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Federal Employers' Liability Act (FELA): A Case Study

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CASE SYNOPSIS

Mr. G is a 44-year-old, right-hand-dominant man who was in a work-related accident, when he fell into a hole approximately three-feet deep with his right leg and sustained injuries involving lumbosacral spine which required surgical intervention for a left sided lumbar disc herniation.

He has continued to have substantial low back and radicular leg pain which has significantly interfered with his activities of daily living and ability to work. Additionally, his right knee condition has worsened and is becoming increasingly problematic for him.

He has incurred substantial lost future income, as detailed in the accompanying Vocational Assessment (VA) and related Economist Analysis (EA) report, as well as significant future medical needs and associated expenses depicted in the form of a comprehensive Life Care Plan (LCP). His physical limitations have been quantified in the accompanying objective Functional Capacity Evaluation (FCE).

PURPOSE OF EVALUATION

Determination of Accident-Related Injury, Necessity and Appropriateness of Treatment, Permanency, and the Need for Future Treatment

MEDICAL SPECIALTY OF EXAMINER

Occupational Medicine/Internal Medicine

ACCIDENT DIAGNOSES: Part I

Dr. AF

Lumbar sprain/strain; L4-5 and L5-S1 disc herniations; L3-4 annular tear; lumbosacral radiculopathy/radiculitis; substantial aggravation of pre-existing lumbar degenerative disc disease (DDD) and spondylosis; aggravation of pre-existing right knee osteoarthritis (OA). Dr. AF stated that Mr. G completed an Oswestry questionnaire and reported high levels of pain.

He believed that the MRI findings correlated with his subjective complaints, and he could associate that the large disc herniation occurred when Mr. G stepped into the hole. He did state that some of the findings pre-existed the fall, but the disk herniation was likely new. He called Mr. G's findings "significant findings" compared to the general population for his age. He stated that the laminectomy surgery was the least invasive surgery type to decompress the nerves and take care of some of Mr. G's symptoms, as given Mr. G's age, he was too young for a fusion. He acknowledged that the surgery, however, was not a great solution for pure back pain. *He stated even with a laminectomy, future interventions such as a fusion operation, would be likely.*

He was asked if a bilateral lower extremity NCS/EMG performed 14 months after surgery would show improvement. Dr. AF opined that it depended on the individual. He stated that some patients could be pain-free with EMGs that showed abnormalities or he could have similar findings that would be labeled as chronic. **He reiterated that Mr. G's spine was "wearing out faster" than if he would not have performed the surgery because disc material was removed and accelerated the degenerative processes.**

He stated that some people with laminectomies and lumbar fusions would be able to return to a light to medium job duty. He also indicated that just because work-hardening programs were pushing a patient, did not mean that it was sustainable. He said, "the reality is they're not going to be able to function like that five days a week, for 40 hours a week". He also clarified that if a restriction, say lifting 20 pounds, truly matched his job, and then at that point, he would have no problem releasing them to 20 pounds in a light duty occupation.

Dr. AF stated that both the radicular symptoms and localized back pain were a result of his injuries. Dr. AF opined that Mr. G had the following functional limitations and restrictions: *constantly lift/carry 10 pounds and frequently lift/carry a maximum of 20 pounds. He could constantly finger, handle and operate foot controls. He could frequently sit and kneel. He could occasionally stand, walk, bend and reach above shoulder. He would not be able to climb or bend. Dr. AF opined that Mr. G's restrictions were permanent.*

ACCIDENT DIAGNOSES: Part II

Dr. WR Defense Medical Opinion and Rebuttal

It is clear from reviewing Dr. WR's report that he only holds other neurosurgeons as potentially credible in offering any medical opinion regarding back surgery. He acknowledges that his fellow neurosurgeon, Dr. AF, diagnosed L4-5 disc herniation with radiculopathy and L5-S1 disc herniation with radiculopathy. He also acknowledged that Dr. AF recommended physical therapy, epidural steroid injections, and laminectomy (*which he ultimately did perform*). He acknowledged that Dr. AF postoperatively reviewed the x-rays and a new MRI scan. He recommended continued observation, followed by a fusion if there was no improvement. He also agreed that future work restrictions would be necessary, and he accepted Dr. AF's assertion that Mr. G's problems were attributable to his railroad related injury.

