[Cite as *State ex rel. Clark v. Indus. Comm.*, 2012-Ohio-937.]

THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Joseph M. Clark,	:	
Relator,	:	
v.	:	No. 11AP-47
Industrial Commission of Ohio and Marketing Services by Vectra,	:	(REGULAR CALENDAR)
Respondents.	:	

D E C I S I O N

Rendered on March 8, 2012

Charles Zamora Co., L.P.A., and *Karen D. Turano,* for relator.

Michael DeWine, Attorney General, and *Derrick L. Knapp*, for respondent Industrial Commission of Ohio.

IN MANDAMUS
ON OBJECTIONS TO THE MAGISTRATE'S DECISION

BROWN, P.J.

{¶ 1} Relator, Joseph M. Clark, has filed an original action requesting that this court issue a writ of mandamus ordering respondent, Industrial Commission of Ohio ("commission"), to vacate its order denying R.C. 4123.57(B) scheduled loss compensation for the alleged total loss of use of his left hand, and to enter an order granting the compensation.

{¶ 2} Pursuant to Civ.R. 53(C) and Loc.R. 12(M) of the Tenth District Court of Appeals, this matter was referred to a magistrate who issued the appended decision,

including findings of fact and conclusions of law, recommending that this court deny relator's request for a writ of mandamus. Relator has filed objections to the magistrate's decision.

{¶ 3} In his first objection, relator argues that the magistrate erred when he found Dr. Douglas Gula's August 10, 2010 addendum report constituted some evidence upon which the commission could rely because the addendum was equivocal and reversed Dr. Gula's prior May 18, 2010 opinion. Relator also asserts that Dr. Gula failed to explain why the physical findings in his first report that supported ankylosis of the left hand and loss of use of the left hand were no longer valid. Relator further contends that the evidence relied upon by Dr. Gula – the surveillance videos from April 17, April 22, and May 31, 2008, and the June 23, 2008 report of Dr. James Popp – does not reflect an accurate picture of the current status of relator's hand; rather, the current status of relator's hand is found in the more recent May 18, 2010 report of Dr. Gula.

{¶ 4} The magistrate found that the equivocation principle does not bar a physician from changing his or her opinion when the change results from evidence that the physician did not previously consider. It is true that equivocal medical opinions are not evidence. *State ex rel. Eberhardt v. Flxible Corp.*, 70 Ohio St.3d 649, 657 (1994). Equivocation occurs when a doctor repudiates an earlier opinion, renders contradictory or uncertain opinions, or fails to clarify an ambiguous statement. *Id*. In the present case, Dr. Gula's ultimate opinions in the two reports differ. However, as the Supreme Court of Ohio has noted, "a medical professional is not precluded from reevaluating his or her opinion in light of new evidence." *State ex rel. L.P. Cavett Co. v. Indus. Comm.*, 118 Ohio St.3d 157, 2008-Ohio-1430, ¶ 16. This court has held similarly that a medical expert's contradictory opinions are not equivocal when he or she explains the reason and rationale for the change of opinion. *See State ex rel. Certified Oil Corp. v. Mabe*, 10th Dist. No. 06AP-835, 2007-Ohio-3877, ¶ 10 - 11.

{¶ 5} Here, Dr. Gula changed his prior medical opinion based upon new evidence presented to him; namely, the 2008 surveillance videos and the report of Dr. Popp. Dr. Gula specifically outlined his reasons for his change of opinion in his August 10, 2010 addendum report. Dr. Gula stated that the videos revealed the absence of any specific limitations as related to relator's function of his left arm. Dr. Gula noted that it was apparent on the videos that the injured part of relator's arm is capable of performing most

commonly performed tasks. This explanation sufficiently provided Dr. Gula's reason and rationale for the change of opinion.

{¶ 6} Relator also complains that Dr. Gula did not explain why the physical findings in his May 2010 report no longer resulted in a total loss of use of the left hand. However, we do not believe such an explanation was necessary. Dr. Gula's May 2010 physical findings are not necessarily contradicted by his August 2010 opinion. Relator may still suffer from many of those same physical indications but still have no resulting total loss of use of the left hand, as demonstrated by the surveillance videos. None of Dr. Gula's physical findings necessarily precluded the possibility that relator could actually still use his left hand, which Dr. Gula apparently believed to be the case, given his opinion in his August 2010 addendum.

{¶ 7} Relator also briefly contends that the evidence relied upon by Dr. Gula was previously on file and available. The magistrate found that these facts did not preclude Dr. Gula's reliance upon Dr. Popp's report and the surveillance video. Relator fails to explain how the magistrate erred in rejecting this contention and cites no authority in support, and we agree with the magistrate's determination. Therefore, we find this argument unpersuasive.

{¶ 8} Although relator also argues under this objection that Dr. Gula could not rely upon Dr. Popp's report and the surveillance videos because they were over two years old, we will discuss this issue in addressing relator's second objection. For these reasons, relator's first objection is overruled.

