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SUPREME COURT OF THE STATE OF WASHINGTON

JAMES TOMLINSON,

Petitioner,

v.

PUGET SOUND FREIGHT LINES & DEPARTMENT OF LABOR &
INDUSTRIES,

Respondents.

BRIEF OF AMICUS CURIAE
DEPARTMENT OF LABOR AND INDUSTRIES

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I. INTRODUCTION

James Tomlinson had advanced arthritis in his left knee, with the cartilage worn so thin it was bone on bone. Medical experts agree his non-work related arthritis had caused longstanding difficulties and would never improve. In 1999, years after his arthritis began, Mr. Tomlinson sustained an industrial injury to his left knee. Because the effects of the knee injury were permanently and partially disabling, the Department of Labor and Industries (Department) ordered payment of a permanent partial disability (PPD) award.

At issue in this case is the correct application of RCW 51.32.080(5), which requires the Department to offset an injured worker's PPD award by the amount of preexisting disability in the injured body part. After the 1999 injury, medical experts evaluated Mr. Tomlinson's knee as 75 percent PPD (as measured against the percentage of a healthy knee). Before the injury, his arthritic left knee had a 50 percent PPD, which the Department offset against the 75 percent PPD. The Court of Appeals concluded that the Department correctly applied RCW 51.32.080(5) to offset Mr. Tomlinson's PPD award by the amount of disability caused by his preexisting arthritis. *Tomlinson v. Puget Sound Freight Lines, Inc.*, 140 Wn. App. 845, 857, 166 P.3d 1276 (2007). Because the Court of Appeals correctly applied RCW 51.32.080(5), the

Department asks the Court to affirm this decision.

II. IDENTITY AND INTEREST OF AMICUS

The Department has a significant interest in compensation awards under the Industrial Insurance Act, which the Department administers and enforces. RCW 51.04.020. RCW 51.32.080(5) governs the compensation due to an injured worker with preexisting PPD. Because of its legislative mandate to provide compensation to injured workers (RCW 51.32.010), the Department is interested in ensuring the correct application of RCW 51.32.080(5) to all workers.

III. SPECIFIC ISSUES ADDRESSED BY AMICUS CURIAE

1. Was Mr. Tomlinson's preexisting knee arthritis "permanent" at the time of his 1999 injury under RCW 51.32.080(5) where the degenerative knee condition was continuing to deteriorate at the time of the industrial injury and was never going to improve?
2. Was Mr. Tomlinson's preexisting knee condition "permanent" at the time of his 1999 injury within the meaning of RCW 51.32.080(5) where, after the industrial injury, his arthritic knee was completely removed and replaced with a prosthetic knee?
3. Was Mr. Tomlinson "disabled" before his 1999 injury within the meaning of RCW 51.32.080(5) where he had suffered from functional impairment of his arthritic knees for years, and the doctors all agreed he was disabled by arthritis?

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IV. ARGUMENT

A. Preexisting “Permanent” Disabilities under RCW 51.32.080(5) Include Incurable Disabilities that Continue to Worsen

1. Degenerative arthritis is incurable because it results in a permanent loss of cartilage

Mr. Tomlinson argues that because the incurable condition of degenerative arthritis is changing over time (albeit for the worse), arthritis is not a “permanent” condition under RCW 51.32.080(5). *E.g.*, Supplemental Br. of Pet’r at 17.¹ This argument ignores that this Court has already recognized arthritis as a condition that may be offset under RCW 51.32.080(5). *See Allen v. Dep’t of Labor & Indus.*, 48 Wn.2d 317, 318-19, 293 P.2d 391 (1956). In *Allen*, the Court applied RCW 51.32.080(5) to a worker who had a twenty percent preexisting disability “by reason of arthritis of the back.” *Allen*, 48 Wn.2d at 317.

Moreover, as the Court of Appeals correctly concluded, “the statutory meaning of ‘permanent’ for purposes of RCW 51.32.080(5) focuses on whether the condition is curable; the legislature did not intend to exclude incurable pre-existing disabilities that continue to worsen.”

¹ Relevant portions of statutes and administrative rules discussed in this brief are set forth in Appendix A to this brief. The full text of RCW 51.32.080(5) reads: “Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent partial disability but not resulting in the permanent total disability of such worker, his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.”

Tomlinson, 140 Wn. App. at 857. The undisputed testimony in this case establishes that arthritis is an incurable disease that continues to deteriorate over time. Dr. James Smith testified that degenerative arthritis is a gradual but progressive wearing away of the cartilage surface, which wears away to the point where the cartilage is “completely gone and the bone beneath it is laid bare.” BR Smith at 15.² Although a patient’s symptoms (e.g. pain, stiffness) may be intermittent or fluctuate over time, “[a] distinguishing feature[] of the cartilage [is] that it’s unable to repair itself.” BR Smith at 15. Consequently, degenerative arthritis is incurable in that it results in a permanent loss of cartilage. *See* BR Smith at 15.

Mr. Tomlinson argues that his condition was not permanent because there was the possibility of surgery. Supplemental Br. of Pet’r at 1. But this does not mean that his degenerative arthritis was not permanent. Although Mr. Tomlinson’s condition was treatable by replacing the affected bone with metal and the missing cartilage with a plastic insert, the lack of cartilage due to preexisting osteoarthritis was permanent. BR Jiganti at 9. The cartilage could not be repaired. BR Smith at 15.

² Testimony in the certified appeal board record is cited as “BR” followed by the witness name.

2. RCW 51.32.080(5) must be interpreted to advance its purpose

RCW 51.32.080(5) is designed to take into account preexisting disabilities when awarding PPD. The intent of the Legislature must be given effect. *See generally In re Electric Lightwave, Inc.*, 123 Wn.2d 530, 536, 869 P.2d 1045 (1994).

The Court of Appeals focused on applying RCW 51.32.080(5) within the context of preexisting incurable degenerative conditions. *Tomlinson*, 140 Wn. App. at 857. A context-based approach has been used in other analogous situations. In *In re James McShane*, BIIA Dec., 05 16629, 2006 WL 3520095 (2006), the Board considered a widow's claim for permanent partial disability made after her husband died for reasons unrelated to the injury. The worker could have received additional treatment before his death. *McShane*, 2006 WL 3520095 at *6. Notwithstanding the potential of further treatment, the Board determined that the lack of medical fixity of an industrial injury at the time of a worker's death from causes unrelated to the industrial injury does not preclude a worker's beneficiary from receiving an award for the deceased worker's permanent partial disability. *McShane*, 2006 WL 3520095 at *5.

The Board in *McShane* held that a beneficiary need only establish that at the time of death, the industrial injury caused a particular

impairment that after treatment would have remained such that—but for his or her death—the condition would have entitled the injured worker to an award for permanent partial disability. *Id.* at *5. The Board in *McShane* considered this Court’s decision in *Pend Oreille Mines & Metals Co. v. Dep’t of Labor & Indus.*, 64 Wn.2d 270, 271-72, 391 P.2d 210 (1964), where the Court addressed the treatment request of a worker who was rendered permanently unable to work due to his injury but required ongoing treatment. This Court held, despite the fact that this circumstance fell within the express terms of the definition of “permanent total disability” in RCW 51.08.160, that it advanced the purposes of the Industrial Insurance Act to not permit rating permanent total disability while the worker was undergoing treatment.

