MY CLAIMS BEFORE THE WORKERS COMPENSATION BOARD

BEFORE THE WORKERS' COMPENSATION BOARD
OF THE STATE OF OREGON

In the Matter of the Compensation) Case No.: 05-08315
Of) Claim No. C6404749910
Edward M. Johnston II, Claimant) Brief for Claimant

This brief is submitted by Edward M. Johnston for himself as the claimant.

I am appealing to you based on the Order on Reconsideration issued by ALJ Jenny Ogawa in my case above, dated July 7, 2006.

I. The Scope of the Injuries and the Hearing

1. The case referred to above is the case formally here on appeal before the WCB. It regards the extent of and compensation for my C4-5 injury from 2001 at Hallmark Inns & Resorts. This was the second injury to my neck; there was an earlier one, deemed not a part of the process that led to this appeal. However, I have only one neck. The basic background is this:

On Nov. 4, 1989, while working as a bouncer at the PipTide Restaurant in Newport, insured by Liberty NW, I was beaten over the back of the neck with a pipe. This FIRST INJURY, though initially and absurdly described by Liberty as "neck strain" was eventually the source of an accepted condition for C5-6. This led to my FIRST SURGERY, an anterior cervical discetomy and fusion at C5-6, done at McKenzie-Willamette Hospital by Physician Robert Hacker 03/03/98 - nearly nine years after the damage was done.

I suffered a SECOND INJURY on July 28, 2001, when I slipped and fell in a puddle of water, working as a cook, at Georgie's Grill, a.k.a. (and organizationally a part of) Hallmark Inn, also insured by Liberty. This injury affected chiefly my neck C4-5. This led to my SECOND SURGERY, another anterior cervical discectomy and fusion with canal decompression with instrumented interbody fusion with allograft at C4-5 on 3/4/2002. At least, this time, Liberty did not succeed in delaying the operation by nine years. The underlying case now at issue, which is the basis of this appeal, addressed the C4-5 injury and conditions.

However, it is bizarre to not also address handling of and compensation for the First, C5-6, Injury. That initial injury damaged both vertebrae and more; the later injury worsened both and more. The two vertebrae are next to each other. They are medically, physically and experientially linked. The 2001 event that caused the Second Injury (which is formally on appeal here) might not have caused as bad an injury if the First Injury (in 1989) had not occurred. The First injury might not now be as bad as it is if the second injury had not happened. The two vertebrae are right next to each other in my neck; other vertebrae adjacent to them also show clear and substantial medical evidence of harm and have for a long time. My compensation for the first injury was minimal, and that condition has grown worse since then, in part due to the second injury. Therefore, I ask that case:

WCB Case No. 03-04430,
Claim No. C604255450,
DOI: 11/04/1989,
WCD File No. G537856,

which addressed my C5-6 injury, also be reviewed here along with the case formally on appeal. And I ask that I received full and fair compensation for the medical harms, medical expenses, and financial losses (calculated as a bouncer, when I was making twice or more than that as much as I was making as a cook) caused by the injuries - or, to be really fair and accurate, the income lost from not being able to return to the private security business, which would have earned me millions each year. Plus, if you please, punitive damages against Liberty for the misbehavior and reasons outlined below.

Additionally, as any review of the medical record (and especially the more recent medical reviews) would show, I in fact have other medical issues in other vertebrae in my neck and back, and they are getting worse, too. These, too, cause me hurt and grief and expenses and, in a fair system of compensation, would be included in the review and compensated for.

2. Further, the medical record from that First Injury clearly includes discussion of a closed head injury from that first incident. I ask the board to include that, in this, appeal, too, along with the rest of the 1989 incident injuries I sustained.

3. In the Transcript of the hearing on which this appeal is based, page 6, ALJ Ogawa states "Any issues regarding the C5-6 condition is what is called under the Board's own motion. I do not have the authority to decide any issues regarding the C5-6. Your C4-5 disc condition was accepted by Liberty under the 2001 injury claim with Hallmark Inns & Resorts. I have the legal authority to decide issues regarding the C4-5 disc condition under the 2001 injury." Clearly, unless Ogawa was wrong, the WC Board has the authority to review both of my cases and all of my medical conditions, under the Board's "own motion" authority. While C4-5 was "accepted," the benefits that have come to me from this have been minimal. I request that the Board review and address it now, in the interests of justice, fairness, and expediting the WC Department process (that is, the hope that all the outstanding issues between me and Liberty can be addressed at one time, instead of further strung out over yet more years, at more cost to taxpayers and harm to me) - and in the hope this can be completed before I die. My reasonable remaining lifespan is not long, by any reasonable standard. I need only to slip and fall again and I can slice my spinal cord, either killing me or paralyzing me. To the extent I prevail, I request that the board act to ensure that whatever decisions against Liberty are reached by the Board be implemented - that the Board instruct Liberty to provide me with a certified check in the amount of the settlement, such that I can cash it and deposit it in my own bank account, and thereby avoid games such as having Liberty put a stop payment on a check, or otherwise force me into a whole second process of collecting on the Board's rulings. Please make failure to immediately implement a decision in my favor a basis for further, much larger and more severe punishment, in whatever, and all ways, that you can. I simply cannot forever play Liberty's game; Liberty as a corporation can go on forever, and play games forever; but I will die, and not too long from now.

4. There is basis in the case history for combining review of both injuries/claims. On July 22, my then attorney Welch wrote Liberty attorney Sally Anne Curey seeking consolidation of hearings on the two different Injuries. (EXHIBIT 1) On July 24, 2003, Liberty NW Insurance lawyer Sally Anne Curey wrote to my then attorney Brian Welch, "First of all, Liberty has no objection, of course, to your moving to

combine the two hearings." (EXHIBIT 2) On 8/12/2003 the Board consolidated the hearings on the different claims. (EXHIBIT 3) If we can do so once, we can do so again.

II. Errors by ALJ in Appealed Case (i.e., Re: C4-5, the Second Injury)

While this section must address the flaws in Ogawa's logic and fact finding, I must here note that I am not merely seeking a reversal of Ogawa's Order Denying Reconsideration dated April 7, 2006. That would merely get me back in the soup of another dubious ALJ review and another stacked Liberty review. I do not a remand back to an ALJ. I am asking the WC Board to not only overrule Ogawa, but to rule on the underlying issues which I sought (unsuccessfully) to get Ogawa to reconsider, too, not just the dismissal of my case, which I want un-dismissed, but a review of the "post-aggravation rights" (the under-girding issue in the case) as dismissed in the Own Motion Order on Reconsideration (Dismissing) dated Jan. 10, 2006, by WC Board members Lowell and Kasubhai. Further, I am asking the Board to reverse the Order of Dismissal dated Jan. 10, 2006 signed by Board members Lowell and Biehl. I am requesting also that I be granted (a) total disability, returning back to the First Injury, (b) full and total compensation of all medical expenses incurred, (c) full and fair compensation for lost income (as noted above calculated on the basis of the income a bouncer, not a cook makes - or on the income I might have made had I gone back into the private security business, which would have earned me millions of dollars. And I am requesting (d) punitive damages against Liberty, for the reasons stated and detailed below. My apologies for the repetition, but I must make it clear that the issues in Ogawa's flawed decision, though I next go into them, are nowhere near the sum and substance of this matter. Finally, I seek a mechanism to assure that, if and when justice is done and I prevail, Liberty will have to act in proper response to my victory and actually do as the Board decides.

Returning to my response to ALJ Ogawa's errors:

1. ALJ Ogawa mistakenly asserts no physician stated I was "not medically stationary or was worse."

Ogawa asserts, though she does so in a footnote (number 1) that "Neither Dr. Theuson, who last saw claimant in July 2005, nor Dr. Throop, who saw claimant in November 2005, indicated that claimant's C4-5 disc condition was not medically stationary or was worse. Rather, Dr. Theuson noted in May 2005 that claimant would probably have gradual deterioration due to aging. Dr. Theuson also reported that, although claimant stated he had worsened, Dr. Theuson found little change, objectively, since the March 2002 surgery."

This statement by the ALJ is not correct.

On Nov. 5, 2003, Dr. Hacker, the surgeon on both my operations, wrote to Ada Wainmayer at WCD that "I expect that Mr. Johnston will likely have a lifelong problem with cervical myelopathy." (EXHIBIT 4) This is something of an understatement, but certainly true. I have, as he expected, since gotten worse.