{¶ 9} Relator argues in his second objection that the magistrate erred when he concluded that the surveillance videos constituted some evidence upon which the commission could rely because the surveillance videos were over two years old and did not accurately reflect the current state of his condition. Relator contends that his condition has worsened in the two years since the videos were taken, as evidenced by Dr. Gallanosa's February 12, 2009 treatment note, and the magistrate improperly rejected Dr. Gallanosa's report on the basis that the commission did not rely upon the report.

{¶ 10} On this issue, the magistrate found the videos were not stale, relying upon the following three cases: *State ex rel. Menold v. Maplecrest Nursing Home*, 76 Ohio St.3d 197 (1996); *State ex rel. Hiles v. Netcare Corp.*, 76 Ohio St.3d 404 (1996); and *State ex rel. Conrad v. Indus. Comm.*, 88 Ohio St.3d 413 (2000). Relator uses these same three

cases to support his argument. In this regard, relator cites *Menold* for the proposition that the probative value of a medical report may be lessened by later changes in the claimant's condition, and the longer the time between the report and the disability alleged, the more likely this is to have occurred. Relator cites *Hiles* for the proposition that the changeable nature of a claimant's ability to work is often affected by time. Relator cites *Conrad* for the proposition that a report that is completed just one month prior to an exacerbation may not be probative of the need for surgery following the exacerbation. Relying upon these authorities, relator contends the video evidence was stale because his condition worsened since the videos were taken in 2008, as evidenced by Dr. Gallanosa's February 2009 treatment note.

{¶ 11} What relator's argument comes down to is whether the commission erred when it failed to find Dr. Gallanosa's February 2009 treatment note was more probative of relator's current condition than Dr. Gula's August 2010 report that relied upon Dr. Popp's report and the 2008 surveillance videos. This is a weight-of-the-evidence argument. In determining a claimant's eligibility for workers' compensation benefits, the commission, not a reviewing court, is exclusively responsible for assessing the weight and credibility of evidence. *State ex rel. Burley v. Coil Packing, Inc.*, 31 Ohio St.3d 18 (1987). That the commission did not rely upon Dr. Gallanosa's note is indicative of an ultimate finding that either it believed the 2008 surveillance videos and Dr. Popp's report were more persuasive than Dr. Gallanosa's note, or that the findings in Dr. Gallanosa's note did not negate the conclusions in Dr. Gula's report. Either way, the commission is only required to cite evidence in support of its decision, and the presence of contrary evidence is immaterial. *Burley*; *State ex rel. West v. Indus. Comm.*, 74 Ohio St.3d 354 (1996). As applied to this case, although Dr. Gallanosa's note may have supported a contrary conclusion, the commission decided to rely upon Dr. Gula's report, which provided some evidence to deny relator's claim. The same rationale holds true regarding the other medical evidence cited by relator that he claims shows a worsening of his condition since the videos were created. Therefore, relator's second objection is overruled.

{¶ 12} After an examination of the magistrate's decision, an independent review of the record pursuant to Civ.R. 53, and due consideration of relator's objections, we overrule the objections. Accordingly, we adopt the magistrate's decision as our own with

regard to the findings of fact and conclusions of law, and we deny relator's request for a writ of mandamus.

Objections overruled; writ of mandamus denied.

KLATT and FRENCH, JJ., concur.

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APPENDIX

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

State of Ohio ex rel. Joseph M. Clark,	:	
Relator,	:	
v.	:	No. 11AP-47
Industrial Commission of Ohio and Marketing Services by Vectra,	:	(REGULAR CALENDAR)
Respondents.	:	

M A G I S T R A T E ' S D E C I S I O N

Rendered on November 21, 2011

Charles Zamora Co., L.P.A., *Charles Zamora*, and *Karen D. Turano*, for relator.

Michael DeWine, Attorney General, and *Derrick Knapp*, for respondent Industrial Commission of Ohio.

IN MANDAMUS

{¶ 13} In this original action, relator, Joseph M. Clark, requests a writ of mandamus ordering respondent Industrial Commission of Ohio ("commission") to vacate its order denying his March 12, 2010 motion for R.C. 4123.57(B) scheduled loss compensation for the alleged total loss of use of his left hand, and to enter an order granting the compensation.

Findings of Fact:

{¶ 14} 1. On February 4, 2004, relator injured his left hand while employed with respondent Marketing Services by Vectra ("Vectra"), a state-fund employer. The industrial claim (No. 04-313211) is allowed for "contusion left hand; left hand reflex sympathetic dystrophy."

{¶ 15} 2. On February 3, 2008, relator's primary care physician, Melissa A. Payne, M.D., conducted a functional capacities evaluation. She then completed a form on which she wrote: "[Left] arm is not functional."