Dr. WR then expressed his interpretation of Dr. AF's rationale and the basis behind his opinions, stating that if Dr. AF had known that his patient had had prior back problems, he would never have opined that his problems were related to the railroad incident, that surgery was needed based upon the incident and that a fusion operation would also be necessary in the future based upon this incident. Obviously, Dr. WR has taken liberty without foundation in construing what Dr. AF meant; and then he ultimately discounted Dr. AF's professional opinions.

Dr. Trangle declared "In terms of my review and the prepared Life Care Plan (LCP), he focuses on the environmental aspect of my background and not on the orthopedic experience that is clearly listed in my resume. Although he is correct in that I did not do surgery, I have worked as a nonsurgical orthopedic provider for several years as an emergency room physician, where a great deal of the problems that are acute and orthopedic in nature. I have established and run urgent care centers for several years where there are individuals who had work-related problems and conditions, including countless back problems".

Dr. Trangle stated, "As an occupational medicine physician, one could state that almost half of the injuries found in the workplace are orthopedic in nature and a significant portion of those are back-related spinal injuries. It is clearly within the realm of an occupational doctor treating individuals with back-related problems is done so regularly on an ongoing basis.

In my case, I also happened to spend several years, evaluating individuals, treating individuals, focusing on rehabilitation, prescribing injections and diagnostic testing and then when necessary, referring individuals to particular surgeons with particular expertise. **Following an individual having surgery, the orthopedic office referred the patients back to my care for rehabilitation oversight as well as return-to-work program initiation.**

RETURN-TO-WORK ISSUES & FUNCTIONAL CAPACITY EVALUATIONS (FCE)

An occupational medicine physician clearly has a better understanding of what an individual does in a work situation and in particular in the railroad position of a conductor. Although the surgeon lists what he believes these types of persons do, it is unclear if he has ever seen a railroad yard, treated a railroad worker for back problems previously or that he understands the complexity of a conductor, engineer or trackman position, the scope of their activities and the ergonomic challenges which they undergo.

Dr. Trangle said, “I have no doubts about a surgeon and his or her opinions in terms of surgical technique, for which that individual is trained and experienced. However, a surgeon is not a specialist in everything. Understanding the FCE and how it plays into making work-related decisions and return-to-work activities is not in the purview of a neurosurgeon. Looking at coefficients of variation, endurance issues as well as extrapolating from the FCE clinic to the field is not something neurosurgeons do. Dr. WR downplayed Mr. G’s continued episodes, where he was seen wincing in pain, catching himself and otherwise having back-related issues. Dr. WR indicates, in his summary, that, in his opinion, his injury was a temporary exacerbation of the pre-existing degenerative condition. He discounts the opinion of Dr. AF, a fellow neurosurgeon, in that he felt Dr. AF was “unaware that Mr. G already complaints and treatment for his back and radiating leg pain, and if so, he would have opined differently.” Dr. WR believed that the claimant should have fully recovered within 6 weeks of his episode.

This is total conjecture. He notes Mr. G’s extensive treatment including preoperative therapy, operative intervention, postoperative therapy including chiropractic therapy, injections and medication, all of which he thought was “unnecessary”. He differed with his colleague in stating that the MRI scan showed neural abnormalities. Mr. G’s operating surgeon obviously felt that the abnormalities required a fusion operation, and his pain was unlikely to improve.