The Samaritan Pacific Communities Hospital Diagnostic Imaging Report (DIR) for exam date 03/30/2005 relating to an MRI of the cervical spine by Dr. Bear, performed

for Dr. Theuson. (EXHIBIT 5) It reported that at C4-5 “There is a mild to moderate broad-based posterior disk bulge/osteophyte, with minor AP narrowing of the spinal canal. There is mild to moderate narrowing of the right neural foramen, and moderate narrowing on the left.” The active changes - “narrowing” (twice noted) - are compared, evidently, to the “Plain films dated August 16, 2002” that also “were reviewed” by Dr. Bear. This comparison clearly indicates changed and worsened conditions since that time (i.e., August 2002, after the March 2002 surgery). This DIR also states that “The AP diameter of the spinal canal is narrowed from C3-4 through C6-7.” That, obviously, must include C4-5. (Note also that this MRI found further worsening conditions at C3-4, C5-6 AND C6-7, also.)

In an undated letter Dr. Theuson stated “I saw Mr. Johnston for his closing exam on March 18 (and 31st), 2005.” (This letter is associated with a range of moition report dated 3/18/05) (EXHIBIT 6) At that time he again reiterated that he has felt a gradual deterioration since his surgery on 3/5/2002. He was evaluated in May 2003 for persisting parasthesias in both upper and lower limbs but nothing definitive was found.” But, he goes on to state, in direct conflict with the ALJ‘s assertion, “1. Yes, I would consider his acute lumbar/cervical strain with C4-5 cervical disc herniation to be medically stationary.” The legal effect of this error (regarding the stability of my medical condition) by ALJ Ogawa is not clear to me, but as the error is part of the logic by which she dismissed my claim for additional compensation, I feel obliged to point it out.

Further, in this vein, on May 5, 2005, in a letter to Liberty Northwest, (EXHIBIT 7) Dr. Theuson starts right off by reiterating “Yes I would consider his acute lumbar/cervical strain with C4-5 cervical disc herniation to be medically stationary as does your IME.” He also wrote there that “The patient has complained of intermittent sensory changes of both his arms and legs, generally worsened by activity and improved by rest. These seemed to be a result of the last surgery and thus would be tied to the same cause. (The need for surgery being due to the injury.)” This, too, indicates worsening conditions related to my 2001 C4-5 injury (the one formally at issue in the Ogawa hearing), contrary to the ALJ’s conclusion that no doctor had, before that hearing date, found my condition getting worse.

The Independent Medical Examiner, Paul Williams, of STAR Medical, on 4/22/05 (EXHIBIT 8) noted “a global decrease in sensation in C4, C5, C6, C7, C8 and T1” (page 3). It is not clear if that decrease is in comparison to prior physician tests or some general standard, but this doctor does state (page 4) that he haqs reviewed a long list of my MRI and X-ray films. The observation is repeated again by Dr. Williams on page 6. So, this strongly appears to be evidence Ogawa was wrong in saying no doctor found I was getting worse - and it is certainly evidence I was much worse than having, as Liberty for years insisted I had, “cervical strain.”

Even Dr. Throop - the “Independent” Medical Examiner, upon whom ALJ Ogawa so heavily depends - stated in his Nov. 15, 2005 letter (EXHIBIT 9) to Tamara L. Schnack at WCD (page 1) “The last MRI scan was done on 03/30/05, which showed a number of disk bulges at the cervical level and osteophytes at all levels, with multiple areas of foraminal encroachment, especially at C6-7 on the left and at C-4 on the left. There was multiple spinal stenosis at multiple levels.” (We note that “C-4” has to have been intended as C4-5.) I note that the foraminal encroachment was new at that point, and had not been in the record at the time of the March 2002 surgery. So much for my not worsening as of the time of Ogawa’s review.

2. There has been deterioration at C4-5 since the first operation.

On Oct. 29, 2002, Dr. Paul Meunier wrote to attorney Conway McAllister (EXHIBIT 10) about my case. "I have for comparison two MRI examinations dated 12/12/1997 and 10/23/2001. Additionally, I have a number of x-ray examinations dated 04/09/1998, 07/22/1998, 02/03/1999 and 11/26/2001. … There is some disc space narrowing at C4-5 and early posterior osteophytic ridging at this same level. There is a small linear calcification anterior to the C4-5 disc level which appears to be ligamentous in origin. Accounting for differences in position and technique, the examinations likewise reveal stable findings at the C4-5 disc level. The findings on MRI correspond with the findings on plain film examination. There is vertebral body endplate spondylosis or hypertrophic degenerative change. The invertebral disc has a corresponding protrusion which is central to left paracentral. There is some compromise of the central canal and apparent displacement of the traversing cervical cord at this level. …"

The Samaritan Pacific Communities Hospital Diagnostic Imaging Report (EXHIBIT 11) for exam date 03/30/2005 related to a MRI of the cervical spine by Dr. Bear, performed for Dr. Theuson. He reported that at C4-5 "There is a mild to moderate broad-based posterior disk bulge/osteophyte" - contrast with the "small" and "early" in the previously cited document) "and, with minor AP narrowing of the spinal canal. There is mild to moderate narrowing of the right neural foramen, and moderate narrowing on the left." The comparison evidently is to the "Plain films dated August 16, 2002" that "were reviewed" by Dr. Bear. This clearly indicates changed and worsened conditions since that time, (i.e., right after the March 2002 surgery). It also states that "The AP diameter of the spinal canal is narrowed from C3-4 through C6-7." This clearly includes C4-5. (Note also that this MRI found further worsening conditions at C3-4, C5-6 and C6-7.)

Thus, from the Oct. 29, 2002 exam to the 03/03/2005 exam, it appears there have been worsened conditions., contrary to Ogawa's conclusion.

3. Do we accept ALJ's view that there is no Sstebnosis at C4-5 or the ALJ's view that the Stenosis at C4-5 did not come from the injury?

Spinal stenosis is defined as "narrowing of the spinal canal."

ALJ Ogawa wrote that (page 3 of 4) "Here, the medical evidence does not clearly establish that the March 2005 MRI findings of spinal stenosis stem from the accepted C4-5 disc condition." She then goes on to, contradictorily, state (same paragraph) that "…Spinal stenosis was not reported at the C4-5 disc level."

I do not see how there can be no stenosis reported at C4-5 when there is also a failure to "establish that the March 2005 MRI findings of spinal stenosis stem from the accepted C4-5 disc condition." Obviously, there was and is a finding of stenosis at C4-5.

And, The Samaritan Pacific Communities Hospital Diagnostic Imaging Report for exam date 03/30/2005 relating to an MRI of the cervical spine by Dr. Bear (EXHIBIT 12), performed for Dr. Theuson confirmed this. It reported that at C4-5 "There is a mild to moderate broad-based posterior disk bulge/osteophyte, with minor AP narrowing of the spinal canal. There is mild to moderate narrowing of the right neural foramen, and moderate narrowing on the left." (Emphasis added.)

4. What did the stenosis come from?

The question becomes what other source beside the "accepted condition" the stenosis could come from. I am not a doctor and do not know the universe of possible answers, but it seems to me that if it did not come from the injury that underlay the "accepted condition," it must have come from degenerative changes. I quote from the Nov. 15, 2005 letter from Dr. Throop (Previous Exhibit 9). (page 4): "The degenerative disease is unrelated to the C4-5 disk herniation condition." If degenerative disease is unrelated, it must have come from the underlying injury-based, accepted condition. The evidence shows the ALJ was wrong on four critical points (points she expressly relied on in denying me compensation for my claims):

My medical condition was not identified as stationary or getting worse. It was, at some points, viewed as "medically stationary" and, more often and more severely as having grown worse, in varying ways, at various times. Indeed, the trajectory has been all in one direction, and it is this very fact that most frightens me. I live in fear of a slip and fall - or simply aging - that could, and almost surely someday will, either make me paralyzed or kill me. Ogawa is dead wrong, if you'll pardon the phrase, where she stated I have neither gotten worse nor been medically stationary (which claim obviously means I am getting better!!!). If this is not basis for over-ruling the ALJ, then the sun really does revolve around the Earth.

There has been deterioration at C4-5 since the first operation.

There is spinal stenosis at C4-5.

The stenosis did not come from degenerative disease, so it must have come from my actual specific accepted medical condition at C4-5.