{¶ 16} 3. On April 7, 2008, attending physician Arvin J.K. Gallanosa, M.D., wrote:

> * * * While Mr. Clark does have some range of motion of the left hand and wrist, he does not really have any functional use of the left upper limb due to his pain from his allowed condition of [reflex sympathetic dystrophy]. Therefore, it is my medical opinion that Mr. Clark does suffer from loss of use of the left hand. He is not able to use his left hand for any type of activity of daily living. He notes that he must dress himself using his right hand. He is not able to tie a tie or even to button a shirt or button or unbutton his pants using his left hand. All of these activities need to be done one-handed using only his right hand.

{¶ 17} 4. On April 14, 2008, relator moved for R.C. 4123.57(B) scheduled loss compensation for the alleged loss of use of his left hand. In support, relator submitted the April 7, 2008 report of Dr. Gallanosa and the February 3, 2008 report of Dr. Payne.

{¶ 18} 5. On May 21, 2008, at the request of the Ohio Bureau of Workers' Compensation ("bureau"), relator was examined by Ralph J. Kovach, M.D. In his three-page narrative report, Dr. Kovach wrote:

> It is my opinion that allowed conditions have resulted in total and permanent loss of use of the left upper extremity to such a degree that the effected body part mainly his left hand is useless for all practical purposes. [Relator] cannot do any significant carrying, gripping, and fine manipulation is not possible.
>
> * * *
>
> [Relator's] grip is extremely weak. He cannot fully flex all of the fingers of the hand to make a fist. He does have good extension but his flexion is significantly limited and his pinch is minimal. There is significant hyperesthesia which prevents full contact on a constant basis with his hand.

> [Relator] has no contractures. There is a moderate amount of edema present in the fingers and hand.

{¶ 19} 6. Apparently, Vectra conducted video surveillance of relator's activities on April 17, April 22, and May 31, 2008.

{¶ 20} 7. On June 23, 2008, at Vectra's request, relator was examined by orthopedic surgeon James E. Popp, M.D. In his five-page narrative report, Dr. Popp states:

> **VIDEO**: Video reviewed from April 17, 2008 showed Mr. Clark obviously using his left hand on the steering wheel to rotate the steering wheel and driving in reverse, and also using his left hand to open and close the car door. This was a total of about 4 minutes of video tape. A second video tape from April 22, 2008 consisted of 22 minutes of video, and it appeared to be the same gentleman wearing a baseball cap this time with a cervical collar in place. He appeared to be at some sort of baseball field. He appears to cross and uncross his arms on several different occasions and, at one point, he also appears to be grabbing something and [sic] is hanging in the back of his shorts with his left hand reaching and grasping it and releasing it without any difficulty. He is also seen with his elbow in an extended and flexed position. At one point at 5:23, he is seen adjusting the bill of his cap with his left hand. At 5:41 of the tape he is also seen walking towards the baseball field and trips over something and reaches instinctively out with his left hand and grabs the fence, and is also seen to be resting his left hand on the fence above his head utilizing all of his fingers. The last video tape is from May 31, 2008, and he seemed to be using he left hand to hold onto the fence, as well as he crossed and uncrossed his arms, and again he does tip the bill of his cap with his left hand. He also appears at one point in the video to be clapping using both hands. He is also visualized clapping his hands, and throwing a ball back and fourth between his right and left hand, and again adjusting his cap. He is also seen zipping a zipper utilizing the zipper in his left hand in a duffel type of bag. In total, I reviewed 78 minutes of video tape of Mr. Joseph Clark from three different dates.
>
> * * *
>
> **ASSESSMENT/PLAN**: The questions asked for me of Mr. Clark are to give my medical opinion about a contusion of the left hand. In my professional opinion, I think that Mr.

> Clark probably suffered a contusion to the left hand. The claim is also allowed for a reflex sympathetic dystrophy of the upper limb. In my professional opinion, I do not think that Mr. Clark has any objective findings of a reflex sympathetic dystrophy or chronic regional pain syndrome of the left upper extremity. Based upon the objective criteria of chronic regional pain syndrome, he does not appear to have any chronic findings of skin or any trophic [sic] criteria of his upper extremity. The only thing I could find objectively on him was he had some questionable loss of hair comparing left to right upper extremity; however, the hair pattern loss on the hand was not [like] any hair pattern loss that I have ever seen nor visualized a person with a chronic regional pain syndrome. He did not have any shiny tropic skin, he did not appear to have any edema of the left hand. The hair pattern loss was one where there was short stubby hair follicles of 2 to 3 millimeters in length on the hand and fingers only, and there is some questionable loss of the forearm comparing left to right; he did not have any muscle atrophy in the left upper extremity. He did not have any nail criteria and did not have any loss of circumference of the fingers nor of the forearm. There is some criteria such as cool skin temperature, edema or mottled skin color for which I was unable to visualize any of the above or feel any of the above.
>
> He also has a bone scan finding back in 2004 that was completely normal. He also has an EMG that was pertinently normal.
>
> Therefore, in my opinion, the diagnosis of chronic regional pain syndrome of the left upper extremity based upon objective findings does not meet an adequate criteria, which is currently allowed is not based upon adequate objective criteria [sic]. Also, based upon the video evidence, Mr. Clark can perform activities and function significantly different that [sic] he subjectively stated.
>
> Therefore, in answer to your questions, I think that he probably early on suffered some partial loss of his left upper extremity. He does not meet any objective criteria of reflex sympathetic dystrophy or chronic regional pain syndrome of the left upper extremity, and has even failed the stellate ganglion blocks and insertion of a spinal cord stimulator. Therefore, I do not think he suffers any permanent damage to the left upper extremity or loss from the left upper extremity. * * *