The Board in *McShane* reiterated its reasoning from *In re Russell Fredericks*, Dckt. No. 05 18867, 2006 WL 2989426 (BIIA June 30, 2006), that focusing on the incurable character of the disability at the time of the worker’s death was not inconsistent with the Supreme Court’s holding in *Pend Oreille Mines* because it advanced the purposes of the Act to pay a PPD award to the beneficiaries. *See McShane*, 2006 WL 2989426 at *3. If the Board had not focused on the incurable nature of the condition, rather than on the need for medical treatment (that was obviated by Mr. McShane’s death), the widow would not have been entitled to any

benefits. *Id.*

As in *McShane*, the Court of Appeals here properly looked to the incurable character of the arthritic condition when determining whether to apply RCW 51.32.080(5). *Tomlinson*, 140 Wn. App. at 857. Here, the purpose of the statute is to offset preexisting disability in making a PPD award. The fact that an incurable preexisting disability like degenerative arthritis will, by definition, continue to worsen should not mean that RCW 51.32.080(5) does not apply.

Mr. Tomlinson cites RCW 51.12.010's liberal construction provision. Supplemental Br. of Pet'r at 11. His theory would mean that under RCW 51.32.080(5) an entire class of disability—degenerative arthritis anywhere in the body—could never be considered when determining preexisting disability under RCW 51.32.080(5). Supplemental Br. of Pet'r at 11. But this theory is adverse to the interests of countless future workers and beneficiaries who would never receive PPD based on degenerative arthritis anywhere in the body caused by industrial injuries. If the worker was not, for a variety of reasons (including medical impossibility for spinal arthritis), treated with a joint replacement, no PPD could ever be paid under Mr. Tomlinson's theory. Such a result would contravene the Legislature's intent in establishing the statutes that compensate PPD and that offset preexisting PPD.

3. Arthritis is a condition doctors treat as a permanent impairment under the AMA Guides

RCW 51.08.150 defines “permanent partial disability” as the loss of certain specified body parts or certain types of dislocations or “*any other injury known in surgery to be permanent partial disability.*” (Emphasis added).³ Under WAC 296-20-2015, the American Medical Association’s Guides to the Evaluation of Permanent Impairment is the rating system used to determine a PPD award for loss of function in the knees.⁴ The AMA Guides evaluate the degree of permanent arthritic impairment by the size of the space between the knee bones and the corresponding amount of cartilage as shown in X-rays. BR Smith at 31-32; BR Chaplin at 45-46. Under the Guides, arthritis is a permanent

³ The Court of Appeals stated that this definition “is not helpful to the issue here.” *Tomlinson*, 140 Wn. App. at 856 n.3. Mr. Tomlinson argues that the statutory definition is “circular and useless here.” Pet. for Review at 10 n.12. But the facts (1) that the AMA Guides for rating PPD, as discussed in this section of the Department’s brief, are incorporated in the Department’s rules for rating PPD, and (2) that those Guides provide for the rating of arthritic conditions for PPD, is indeed helpful, if not dispositive, here. The AMA Guides explain, within the meaning of the language of RCW 51.08.150, what is “*known in surgery to be permanent partial disability.*” The Department has provided in Appendix B to this brief copies of the relevant pages of the AMA Guides that (1) define “maximal medical improvement” for PPD-rating purposes (essentially mirroring the definition of “maximum medical improvement” in WAC 296-20-01002) (AMA Guides, p. 19, 601 (5th ed. 2001)); (2) explain that conditions expected to deteriorate over time are permanent (AMA Guides, p. 26-27 (6th ed. 2008)); and (3) provide specific guidance on the rating of PPD due to arthritic conditions (AMA Guides, p. 544-545 (5th ed. 2001)).

⁴ Courts give deference to an agency’s interpretation of its administrative rules. *Silverstreak, Inc. v. Dep’t of Labor & Indus.*, 159 Wn.2d 868, 884-85, 154 P.3d 891 (2007). Deference is appropriate because the agency has expertise and insight in administering the rule that reviewing courts do not possess. *Id.* Deference is also given the Board’s interpretations of RCW 51. *Weyerhaeuser Co. v. Tri*, 117 Wn.2d 128, 138, 814 P.2d 629 (1991).

disability. *See* Appendix B. Dr. Smith testified that arthritis in a knee is one factor the AMA Guides consider when rating a worker's degree of *permanent* impairment. BR Smith at 11.

Applying the AMA Guides, all three medical experts concluded that there was no space between Mr. Tomlinson's bones before the work injury. BR Chaplin at 46-47; BR Smith at 32; BR Jiganti at 26-27. This was confirmed by Dr. John Jiganti's post-injury surgical findings. BR Smith at 32; BR Jiganti at 18-19; BR Chaplin at 47. Under the AMA Guides, a complete lack of cartilage indicates a 50 percent impairment. BR Chaplin at 46-47; BR Smith at 32; BR Jiganti at 26-27.

Although Mr. Tomlinson's longstanding symptoms fluctuated over time prior to his 1999 fall, the cartilage in his knees was gradually—and *permanently*—wearing away. Thus, his knee was permanently disabled. Had this been work-related arthritis, despite fluctuations in his symptoms and despite the future possibility of knee replacement surgery, he would have been eligible for a PPD award, even if his knee was never replaced. But Mr. Tomlinson's arguments would prevent this pro-worker outcome.

4. WAC 296-20-01002 allows for fluctuations in levels of pain and function when determining whether a worker's condition may be rated

Mr. Tomlinson asserts that "permanent" means "fixed and stable," and because the symptoms of his preexisting arthritic condition fluctuated,

it was not permanent under RCW 51.32.080(5). Supplemental Br. of Pet'r at 3 n.10, 12, 17; Pet. for Review at 1, 11. Mr. Tomlinson fails to note that under WAC 296-20-01002⁵, "maximum medical improvement" ("equivalent to 'fixed and stable'") occurs when:

no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present *though there may be fluctuations in levels of pain and function*. A worker's condition may have reached maximum medical improvement *though it might be expected to improve or deteriorate with the passage of time*. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary.

WAC 296-20-01002 (defining "proper and necessary") (emphasis added).

Mr. Tomlinson argues that "[a]n impairment is considered permanent when it has reached maximum medical improvement (MMI), meaning it is well stabilized and unlikely to change substantially in the next year with or without medical treatment." Pet. for Review at 3-4. But under WAC 296-20-01002, an injured worker may reach maximum medical improvement or be fixed and stable even though the worker's

⁵ Mr. Tomlinson cites to WAC 296-20-01002 for the proposition that under the "Department's rules," a PPD is a disabling condition that is "determined to be stable or nonprogressive," and because his arthritis was progressive, it was not a PPD. Pet. for Review at 13. But as the Court of Appeals correctly noted, in 2002 that definition was moved to a new section, WAC 296-20-19000, which deals with "permanent partial disability *award[s]*," not what is at issue here, a retrospective rating of PPD. 140 Wn. App. at 857 n.4. The Court of Appeals ultimately declined to consider whether WAC 296-20-19000 applies, because it was not briefed by either party. *Id.* In any event, WAC 296-20-19000 incorporates the concept of "maximum medical improvement" discussed in this brief, a concept that is defined in WAC 296-20-01002.

symptoms fluctuate and the condition deteriorates over time.

When the experts in this case determined that Mr. Tomlinson's degenerative arthritis caused a preexisting 50 percent permanent partial disability, such a rating was appropriate under WAC 296-20-01002. This is true even though an arthritic joint deteriorates and arthritis symptoms may fluctuate over time, thus changing as expected under WAC 296-20-01002. In short, Mr. Tomlinson's pre-injury condition was "fixed and stable" under WAC 296-20-01002.