What follows next is from the August 13 letter that I sent to the WCB. As I stated in my letter then, the below include issues of (a) closed head injury; (b) bad faith rejection of medical evidence of the C4-5, (c) rejection of my C6-7 injury, (d) harassment of my physicians by Liberty, and (e) manipulation of evidence. All these should be sufficient to (i) award me compensation back to the appropriate dates when the need for medical insurance became apparent and it was not provided by the insurer despite repeated requests it do so, (ii) medical, travel and other injury related expenses and (iii) punitive damages for misbehavior, lost or missing evidence and harassment of my doctors.

III. Closed Head Injury

The C4-5 disc injury came from the original 1989 injury, for which Liberty NW totally disabled me on 5/31/90 for C4-5 and C5-6 and "closed head injury." (EXHIBIT 13) Liberty NW in fact, gave me a total disability finding in 1990 for C4-5 and C5-6 and closed head injury. Somehow, thereafter, the recognition of the closed head injury by Liberty dropped off their computer. Note that the closed head injury is mentioned in the July 9, 1990 letter to Liberty from Drs. Stanford and Barth at BBV medical service (EXHIBIT 14) - even before the cervical disc injuries had been property identified as significantly more than "strains." On Jan. 17, 1991, Western Medical Consultants, Dr. Grizka and Dr. Snodgrass (EXHIBIT 15) also found closed head injury, as well as other injuries, including at C5-6. I have never received compensation for this, nor even a review of it.

IV. THE C5-6 ISSUE.

While attorney Curey strenuously tried to limit this case to just the C4-5 injury from the Second Incident (at Georgies), and will surely seek to limit this review by the WC Board to just that injured vertebrae, C4-5, I also ask the WC Board to review the 1989 injury to C5-6 at the Piptide and such compensation as I may have gotten for it - and what I should receive for it. In fact, C5-6 was the initially most damaged vertebrae, and the object of my first surgery. Though the damage and the lost income caused has been great, the compensation I have gotten for it has been tiny.

I have all along insisted on retaining my rights to raise claims about and seek full and just compensation for BOTH incidents, both injuries and the medical consequences of both. Liberty NW, in fact, gave me a total disability finding in 1990 for C4-5 and C5-6 and closed head injury. (See previous Exhibit 13) Somehow, now, the recognition of the C5-6 injury dropped off their computer.

On Nov. 28, 1990, Portland Magnetic Imaging Labs, Dr. John English, (EXHIBIT 16) recommended surgery on C4-5 and C5-6 because of the First Injury. I waited, however, for updated, improved surgical procedures because the existing science was not encouraging back then. This was, in fact, at the suggestion of one of my physicians, Dr. William Bernstein; so I waited before having surgery. Maybe that was a mistake, because it gave Liberty time to develop various arguments to oppose the surgery (and maybe not, as Liberty probably would have opposed it anyway, at any time and however bad my need for it). Further, if it made the surgery that I did eventually receive more helpful and less likely to have killed me, I think it was worth it. (Emphasis added.)

On Jan. 17, 1991, Western Medical Consultants, Dr. Grizka and Dr. Snodgrass, (see previous Exhibit 15) found (besides a closed head injury), “very small central disc herniation at the C4-5 level, left paracental disc herniation considered to be present at the C5-6 level, but not well visualized.” (Emphasis added.) They found I was “not medically stationary” and that I probably would not be for four months. Thus, the C5-6 injury is shown, again, to have began as a result of the First Injury. My compensation for C5-6 should go all the way back to the First Injury.

On May 23-24, 1991, the Oregon Pain Center (OPC) (EXHIBIT 17) found “Mild herniated disc C5-6 left by MRI, questionable significance without objective neurological correlate. (p.1) On May 29, OPC limited me to “work in the medium category.” (EXHIBIT 18)

A year later, on May 7, 1992, the Workers Compensation ORDER ON RECONSIDERATION (EXHIBT 19) reduced what had by then become my partial (no longer total as was originally found by Liberty) disability “to NONE.” The logic of this escaped me at the time and still escapes me. That decision did not, however, make the pain go away. I had pain, and even some black-outs, subsequently.

On 9/22/97 a Diagnostic Imaging Report taken at Samaritan Pacific Communities Hospital Emergency Room (EXHIBIT 20) found “There is some degenerative change at C4-5 and C5-6 consisting primarily of intervertebral disc narrowing and anterior bulging. There is some suggestion of spasm.”

But it was not just degenerative matters or merely spasm, as subsequent medical reviews, and surgery, proved. Two months later, Robert Hacker, Neurosurgeon, wrote (EXHIBIT 21) in a letter to Dr. Cephus Allin (dated 11/12/97): “In my opinion Mr. Johnson may well have a painful cervical spondylosis disorder. ... repeat MRI scan is probably reasonable to determine whether there have been late changes with significant root or spinal cord entrapment.”

That was done. There is a letter dated Dec 12, 1997, in which MR Imaging Associates

(EXHIBIT 22) wrote to Dr Hacker finding "Abnormality at C5-6 on the left is larger than expected from plain film findings and probably a combination of cervical spondylosis, foraminal narrowing and disc herniation." In December 1997, when the pain had grown excruciating to me, Dr. Hacker recommended surgery on C4-5 and C5-6 discs; Liberty refused to accept 4-5 and accepted only 5-6. In the interim, I had only gotten worse, and who knows what further damage has been done me - first from the initial delay due to Liberty after the surgery became (in my physicians' opinion) worth the risk it entailed, then due to Liberty's refusal to deem the condition one that needed an operation, and also from Liberty's refusal to support an operation on the 4-5 disc until 2002. With Liberty still denying I had anything worse than cervical strain, it took me till 1997 to get authorization from OMAP for the surgery at C5-6, and OMAP did pay for the surgery, which occurred March 3, 1998 (my first surgery). On July 30, 1998, a letter from my then attorney Strooband (EXHIBIT 23), notes on page 2 that IME Western Medical on 1/16/91 (Gritzka and Snodgrass) had "concluded Mr. Johnston had a herniated disc at C5-6 caused from the work incident of 11/4/89." The attorney's letter then asked Dr Hacker if he had reviewed the Western Med 1/17/91 report and if he agreed or disagreed with Gritzka and Snodgrass regarding existence of a herniated disc at C5-6 and their view that it was due to the 11/4/89 injury. Dr. Hacker circled the "I agree" words.

I continued my efforts to get surgery, once it had become less risky, and indeed got it (on March 3, 1998) - but only after both C4-5 AND C5-6 had more than once been identified as actually entering the spinal cord. More timely surgery - on C5-6 [the First Surgery] and on C4-5, too - might have avoided or significantly delayed that unhappy development.

In (EXHIBIT 24) a July 7, 1998 OWN MOTION ORDER REFERRING FOR CONSOLIDATED HEARING (still, despite all the above, referring to my problem as "acute neck strain"), the Board noted that Liberty had denied compensation for "current cervical disc herniation C5-6 left condition. … (and) opposes reopening on the following grounds: (1) the insurer is not responsible for claimant's current condition, (2) surgery of hospitalization is not reasonable and necessary for the compensable injury; and (3) claimant was not in the work force at the time of disability." This was wrong because (1) the insurer insured both employers of mine and is only "no responsible" for my condition in the sense it is not responsible for anybody's injury except the injury of persons hurt by an employer or vehicle or other equipment employed or owned by the insurer; (2) the medical record established that surgery was reasonable and necessary for both injuries by the date of that assertion by Liberty, and (3) because I was working at the time, and h claim to the contrary was a bald lie.

In effect, Liberty passed me off to the taxpayer, as a burden to the system. Now, because of what Liberty has done, because of its delays and dishonesty, I am indeed a burden to that system and to the taxpayer, when I should not be. Thus, the issue of compensation of C5-6 should be reopened, because that matter was mishandled by the Liberty, and at points the agency, over an extended period of years.

The Board, by its OWN MOTION ORDER of Feb 10, 1999, (EXHIBIT 25) authorized reopening of my 1989 injury claim re: C5-6 to "provide temporary disability compensation beginning March 8, 1998..." (I do not believe I ever got compensation for a decades worth of suffering relating to C5-6 and incapacity - and have not gotten same for continued suffering related to C5-6 and incapacity thereafter to the extent it arose from C5-6. And the compensation I have gotten relating to C4-5 has been fairly minimal.) However, this Order got some of it right. This order states

that “on December 21, 1998, ALJ Spangler issued an Opinion and Order which set aside the insurer’s denial. In doing so, ALJ Spangler found the claimant’s cervical disk herniation at C5-6 was causally related to the November 1989 compensable injury. The ALJ’s order has not been appealed” by Liberty, this noted. (They knew they were lying. But they still haven’t paid compensation.) “On March 8, 1998, claimant underwent anterior cervical fusion. Thus we conclude that claimant’s compensable injury has worsened requiring surgery. Furthermore, as previously noted, we find that claimant was in the work force at the time of his disability. Accordingly, we authorize the reopening of claimant’s 1989 injury claim to provide temporary disability compensation beginning March 8, 1998, the date claimant was hospitalized. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.”

