Appeal Before the Workers Comp Board Part 2

APPEAL BEFORE THE WORKERS COMP BOARD part 2

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.