5. Mr. Tomlinson cites case law that is not helpful in determining permanency under RCW 51.32.080(5)

Notwithstanding WAC 296-20-01002's definition of maximum medical improvement, Mr. Tomlinson cites the *Summers*, *Hiatt*, *Williams*, and *Shea* cases, which describe "permanent" in part as something "incapable of alteration, fixed or immutable," and "not subject to fluctuation or alteration."⁶ Supplemental Br. of Pet'r at 15-17 (citing *Summers*, 130 Wn. App. at 216; *Hiatt*, 48 Wn. 2d at 846; *Williams*, 75 Wn. App. at 585; *Shea*, 12 Wn. App. at 415). Mr. Tomlinson advances an interpretation of the term "permanent," which, if applied to RCW 51.32.080(5), would produce a "strained result that the legislature most

⁶ *Summers v. Great S. Life Ins. Co.*, 130 Wn. App. 209, 122 P.3d 195 (2005), review denied, 157 Wn.2d 1025, 142 P.3d 609 (2006); *Hiatt v. Dep't of Labor & Indus.*, 48 Wn.2d 843, 297 P.2d 244 (1956); *Williams v. Virginia Mason Med. Ctr.*, 75 Wn. App. 582, 880 P.2d 539 (1975); *Shea v. Dep't of Labor & Indus.*, 12 Wn. App. 410, 529 P.2d 1131 (1974), review denied, 85 Wn.2d 1009 (1975).

likely did not intend with RCW 51.32.080(5).” *Tomlinson*, 140 Wn. App. at 857 (“the legislature did not intend to exclude incurable pre-existing disabilities that continue to worsen”).

Summers involves application of a private insurance policy’s “permanent” disability clause to a worker with indisputably *temporary* disability. *Summers* interpreted the insurance policy as not applying to the temporary disability and merely cites *Hiatt*, *Shea* and *Williams* in a footnote without discussion. *Summers*, 130 Wn.App. at 216 n.3. It is unhelpful on the “permanency” issue.

Hiatt is likewise unhelpful. It involved a worker with an indisputably *temporary* injury-caused condition that would have resolved in a few months had he not died due to an unrelated cause during that temporary disability. *Hyatt*, 48 Wn.2d at 847. His disability was “temporary rather than permanent” and his beneficiaries were not entitled to a pension for injury-caused permanent total disability at death. *Id.*

Shea is similarly unhelpful. That case involved a worker whose injury indisputably caused *permanent* disability that was a proximate cause of permanent total disability. *Shea*, 12 Wn. App. at 412. *Shea* applied the multiple-proximate-causes rule and held that preexisting, non-injury, permanent total disability does not preclude award for injury-caused permanent total disability. *Shea*, 12 Wn. App. at 415-16.

Finally, *Williams* involved a dispute over wording of jury instructions regarding the element of retrainability in the assessment of permanent total disability. *Williams*, 75 Wn. App. at 585-88. *Williams* held that retrainability goes to totality, not permanency, of disability. *Id.* It has no relevance here.

Thus, none of these four cases cited by Mr. Tomlinson required the appellate court to determine what it means for disability to be “permanent” under the Industrial Insurance Act generally, much less in the context of determining preexisting PPD under RCW 51.32.080(5).

Mr. Tomlinson also misplaces reliance on four separate lines of workers’ compensation cases that he intertwines and sometimes conflates at various points in his briefing. He appears to suggest that because his 1999 injury exacerbated his already-disabling arthritis, this exacerbation somehow precludes application of RCW 51.32.080(5) to offset that preexisting PPD.

There is no relevance here in the concepts of: (1) “lighting up” of *previously asymptomatic* conditions;⁷ (2) combining of the effects of an

⁷ Supplemental Br. of Pet’r at 10 (citing lighting up cases, *Harper v. Dep’t of Labor & Indus.*, 46 Wn.2d 404, 405, 281 P.2d 859 (1955); *Lyle v. Dep’t of Labor & Indus.*, 66 Wn.2d 745, 747-48, 405 P.2d 251 (1965) (*Lyle* also addresses a “second injury fund” issue)); Supplemental Br. of Pet’r at 9 (citing lighting up cases, *In re Cecil Channing*, Dckt. No. 88 2165, 1990 WL 127360 (BIIA July 25, 1990); *In re William Nussbaum*, Dckt. No. 90 3176, 1992 WL 160680 (BIIA May 12, 1992)); Pet. for Review at 9, 17-19 (citing lighting up cases, *Bennett v. Dep’t of Labor & Indus.*, 95 Wn.2d 531, 531-35, 627 P.2d 104 (1981); *Lyle*, 66 Wn.2d at 747-48; *Miller v. Dep’t of Labor &*

industrial injury with non-injury disability in determining permanent *total* disability;⁸ (3) the take-the-worker-as-you-find-him rule *for allowing claims and determining proximate cause of disability*;⁹ and (4) “previous . . . disability” within the meaning of RCW 51.16.120, the “second injury fund” statute that affords relief to employers who hire or retain workers *whose disabilities prior to injury limited their earning capacity*.¹⁰ Nothing in those lines of cases and the concepts addressed therein has any relevance to Mr. Tomlinson’s case that involves exclusively (1) *the fact of symptomatic knee arthritis that preexisted his 1999 industrial injury*, and (2) *the legal question of whether, under RCW 51.32.080(5), that preexisting symptomatic condition constituted, as the medical witnesses*

Indus., 200 Wash. 674, 684, 94 P.2d 764 (1939); *In re Suzanne Dyer*, Dckt. No. 03 15747, 2005 WL 1658404 (BIIA Mar. 1, 2005)). Cf. *Zipp v. Seattle Sch. Dist. No. 1*, 36 Wn. App. 598, 606-07, 676 P.2d 1984 (1984) (where a condition was previously symptomatic, the lighting up doctrine does not apply).

⁸ Supplemental Br. of Pet’r at 7, Pet. for Review at 19 (citing *In re Lawrence Musick*, BIIA Dec., 48,173, 1978 WL 182673 (1978)); Pet. for Review at 18, 19 (citing *Miller*, 200 Wash. at 682 (*Miller* discusses both lighting up and combined effects concepts, but again, neither concept is implicated here); *In re James McIntosh*, Dckt. No. 89 2352, 1991 WL 52041 (BIIA Jan. 30, 1991)).

⁹ Supplemental Br. of Pet’r at 18 (citing *City of Bremerton v. Shreeve*, 55 Wn. App. 334, 340, 777 P.2d 568 (1989); *Wendt v. Dep’t of Labor Indus.*, 18 Wn. App. 674, 682-83, 571 P.2d 229 (1977); *Champion Int’l Inc. v. Dep’t of Labor & Indus.*, 50 Wn. App. 91, 93, 746 P.2d 1244 (1987); *Dennis v. Dep’t of Labor & Indus.*, 109 Wn.2d 467, 471, 745 P.2d 1295 (1987) (note that *Dennis*, 109 Wn.2d at 476, expressly recognized the applicability of RCW 51.32.080(5) in relation to PPD assessment where there is preexisting PPD); *Shea*, 12 Wn. App. at 414)).

¹⁰ Supplemental Br. of Pet’r 19 (citing *In re Leonard Norgren*, BIIA Dec., 04 18211, 2006 WL 481048 (2006) (noting, consistent with *Rothschild Int’l Stevedoring Co. v. Department of Labor & Industries*, 3 Wn. App. 967, 969, 478 P.2d 759 (1971), that “previous . . . disability” under RCW 51.16.120 takes into account not only functional impairment, but also affect on earning power, a consideration not relevant under RCW 51.32.080(5)); *In re Mariah Smith*, Dckt. No. 89 1277, 1990 WL 208001 (BIIA Oct. 25, 1990)).

all rated it, a preexisting permanent partial disability.