Thus, C5-6 is an issue in my life and in this case and the Board has already found that “C5-6 was causally related to the November 1989 compensable injury” (see previous exhibit 25). There is no sane reason why the C5-6 injury and compensation for it should not be addressed by the Board now, when it clearly is related to the second injury, and the harms from that second injury are, to some extent, “medical sequalae” of the first injury. Indeed, Liberty’s evident bad faith, as detailed below, in denying the need for the first surgery should give anybody with an ounce of decency pause before asserting that they don’t owe me insurance compensation for the expenses of and the losses due to the C5-6, as well as the C4-5 harms (i.e., for losses, harms and expenses related to both the First Injury, which harmed both C4-5 and C5-6, and costs of the First Surgery (on C5-6) and the losses, harms and expenses related to the Second Injury (on C4-5) and the costs of the Second Surgery. For justice to be rendered to me, the Board must address not just C4-5 (and its injury and surgery) but also C5-6 (and its injury and surgery).

V. MANIPULATION OR LOSS OF EVIDENCE.

When I was injured at Georgie’s Beachside Grill (the second injury), Liberty’s investigator picked up the video tape of the event. It has not been seen since, though I have asked for a copy of the tape of the investigative interview between me and him. Also, the restaurant had a videotape of my fall (Georgies) and that was given to the Liberty investigator. Where did it go?

Plus, there should be a letter from Samaritan Pacific Communities Hospital already in evidence discussing a number of missing MRIs. I am in the process now of receiving another letter discussing the MRIs, from the individual at Liberty who wrote that letter, in case it is not in evidence. I made the mistake of innocently turning over to Liberty the MRIs in the hope and expectation the insurer would use them to arrive at a fair and just conclusion as to the degree of disability involved, and amount of compensation warranted, in my case. Evidently, the transfer of possession of such MRIs to the insurer is normal - which makes sense, otherwise how could it make its own assessment of how disabled the claimant is and how much to pay out in compensation? But it only makes sense if the insurer is not going to lose, damage or destroy the MRIs. Liberty lost and never found those MRIs. But the MRI technician at the MRI imaging trailer at Samaritan Pacific Communities Hopsital had retained copies in his system and was able to regenerate them for me. They are in evidence.

Why did Liberty lose them? And isn't it a rule of law that when a party loses or destroys evidence it is taken that the evidence supported the arguments of the other side?

As further evidence of the loss of the MRIs, I note a letter regarding my Neurosurgical History and Physical, by Dr. Hacker, dated Nov. 12, 1997. (EXHIBIT 26) "A review of outside films confirms degenerative changes, most pronounced at the C4-5 and C5-6 level. There is nothing to suggest an obvious deformity or subluxation. The patient has an MRI report that is several years old, documenting spondylotic change at C4-5 and C5-6. These studies apparently have been lost." Gentlemen, it wasn't me that lost them. And, as noted above, isn't there a rule in law that if evidence is lost or destroyed, one can infer that it hurt the party that lost or destroyed it?

3. Then there is the January 17, 2003 letter from my then-attorney Brian Welch (EXHIBIT 27) to attorney McAllister for LiBerty, "I would appreciate your kindness in locating those x-rays and forwarding them to Dr. Hacker…" To the best of my knowledge, Dr. Hacker never got the requested x-rays.

VI. LIBERTY BAD FAITH

There is so much mishandling of the medical evidence and related evidence, so many false assertions, so much skewered evidence that, in some instances individually, and together as a whole, they must indicate bad faith or worse> Because of the volume of this, I will (to make it easier for you to follow and me to present) break it down into groups of years.

The 1990s

1. A medical arbiter report by BBV (two doctors, Dr. Thad Stanford, orthopedic surgeon, and Dr. Berle Barth, a neurologist) (see previous exhibit 14) was made on July 9, 1990, somewhat more than a year after my First Injury. In it, the problems that would grow worse had begun to manifest, and so the medical report was a mixed one. It found a closed head injury, and "moderate cervical strain, upper cervical area…" The doctors wrote "we do not feel this man is able to pursue employment as a doorman/bouncer. … Estimate of resuming employment is difficult. We would guess three months. We would expect that this man will recover from these injuries and have no restrictions. His current problems are primarily due to his November 4, 1989 injury though he probably did not do it any good when he was injured again, in April of 1990. It does not appear that his condition is stationary at this point. We feel that the neurological base has to be touched."

One must here note three things. One is that the fight I had gotten into, still working as a bouncer (one has to make a living) was dismissed as merely not doing me any good. The second is that this altercation was on the job, at PipTide, where I was working because, besides needing an income, the doctors had told me I could, at that point, work there, if I did not get into a fight. I knew it was a risk - bouncers get in fights, and even if I tried to avoid them what could I do if someone started swinging at me? - but one I had no choice at the time but to take.

The third is that this was a complex, nuanced statement by the two doctors, contrary to how it was described later on by Liberty, which referred to a report of "Dr. Sanford" that said I was hunky-dory. This was that Dr. Sanford's report, as described here, and it suggested neurological issues and a non-medically stationary condition

and a delay in return to work, as well as (on the other hand) a longer-term expectation I could return to work, though - it is not clear, but implied - probably not as a bouncer.

Dr. Gilbert Lee concurred with the medical arbiter/BBV report, on 7/23/90. (EXHIBIT 28)

I received a Work Release by Dr. Bernstein on 9/24/90. It prescribed sedentary work and light work (lifting 20 lbs, carrying 10 lbs), not light/medium, nor medium nor heavy work. It stated the restrictions are permanent. (EXHIBIT 29)

Portland Magnetic Imaging Lab, Dr. John English, did an MRI Interpretation dated 11/28/90. If found "very small central disc herniation at the C4-5 level. A left paracentral disc herniation is considered to be present at the C5-6 level but is not well visualized. Developmentally narrow AP diameter of the spinal canal." (See previous Exhibit 16)

In a letter to Liberty dated 1/3/91, Dr. Bernstein predicted I will be medically stationary "within the next month or two." (EXHIBIT 30)

He sent me to Dr. Serbu for a neurological consult. Dr. Serbu (EXHIBIT 31) found me "neurologically negative. I do not believe he has a herniated disk. He does have a slight central bulge, but I do not believe that is symptomatic. I believe this man's best treatment would be to return back to heavy work which he did previously," he wrote on 1/7/91. Serbu, provided the basis for Liberty to pretend I was not injured. His findings and conclusions were insane, and contrary to the vast majority of the rest of the evidence, before and after I saw him - and contrary to the need for the surgeries, as those needs grew ever larger and more present over time.

Bernstein agreed in part, disagreed in part. He disagreed with my work capacities, stating I can do "lighter, sedentary physical work … less than 20 pounds on a regular basis" in his letter dated 1/17/91. (EXHIBIT 32)

Bernstein also sent me to (see previous exhibit 15) another set of outside experts, at Western Medical Consultants. Two weeks after Serbu's misdiagnosis, on 1/17/91, they found "Herniated intervertebral disc at C5-6 on the left." "Mr. Johnston is capable of modified, but not regular work." He is "not medically stationary" and probably won't be for four months. And this was from not one physician's review but two - Dr Thomas Gritzka, Orthopedist, and R. Glenn Snodgrass, neurologist.

In short, Liberty relied on one bad medical review, that was in greater or lesser part contradicted by several other physicians. At what point does defending the insurer's bank account become willful non-payment of compensation justly owed? Are we there yet?

There is the note (EXHIBIT 33) from an unidentified party that is undated, as it appears to be only one part of a larger document, but which refers to an incident which apparently occurred the next month . It could be from my then attorney at Bishop Strooband, or from a doctor, or from another person. Whoever it is from, it states

"On 2/11/91, Dr. Bernstein was apparently worn down by Liberty Northwest's harassment and responded to a phone call from the claims examiner by saying 'I believe that he is currently medically stationary,' but he continued that he also

believed that '(Edward Johnston) will need three times a week physical therapy for the next three months in order to maintain this.' This coerced and qualified statement does not even come close to a medically stationary finding, despite the use of the 'magic' words. On April 10, 1991, Dr. Bernstein referred Edward Johnston for 'evaluation and possible' entry into the Oregon Pain Center. Edward Johnston is obviously not medically stationary."