Dr. WR’s description that Occupational Medicine (OM) physicians are not competent to diagnose or treat back related ultimately surgery related patients is not accurate. Not only do physicians in the specialty of Occupational Medicine treat back related injuries, but so do other specialists on a regular basis. Pain management specialists, physiatrists, chiropractors, sports medicine, back doctors, neurologists, and orthopedists and in many cases doctors of osteopathy, among others, are quite capable of offering medical opinions regarding back-related issues such as interpretation of MRI scans, necessity for treatment, injections and therapy as well as longer-term prognosis.

A surgeon’s training is in surgical technique, approach and treatment. It is not in making decisions as to necessarily even the postoperative rehabilitation, FCE, return-to-work issues, ergonomic adjustment, life care planning, vocational analysis and assessment or other aspects of treating patients, which are just as necessary.

REVIEW OF IMPRESSIONS, SECOND OPINIONS & OTHER RECOMMENDATIONS

The overall medical evidence in this case establishes that Mr. G suffered a significant injury involving his lumbosacral spine during his time as a conductor. He indicated that at the time of the incident, he was walking along the tracks when he inadvertently stepped into a hole in the ground which was covered by snow. This incident caused his torso to be forcibly twisted and bent with his left leg remaining at the surface such that his body remained in a very awkward position. He was sent home and has not worked since then.

At his first medical visit, he was diagnosed with an acute **lumbar sprain with radiculopathy**.

He was seen 4 years before this most recent incident for low back pain with intermittent paresthasias in his left leg. His neurological exam was again unremarkable. Lumbar spine x-rays were unremarkable. He was able to return to work without restrictions.

In summary, his previous clinical presentations for low back pain were all relatively short-lived and all of his symptoms resolved with only conservative treatment. No advanced imaging such as an MRI was deemed necessary or obtained. At least 4 years passed without treatment, physician visits or any noted back problems at the time of this injury.

The findings of a lumbar spine MRI scan, which was performed just 12 days after the workplace incident, reflected **acute pathology** in the setting of pre-existing degenerative changes. To a high degree of medical certainty, **the large central disc herniation at L4-5 with bilateral L5 nerve root compression and the left paracentral disc protrusion at L5-S1 (later characterized by as a herniation)** with **left S1 compression represented acute pathology** with an **annular tear** noted at **L3-4** was also an acute finding. Underlying these acute findings was multilevel disc desiccation and degenerative facet arthropathy with foraminal stenosis, most significant at L4-5 and L5-S1.

At the time of his fall, he experienced the acute onset of severe low back pain and radicular symptoms in his left leg with clear nerve root tension signs and nerve root dysfunction which correlated with the disc pathology at L4-5 and L5-S1. At a minimum, the injury that occurred on 02/03/2015 caused the diagnosed conditions, or at least a substantial aggravation of the disc pathology with significant neurological sequela.

EMG/NCV study confirmed subacute left L5 radiculopathy with active denervation.

Surgery was a fairly extensive decompression from L4 through S1 bilaterally with an L4-5 microdiscectomy during which he specifically noted the left L5 nerve root was extremely tense, compressed, swollen and erythematous. The L4-5 disc herniation was clearly contributing to L5 nerve compression as he identified and removed herniated disc material including a large free-fragment which resulted in an immediate decrease in tension on the left L5 nerve root. The left S1 nerve root was somewhat compromised such that he performed a foraminotomy without discectomy.

These findings are consistent with an acute and new injury.

The patient remained off work and entered a work hardening/conditioning program which he completed after which an FCA was conducted. The employee continued to report significant low back pain which likely represented a residual sequelae of the original incident and the surgery which was required to decompress his nerve roots. The process of performing bilateral laminectomies inherently included partial facetectomies at L4-5 and L5-S1 in addition to the discectomy performed at L4-5. This resulted in mild retrolisthesis at L5-S1 with neural foraminal narrowing in addition to disc space collapse at that level with extrusion of disc material.

These postsurgical changes, in conjunction with acceleration of his underlying degenerative changes, are responsible for his persistent low back pain complaints and would be expected to worsen over time. Expectedly, nerve root compression will likely occur at other levels.