B. RCW 51.32.080(5) Includes as a “Permanent” Disability Preexisting Conditions that Are Later Treated by Knee Replacement Surgery

Mr. Tomlinson argues that because his arthritic knee joint was removed during knee replacement surgery, the arthritis was temporary, and thus not a preexisting permanent disability under RCW 51.32.080(5). Pet. for Review at 14, 20; *see also* Supplemental Br. of Pet’r at 1, 17. Under Mr. Tomlinson’s reasoning, any degenerative condition preexisting an industrial injury of the affected body part would be considered temporary if that body part could be replaced or removed. The Legislature did not intend such an outcome, as shown by RCW 51.32.080(5)’s application to work injuries that result in amputation of a partially disabled body part.

In a case where a worker’s previously disabled body part is amputated because of a work injury, the worker’s PPD award is offset by the degree of impairment existing before the injury. But under Mr. Tomlinson’s logic, the amputation would remove the body part, and thus cure the preexisting condition. Such an interpretation would render RCW 51.32.080(5)’s provision regarding amputation meaningless, a result not intended by the Legislature. *Fraternal Order of Eagles, Tenino Aerie No. 564 v. Grand Aerie of Fraternal Order of Eagles*, 148 Wn.2d 224, 239, 59

P.3d 655 (2002) (when interpreting a statute, courts avoid interpretations that result in absurd or strained consequences).

RCW 51.32.080(5) plainly provides that even if a body part is amputated—and the preexisting disability removed—the Department must offset a PPD award by the degree of preexisting PPD. *See Tomlinson*, 140 Wn. App. at 853-54 (discussing *Beyer v. Dep't of Labor & Indus.*, 17 Wn.2d 29, 32, 134 P.2d 948 (1943)).

Mr. Tomlinson also contends that his permanent impairment was not an aggravation or increase of his arthritis, but a sole result of the knee replacement. Pet. for Review at 8. This argument ignores that the permanent arthritic condition and the 1999 injury combined to necessitate surgery. Moreover, under RCW 51.32.080(5), post-injury compensation must be determined by taking into account the disability that pre-existed the work injury, without regard for the degree of preexisting disability present at the time of the final PPD rating. *See Enevold v. Dep't of Labor & Indus.*, 51 Wn.2d 648, 649, 320 P.2d 1096 (1958) (RCW 51.32.080(5) requires that the Department segregate and apportion the amount of PPD attributable to an injured worker's preexisting condition and his work injury); *see Allen*, 48 Wn.2d at 318 *Voshalo v. Dep't of Labor & Indus.*, 75 Wn.2d 43, 45-46, 449 P.2d 95 (1968) (same). Consequently, the statute requires that the 75 percent permanent impairment that resulted

from Mr. Tomlinson's knee replacement be offset by the 50 percent degree of permanent impairment existing before the 1999 industrial injury.

C. Mr. Tomlinson Suffered Functional Loss in his Arthritic Left Knee and Therefore Was "Disabled" Before the 1999 Injury

A determination of "disability" for purposes of the Industrial Insurance Act cannot be based solely on X-ray evidence without evidence showing functional loss. See *Naillon v. Dep't of Labor & Indus.*, 65 Wn.2d 544, 545-46, 398 P.2d 713 (1965); *In re Richard Murray*, Dckt. No. 87 0440, 1991 WL 172059 (BIIA Aug. 6, 1991) (citing *Naillon*). Mr. Tomlinson argues that there is no evidence of functional loss in the record, and that he therefore should prevail as a matter of law. Supplemental Br. of Pet'r at 17-19. The Court of Appeals correctly rejected this argument by pointing to the ample evidence supporting the Board's determination of preexisting functional loss. *Tomlinson*, 140 Wn. App. at 852-53.

Mr. Tomlinson testified that long before the work injury, he sought medical treatment for ongoing discomfort in both knees. BR Tomlinson at 17, 20-21, 24, 25-26. He was treated by the Veterans' Administration (VA) for left knee problems intermittently since the 1960s. BR Tomlinson at 14. He injured his left knee again in 1991, and was diagnosed with degenerative joint disease in both knees. BR Chaplin at 30-31. In March 1992 he was seen for left knee pain, and the exam showed that his left

knee was swollen and had crepitus or grating. BR Chaplin at 35. That year, a physician advised Mr. Tomlinson that he was a candidate for left knee replacement because of the degree of arthritis and problems he was experiencing. BR Tomlinson at 17, 24; BR Chaplin at 34-35.

In April 1992, VA doctors rated Mr. Tomlinson's left knee as 10 percent impaired due to arthritis. BR Chaplin at 35. In February 1995, he was continuing to have left knee pain and sought medical care. BR Chaplin at 38. That same year, an orthopedist told him that he had arthritis in both knees and would need a knee replacement eventually. BR Smith at 25.

Dr. Jiganti treated Mr. Tomlinson after the 1999 industrial injury and diagnosed him with an arthritic exacerbation of his left knee. BR Jiganti at 6. Dr. Jiganti performed two left knee replacement surgeries. BR Jiganti at 9-10. He testified that before the injury, Mr. Tomlinson's left knee was "significantly deteriorated with arthritis," and the extent of arthritis in his left knee joint was virtually the same before his work injury as it was after the injury. BR Jiganti at 19-20. Dr. Jiganti's operative report described "bone on bone" in the lateral compartment of the knee, and almost bone on bone on the medial side. BR Jiganti at 22; BR Smith at 17. As Dr. Smith explained, this means that Mr. Tomlinson "had very little cartilage on which to stand." BR Smith at 17.

Based on his examination of the claimant and his review of the VA records, Dr. Smith concluded that it was “virtually inconceivable” that Mr. Tomlinson’s knee would not be symptomatic before the work injury. BR Smith at 19. Dr. Chaplin noted that both Mr. Tomlinson’s knees would occasionally lock and interfere with walking. BR Chaplin at 33. Additionally, Dr. Chaplin explained that end-stage arthritis “implies that there will be stiffness, there will be pain with weight-bearing and there will be grating and pain with motion, especially if that motion is when the joint is loaded.” BR Chaplin at 41-42. Dr. Jiganti admitted that pain can cause functional limitations. BR Jiganti at 29.

Mr. Tomlinson quotes from a Board decision stating that, on the record in that case, X-ray findings alone were not enough to support a disability award without “clinical findings.” Supplemental Br. of Pet’r at 19 (quoting *In re Walter Johnston*, Dckt. No. 97 4529, 1999 WL 190864 (March 2, 1999)). The Board in *Johnston* did not cite any authority for this statement and did not suggest that *other evidence showing functional loss* would not also support a finding of disability. The Department is aware of no such authority, and Mr. Tomlinson cites none. In any event, the equivalent of clinical findings are present here in Dr. Jiganti’s observation of the inside of Mr. Tomlinson’s left knee during surgery. BR Jiganti at 18-19, 22-23.

Mr. Tomlinson also argues that PPD for an industrial injury “is not addressed until the injury becomes fixed and stable, which may not happen until long after the injury occurred,” implying that, as he argued that the Court of Appeals, the Department cannot find a preexisting disability absent a contemporaneous medical rating. Supplemental Br. of Pet’r at 1. Mr. Tomlinson cites no authority for his argument, and as the Court of Appeals noted, the language of the statute covers preexisting disabilities “from whatever cause,” not just those caused by work injuries. *See Tomlinson*, 140 Wn. App. at 855.

In sum, a wealth of evidence supports the determination below that the arthritis in Mr. Tomlinson’s knee resulted in a loss of functioning.