The "magic words" which Liberty harassed my doctor to try to elicit were, of course, 'medically stationary.' As cane be seen from the above, Liberty was not trying to determine or asses actual medical facts; it was trying to achieve a pre-set goal and justify a pre-determined conclusion.
On May 6, 1991, in a letter (EXHIBIT 34) to Liberty's Linda Hepp, Dr. William Bernstein noted I was "worsening" as a matter of his "objective findings," thereby reversing his unhappy donation of the tooth that Liberty had pulled from him three months earlier. But there was (and is) still no willingness from Liberty to accept the truth.

On 5/5/92, somehow - it is not clear how or why - the Appellate Unit Worksheet states that Dr Thad Stanford found no objective bases of impairment. (EXHIBIT 35) This Worksheet presented a one-sided representation of a complex and nuanced set of conclusions that Dr. Stanford (and Dr. Berle Barth) had made. My guess is this misrepresentation by the agency was a result of something Liberty submitte and/or argued, that I do not have, since the medical record and in fact the report from Dr. Stanford and Dr. Berle was very different from this assertion. But it nonetheless led to a May 7, 1992 ORDER ON RECONSIDERATION: Claimant requested reconsideration…. Partial disability is reduced to NONE." (EXHIBIT 36) On the basis of a misrepresentation about Dr. Stanford's report, I was demoted to zero disability.
Are we at fraud yet?

2. That malignant conclusion and finding was changed, in the OPINION AND ORDER dated August 26, 1992, (EXHIBIT 37) which assigned me a 15% disability for unscheduled neck and left shoulder permanent partial disability. It noted that the "award was reduced to zero by Order on Reconsideration dated May 7, 1992 on a finding of no impairment by Dr. Stanford the appointed medical arbiter. … Dr. Stanford should not have been appointed medical arbiter since he was previously involved with this case as an agent of a party" - i.e., as an insurance company consultant. By Referee D. W. Daughtry (underline added.)
Are we are at fraud yet?

3. Also, there is Dr. Cephus Allin's brief February 9, 1998 cover letter (EXHIBIT 38) to Liberty, which evidently went with a large volume of papers to Liberty. For that cover letter, Dr. Allin wrote only: "Ms. Jones, 384 pages. Go to hell." That was the point after which Dr. Allin refused to see me any more, because of the harassment he was suffering from the insurer.

4. On February 21, 1998, MY SURGEON Dr Hacker wrote (EXHIBIT 39), evidently in some frustration, to Liberty (page 2) that "The patient's present condition is due to a cervical disc herniation, as mentioned above. It is not related to a cervical strain. Cervical spondylosis and foraminal narrowing may indeed be superimposed

upon his condition." The evident frustration rings through clear enough; the doctor was getting tired of having Liberty press for an inappropriate or untrue diagnosis. The letter from Liberty it responds to is not in the record but is evidently dated 2/6/98. The Hacker letter makes it clear the Liberty letter must have been manipulative, misleading and unhelpful - at best, it would be called, I believe, "leading the witness." (Better: "misleading the witness.") Hacker replies by numbered paragraphs, presumably in response to numbered questions from Liberty. 1. "… my examination is different now in the sense that his MRI scan documents a large deformity with disc protrusion at the left C5-6 level with compression of the nerve root and spinal cord. Also, the patient has evidence of diminished biceps strength on his left side." 2. "Yes. Be so advised." 3. "Is this a question?" 4. To characterize the nature of this accident as 'neck strain,' in my opinion, is probably incorrect. On the other hand, I expect that cervical spine injury with the episode described has resulted in an osteophyte formation and disc hernia. ... my MRI findings, as well as Dr. Holmes' report are continued within your medical record file. … 6. The patient's present condition is due to a cervical disc herniation, as mentioned above. It is not related to a cervical strain. Cervical sponsylosis and foraminal narrowing may indeed be superimposed upon this condition."

Was this doctor being pressured by Liberty?

5. On 03/03/98, the doctor at McKenzie Willamette Hospital (RJH, that is, Dr. Hacker), in his "current complaint" (EXHIBIT 40) pre-surgery document, wrote (bottom page 1) "A review of the patient's MRI scan documents a large osteophytic deformity with disk protrusion at the left C5-6 level compressing the nerve root and spinal canal." As I understand it, however, OMAP, not Liberty, paid for my operation at C5-6. At what point does the obstinate refusal by an insurer to hear, see and accept the medical truth go from being obstinacy to bad faith - or fraud and criminal conspiracy to deny lawful benefits?

Are we there yet?

6. There is also a note by Dr. Hacker dated 7/27/98 (EXHIBIT 41), where Hacker wrote that, after talking with "an attorney" - "the fact that the patient found the onset of his symptoms with the injury described would point to the injury as being the major contributing cause of his disk herniation and need for surgical treatment." The logic should be obvious; so, too, should the reality that Dr. Hacker - like Dr. Bernstein, and Dr. Allin - was responding to absurd misdiagnoses by Liberty and to pressure from Liberty to adopt those misdiagnoses and give them cover of medical legitimacy.

2000 (no relevant papers), 2001, early/mid 2002,

1. On October 10, 2001, Richard Arbeene, an IME examined claimant. He ordered no diagnostic imaging, and had none available, he wrote. (EXHIBIT 42) (Why is not clear.) Nonetheless, he found work-related strain and predicted they would "resolve within a period of six to eight weeks." What he called "Diagnosis #1, the strain, was a result, he wrote, of the 7/28/01 injury, and he concluded that produced the "strains," and no more. Other doctors would disagree strongly with that. Diagnosis #2, he wrote, was a pre-existing condition, of which he wrote "We are dealing with subjective complaints in this type of care." This, of course, was insane. Whichever injury he was referring to - it is not clear - as "strains" - I ended up with operations for both. Nonetheless, he predicted, as noted above, that I'd be okay in 6 to 8 weeks. So much

for Dr. Arbene. Nonetheless, Liberty rested its opposition to doing its duty to me as an insured injured worker, on the basis of this nonsense - nonsense based on a medical examination of the spine done without benefit of prior or a new MRI or x-ray. Is this even competent?

There is a 11/26/01 Hacker document entitled: "Current Complaint" (EXHIBIT 43) that followed by Second Injury of July 28, 2001 and preceded my Second Surgery, for C4-5, by 4 months. It states "A review of his MRI scan confirms spinal cord compression and a disc herniation at the C4-5 level with previous cervical fusion at C5-6. Cervical myelopathy due to disc hernia, C4-5."

About two weeks later (12/7/2001), we have a faxed memo from Liberty apparently to Liberty ("To: Alice"). (EXHIBIT 44) "We only accepted an acute cervical and lumbar strain. These are not surgical conditions and therefore we are not authorizing the surgery for a cervical disc." This is dated 12/7/2001. So, when facts meet insurer opinion, insurer will not change opinion. What's wrong with this? In three months I would be operated on, and the basis and cause for that operation were already evident at the time of Liberty's internal memo. What is going on there?

On 2/27/02 Dr. Greg Bear did a MRI of my lumbar spine (note, not neck).Dr. Bear found (EXHIBIT 45): "There is mild disc space narrowing from L3-4 through L5-S1; these discs also demonstrate decreased signal intensity consistent with desiccation. There is somewhat prominent lumbosacral lordisis….. L3-4 mild broad-based posterior disc bulge, resulting in mild stenosis of the spinal canal. There is mild encroachment on both neural foramina, but no evident impingement upon the existing nerve roots. L4-5, there is a broad-based posterior disc bulge/osteocyte, resulting in minimal stenosis of the spinal canal. The disc bulge is slightly more pronounced posterolaterally to the right. There are mild hypertropic changes in the facets. These factors combine to result in encroachment upon the right neural foramen. There is mild partial effacement of the perineural fat planes associated with the existing portion of the right L4 nerve root."

In short, the damage from the two injuries was spreading, and was now very clearly present in my lumbar spine, as well as my neck. Meanwhile, on another planet, Liberty was still denying I had any problem, anywhere. Just "strain."

Are we at fraud and conspiracy yet?