> I also believe that Mr. Clark has also reached the maximum medical improvement. I think that he is also able to return to his previous position of employment in the mail department. I also believe that he can return to his previous employment without any restrictions given temporary or permanent based upon the objective criteria and the video evidence submitted to me for my evaluation.

{¶ 21} 8. Relator's April 14, 2008 motion for R.C. 4123.57(B) scheduled loss compensation was scheduled to be heard by a district hearing officer ("DHO") on August 6, 2008. However, prior to the hearing, relator withdrew his motion. The DHO issued an order noting the withdrawal and dismissing the motion on that basis.

{¶ 22} 9. On February 25, 2010, Dr. Gallanosa wrote:

> * * * Mr. Clark has been suffering from left upper limb [reflex sympathetic dystrophy] for a number of years. Due to his [reflex sympathetic dystrophy] he is unable to use his left upper limb at all. Therefore, in my medical opinion, Mr. Clark has complete functional loss of his left hand. He is not able to use his left hand in any functional way due to his BWC allowed condition of [reflex sympathetic dystrophy]. I am in agreement with the BWC examination done by Dr. Ralph Kovach from 05/21/08 where he states "it is my opinion that allowed conditions have resulted in total and permanent loss of use of the left upper extremity to such degree that the affected body part (mainly his left hand) is useless for all practical purposes."

{¶ 23} 10. On March 12, 2010, relator again moved for R.C. 4123.57(B) scheduled loss compensation for the alleged loss of use of his left hand. In support, relator submitted the February 25, 2010 report of Dr. Gallanosa. Also, relator cited to the May 21, 2008 report of Dr. Kovach, the February 3, 2008 report of Dr. Payne, and the April 7, 2008 report of Dr. Gallanosa.

{¶ 24} 11. On May 18, 2010, at the bureau's request, relator was examined by Douglas C. Gula, D.O. In his five-page narrative report, Dr. Gula states:

> **History of Present Illness:** Mr. Joseph Clark is a 42-year-old male who was evaluated in the office for an Independent Medical Examination on May 18, 2010, because of injuries sustained to the left hand. Mr. Clark does state that, on February 4, 2004, he was working for the Marketing Services by Vectra as a machine operator. He does state he was

pushing a machine into a machine when he hit a bar. He does state he yanked his hand before it got smashed between the machines and struck the dorsum of his hand. He noted significant pain about the hand and, for that reason, was seen in the emergency department at Mount Carmel Hospital. X-rays were obtained, which demonstrated no evidence of fracture, and it was felt that he did indeed have a contusion as related to the left hand. Thereafter, he developed more parethesias with decreasing range of motion over the course of time.

Approximately one month later, Mr. Clark was seen by Melissa Payne, M.D., who felt that a conservative course of treatment was most appropriate. An injection of cortico-steroid as related to the left wrist was accomplished, from which he did not see any significant improvement.

Thereafter, Mr. Clark was subsequently seen by Arvin J. Gallanosa, M.D., a pain management physiatrist who felt that physical therapy and acupuncture were most appropriate. Unfortunately, these treatments did not afford Mr. Clark significant improvement. He was subsequently seen by Dr. Rock, a pain management specialist who felt that injections were most appropriate. The stellate ganglion nerve block was next performed. Mr. Clark does state the injections were of minimal benefit to him. Dr. Deshpande, a pain management specialist, felt that more nerve blocks were most appropriate. The nerve blocks were performed, but unfortunately were unsuccessful.

Mr. Clark, in 2009, did undergo a spinal cord stimulation trial and, subsequently because of success, permanent implantation of the spinal cord stimulation unit. He did have issues with regard to the lead placement and, in April of 2009, they were changed. The spinal cord stimulation device does take the edge off of the shooting pains.

Mr. Clark does continue to follow with Dr. Payne at the office on a monthly basis. It has been stated by another physician that there are other treatment options for Mr. Clark.

Current Symptoms: Mr. Clark does state to a burning pain, shooting in nature as related to the left upper extremity. His pain is a 5-7-8 on a scale of 1 to 10. Any type of pressure as related to the left upper extremity does cause increased pain. He does admit to weakness and swelling as related to the left upper extremity. He also does admit to

pins and needles as related to the upper extremity. He has attempted to return to work but has been unable to do so.