V. CONCLUSION

Under RCW 51.32.080(5), end-stage arthritis that causes functional loss constitutes a permanent disability to be offset in a PPD award. Accordingly, the Department respectfully requests that this Court affirm the decision of the Court of Appeals.

RESPECTFULLY SUBMITTED this 22 day of December, 2008.

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Appendix A

RELEVANT PARTS OF STATUTES CITED IN BRIEF

RCW 51.32.080(5)

Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent partial disability but not resulting in the permanent total disability of such worker, his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.

RCW 51.04.020 (Powers and duties) (in full)

The director shall:

- (1) Establish and adopt rules governing the administration of this title;
- (2) Ascertain and establish the amounts to be paid into and out of the accident fund;
- (3) Regulate the proof of accident and extent thereof, the proof of death and the proof of relationship and the extent of dependency;
- (4) Supervise the medical, surgical, and hospital treatment to the intent that it may be in all cases efficient and up to the recognized standard of modern surgery;
- (5) Issue proper receipts for moneys received and certificates for benefits accrued or accruing;
- (6) Investigate the cause of all serious injuries and report to the governor from time to time any violations or laxity in performance of protective statutes or regulations coming under the observation of the department;
- (7) Compile statistics which will afford reliable information upon which to base operations of all divisions under the department;
- (8) Make an annual report to the governor of the workings of the department;
- (9) Be empowered to enter into agreements with the appropriate agencies of other states relating to conflicts of jurisdiction where the contract of employment is in one state and injuries are received in the other state, and insofar as permitted by the Constitution and laws of the United States, to enter into similar agreements with the provinces of Canada; and
- (10) Designate a medical director who is licensed under chapter 18.57 or 18.71 RCW.

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RCW 51.32.010 (Who entitled to compensation) (in full)

Each worker injured in the course of his or her employment, or his or her family or dependents in case of death of the worker, shall receive compensation in accordance with this chapter, and, except as in this title otherwise provided, such payment shall be in lieu of any and all rights of action whatsoever against any person whomsoever: PROVIDED, That if an injured worker, or the surviving spouse of an injured worker shall not have the legal custody of a child for, or on account of whom payments are required to be made under this title, such payment or payments shall be made to the person or persons having the legal custody of such child but only for the periods of time after the department has been notified of the fact of such legal custody, and it shall be the duty of any such person or persons receiving payments because of legal custody of any child immediately to notify the department of any change in such legal custody.

RCW 51.08.160 ("Permanent total disability") (in full)

"Permanent total disability" means loss of both legs, or arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful occupation.

RCW 51.12.010 (Employments included – Declaration of policy)

. . . This title shall be liberally construed for the purpose of reducing to a minimum the suffering and economic loss arising from injuries and/or death occurring in the course of employment.

RCW 51.080.150 ("Permanent partial disability") (in full)

"Permanent partial disability" means the loss of either one foot, one leg, one hand, one arm, one eye, one or more fingers, one or more toes, any dislocation where ligaments were severed where repair is not complete, or any other injury known in surgery to be permanent partial disability.

51.16.120 (Distribution of further accident cost) (in full)

(1) Whenever a worker has a previous bodily disability from any previous injury or disease, whether known or unknown to the employer, and shall suffer a further disability from injury or occupational disease in employment covered by this title and become totally and permanently disabled from the combined effects thereof or die when death was substantially accelerated by the combined effects thereof, then the experience record of an employer insured with the state fund at the time of said further injury or disease shall be charged and a self-insured employer shall pay directly into the reserve fund only the accident cost which would have resulted solely from said further injury or disease, had there been no preexisting disability, and which accident cost shall be based upon an evaluation of the disability by medical experts. The difference between the charge thus assessed to such employer at the time of said further injury or disease and the total cost of the pension reserve shall be assessed against the second injury fund. The department shall pass upon the application of this section in all cases where benefits are paid for total permanent disability or death and issue an order thereon appealable by the employer. Pending outcome of such appeal the transfer or payment shall be made as required by such order.

(2) The department shall, in cases of claims of workers sustaining injuries or occupational diseases in the employ of state fund employers, recompute the experience record of such employers when the claims of workers injured in their employ have been found to qualify for payments from the second injury fund after the regular time for computation of such experience records and the department may make appropriate adjustments in such cases including cash refunds or credits to such employers.

(3) To encourage employment of injured workers who are not reemployed by the employer at the time of injury, the department may adopt rules providing for the reduction or elimination of premiums or assessments from subsequent employers of such workers and may also adopt rules for the reduction or elimination of charges against such employers in the event of further injury to such workers in their employ.

(4) To encourage employment of injured workers who have a developmental disability as defined in RCW 71A.10.020, the department may adopt rules providing for the reduction or elimination of premiums or assessments from employers of such workers and may also adopt rules for the reduction or elimination of charges against their employers in the event of further injury to such workers in their employ.

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RELEVANT PARTS OF RULES CITED IN BRIEF

WAC 290-20-2015 (What rating systems are used for determining an impairment rating conducted by the attending doctor or a consultant?) (in full)

The following table provides guidance regarding the rating systems generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation
<i>AMA Guides to the Evaluation of Permanent Impairment</i>	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-20-01002 (Definitions)

Proper and necessary (3): The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

WAC 296-20-19000 (What is a permanent partial disability award?) (in full)

Permanent partial disability is any anatomic or functional abnormality or loss after maximum medical improvement (MMI) has been achieved. At MMI, the worker's condition is determined to be stable or nonprogressive at the time the evaluation is made. A permanent partial disability award is a monetary award designed to compensate the worker for the amputation or loss of function of a body part or organ system. Impairment is evaluated without reference to the nature of the injury or the treatment given. To ensure uniformity, consistency and fairness in rating permanent partial disability, it is essential that injured workers with comparable anatomic abnormalities and functional loss receive comparable disability awards. As such, the amount of the permanent partial disability award is not dependent upon or influenced by the economic impact of the occupational injury or disease on an individual worker. Rather, Washington's Industrial Insurance Act requires that permanent partial disability be established primarily by objective physical or clinical findings establishing a loss of function. Mental health impairments are evaluated under WAC 296-20-330 and 296-20-340.

Appendix B

(relevant pages of AMA Guides)

If apportionment is needed, the analysis must consider the nature of the impairment and its relationship to each alleged causative factor, along with an explanation of the medical basis for all conclusions and opinions. Using this approach to apportionment requires accurate information and data to determine all impairment ratings both before and after the most recent injury. If different editions of the *Guides* have been used, the physician must assess their similarity. If the basis of the ratings is similar, a subtraction is appropriate. If the bases of the ratings differ markedly, the physician should evaluate the circumstances and determine whether conversion to the earlier or latest edition of the *Guides* for both ratings is possible. The determination should follow the local jurisdiction's guidelines and consider whichever edition best describes the individual's impairment. If no rating was previously assigned, the examiner must use available information to estimate what the rating was before the new injury, and subtract this from the "new" rating as noted earlier.

2.5d Changes in Impairment From Prior Ratings

Although a previous evaluator may have considered a medical impairment to be permanent, unanticipated changes may occur. The condition may have become worse as a result of aggravation or clinical progression, or it may have improved. The physician should assess the current state of the impairment according to the criteria in the *Guides*. If an individual received an impairment rating from an earlier edition and needs to be reevaluated because of a change in the medical condition, the individual is evaluated according to the latest information pertaining to the condition in the current edition of the *Guides*.

Valid assessment of a change in the impairment estimate depends on the reliability of the previous estimate and the evidence on which it was based. If a prior impairment evaluation was not performed, but sufficiently well documented information is available to currently estimate the prior impairment, the assessment would be performed based on the most recent *Guides'* criteria. However, if the information is insufficient to accurately document the change, the physician must explain the basis of a prior determination and should not estimate the change.