2. On March 18, 2002, in a letter to Dr. Theuson (EXHIBIT 46), Liberty assumes facts not agreed to by the doctor or patient, writing, "It was later determined that Mr. Johnston had some disc problems, but that these were degenerative in nature and unrelated to his work injury." No such determination was ever made, of course, except by Liberty's hired guns. But having slipped this misrepresentation into the letter, Liberty then asked my doctor "Do you agree that his acute cervical/lumbar strain resolved and is medically stationary?" Here, there is, without the doctor answering in some detail, no way the doctor can fail to do what Liberty wants, since the key finding - that there was just a "strain" - is taken as a given, and the question the doctor is asked to answer assumes that there is strain present and nothing more. This is the professional equivalent of asking "have you stopped beating your wife yet?" You have to first expose and deny its premise. Any answer that does not deny the implicit claim of mere strain accepts that claim, on the way to the question actually asked by Liberty (i.e., is he medically stationary). Dr. Theuson did not buy into Liberty's game. In reply he wrote, by hand, "As of 10/23/01 MRI my Rx changed from strain to herniated dics C4-5 level & (unclear) due to this injury."

The next question Liberty had asked of him also is of the "have you stopped beating

your wife?" kind. It asked, "Do you agree that with regards to his accepted strain only he could do his regular work?" This again assumes that there is only a strain, because it is the only "accepted" condition (accepted, of course, by Liberty) - which assumption was false. And, by then, Liberty had good reason to know it was false. Dr. Theuson replied to this question, too, in handwriting, "He worked up until the time of his surgery & cannot work now until recovered." The doctor was being reasonable and sane (was Liberty?) and also a bit curt, evidence of his frustration with the games Liberty was subjecting him to. And Liberty's basis for doing all this was the IME report by a doctor who thought it proper to do a cervical/spinal exam without benefit of x-ray or MRI!

3. The next item comes under the heading of comic relief; or would, if it weren't so serious. (EXHIBIT 47) On 5/2/2002: Liberty wrote to me "we find that your work injury/activity is not the major cause of your C4-5 cervical disc herniation." They didn't say what was - perhaps breathing poor air, or perhaps the huge frustration of dealing with Liberty's dishonest, nonsensical, damaging legalistic lies. On the very same day, 5/2/2002, the state Occupational Safety and Health Administration issued a "Citation and Notification of Penalty" to Georgies. "The floor area between the dishwashing department and the grill work area, in the kitchen, becomes slick when water from the dishwashing department is tracked or spilled and grease from the grill area is tracked on to the wet floor." OSHA got it, and fined Georgies for allowing the continuation of a hazardous condition that had created my Second Injury. Liberty didn't get it - or pretended not to - and was still manning the fort of a hypothetical and minimal "strain."

On 5/28/02, referring to cervical disc hernia operation, Dr. Hacker referred me to Physical Therapy.

3. On 8/16/02, a Diagnostic Imaging Report, (EXHIBIT 48) from Samaritan Pacific Communities Hospital, regarding 4 views of my cervical spine, found "… generalized straightening of the cervical curvature … There (are) inferior plate screws inset at the inferior aspect of the C5-6 disk space, and the disk space appears to be ossified. There are moderate degenerative changes at C6-7. … The immediate prevertebral soft tissues are abnormally thickened at the C3 level."

On 9/23/02 in another report (EXHIBIT 49), Dr. Hacker found the patient "continues to have symptoms consistent with myelopathy, with electric shocks which will radiate into his arms and won into his legs. He tells me these symptoms do not seem to have changed much."

A report on a 10/09/2002 MRI of my cervical spine by Dr. Larry Wampler (EXHIBIT 50) found: "C3-4 level reveals mild disk bulging with no focal or discrete herniation and no significant canal or foraminal narrowing. C4-5 and C5-6 levels reveal interbody fusions. … No significant canal or foraminal stenosis identified. There appears to be a mild disc bulge at C6-7 with no significant canal or foraminal narrowing. Mild left foraminal narrowing is noted."

Late 2002, 2003 and 2004

1. The plot thickens a bit more with a 10/29/2002 letter to attorney Liberty McAllister, answering questions (EXHIBIT 51). The letter is written by Dr Paul Munier, who had done some x-rays of me. "There is some disc space narrowing at

C4-5 and early posterior osteophytic ridging at the same level. There is a small linear calcification anterior to the C4-5 disc level which appears to be ligamentous in origin. … this entire series of examinations are not appreciable changed. The MRI examinations likewise reveal stable findings at the C4-5 level. The findings on MRI correspond with the findings on plain film… There is vertebral body endplate spondylosis or hypertropic degenerative change. The intervertebral disc has a corresponding protrusion which is central to left paracentral. There is some compromise of the central canal and apparent displacement of the traversing cervical cord at this level. … the examinations are not appreciably or objectively changed between 12/12/97 and 10/23/2001." Meunier finds an extruded disc fragment, and explains that the difference between this and a disc herniation is "a semantic difference that really has no importance in this situation…" He believes the hernia pre-existed the slip and fall incident of 2001. He does not say why.

There are a number of points to note here. One is the numerous, widespread, cervical problems at C4-5, upon which I did not get - could not get - surgery till 3/5/02. Another is the disconnect between the flippant conclusion of no change and the identified problems:

- disc space narrowing at C4-5 and
- early posterior osteophytic ridging at the same level;
- small linear calcification anterior to the C4-5 disc level;
- vertebral body endplate spondylosis or hypertropic degenerative change
- the intervertebral disc has a corresponding protrusion which is central to left paracentral.;
- some compromise of the central canal and apparent displacement of the traversing cervical cord at this level;

This is, in fact, the picture of a badly deteriorating central cervical spine. If there is little deterioration from the exam cited of 10/23/2001, it is almost certainly false to say there is little deterioration from 12/12/97, before the Second Injury. So what was going on here? This doctor's conclusions seem to be (a) divorced from the historic facts, and (b) manage to ignore the central fact of conclusion evident in the data - that my neck was, by this time, suffering numerous and serious medical ailments, and that all of them are traceable to the two injuries.

He may have been saying what Liberty wanted to hear in the way of conclusions, but, at least he is not saying there is only "strain."

In a letter dated 2/11/2003, from Dr. Hacker to Liberty lawyer Jacqueline Jacobson, (EXHIBIT 52), Dr. Hackers disagreed with Munier. This must be quoted at some length:

"I have read your attached report authored by Dr. Munier dated 10/29/2002. I find myself in disagreement with Dr. Munier's report. Dr. Munier tells us that Mr. Johnston's MRI scans from 1997 and 2001 are essentially the same. This is not accurate and is not supported by my interpretation as well. Dr. Hall, the radiologist who read Mr. Johnston's 12/12/1997 MRI described the C4-5 level as follows: 'Smaller, midline left abnormality at C4-5, probably representing cervical spondylosis rather than disc herniation.' Dr. Wampler described the abnormality at the C4-5 level identified on the October 2001 scan as follows: 'Broad-based disc protrusion, C4-5, which is biased slightly to the left and compresses the cord along its ventral surface. The AP diameter of the canal if reduced approximately 7 mm at this level and the AP diameter of the disc protrusion is estimated to be approximately 4 mm.' In my chart

review, I described the patient's MRI scan as showing spinal cord compression and a disc herniation at the C4-5 level on 11/26/2001. This is in comparison to my description dated 12/22/1997 in which I said: 'The MRI scan is reviewed, documenting a large osteophytic deformity with perhaps associated disc protrusion at the left C5-6 level compressing the nerve root and spinal cord on the left side. At the C4-5 level, there is a small lesion which appears to be an asymptomatic cervical disc protrusion.' In any event, it appears that both radiologists and myself have a different opinion than Dr. Munier in regard to the significance of the disc herniation and the significance of the disc herniation and its size. I do not find myself able to agree with this characterization , as it appears quite incorrect, based on my own as well as the other two doctors' interpretation."

This whole episode with Dr. Munier would seem merely to be a case of poor diagnosis (and strain?) if not for the whole of the rest of the falsities and distortions employed by Liberty in this case. In that context, the Munier episode appears as more evidence suggesting that Liberty had somehow manipulated Dr. Munier (or manipulated the choice of this doctor).

Shortly thereafter, on 2/25/2003, my then attorney Welch wrote Liberty (EXHIBIT 53) requesting Liberty accept herniated disc C4-5 as directly caused by injury of Nov 4, 1989 or as having developed as consequence thereof. Liberty, of course, would soon say no. Did it ever meet an injury it thought compensable? When does incompetence or defending the company bank account become fraud and conspiracy? Are we there yet?

2. On 2/26/2003 I wrote to my then attorney Welch (EXHIBIT 54) saying the evidence shows C4-5 was herniated, as of the Nov. 4, 1989 injury and became compressed July 28, 2001 from that date injury. Welch replied on March 19, 2003 (EXHIBIT 55) that there are benefits available to me on "LIFETIME BASIS, including medical care and treatment related to the accepted condition." If this is legally so, why haven't I seen anything like it?
Are we there yet?