He does admit to difficulty with grooming, dressing, standing, sitting, walking, pushing, pulling, and climbing. In addition, he has difficulty with grasping, holding and pinching. Riding and driving are aggravating activities. Problems with regards to sleep, sexual activity and participating in hobbies, sports, and activities are noted to be present.

* * *

Physical Exam: This is a healthy appearing male-42 years of age, five foot five inches, weighing 190 lbs. He does not appear to be in distress at this time. He does wear a combination of a glove and tape as related to the left wrist. There is significant swelling as related to the metacarpo-phalangeal joint. There is extreme hyperpathia and allodynia. The range of motion of the left wrist reveals flexion 40 degrees, extension 30 degrees, ulnar deviation 15 degrees, and radial deviation 10 degrees. There is marked weakness with regards to any attempt at grip and pinch.

Examination of the left thumb: There is a decreased range of motion of the thumb: adduction is 1 cm, opposition is 1 cm, abduction is 40 degrees, metacarpophalangeal motion is 10 degrees to 20 degrees of flexion, and finally interphalangeal motion is 0 degrees to 40 degrees of flexion. Swelling is noted. Hyperpathia and allodynia is noted as related to the thumb.

The small finger and the index finger are more affected with tenderness, swelling and pain to be present.

The range of motion is the following:

Index finger is MCP(10-20), PIP(10-40), DIP(10-20)
Middle finger is MCP(10-20), PIP(10-50), DIP(10-10)
Ring finger is MCP(10-10), PIP(10-20), DIP(0-0)
Small finger is MCP(10-10), PIP(10-20)[,] DIP(0-0)

There is noted to be a decreased sensation throughout the left hand. I can appreciate a coolness to the left upper extremity. Hyperpathia and allodynia are noted to be present throughout the left hand and upper extremity.
* * *

> The injured worker has filed an application for loss of use of the left hand. Please address the questions below:
>
> [One] **In your medical opinion, has the allowed injury resulted in total, permanent loss of use to such a degree that the affected body part is useless for all practical purposes, that is, the body part though present is not capable of performing most of the functions for which it commonly performs as a result of the allowed conditions in this claim?**
>
> Based upon the review of the medical records and the results of the independent medical examination it is my opinion that the injured worker does suffer from the loss of use of the left hand. This is based upon the ranges of motion of the digits of the left hand, as well as the thumb, in conjunction with the abnormalities with regards to any attempt at function of the left hand: even simple maneuvers such as pinch and grip. There, in addition, is a severe limitation of function of the left wrist as well.
>
> These findings are noted despite the very aggressive treatment that the injured worker has received and continues to receive. Treatment has been successful but only in the sense of decreasing the amount of pain that is present. There is still a pain level on the Visual Analog Scale of anywhere from 5 to 7-8 on a scale of 1-10. Once again function has not improved but in fact has gotten worse despite the treatment that has been rendered.

{¶ 25} 12. On June 9, 2010, the bureau mailed an order additionally allowing the claim for "ankylosis left hand" and awarding R.C. 4123.57(B) compensation for the loss of use of the left hand. The order states reliance upon the May 18, 2010 report of Dr. Gula. The order provides that compensation is to begin effective February 25, 2010, which is the date of one of Dr. Gallanosa's reports.

{¶ 26} 13. Relator administratively appealed the bureau's June 9, 2010 order. In his online appeal, relator states, as a reason for his appeal, that "[t]he award should therefore commence either 4/7/08 or 5/21/08, the date of the earliest medical report supporting the loss of use of the left hand."

{¶ 27} 14. Following a July 7, 2010 hearing, a DHO issued an order stating:

> The order of the Administrator, issued 06/09/2010, is modified to the following extent.
>
> The District Hearing Officer affirms the additional allowance of "ANKYLOSIS LEFT HAND."
>
> District Hearing Officer further affirms the Scheduled Loss/Loss of Use Award for a total loss of use of the Left Hand.
>
> District Hearing Officer modifies the Bureau of Workers' Compensation order in that this loss of use award shall begin on 04/07/2008, the date of the report of Dr. Gallanosa, one of Injured Worker's physicians who opines in the 4/07/08 report that Injured Worker has a total loss of use of the left hand.
>
> Therefore, [Injured Worker] shall be paid a scheduled loss of use award for a total loss of use of the left hand beginning 4/07/08, in accordance with ORC 4123.57.
>
> District Hearing Officer finds the weight of medical evidence supports the Injured Worker has a total loss of use of the left hand and left hand ankylosis due to the industrial injury in this claim.
>
> This order is based on the reports of Dr. Gallanosa dated 04/07/2008, 02/25/2010 and 03/17/2010, Dr. Kovach dated 05/21/2008 and Dr. Gula dated 05/18/2010.

(Emphasis sic.)

{¶ 28} 15. The bureau administratively appealed the DHO's order of July 7, 2010.