2.5e Maximum Medical Improvement

Maximum Medical Improvement refers to a status where patients are as good as they are going to be from the medical and surgical treatment available to them. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected change. The *Guides*, however, does not permit the rating of future impairment. There

can be some scenarios with individuals now at MMI but with potential for future progression of their disease. For example, an individual exposed to asbestos who is currently stable with perhaps some current objective findings that are unlikely to change in the next 12 months but with a potential for malignancy in the distant future. Nevertheless, these individuals can be rated based on the current findings with the notation of a potential for progression in the distant future.

Thus, MMI represents a point in time in the recovery process after an injury when further formal medical or surgical intervention cannot be expected to improve the underlying impairment. Therefore, MMI is not predicated on the elimination of symptoms and/or subjective complaints. Also, MMI can be determined if recovery has reached the stage where symptoms can be expected to remain stable with the passage of time, or can be managed with palliative measures that do not alter the underlying impairment substantially, within medical probability.

Maximum Medical Improvement does not preclude the deterioration of a condition that is expected to occur with the passage of time or as a result of the normal aging process; nor does it preclude allowance for ongoing follow-up for optimal maintenance of the medical condition in question.

In certain instances, the treatment of an illness may result in apparent total remission of the person's signs and symptoms. Examples include the treatment of hypothyroidism with levothyroxine and the treatment of type 1 diabetes mellitus with insulin. However, if the examiner concludes that with such permanent treatment based on objective findings, the patient has actually not regained his or her previous function, and if the *Guides* has not provided specific criteria to rate such impairment, the physician may choose to increase the impairment estimate by a small percentage (eg, 1% to 3%). Such a discretionary impairment is provided only once and is not to be duplicative of impairment provided for BOTC.

In some instances, as with organ transplant recipients who are treated with immunosuppressant pharmaceuticals or persons treated with anticoagulants, the pharmaceuticals themselves cause impairments. In such instances, if the impairment is permanent, the physician should use the applicable parts of the *Guides* to evaluate actual impairment related to pharmaceutical effects and combine it with the primary organ system impairment, by means of the Combined Values Chart (Appendix).

2.5f Permanency

Permanency is the condition whereby impairment becomes static or well stabilized with or without

medical treatment and is not likely to remit in the future despite medical treatment, within medical probability. This term is usually synonymous with MMI, usually occurring when all reasonable medical treatment expected to improve the condition has been offered or provided.

Impairment ratings are to be performed when an individual is at a state of permanency. However, many systemic or organ-based conditions are dynamic rather than static in nature and are, to some extent, never at permanency. In such cases, one can usually anticipate future functional decline based on the natural history of the disease process, which is generally well established in the literature.

2.5g Cultural Differences

Cultural differences between the examiner and the patient can greatly increase the risk of the examiner misinterpreting the patient's responses.⁵ For example, Waddell's signs are not valid in non-Anglo cultures, as their reliability has been tested only among English and North American patients. Effective medical communication requires an understanding of and respect for the patient's cultural background, religious beliefs, and ability to assimilate medical information. Examiners are expected to use qualified interpreters—not family members or untrained office staff—for impairment rating examinations.

Sensitivity and awareness are the keys for examiners. The examiner should ensure the involvement of a qualified interpreter for the impairment examination. In most systems the insurers are required to pay for the interpreter, but frequently the examiner must request the interpreter. When the examiner has established a level of comfort with the patient, questions about what the patient believes caused the condition and who has advised and/or treated them can be very revealing and lead to an accurate impairment rating. When patients from a different culture have an unexpected response to treatment of their condition, consider cultural differences.

2.6 Impairment Evaluation and the Law

Physicians have traditionally been regarded as an authority in their craft and are accustomed to getting their opinions accepted as the final truth.⁶ However, in a legal proceeding, the physician's opinion when unsupported by established science can lead to challenges and cause needless frustration and anxiety for the physician and others. Contemporary adjudication process increasingly questions the science behind

Cultural Differences Examples

The examiner must be cognizant of the difference in the patient's fundamental cultural values and the traditional Western medical view. The following are examples of essential differences in philosophy toward disease and injury. American Native Indians may believe illness is a price to be paid for past or future personal deeds. Individuals from hierarchical cultures, such as traditional Asian and Hispanic cultures, are less likely to disagree with a physician out of respect for the physician's education and experience. This may lead a patient to be reluctant to answer open ended questions or to try and guess the answer desired by the physician when answering such questions. They are also likely to view the physician as an authoritative figure and as such be reluctant to participate in physician-patient decision making, since the physician is expected to know the correct treatment. Both cultures are also likely to seek care outside of the western medicine. Asians expect to experience some distance between the provider and themselves and may be uncomfortable with social physical contact. Hispanics, however, generally prefer a social situation and are more comfortable if the encounter includes some conversation about family and some physical contact such as a hand shake. In cultures where physical ability is considered an essential element of masculinity, males may suffer extreme psychological distress over a physical impairment that decreases their earning capacity and lowers their internal sense of masculinity.⁷ Naturally, no generalization represents a culture accurately and all patients must be treated as individuals.

the doctor's assertions, and doctors are increasingly faced with the challenge of litigants demanding multiple opinions.

In the legal context, an impairment evaluation is a form of expert testimony. The use of the *Guides* requires the physician to use the same skills, knowledge, and ability as in the therapeutic practice of medicine in the collection of data and making of an accurate diagnosis. The *Guides* then is used to channel that information and translate it into an impairment number.

Judicial decisions state that arbitrary and dogmatic opinions, even from well-qualified experts, are not held credible. Therefore, doctors providing independent medical examinations and expert testimony

2.4 When Are Impairment Ratings Performed?

An impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized, often termed the date of **maximal medical improvement (MMI)**. It is understood that an individual's condition is dynamic. Maximal medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached MMI, a permanent impairment rating may be performed. The *Guides* attempts to take into account all relevant considerations in rating the severity and extent of permanent impairment and its effect on the individual's activities of daily living.

Impairments often involve more than one body system or organ system; the same condition may be discussed in more than one chapter. Generally, the organ system where the problems originate or where the dysfunction is greatest is the chapter to be used for evaluating the impairment. Thus, consult the vision chapter for visual problems due to optic nerve dysfunction. Refer to the extremity chapters for neurological and musculoskeletal extremity impairment from an injury. However, if the impairment is due to a stroke, the neurology chapter is most appropriate. Whenever the same impairment is discussed in different chapters, the *Guides* tries to use consistent impairment ratings across the different organ systems.

2.5 Rules for Evaluation

2.5a Confidentiality

Prior to performing an impairment evaluation, the physician obtains the individual's consent to share the medical information with other parties that will be reviewing the evaluation. If the evaluating physician is also that person's treating physician, the physician needs to indicate to the individual which information from his or her medical record will be shared.

2.5b Combining Impairment Ratings

To determine **whole person impairment**, the physician should begin with an estimate of the individual's most significant (primary) impairment and evaluate other impairments in relation to it. It may be necessary for the physician to refer to the criteria and estimates in several chapters if the impairing condition involves several organ systems. Related but separate conditions are rated separately and impairment ratings are combined unless criteria for the second impairment are included in the primary impairment. For example, an individual with an injury causing neurologic and muscular impairment to his upper extremity would be evaluated under the upper extremity criteria in Chapter 16. Any skin impairment due to significant scarring would be rated separately in the skin chapter and combined with the impairment from the upper extremity chapter. Loss of nerve function would be rated within either the musculoskeletal chapters or neurology chapter.