The claimant developed right knee pain. Examination and radiographic findings were consistent with osteoarthritis changes in right knee. Given his history of an antalgic gait due to low back pain and radicular symptoms in his left lower extremity, increased mechanical forces were exerted on his right knee such that arthritic changes began to develop. This can be considered as a **flow-through type condition** which stems from the original incident. This will likely progress over time and require further treatment, likely including future surgery.

Various treatments have been discussed including placement of a spinal **cord stimulator** as well as ultimately a **lumbosacral fusion operation** which should be deferred as long as can be. His treating surgeon opined that he ultimately would require a spinal fusion.

I am in full agreement, he will require additional lumbar surgery to include an instrumented fusion. The literature and the set of circumstances in this instance, in a man of only 46 years of age, would imply there is a high likelihood of needing future surgery, on the order of 80% or more. I would expect the need for multiple surgical interventions.

He will require additional x-rays, MRIs and CT scans, periodic physician visits, oral medications, physical therapy and interventional pain procedures such as epidural steroid injections, facet injections and facet rhizotomy.

THE ROLE OF THE OCCUPATIONAL MEDICINE PHYSICIAN

Kevin Trangle, M.D., M.B.A.

Fellow, American College of Occupational and Environmental Medicine (FACOEM)

Fellow, American Academy of Disability Evaluating Physicians (FAADEP)

Board Certified Internal Medicine (BCIM)

Certified, American Board of Independent Medical Examination (ABIME)

Certified Independent Medical Examiner (CIME)

Certified Medical Review Officer (CMRO)

A Board-Certified Occupational Medicine physician focuses both on orthopedic spinal related injury, and other aspects of disability, work tasks, activities of daily living and transferrable skills. An occupational physician is trained specifically to deal with matters as related to functional ability. As an Occupational Medicine specialist with a MBA degree from Case Western University and MHA training at the University of Washington, Dr. Trangle is qualified to opine on current and future functional capability, economic damages, Life Care projected needs and associated costs, and return to work and accommodation needs.

As a Board-certified Occupational Medicine specialist, Dr. Trangle has worked extensively with individuals in terms of accommodating any particular employee to work situations, assessing medical status from physical, disability and vocational return-to-work status perspectives. Dr. Trangle has opined in many different situations in these particular types of claimants, patients and employees. “As medical director of various corporations throughout my career, I have had the opportunity to look at employees in terms of deciding how any particular worker can return to work, how ergonomically the specific medical condition is suited to various types of occupations, accommodations, retesting or retooling and retraining. In any case, this area of expertise falls clearly in the purview of Occupational Medicine.”

EVALUATION & EXPERT OPINIONS

Dr. Kevin Trangle

According to Dr. Trangle, “Orthopedic surgeons are skilled in operations, but not necessarily in return-to-work issues, future care and costs, job accommodation concerns and the like. I have and continue to work with surgeons of all sorts in that my particular expertise does address these relevant issues in patient care; I am typically referred patients from surgeons to facilitate rehabilitation and return to work protocols.”

“I would highly doubt that any neurosurgeon is trained or is knowledgeable, for example, on the requirements of a Commercial Driver’s License (CDL) as defined by the Federal Motor Carriers Safety Agency (FMCSA), in the Federal Railroad Administration (FRA) guidelines, ergonomic and job accommodation issues, as well as being adept in evaluating Functional Capacity Evaluation (FCA) techniques, and quality.”

Functional Capacity Evaluation (FCE)

One employed methodology is to do a Functional Capacity Evaluation (FCE). These are standardized tests for individuals; typically done in a physical therapy clinic under controlled circumstances and careful observations. The test is used to determine what an individual is capable of doing. A good Functional Capacity Evaluation will determine the extent of movement with ranges of motion as well as determining abilities and capabilities in terms of lifting, standing, sitting, walking, carrying, moving in certain directions and doing certain activities. A good Functional Capacity Evaluation will look at coefficients of variation to determine the accuracy and consistency of movements for any particular tests and in general. Lastly, a good Functional Capacity Evaluation will look at the efforts that are expended using a variety of different techniques that have been developed over the years and standardized as to demonstrating true effort in determining one's function.