{¶ 29} 16. By letter dated August 2, 2010, the bureau asked Dr. Gula to view the surveillance videos and the June 23, 2008 report of Dr. Popp. The letter to Dr. Gula requested:

> Based upon the report of Dr. Popp and this video evidence in 2008, is it still your opinion that the allowed injury resulted in total, permanent loss of use, to such a degree that the effected body part is useless for all practical purposes? That is, the body part, though present, is not capable of performing most of the functions for which it commonly performs as a result of the allowed condition in this claim? Please be specific.

> This letter is to request an addendum report that addresses this question. * * *

{¶ 30} 17. On August 10, 2010, Dr. Gula issued his addendum:

> I did review the Independent Medical Examination of James E. Popp, M.D. It was felt that the injured worker did not have any objective findings of reflex sympathetic dystrophy or chronic regional pain syndrome as related to the left upper extremity. In addition, I reviewed the bone scan of 2004. It was felt to be normal.
>
> In addition, I reviewed the surveillance videos of April 17, 2008, April 22, 2008, and May 31, 2008 as provided. Mr. Clark did demonstrate an absence of any specific limitations as related to function of the left upper extremity based upon the surveillance videos as described. Thus, based upon the video evidence of 2008 and the Independent Medical Examination of Dr. Popp, it is my opinion that the allowed injury of February 4, 2004, did not result in a total permanent loss of use as related to the left upper extremity. It is apparent on the surveillance videos that the injured part of the left upper extremity is capable of performing most of the tasks, which are commonly performed.
>
> To summarize, there does not appear to be any limitation of function as related to the left upper extremity based upon primarily the surveillance videos and a review of the Independent Medical Examination of Dr. Popp. Thus, the medical information does not support that the allowed injury resulted in total permanent loss of use as related to the left upper extremity.

{¶ 31} 18. Following a September 29, 2010 hearing, a staff hearing officer ("SHO") issued an order that vacates the DHO's order of July 7, 2010, and denies relator's March 12, 2010 motion. The SHO's order explains:

> The Injured Worker's C-86 motion, filed 03/12/2010, requesting an additional allowance for ANKYLOSIS LEFT HAND AND TOTAL LOSS OF USE OF THE LEFT HAND DUE TO ANKYLOSIS is DENIED.
>
> The Hearing Officer does not find there is ankylosis of the left hand. The Hearing Officer relies upon Dr. Gula's addendum report, filed 08/10/2010. The Hearing Officer notes that Dr. Gula originally examined the Injured Worker

> on 05/18/2010 and rendered an opinion that the Injured Worker had a loss of use with the left hand. However, following that examination, the Bureau of Workers' Compensation submitted video surveillance tapes of some of the Injured Worker's activities from April and May of 2008. Following Dr. Gula's review of the surveillance video tapes, Dr. Gula opined in his 8/2010 addendum report that there does not appear to be any limitation of function related to the Injured Worker's left upper extremity. Per Dr. Gula's addendum report, the surveillance videos showed the injured part of the left upper extremity is capable of performing most of the tasks which are commonly performed. Dr. Gula opined in her [sic] addendum that the allowed injury did not result in a total permanent loss of use of this left upper extremity. Dr. Gula further found no limitation of function of the left upper extremity based upon the s[u]rveillance videos and review of Dr. Popp's report. The Hearing Officer reviewed portions of the 5/31/2008 video tape at hearing. This video tape demonstrated the Injured Worker holding mail with his left hand, holding a credit card in his left hand and utilizing a gas station credit card machine, grabbing a receipt with his left hand, lifting his baseball hat with his left hand, scratching his back with his left hand, clapping, grabbing the top of a fence with his left hand, grabbing a ball bag, carrying and zipping a ball bag with his left hand. The Hearing Officer finds that the activity demonstrated on the surveillance tape failed to demonstrate the total loss of use of the Injured Worker's left hand. The Hearing Officer finds that for all practical purposes the Injured [W]orker has not lost use of his left hand to the same extent and effect as if the hand had been amputated. The Hearing Officer, therefore, denies the request for ankylosis of the left hand and denies the request for a total scheduled loss of use of the left hand. The Hearing Officer relies specifically on the surveillance video tape taken 5/31/2008 as well as Dr. Gula's addendum, filed 08/10/2010.

(Emphasis sic.)

{¶ 32} 19. On October 22, 2010, another SHO mailed an order refusing relator's administrative appeal from the SHO's order of September 29, 2010.

{¶ 33} 20. On January 13, 2011, relator, Joseph M. Clark, filed this mandamus action.

Conclusions of Law:

{¶ 34} In denying the motion for scheduled loss compensation, the commission, through its SHO, relied upon Dr. Gula's addendum report and the May 31, 2008 video surveillance. In his addendum report, Dr. Gula changes the opinion he rendered in his May 18, 2010 report. Dr. Gula's change of opinion was based upon his review of the surveillance videos and the June 23, 2008 report of Dr. Popp. Earlier, upon his examination of relator and his review of the surveillance videos, Dr. Popp had opined that relator does not suffer a loss of use of his left hand.