In the case of two significant yet unrelated conditions, each impairment rating is calculated separately, converted or expressed as a whole person impairment, then combined using the Combined Values Chart (p. 604). The general philosophy of the Combined Values Chart is discussed in Chapter 1.

2.5c Consistency

Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's lumbosacral spine range of motion (Section 15.9) are good but imperfect indicators of people's efforts. The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the *medical evidence* appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.

17.2h Arthritis

Roentgenographic grading systems for inflammatory and degenerative arthritis are well established and widely used for treatment decisions and scientific investigation. For most individuals, roentgenographic grading is a more objective and valid method for assigning impairment estimates than physical findings, such as the range of motion or joint crepitation. While there are some individuals with arthritis for whom loss of motion is the principal impairment, most people are impaired more by pain and sometimes weakness, but they still can maintain functional ranges of motion, at least in the early stages of the process. Range-of-motion techniques are therefore of limited value for estimating impairment secondary to arthritis in many individuals. Crepitation is an inconstant finding that depends on such factors as forces on joint surfaces and synovial fluid viscosity.

Certain roentgenographic findings that are of diagnostic importance, such as osteophytes and reactive sclerosis, have no direct bearing on impairment. The best roentgenographic indicator of disease stage and impairment for a person with arthritis is the cartilage interval or joint space. The hallmark of all types of arthritis is thinning of the articular cartilage; this correlates well with disease progression.

The need for joint replacement or major reconstruction usually corresponds with complete loss of the articular surface (joint space). The impairment estimates in a person with arthritis (Table 17-31) are based on standard x-rays taken with the individual standing, if possible. The ideal film-to-camera distance is 90 cm (36 in), and the beam should be at the level of and parallel to the joint surface. The estimate for the patellofemoral joint is based on a "sunrise view" taken at 40° flexion or on a true lateral view.

In the case of the knee, the joint must be in neutral flexion-extension position (0°) to evaluate the x-rays. Impairments of individuals with knee flexion contractures should not be estimated using x-rays because measurements are unreliable. In these individuals, the range-of-motion method should be used. X-rays of the hip joint are taken in the neutral position. The cartilage interval (joint space) of the hip is relatively constant in the various positions; therefore, positioning is not as critical as for the knee x-rays. The ankle x-ray must be taken in a mortise view, which is 10° internal rotation; 10° flexion or extension is permissible. Evaluation of the foot joints requires a lateral view for the hindfoot and an anteroposterior view for the midfoot and forefoot. If there is doubt or controversy about the suitability of the

Table 17-31 Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals

Joint	Whole Person (Lower Extremity) [Foot] Impairment (%)			
	Cartilage Interval			
	3 mm	2 mm	1 mm	0 mm
Sacroiliac (3 mm)*	—	1 (2)	3 (7)	3 (7)
Hip (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Knee (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Patellofemoral†	—	4 (10)	6 (15)	8 (20)
Ankle (4 mm)	2 (5) [7]	6 (15) [21]	8 (20) [28]	12 (30) [43]
Subtalar (3 mm)	—	2 (5) [7]	6 (15) [21]	10 (25) [35]
Talonavicular (2-3 mm)	—	—	4 (10) [14]	8 (20) [28]
Calcaneocuboid	—	—	4 (10) [14]	8 (20) [28]
First metatarsophalangeal	—	—	2 (5) [7]	5 (12) [17]
Other metatarsophalangeal	—	—	1 (2) [3]	3 (7) [10]

* Normal cartilage intervals are given in parentheses.

† In an individual with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on x-rays, a 2% whole person or 5% lower extremity impairment is given.

radiographic method in a specific individual, range-of-motion techniques may be used instead.

A person who has an intra-articular fracture and subsequent rapid onset of arthritis should be evaluated using the arthritis section combined with Section 17.2j on diagnosis-based estimates.

Example 17-13

15% Impairment Due to Arthritis and Malalignment From a Tibia Fracture

Subject: 48-year-old man.

History: Fell from a loading dock 23 years ago, sustaining a right tibia fracture.

Current Symptoms: Resumed work. Over the last several years, had right knee pain toward the end of the day. Occasional mild swelling of the knee joint.

Physical Exam: The fracture healed with a 10° varus deformity of the right tibia. He has almost full range of motion of the injured knee, 0° through 125°, and mild crepitation.

Clinical Studies: Standing x-rays: cartilage interval is 2 mm on the medial side of the right knee.

Diagnosis: Moderate degenerative arthritis of the right knee.

Impairment Rating: 15% impairment of the whole person.

Comment: Symptoms worsen after a day's work. The cause of pain and impairment is the development of osteoarthritis in the knee joint. Accurate x-rays are an objective way to estimate this impairment. Based on the x-rays, this individual has an 8% whole person impairment and 20% impairment of the lower extremity due to arthritis (Table 17-31). The 8% whole person impairment related to knee arthritis should be combined with an 8% whole person impairment due to the tibia fracture malalignment, 10° varus of the tibia (see Table 17-33). Combining two 8% whole person impairments yields a 15% whole person impairment (Combined Values Chart, p. 604).

17.2i Amputations

Impairments of the lower extremity due to amputations are estimated according to Table 17-32.

Example 17-14

28% Impairment Due to Amputation From a Crush Injury

Subject: 35-year-old man.

History: Sustained a crush injury to the left leg in a motor vehicle accident. Below-knee amputation.

Current Symptoms: Ambulates with a below-knee prosthesis, without the need for a cane or support. Has no pain in the stump and no phantom pain.

Physical Exam: The left knee is stable, has no sign of arthritis, and has full motion.

Clinical Studies: X-rays: 13 cm (5 in) of retained proximal tibia in the stump. The stump is well healed, and he has not had any trouble with stump breakdown.

Diagnosis: Below-knee left leg amputation.

Impairment Rating: 28% impairment of the whole person.

Comment: Table 17-32 shows that this condition receives a 28% whole person impairment rating. In this case, there was no concomitant knee injury. If there is an injury to the knee, or more proximal to the leg, that may also need to be rated.

Table 17-32 Impairment Estimates for Amputations

Amputation	Whole Person (Lower Extremity) [Foot] Impairment (%)
Hemipelvectomy	50
Hip disarticulation	40 (100)
Above knee	
Proximal	40 (100)
Midhigh	36 (90)
Distal	32 (80)
Knee disarticulation	32 (80)
Below knee	
Less than 3"	32 (80)
3" or more	28 (70)
Syrne (hindfoot)	25 (62) [100]
Midfoot	18 (45) [64]
Transmetatarsal	16 (40) [57]
First metatarsal	8 (20) [28]
Other metatarsals	2 (5) [7]
All toes at metatarsophalangeal (MTP) joint	9 (22) [31]
Great toe at MTP joint	5 (12) [17]
Great toe at interphalangeal joint	2 (5) [7]
Lesser toes at MTP joint	1 (2) [3] each

17.2j Diagnosis-Based Estimates

Some impairment estimates are assigned more appropriately on the basis of a diagnosis than on the basis of findings on physical examination. A good example is that of an individual impaired because of a successful replacement of a hip. This person may function well but require prophylactic restrictions of activities of daily living to prevent a further impairment, such as premature failure of the prosthesis. Table 17-33 provides impairment estimates for certain lower extremity impairments. For most diagnosis-based estimates, the ranges of impairment are broad, and the estimate will depend on the clinical manifestations and their impact on the ability to perform activities of daily living. Hip replacements should first be rated using Table 17-34 and knee replacements using Table 17-35. The points obtained from the assessment are then applied to Table 17-33 for the diagnosis impairment rating. If limb length discrepancy also exists, that impairment rating should be combined with the impairment from the joint replacement using the Combined Values Chart (p. 604).