An FCA is usually conducted for 4 hours on a single day. This represents a recognized limitation in terms of being able to use the FCA data to extrapolate ability to perform activities requiring significant physical exertion as well as prolonged standing and walking which are normally performed over the course of at least five consecutive 8-hour workdays. The evaluator opined that the patient demonstrated full effort and the results were valid, albeit it with significant reported low back pain during testing which limited his overall abilities. Over the course of a typical work week in his own occupation or another medium physical demand level job, he would be expected to experience progressively worsening symptoms which would significantly limit his ability to perform his required job duties on a consistent basis.

The FCE showed a borderline ability to function in the medium category at least for limited periods of time. His actual capacity for work on a full-time consistent basis falls in the light range more appropriately. He can function in the median range for a limited period of time. His essential tasks, however, although designated as "medium in nature", are described as such, that this job would be in the heavy duty DOL category. He would occasionally need to push up to 100 pounds in order to have enough push force to throw a switch. Pulling activities were described as occasionally to continuously repetitive in order to pull between 30 and 100 pounds.

Given his expected clinical course as outlined above, it would be much more appropriate to place him in a light duty capacity as ongoing physical exertion to a higher degree will likely be unsustainable. A FCA is a guideline to ergonomically suitable job accommodation which requires a physician knowledgeable in return to work placements.

Further Medical Opinion

Mr. G had disc bulging without herniations at L4-5 and L5-S1 prior to the incident, these were essentially asymptomatic except for lower extremity pain which resolved more than 4 years prior to this incident. These minor degenerative changes are normal in a man of this age.

At a minimum, the injury caused a substantial aggravation of the disc pathology with significant neurological sequela. Furthermore, the severity and duration of his low back complaints clearly reflects acute trauma to above noted discs as well as aggravation of his underlying facet arthropathy and other degenerative changes.

This resulted in mild retrolisthesis at L5-S1 with associated neural foraminal narrowing in addition to disc space collapse at that level with extrusion of disc material.

These postsurgical changes, in conjunction with acceleration of his underlying degenerative changes, are responsible for his persistent low back pain complaints and would be expected to worsen over time. Because of altered anatomy, and changed vectors in terms of movements and forces, nerve root compression will likely occur at other levels.

LIFE CARE PLANNING (LCP)

Kevin Trangle & Associates (KTA)

A Life Care plan was prepared for Mr. G. Life Care planning is a regular part of the assessments done hand in hand by an Occupational Medicine doctor experienced in LCP conjunction with either the life care certified planner in our office, or with one chosen by the attorney.

Together, we often prepare life care plans, assessing the variety of different medical needs of an individual into the future based upon their incident-related claims and diagnoses. Mr. G was referred to Kevin Trangle & Associates (KTA) for the development of a Life Care Plan. The KTA team developed a custom Life Care Plan to address current and future medical and non-medical needs related to the injuries Mr. G sustained.

KTA provided Mr. G with a comprehensive Life Care Plan report that addressed current and future medical treatment recommendations with associated costs as related to the accident. Recommendations included in this Life Care Plan report were based on a reasonable degree of certainty in an effort to manage symptoms, reduce complications/secondary diagnosis, maintain functioning and optimize independence throughout Mr. G's lifespan. Every aspect the plan care was reviewed by a treating physician, expert physician consultant or other specialist trained and certified, such as a physical therapist, or others. All this is done keeping in mind the Daubert criteria in order to have medically sound and supportable report.

KTA made recommendations based on information provided by medical provider medical records and an Independent Medical Examination, as well as knowledge/experience from this Life Care Planner. The Life Care Plan report and tables were completed following a review of the provided medical records, his examination findings and assessment questionnaire.