{¶ 35} Three issues are presented: (1) whether the addendum report of Dr. Gula is equivocal with respect to his May 18, 2010 report and thus cannot constitute some evidence upon which the commission can rely; (2) whether Dr. Popp improperly failed to accept the allowed conditions of the claim and, if so, such failure taints the addendum report of Dr. Gula; and (3) whether the surveillance videos must be found to present stale evidence upon which the commission cannot rely.

{¶ 36} The magistrate finds: (1) Dr. Gula's addendum report is not equivocal; (2) Dr. Popp did not improperly fail to accept the allowed conditions of the claim; and (3) the surveillance videos need not be viewed as presenting stale evidence.

{¶ 37} Accordingly, it is the magistrate's decision that this court deny relator's request for a writ of mandamus, as more fully explained below.

{¶ 38} Turning to the first issue, equivocal medical opinions are not evidence. *State ex rel. Eberhardt v. Flxible Corp.* (1994), 70 Ohio St.3d 649, 657. Equivocation occurs when a doctor repudiates an earlier opinion, renders contradictory or uncertain opinions, or fails to clarify an ambiguous statement. *Id.*

{¶ 39} A physician's report can be so internally inconsistent that it cannot be some evidence supporting the commission's decision. *State ex rel. Lopez v. Indus. Comm.*, 69 Ohio St.3d 445, 449, 1994-Ohio-458; *State ex rel. Taylor v. Indus. Comm.* (1995), 71 Ohio St.3d 582, 585.

{¶ 40} According to relator, because Dr. Gula changed his opinion in his addendum report, the opinion is, by definition, equivocal, and cannot be relied upon by the commission. The magistrate disagrees.

{¶ 41} Clearly, the equivocation principle does not bar a physician from changing his or her opinion when the change results from evidence that the physician did not previously consider.

{¶ 42} In rendering his initial opinion in his May 18, 2010 report, Dr. Gula was not asked to view the surveillance videos of April 17, April 22, and May 31, 2008. Thus, in his addendum report, after reviewing the surveillance videos, it was not an equivocation to render an opinion that differed from the one rendered earlier.

{¶ 43} Moreover, contrary to relator's suggestion, that the surveillance videos were in existence prior to the date Dr. Gula rendered his first report, does not bar their use in a second or addendum report.

{¶ 44} One of the prerequisites of the commission's continuing jurisdiction is new and changed circumstances which also encompasses the rule regarding previously undiscoverable evidence. See *State ex rel. Nicholls v. Indus. Comm.*, 81 Ohio St.3d 454, 1998-Ohio-616, and *State ex rel. Keith v. Indus. Comm.* (1991), 62 Ohio St.3d 139. Here, relator inappropriately suggests that the above-noted prerequisite of continuing jurisdiction is also applicable to Dr. Gula's addendum report such that Dr. Gula was barred from reviewing the surveillance videos because of their existence or availability as of the date of Dr. Gula's original report. Clearly, that the surveillance videos were in existence or even available prior to or at the time that Dr. Gula rendered his original report on May 18, 2010 does not bar Dr. Gula's subsequent review of the surveillance videos and his issuance of an addendum report.

{¶ 45} Turning to the second issue, as a general proposition, it can be said that an examining physician must accept the allowed conditions of the claim in rendering his or her opinion as to medical impairment. *State ex rel. Middlesworth v. Regal Ware, Inc.*, 93 Ohio St.3d 214, 2001-Ohio-1331; *State ex rel. Domjancic v. Indus. Comm.*, 69 Ohio St.3d 693, 1994-Ohio-95. However, acceptance of an allowed condition does not mean that a physician is required to affirm the continued existence of an allowed condition that, in the doctor's opinion, has medically resolved. *State ex rel. Ganu v. Willow Brook Christian Communities*, 108 Ohio St.3d 296, 2006-Ohio-907, ¶40, citing *Domjancic*. A physician, however, must accept that an allowed condition once existed and not disallow its initial allowance. *Ganu* at ¶40, citing *Middlesworth*.

{¶ 46} In his report, Dr. Popp states:

> * * * In my professional opinion, I think that Mr. Clark probably suffered a contusion to the left hand. The claim is also allowed for a reflex sympathetic dystrophy of the upper limb. In my professional opinion, I do not think that Mr. Clark has any objective findings of a reflex sympathetic dystrophy or chronic regional pain syndrome of the left upper extremity. * * *
>
> * * *
>
> * * * I think that he probably early on suffered some partial loss of his left upper extremity. He does not meet any objective criteria of reflex sympathetic dystrophy or chronic regional pain syndrome of the left upper extremity[.] * * *

{¶ 47} According to relator, "Dr. Popp does not accept all of the allowed conditions." (Relator's brief, at 12.) According to relator, "[b]ecause Dr. Popp does not accept 'left hand reflex sympathetic dystrophy' based upon **HIS** objective findings, his opinion may not be considered credible evidence." Id. (Emphasis sic.) The magistrate disagrees with relator's argument.