3. The reality of spreading, serious, medical deterioration is furthered by the 3/20/2003 MRI by Dr. Greg Bear of my cervical spine (as opposed to neck). (EXHIBIT 56) Its Findings include "Mild degenerative disk disease from L3-4 through L5-S1; Minor posterior disk bulges/osteophytes at L3-4 and L4-5; consequent compromise at the neural foramina at L4-5, more pronounced on the right. There may be impingement upon the existing portion of the right L4 nerve root." My problems were spreading further.

4. Things get weirder. After I had sought further review, Liberty, in a letter to the WCB's Own Motion Unit (dated 6/13/2003) (EXHIBIT 57) asserted "our position is that this motion" to accept C4-5 as a accepted condition "is actually a new, but unrelated condition, and therefore, continue to recommend denial of reopening for Own Motion benefits. By this time, C4-5 had gotten bad enough to require an operation, and all the relevant parties but Liberty understood this. Liberty was looking for a legalistic way to evade its obligations.

5. On 8/12/2003, Dr. Theuson, in his Workers and Physicians Report for W/C

Claims (EXHIBIT 58) indicated I "cannot lift greater than 20 pounds occasionally" and that I must "Limit standing or walking," In response to the question, "Has the injury/illness caused permanent impairment?" he answered "Yes."

2005

1. There is also implicit evidence of harassment in the record from Dr. Gary Theuson, where he wrote, on O3/04/05, upon and in response to a "Rush Please" note from Liberty's Theresa Tracy (EXHIBIT 59) - in evident frustration with Liberty's agent putting words in his mouth (or in his pen) - that he (Dr. Theuson) did not concur with the claim from Liberty that I was able to go back to work at Georgies effective January 1, 2003. In reply to the familiarly misleading question that followed - "If no, when" - the doctor handwrote a blunt answer: "I don't think he can return to any vigorous demand job with cervical myelopathy."

Here, the frustration is beneath the surface, but evident. Once again, Liberty is seeking to lead or mislead the physician, and once again, Liberty is assuming facts not agreed to by the physician (in this case, that I could go back to the kind of work that I had done, and that paid me best, the "vigorous" physical work of being a bouncer or - as I read it - being a short-order cook, either.)

2. On 10/05/05, in another, similar transmittal, (EXHIBIT 60) Liberty's Theresa Tracey requested that Dr. Theuson concur with Liberty's claim that I was medically stationary on 12-16-02. In response, Theuson wrote by hand (excluding the unclear/unreadable handwriting), "12/02 was 'guesstimate' … 7/1/03 IME eval 4/22/05 & my agreement he was medically stationary was dated May 5, 2005."

Evidently, the game is still on: we have both Dr. Theuson and the IME giving quite uncertain medically stationary predictions, which Liberty then sought to treat as certainties - even (since Liberty still continued to contest this) after the doctor involved had changed his guesstimate. Further, if I was not medically stationary till May 2005, where are my time loss payments for 2002, 2003, 2004 and the first half of 2005 - and my medication costs for all that time?

Dr. Theuson now does not want to see me because he does not want to be harassed by Liberty.

Further, in a hearing, Liberty stated it did not want evidence of its harassment brought into evidence, and I demanded that it be brought in as showing what the insurance company has done to me all along. I wonder why Liberty did not want evidence of harassment of my doctors to become evidence?

3. On 2/4/05 Liberty finally, in a STIPULATION, accepted the C4-5 herniation as an accepted condition. (EXHIBIT 61) This was nearly three years after the surgery at that site. The taxpayers paid for it, I guess, because I didn't and Liberty didn't. I do not know what benefit, if any, I got from this belated recognition of reality by Liberty. I certainly have not seen any.

4. I had two MRIs done on 3/30/2005 by Dr. Bear, one on my cervical region, one on lumbar. The Diagnostic Imaging Rpt, signed 4/06/05 by Dr. Bear, reported the cervical spine (EXHIBIT 62) MRI found: "Multi-level fusion; Posterior disk bulges/osteophytes at most cervical levels" (C3-4, C4-5, C5-6, C6-7) more pronounced to left of midline. There is resultant mild to moderate stenosis… There is also encroachment on numerous neural foramina, most severe on the left at C6-7.

Correlate with clinical evidence of compression of the left C7 nerve root. There may also be impingement of the left C4 through C6 nerve roots."

The Diagnostic Imaging Rpt, on the lumbar spine MRI (EXHIBIT 63), reported: T12-L1, mild posterior disk bulge/osteophyte, with mild spinal stenosis. L3-4, mild broad-based posterior disk bulge/osteophyte with mild spinal stenosis. Nerve root exists freely. L3 nerve exists without impingement. L4-5 mild posterior disk bulge/osteophyte. No significant compromise at the spinal canal. There is mild encroachment on the neural foramina, without definite root impingement. L5-S1, degenerative changes in the facet joints.

In short, I was getting even worse - and in my back as well as cervical spine.

5. There followed a letter to Ms. Tracy at Liberty from Dr. Theuson. (EXHIBIT 64) He had found 41% impairment. Estimated 60% of the problem is from my second injury (i.e., C4-5, which is formally at issue in this hearing) and the rest degenerative or from my prior (first) injury. (This is undated, but states it was written after seeing me March 18 and 31st and from its content I believe is from 2005.)

I cannot conceive how Liberty can escape obligation on this. This letter addressed C4-5, my second injury (formally at issue this hearing); but the other cause of my disability was the prior (first) injury, at C5-6 (which I want also addressed by the WC Board, too). As I noted in the part of this brief regarding Ogawa's mistakes, quoting from the Nov. 15, 2005 letter by Liberty's hired lapdoctor, Dr. Throop. (page 4): "The degenerative disease is unrelated to the C4-5 disk herniation condition." If degenerative disease is unrelated, it must have come from one or the other or both injuries.

Continuing with what Dr. Theuson wrote: "The worker is not able to do the work he used to do prior to his injury. He is capable of reduced work hours with different work duties. He is able to lift 5 lbs continuously, 10 lbs occasionally, 25 lbs rarely. It also limits me against work that "requires stooping, bending, crouching, crawling, kneeling, climbing, balancing. He has significant limitations in twisting, reaching, pushing, pulling as well."

You'd think this was enough, but the game was by no means done yet. Could it be they were just hoping to play this through till I was dead and gone?

Next followed a visit to Star Medical, and an exam by Paul Williams, MD, on 4/22/05. (EXHIBIT 65) He found me medically stationary for the accepted condition. "There is no permanent impairment associated with a cervical or lumbar strain due to range of motion." Interesting - at this very late date we were back to the nonsense about "strain" again. "The ranges of motion of the cervical and lumbar spine are not a direct consequence of Mr. Johnson's cervical and lumbar strain as a result of his work activities of 07/28/01," he wrote. And, he added, I "May lift occasionally 50 pounds frequently, more or less weight" - directly contradicting Dr. Theuson (who knows my situation far better) as to the activities limitation list of his March 18 and 31 exams. "The C4-5 disc herniation has been accepted as it relates to the work related event of 07/28/01, and apparently was 100% caused by the work activity of 07/28/01. There is impairment associated with the C4-5 disc herniation." It took him long enough to get to part of the basic reality. And, he added, if it were not obvious, "Mr. Johnston will likely experience intermittent and transient increase in neck pain." Still, I could do any work that requires sitting, standing or walking, working the same amount of hours as he did before the injury, stooping, bending, crouching, crawling, kneeling, climbing, balancing. Reaching, pushing or pulling, as it related to his work related event of 07/28/01. Although this exam noted my two surgeries, it sounded like they

never happened and were never needed.

On 5/2/05, Teresa Tracy at Liberty faxed a “Please Rush” letter to Dr. Theuson. It was another of those mean-spirited “Do you concur?” letters, noted that “Enclosed is report from Star Medical exam.” The doctor checked the “I do not concur” box. (EXHIBIT 66)

On 5/5/05, Theuson wrote back to Liberty (EXHIBIT 67). “Yes, I would consider his acute lumbar/cervical strain with C4-5 cervical disc herniation medically stationary as does your IME” - reinforcing on Liberty the fact that there is disc herniation. Dr. Theuson found my Ranges of Motion “not considered normal,” and indicating “a whole person impairment of 41%,” and agreed with the IME this is not normal and “at least in his neck is obviously due to his injury and subsequent surgery. This should be attributed to the herniated disc which is what the final diagnosis was concerning his injury rather than the original diagnosis of cervical strain only. … I would estimate that 60% + of his problem is from the injury and the rest is degenerative or pre-existing from prior injury. Your IME felt the herniated disc was 100% caused by his more recent work injury so this leads to 60%+ that this injury is the main cause of his current condition.” Theuson though I was likely to improve over time. But that was, presumably, on the basis of my not trying to do heavy exertions beyond the limits he had set.