Mr. G was evaluated by Dr. Kevin Trangle and his team of specialists. At this time, Mr. G completed a Life Care Plan Assessment questionnaire.

Mr. G had been employed at his former company for 22 years, working his way up from a Hostetler to a Conductor. As a Conductor, his responsibilities included occasional lifting and carrying up to 20 pounds of weight and an occasional need to push 100 pounds to throw a switch. His position required bending, stooping, squatting and sitting less than occasionally, and continuous standing and ambulating. Repetitive climbing was frequent with occasional reaching up and continuous reaching out. His fiancé is employed as a counselor. He has three children ages five and three-years and six-months old. He does find it difficult to watch them.

He does not smoke tobacco and drinks up to one cup of coffee per day. He does daily back stretch and sleeps up to five hours per night. He has difficulty standing at times and cannot bend. He intermittently wears a back and knee brace as well as using a cane for ambulation.

Mr. G reported ongoing lower back pain and numbness. He stated that he is currently not receiving any specific treatment while waiting on his insurance to cover the costs. He did, however, state that he was scheduled to have lumbar trigger point injections and lumbar blocks, most likely facet and epidural.

With regard to self-care, on some days he is unable to put on his own socks and finds putting on his upper body clothing is easier than dressing his lower body. He has difficulty pushing, bending to sit and standing during his toileting and grooming.

Mr. G is able to perform very little yard work or home maintenance and performs no car maintenance. His fiancé completes most of the household chores including shopping, cleaning and meal preparation. For the majority of the chores, they have a house cleaner who comes twice a month as well as a lawn service for outdoor maintenance. He does assist with laundry at times and they otherwise utilize a laundry service. Depending on how he is feeling, he is able to take care of his finances and bill paying. He does not participate in community outings and on many days remains at home. However, Mr. G is able to drive as necessary.

A typical day for him was described as follows: he awakens, usually in pain, and does stretching exercises he learned in physical therapy. He runs errands and visits a friend's cigar shop, trying to learn the business. He also takes care of his young son and walks him in a stroller at a nearby mall. He tries to perform normal activities, but his pain can flare at any time and as the result of doing too much activity. Mr. G reported ongoing back pain with less radicular symptoms than prior to his laminectomy. Prior to his injury, he had instances of back pain and reported sciatica pain after shoveling snow.

KTA SUMMARY & TREATMENT RECOMMENDATIONS

It is anticipated Mr. G will have chronic symptoms and residual disabilities resulting from the work-related accident. Given the severity of his medical condition, it is also anticipated long term medical care is expected through his life. As Mr. G ages, complications are likely. Various treatments have been discussed including placement of a spinal cord stimulator as well as ultimately a lumbosacral fusion operation which should be deferred as long as can be. His treating surgeon opined that he ultimately would require a spinal fusion.

He will require additional lumbar surgery to include an instrumented fusion. The literature and the set of circumstances in this instance, in a man of only 46 years of age, would imply there is a high likelihood of needing future surgery, on the order of 80% or more. I would expect the need for multiple surgical interventions.

He will require additional x-rays, MRIs and CT scans, periodic physician visits, oral medications, physical therapy and interventional pain procedures such as epidural steroid injections, facet injections and facet rhizotomy.

Social Security Retirement and Survivors Benefits yields an average life expectancy of a 48 year old to be 37.5 additional years, which was used in determining frequency and cost of Mr. G's medical/psychological/rehabilitation needs.

While it is not possible to predict with absolute certainty all future medical and technological advances or associated complications pertaining to Mr. G's case, it is highly likely over the course of his lifetime Mr. G will incur an estimated total cost in the amount of \$1,400,000 for his future medical care. The Life Care Plan is a projection of Mr. G's current and future medical and non-medical needs and should be updated with significant changes to his condition.