Functional limitations The inability to completely perform a task due to an impairment. In some instances, functional limitations may be overcome through modifications in the individual's personal or environmental accommodations.

Functional Vision Score (FVS) The *functional vision score* combines the Functional Acuity Score and the Functional Field Score (see Table 12-1) with individual adjustments if needed (see Section 12.4b). Higher values indicate better vision.

Handicap A historical term used to describe disability or a person living with a disability or disabilities. A handicapped individual has been considered to be someone with a physical or mental disability that substantially limits activity, especially in relation to employment or education.

Hernia A protrusion of an organ or body part through connective tissue or through a wall of the cavity in which it is normally enclosed.

HIV See Human immunodeficiency virus (HIV).

Hormone A product of living cells that circulates in body fluids and produces a specific effect on the activity of cells remote from its point of origin.

Human immunodeficiency virus (HIV) Any of a group of retroviruses, and especially HIV-1, that infect and destroy helper T cells of the immune system, causing the marked reduction in their numbers that is one of the diagnostic criteria of AIDS. Also called AIDS virus.

Impairment A loss, loss of use, or derangement of any body part, organ system, or organ function.

Impairment evaluation A medical evaluation performed by a physician, using a standard method as outlined in the *Guides*, to determine permanent impairment associated with a medical condition.

Impairment percentages or ratings Consensus-derived estimates that reflect the severity of the impairment and the degree to which the impairment decreases an individual's ability to perform common activities of daily living as listed in Table 1-2.

Independent medical evaluation (IME) An evaluation performed by an independent medical examiner, who evaluates—but does not provide care for—the individual.

Inherited condition A condition received from a parent or ancestor by genetic transmission.

Legal blindness A term used to indicate eligibility for certain benefits. It is a misnomer, since 90% of "legally blind" individuals are not blind. The preferred term, as used in *ICD-9-CM*, is *severe vision loss* (see Section 12.2b.1).

The definition of *legal blindness* varies slightly in different statutes. A common definition is "visual acuity of 20/200 or less." Implementation of this definition depends on the chart used (see Section 12.2b.1). An alternative definition is "visual field loss to a 20° diameter or less." This definition does not address nonconcentric field losses.

Malingering A conscious and willful feigning or exaggeration of a disease or effect of an injury in order to obtain specific external gain. It is usually motivated by external incentives, such as receiving financial compensation, obtaining drugs, or avoiding work or other responsibilities.

Maximal medical improvement (MMI) A condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change; however, further recovery or deterioration is not anticipated.

Menopause The period of natural cessation of menstruation, usually occurring between the ages of 45 and 55.

METS Multiples of resting metabolic energy used for any given activity. Each MET represents 3.5 cc of oxygen consumption per kilogram per minute. One MET equals oxygen uptake at rest. The results of stress testing are expressed in METs.

Motivation A need or desire that causes a person to act.

Neutral zero measuring method An approach used by the *Guides* to measure range of motion that defines the neutral or starting position of reference for any joint being measured as the standing anatomic position. The neutral or anatomic position is recorded as the 0° position.

Normal A range or zone that represents healthy functioning and varies with age, gender, and other factors, such as environmental conditions.

Occupational history A tool used in a comprehensive clinical assessment to obtain, organize, and assess information about the current and prior workplace environments and exposures and their relationship to illness and injury. An occupational history can provide essential information to improve treatment, prevent further or additional illness or injury, and assist in the determination of whether work directly caused or contributed to the development of the injury or illness.

Pain An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Pain behavior Verbal or nonverbal actions understood by observers to indicate that a person may be experiencing pain, distress, and suffering. These actions may include audible complaints, facial expressions, abnormal postures or gait, use of prosthetic devices, or avoidance of activities.

Paresthesias A sensation of pricking, tingling, or creeping on the skin, usually associated with injury or irritation of a sensory nerve or nerve root.

Patch test Patch tests are used to diagnose allergic contact sensitivity. Small patches containing non-irritating concentrations of the allergens to be tested are applied to unbroken skin, usually on the upper back, for 48 hours. A positive test reaction occurs when dermatitis develops at the site of application 48 to 168 hours later.

Permanent impairment An impairment that has reached maximal medical improvement.

Prosthesis An artificial device to replace a missing part of the body.

Psychogenic pain Severe and prolonged pain that is inconsistent with neuroanatomic distribution of pain receptors or without, or grossly in excess of, detectable organic or pathophysiologic mechanisms. As a result, the report of pain is attributed primarily to psychological factors.

Pulmonary function tests Studies of lung function including such measurements as lung volumes, inspiratory and expiratory flow rates, and efficiency of gas transfer.

Radiculopathy Any pathological condition of the nerve roots.

Raynaud's phenomenon A vascular disorder marked by recurrent spasm of the capillaries, especially those of the fingers and toes upon exposure to cold, that is characterized by pallor, cyanosis, and redness in succession and usually accompanied by pain.

Recurrence A return of the disorder or disease after a remission.

Reflex sympathetic dystrophy See **Complex regional pain syndromes**.

Reliability See **Reproducibility**.

Remission Improvement or a state or period during which the symptoms of a disease are abated.

Replacement medication or therapy Treatment that involves the supply of something (an element, compound, or hormone) lacking or lost to the body's system. Although the person may be fully functional on an everyday basis while taking replacement medication, he or she may be unable to respond properly to stresses such as fever, trauma, or infection. This impaired ability to respond to stress needs careful consideration.

Reproducibility Synonymous with reliability. Consistency in results when examinations (tests) are repeated.

Sciatica Pain along the course of a sciatic nerve, especially in the back of the thigh, caused by compression, inflammation, or reflex mechanisms.

Sensitivity The extent to which individuals with a condition are correctly classified.

SFTR documentation system A numeric method for recording range-of-motion measurements taken by the neutral zero method.

Social functioning An individual's ability to interact appropriately and communicate effectively with other individuals.

Somatoform pain disorder According to *DSM-IV*, this is preoccupation with pain in the absence of physical findings that adequately account for the pain and its intensity, as well as the presence of psychological factors that are judged to have a major role in the onset, severity, exacerbation, and maintenance of pain.

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Cc: jerryk@rmcomplaw.com; john@rrba-law.com; Wasberg, John (ATG); Sandstrom, Anastasia (ATG)
Subject: RE: Tomlinson v. Puget Sound Freight Lines & DLI, No. 80811-2, DLI Amicus Brief

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From: Feldstein, Rachel (ATG) [mailto:RachelB@ATG.WA.GOV]
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Subject: Tomlinson v. Puget Sound Freight Lines & DLI, No. 80811-2, DLI Amicus Brief

Dear Clerk,

Attached for filing in *Tomlinson v. Puget Sound Freight Lines & DLI*, No. 80811-2, is the Department of Labor & Industries' (1) Motion to File an Amicus Brief, (2) Brief of Amicus Curiae Department of Labor and Industries, and (3) Brief Appendices (A and B).

<<DLI Motion to File Amicus Brief - Tomlinson.pdf>> <<DLI Amicus Brief - Tomlinson.pdf>> <<Appendix A to DLI Amicus Brief.pdf>> <<Appendix B to DLI Amicus Brief.pdf>>

The attorneys for Mr. Tomlinson and PSFL have agreed to service by e-mail. They were served by e-mail earlier today, and are copied on the cc: line of this e-mail.

Sincerely,

Rachel Feldstein, WSBA # 36892

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