As to the other doctor’s happy conclusions about how long I can walk and stand up and how much weight I can carry, Theuson wrote: “Objectively it would seem he is more capable than this but if his fatigability is accurate then he should not be expected to work in any task that requires stooping, bending, crouching, crawling, kneeling, climbing, balancing. He has significant limitations in twisting, reaching, pushing, pulling as well.”

Note that all debate this did not include any impact from the spreading other medical issues, as the problems have spread to virtually all of my neck and back vertebrae, as the discussion remained restricted to what were, finally, the two accepted conditions.

6. I received Liberty’s Notice of Closure dated 6/15/05 ((EXHIBIT 68) and a whole pile of related documents; why there are so many is not clear to me, but it certainly does serve to obscure, rath3er than clarify, what they finally accepted. The Notice of Closure asserted I became medically stationary 12/16/02 and my aggravating rights end 7/28/06. It gave me 46% disability, dollar value $34,027. How calculated - that sum is about half a year’s worth of my previous employment as a bouncer, about one year as a cook, a fraction of a year’s as a security consultant! - is not stated, but it is obviously inadequate and absurd. Also dated June 15, 2005 is an “Updated Notice of Acceptance at Closure, (EXHIBIT 69). One would think that was the end of the shell game of hiding which injury they were accepting. But no.

Speaking of aggravation: Liberty sent me a Rescinding Notice of Closure, dated 6/21/05, (EXHIBIT 70) replacing the prior Notice of Closure, and cutting the percentage of disability (God knows how they come up with this stuff; there was a “worksheet for the earlier closure but it was clear as mud) to a slightly smaller 42%, with a dollar amount of disability valued at $28,619.77. There were technical mistakes in Liberty’s paperwork, and the WC office told Liberty to do it all over again, which they did.

Then came another, somewhat modified, Notice - an Insurer Notice of Closure Summary, dated 7/25/05 (Exhibit 71): Total medical costs asserted paid $25,312.92 time loss paid $9,847. (Down, if the comparison is right, from a disability value of $28,619.) Again, the numbers on time loss were absurd, and the explanation of how

arrived at weak. And they were, after having reached one conclusion, reducing it, in a hidden process not explained afterwards. Sort of like the old Soviet system.

7. On July 25, 2005, in the same document noted above (EXHIBIT 71) to make things worse, in its Insurer Notice of Closure Summary, Liberty identified me as a "Return to work type" that could not return to "job at injury" nor to "job at aggravation" and indeed, checked the box "No Job." This, despite its consistent earlier assertions that I could go back to work, could do anything I could ever have done, and could do them in various capacities and in ways that my own doctor consistently said were unsafe to me. All of a sudden, now I can't do anything. Which is perhaps closer to the truth, but still not the truth. I am not yet in a wheelchair or bed-ridden. Not yet. With the claim I can take "No Job," Liberty has made me, for all practical purposes, unemployable and uninsurable (and, as uninsurable, doubly unemployable) - even while still refusing to cover the great majority of my medical ailments, needs and costs. This game of trapping the victim/claimant is vicious, deceitful and complex - and should not go unpunished.

8. There was more to come: I received a Notice of Postponement of Reconsideration, dated 10/14/05. (EXHIBIT 72) The WC office was sending it to a medical arbiter for review. With it was a list of six doctors to choose from. Shortly thereafter, there was a choice, by Liberty, of one Dr. Throop, and a No Conflict of Interest letter signed by Dr Throop and dated 10/24/05. "This examination is only for the newly accepted condition of C4-5 disc herniation." Three years after I had had an operation for this condition, Liberty and the WC Division wanted a medical exam to see if I had a problem at C4-5. Is this even sane? Why are taxpayers paying for this nonsense, while injured workers are going wanting?

Dr. Throop's medical exam report, dated 11/15/05, was four pages long. (See EXHIBIT 9 above) "There is no evidence of peripheral nerve or nerve root malfunction," he wrote, contrary, to virtually everything that had gone before. Also, "there is no limitation to repetitive use of the cervical spine." And, he wrote, "The only abnormal finding is a decreased range of motion and this is due to his severe diffuse degenerative disease of the cervical spine at a 94% level. The degenerative disease is unrelated to the C4-5 disk herniation. … The worker had surgery at one of these levels for this condition and 50% of the problem at this level (C4-5) was due to degenerative disease, hence the calculated percentage." He said I can "Occasionally carry 50 pounds, frequently 35, constantly 25…" and "sit, stand, and walk eight hours. There is no preclusion from any of the activities listed. But Throop's work included a brief, one page cervical range of motion study, and addressed only C4-5. That was not his fault; an administrative rule or ORS (see page 1 of his statement) restricted him to it, even though my neck vertebra are connected (albeit with a metal plate in a couple places). I shortly after that wrote, "If one ignores or discounts the most severe of my several medical problems and ignores the great majority of them, one can achieve almost any desired conclusion." And that is what Throop did.

Throop's bizarre report led to an ORDER ON RECONSIDERATION, by ALJ Ogawa, on 11/28/05, in reviewing the "newly accepted condition of C4-5 herniation" (by then several years old, in fact, but newly accepted!). She would, Ogawa wrote, use the Throop report, because she found it "thorough and persuasive." With that, she cut the payment to me to $5,875 and my disability to a mere 12 percent disability, down from 42%. (itself down from 46%). As I argued in papers to the WC Board and ALJ Ogawa (EXHIBIT 73), the report was absurd on the face of it, based on the brief and

inadequate medical exam by Throop.

I see only two ways to view the above sorry, deceitful, dishonest and manipulative history by Liberty. One is to conclude that Liberty's behavior, for whatever reason, singled me out and treated me in an illegal, improper and highly unusual manner. The other is to conclude that Liberty did not single me out and treated me in an illegal, improper but not particularly unusual manner. In either instance, punitive damages are warranted. But in the first interpretation, they do not indicate systemic failure. In the second interpretation, they do.

Please remember that the above is only a portion of the legalistic games and deceit and falsification that I have had to respond to.

A summary in spreadsheet form follows. It may help to make visible the extraordinary behavior by Liberty in this matter.

That, too, does not reference the exam notes from every E/R visit and nothing from the P/T visits I have had, nor all the various legal back-and-forth that I have had to pursue. The record on the case at WC Board should do that.

Meanwhile, physically, the reality is my neck and back are falling apart, I am in constant pain for which I can only sometimes afford pain medicine, and Liberty has continued to play legalistic, and dishonest, games with me. My doctors have sought to repulse the worst of the misbehavior and falsification by Liberty, but they are doctors, not lawyers versed in playing legal games. My physical deterioration has been more or less continuous since - and not present before - the First Injury, and has become more rapid since the Second Injury. I am dying and count my remaining time in years (or months) not decades, though Liberty continues to pretend I am fine. How much of this am I supposed to take? If you had lived through the above, what would you do? And what would you demand of Liberty and of the WC Board?

This pattern of misbehavior, evidence disappearance, harassment of physicians, employment of biased examiners, and the ongoing massively frustrating denial of what is patently obvious, should be the basis not only for a re-opening of the issues before the ALJ and an award in my favor on them, but a reopening of the C5-6 issues, too, and an

award in my favor thereon - and a recognition of the expanding medical problems I face arising from the two injuries - and, most importantly, for punitive damages for the foul play by Liberty, as well. And of measures to ensure that once the WC Board has rendered a decision, Liberty cannot play yet further games to avoid paying out whatever compensation is determined right in the hope that I will die and cease being a problem before Liberty has to actually make good my compensation. Therefore, please require, on penalty of contempt of court (or failing that, your promise to testify in state or federal court as need be to the reasons for your decision awarding compensation) so as to ensure that there is not a new Part Two to all this, in which I have won the case but lose the war due to dying before Liberty - a creature that lives in perpetuity - pays up.

Thank you.

Submitted by Edward M. Johnston, Claimant, for himself.
I swear that the above is true and correct to the best of my knowledge.