CONCLUSION

Mr. G had accident-related injuries consisted of the following:

1. *Lumbar sprain/strain;*
2. *L3-4 annular tear;*
3. *L4-5 and L5-S1 disc herniation with radiculopathy at these same levels;*
4. *Substantial aggravation of pre-existing degenerative disc disease and spondylolisthesis;*
5. *Substantial aggravation of pre-existing right knee arthritis.*

The medical records confirm ongoing pain. The MRI scan showed progressive narrowing and foraminal stenosis at L5-S1 mainly on the left side corresponding with symptoms and findings.

What can be said to a reasonable degree of medical certainty is that Mr. G will require future medical treatment secondary to the injuries that he sustained at the time of his accident and secondary spinal operation. Future medical interventions, associated costs, and a Life Care Plan can be found above.

I have reviewed the Vocational Assessment (VA) of what kinds of jobs would be available to an individual with his physical limitations, which I have listed and which I believe are accurate based on history, medical records and examination. I have read what transferable skills he possesses, and I have noted the existing job opportunities based on a labor market survey. As an Occupational Medicine Board Certified specialist, I am routinely involved in making decisions as to Return to Work (RTW) status and hiring suggestions. I fully concur with the VA offered; it is realistic and conforms with my training and experience.

As to the Economist Analysis (EA) and calculations, I do not hold myself out to be an Economist expert. However, as a result of having obtained a MBA degree; having gone to a MHA program, participated in owning and running a business; having familiarity with spreadsheets, projections, budgets and proformas, as well as discounting calculations, I did review the EA. In my opinion, it is factual in nature, based on valid medical evidence.

APPENDIX A

Competencies in Occupational Environmental Medicine in the FELA Arena Of Railroads

Accreditation Council for Graduate Medical Education (ACGME) is an independent not-for-profit physician-led organization that sets and monitors professional educational standards essential in preparing physician to deliver safe, high-quality medical care to all Americans. It is the only certifying agency. It is based in Chicago. It is comprised of almost 250 people overseeing this process. The accreditation process by ACGME uses specific specialty committees to determine for each of the subspecialties in medicine what uniform set of standards is in order to become accredited.

It sets out the requirements, best practices, scope of training and scope of involvement for each specialty. It is based upon these 28 specific review committees that the standards for who does what in medicine in America is set. The following discussion is based upon the ACGME approach toward relegating and delegating specific responsibilities to specific professions. The focus will occur on the occupational medicine subspecialty and its role in medicine and performing activities within the workplace and within the scope of practicing medicine in general in this country (www.acgme.org/about).

Stemming from this oversight committee, the American College of Occupational and Environmental Medicine (ACOEM) issued a guidance statement specifically based upon the core competencies as defined by the ACGME (JOEM; Volume 56 (5)).

Occupational and Environmental Medicine focuses on interactions between work and health and physicians in the workplace. It includes managing employee absences, work capacity, return-to-work issues, disability, and assessing fitness for work, advising appropriate work restrictions and implementing employment wellness programs in the context of preventive medicine.

Occupational and Environmental Medicine (OEM) physicians typically and by design interact with a wide range of other professionals and provide guidance as to necessary treatment, procedures, and fitness for duty and return-to-work issues. Board certification in this discipline entails understanding and mastering of core competencies as indicated above.

The core competencies are defined in depth and include the following:

1. *Clinical OEM;*
2. *OEM-related law and regulations;*
3. *Environmental health;*
4. *Toxicology;*
5. *Return-to-work;*
6. *Work fitness disability and disability management;*
7. *Hazard recognition, evaluation and control;*
8. *Health and productivity;*
9. *Public health, surveillance and disease prevention;*
10. *Disaster management.*

Under the clinical aspects of what is necessary as core competency is clearly defined that it is the purview of the occupational doctor to look at the history, signs, symptoms, physical findings, laboratory, imaging and other data in order to determine a treatment plan. This is necessary both in terms of work-related injuries in workers' compensation cases but also in non-work-related injuries where fitness for duty is an issue and almost always is in the work setting.