{¶ 48} To begin, Dr. Popp acknowledges that the claim is allowed for reflex sympathetic dystrophy of the left hand. However, upon his examination, Dr. Popp could not find objective findings to meet the criteria for the allowed condition. Dr. Popp specifically stated his acceptance that, early on, relator suffered from the allowed condition. However, Dr. Popp is of the opinion that, as of the examination date, relator no longer suffers from the allowed condition.

{¶ 49} Given the above-noted authorities, none of which the parties cite in this action, it is clear that relator's argument lacks merit.

{¶ 50} The third issue, as previously noted, is whether the surveillance videos must be found to present stale evidence upon which the commission cannot rely.

{¶ 51} The Supreme Court of Ohio has addressed evidentiary staleness in several cases worthy of mentioning here.

{¶ 52} In *State ex rel. Menold v. Maplecrest Nursing Home*, 76 Ohio St.3d 197, 202, 1996-Ohio-146, the court states:

> The commission is exclusively responsible for judging evidentiary weight and credibility. *State ex rel. Burley v. Coil*

> *Packing, Inc.* (1987), 31 Ohio St.3d 18, 31 OBR 70, 508 N.E.2d 936. Claimant's contention that McCloud's report is nonprobative simply because it predates the claimed disability period lacks merit. Certainly, the probative value of a medical report may be lessened by later changes in the claimant's condition, and the longer the time between the report and the disability alleged, the more likely this is to have occurred. Claimant, however, has failed to show that McCloud's report was no longer probative.

{¶ 53} In *State ex rel. Hiles v. Netcare Corp.*, 76 Ohio St.3d 404, 407, 1996-Ohio-169, the court states:

> A finding of evidentiary staleness should always be approached cautiously. More relevant than the time at which a report was rendered are the content of the report and the question at issue. For example, where the issue is maximum medical improvement, a report that finds a permanent impairment is rarely rendered invalid by the passage of time. Conversely, the changeable nature of a claimant's ability to work is often affected by time.

{¶ 54} In *State ex rel. Conrad v. Indus. Comm.*, 88 Ohio St.3d 413, 2000-Ohio-365, Dr. Rutherford had examined the claimant in October 1994 and found that "she would not benefit from any further surgical procedure at this time." One month later, the claimant had an acute exacerbation of her lower back condition that required emergency hospitalization. In mid-October 1995, the claimant's treating physician, Dr. Rohner, sought emergency authorization for surgery. The self-insured employer refused to authorize the surgery and the commission denied the claimant's request for authorization, citing Dr. Rutherford's report. The *Conrad* court held that Dr. Rutherford's report was not probative of the need for surgery following the 1994 exacerbation of the claimant's condition.

{¶ 55} Turning to the instant case, according to relator, the surveillance videos of April 17, April 22, and May 31, 2008 cannot be probative of relator's medical condition as of May 18, 2010, the date of Dr. Gula's examination at the bureau's request. Pointing out that the surveillance videos were made two years prior to Dr. Gula's examination, relator asserts that the surveillance videos "cannot accurately be relied upon to be a current reflection of [relator's] physical limitations." (Relator's brief, at 15.) This is so, according

to relator, because relator's condition "has continued to worsen as supported by [relator's] treating physician, Dr. Gallanosa." Id.

{¶ 56} In support of his position that his condition worsened since the surveillance videos were made, relator points to a February 12, 2009 report from Dr. Gallanosa:

> Mr. Clark returns for followup regarding his left upper limb [reflex sympathetic dystrophy]. He notes that last Saturday he had an incident where he was bending his elbow and felt a "crack" in his elbow. He states that this caused some increased pain in his left upper limb entirely. He went to physical therapy and it was noted that he had some increased swelling in the left elbow as well. The therapy was therefore light for him that day. He continues to have problems in his hand and his elbow with pain. He has shooting pains into the left upper arm and into his forearm. * * * He continues with therapy twice a week for right now, although this does not seem to be helping with his pain. He states that his pain is about 8/10 and constant, and worse than before.

{¶ 57} Relator's argument ignores that the commission, through its SHO's order of September 29, 2010, did not rely upon any of Dr. Gallanosa's reports. Rather, the commission relied upon the August 10, 2010 addendum report of Dr. Gula. The presumption is that Dr. Gallanosa's February 12, 2009 report was found not to be persuasive.

{¶ 58} Because it is the commission that weighs the evidence, relator cannot, in this action, revive Dr. Gallanosa's reports in order to show a worsening of his medical condition. Thus, relator's staleness argument must fail.

{¶ 59} Accordingly, for all the above reasons, it is the magistrate's decision that this court deny relator's request for a writ of mandamus.

s/s Kenneth W. Macke
KENNETH W. MACKE
MAGISTRATE

NOTICE TO THE PARTIES

> Civ.R. 53(D)(3)(a)(iii) provides that a party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion as required by Civ.R. 53(D)(3)(b).