in this case, but also suggests that the manner in which it was done in this case was arbitrary.

The Single Commissioner, as well as the Appellate Panel, outlined the specific evidence, revealed by the uncontradicted and reliable visual video images, to support the Commission's decision in this case. The Respondents certainly agree that an injured worker need not show abject helplessness in order to be deemed totally disabled, but submit here that the Appellant's physical capabilities rise well beyond such a level.

And again, the video evidence must be paired and compared with the medical evidence to view the totality of the circumstances here and reach a fair and just decision with respect to an appropriate award of compensation for Mrs. Spencer. The Respondents submit that the Commission properly weighed and evaluated the evidence in this case, and reached a fair and just decision.

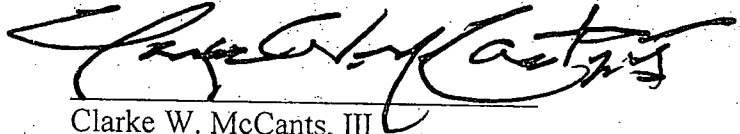
II. THE FULL COMMISSION DID NOT ERR WITH RESPECT TO MRS. SPENCER'S CLAIM FOR A WAGE LOSS UNDER § 42-9-20.

The Respondents do not dispute that the Commission did not specifically make findings of fact or conclusions of law with regard to Mrs. Spencer's claim for wage-loss benefits under S.C. Code Ann. § 42-9-20 (1976). The Respondents continue to contend, however, that such a ruling is not necessary in this case given the evidence presented to the Commission, and the manner in which Mrs. Spencer presented her case below.

CONCLUSION

For the reasons stated above the Respondents respectfully submit that this Court should grant their Petition for rehearing in this case.

Respectfully Submitted,



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Counsel for Respondents

Dated: December 13, 2017

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

APPEAL FROM THE S.C. WORKERS'  
COMPENSATION COMMISSION

Appellate Case No. 2015-002112

RECEIVED

DEC 13 2017

SC Court of Appeals

Lettie Spencer, Employee Appellant,

v.

NHC Parklane, Employer/Respondent,

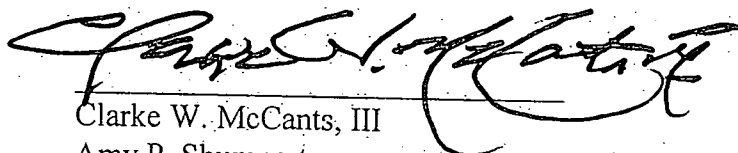
and

Premier Group Insurance Co., Inc. Carrier/Respondent.

PROOF OF SERVICE

I certify that I have served a copy of the Petition for Rehearing with Memorandum on Counsel for the Appellant, Andrew W. Creech, Esquire and Garrett B. Johnson, Esquire, by depositing a copy of the document in the United States Mail, postage prepaid, on December 13, 2017 addressed to Andrew W. Creech, Esquire and Garrett B. Johnson, Esquire, Elrod Pope Law Firm, P.O. Box 11091, Rock Hill, SC 29731

December 13, 2017



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Attorneys for Respondents

# The South Carolina Court of Appeals

Lettie Spencer, Employee, Appellant,

v.

NHC Parklane, Employer, and Premier Group Insurance  
Co., Inc., Carrier, Respondents.

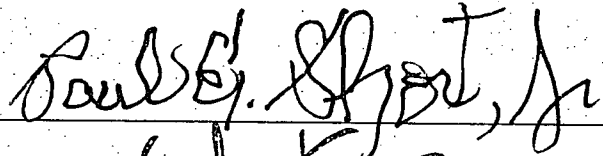
Appellate Case No. 2015-002112

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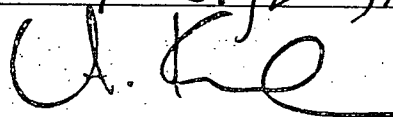
## ORDER

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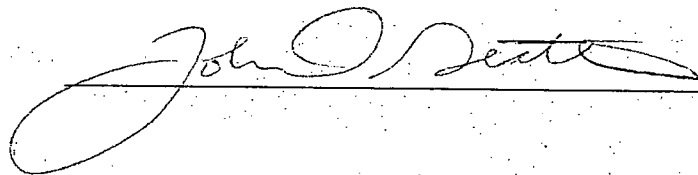
After careful consideration of the petition for rehearing, the Court is unable to discover any material fact or principle of law that has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.



J.



J.



J.

Columbia, South Carolina

cc:

Andrew Wade Creech, Esquire  
Clarke W. McCants, III, Esquire  
Garrett Brendan Johnson, Esquire

**FILED**

January 18, 2018

Amy Patterson Shumpert, Esquire  
Amy Bracy