Therefore, OEM doctors are often asked to identify, evaluate and opine upon treatment modalities, types of treatments and efficacy of treatments. This is defined in evidence-based ACOEM position statements and in the ACOEM Guidelines to Clinical Practice.

Requirements for clinical specialties are outlined ranging from cardiology and dermatology to orthopedics and many others. Specifically, in the musculoskeletal region, an occupational doctor is noted to be able to clearly understand the anatomy, physiology and pathology of the musculoskeletal systems as well as appropriate treatment, management and duration of such interventions based upon clinical evidence.

These include spinal disorders including low back disorders as well as cumulative trauma and degenerative disease disorders. It is clearly defined by the ACOEM organization as well as by the American College of Medical Education that this is in the purview of the occupational doctor and is commonly used in both assessing work-related treatment programs and plans as well as fitness for duty and the appropriate placement ergonomically of individuals with medical issues including orthopedic and spinal issues.

A subset of the physicians who are part of the ACOEM include the Occupational Health Centers medical center group. This is comprised of almost 100 of the largest medical centers and medical directors that do these types of evaluations and provide care for the workforce. As noted in the records documented in this report, it is certainly in the purview of the occupational medical director to do periodic medical evaluations, episodic medical evaluations with job transfers or following an injury or surgical or other medical treatment. It is incumbent upon the occupational medical director and specialist to be able to evaluate job fitness. This includes understanding musculoskeletal injuries, the pathophysiology of the problem, the clinical setting of the problem, extent of impairment, surgical intervention and what that portends in terms of future care, treatment and work capability.

Dr. Trangle stated “This is what I did as Medical Director the Hospital.” It is part of the management and expectation of the occupational doctor to understand the peer-reviewed literature on these types of medical problems, medical interventions, and surgical procedures.

Although a specialty surgeon is clearly skilled in the techniques of providing surgery, doing the actual operation and the approach, there is no specific indication that only the person doing the technical task is capable of assessing the future of the epidemiological course of events of any particular individual. Peer-reviewed literature with published studies of specific kinds of operations, return-to-work and fitness for duty issues clearly falls in with the category of occupational medicine. There are other subspecialties that also review the literature and that have practitioners that are clearly competent to provide opinions such as orthopedic surgeons, physiatrists, neurologists and others. One does not have to be a surgeon trained in a specific technique to offer opinions as to prognosis, return-to-work issues and future fitness for duty.

The American Medical Associates (AMA) has similarly published the role of the OEM doctor based upon understanding of the individual responsibilities in the medical field.

The occupational environmental specialist deals with absenteeism and productivity, return-to-work, fitness for duty and understanding accommodations and future course of various treatments, illness and medical interventions. Even the American Academy of Family Physicians has corroborated based on the ACGME, the American Academy of Family Practice and the ACOEM what is needed for a practitioner in order to be at least knowledgeable somewhat in what occupational medicine entails. Clearly, the above factors play a critical role.

Lastly, the role of the physician’s return-to-work process following disability is noted in the reference document, once again further refined, identifies and reinforces the role of the occupational physician in understanding return-to-work practices. Without belaboring the point, return to work involves understanding the issue for which the individual went out of work and, in this case, understanding spinal pathology, spinal clinical findings and spinal surgical interventions and the future statistical evidence-based outcomes.

In addition, understanding economics and job activities in the workplace is paramount. **The occupational physician is the one who is best determined to play that role in return-to-work policy.** In many cases, the occupational and environmental medicine physician needs to look up a specific medical disease, illness, treatment or surgical procedure in order to determine the peer-reviewed evidence of future expected interventions. Further, understanding ergonomics of the actual the job itself and visualizing the job and seeing the job, either in person or by film, is part of the comprehensive responsibility of occupational and environmental medicine.

In short, the occupational and environmental physician plays an integral role in the recovery of workers’ injury or illness, understanding the future expected course of events, costs and medical interventions as well as the integration of this individual on an ergonomic basis into the workplace wherever possible based upon capabilities.