STATE OF RHODE ISLAND

PROVIDENCE, SC.

WORKERS' COMPENSATION COURT
APPELLATE DIVISION

LAURIE CAIRONE	)	
	)	
VS.	)	W.C.C. No. 2017-06663
	)	
COASTAL MEDICAL, INC.	)	

FINAL DECREE OF THE APPELLATE DIVISION

This matter came on to be heard by the Appellate Division upon the claim of appeal of the petitioner/employee and upon consideration thereof, the employee's claim of appeal is denied and dismissed, and it is

ORDERED, ADJUDGED, AND DECREED:

That the findings of fact and the orders contained in a decree of this Court entered on May 27, 2020 be, and they hereby are, affirmed.

Entered as the final decree of this Court this 21st day of July, 2022.

PER ORDER:

/s/ Nicholas DiFilippo
Administrator

ENTER:

/s/ Olsson, J.

/s/ Pepin Fay, J.

/s/ Cardoza, J.

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DECISION OF THE APPELLATE DIVISION

OLSSON, J. This matter is before the Appellate Division on the employee's claim of appeal from the trial judge's decision and decree denying the employee's original petition alleging that she suffered an occupational injury to her left shoulder due to repetitive computer use. After a thorough review of the record and consideration of the arguments presented by both parties, we deny and dismiss the employee's appeal and affirm the trial judge's decision and decree.

On November 20, 2017, the employee filed an original petition in which she alleged she developed an occupational injury to her left shoulder "on or about November 2016." Ct's Ex. III, Ee's Petition for Compensation Benefits dated 11/20/2017. On January 10, 2018, the trial judge entered an interlocutory order finding that the employee sustained a work-related left shoulder injury in the nature of an occupational disease and ordering the payment of weekly benefits for partial incapacity beginning January 10, 2018. On that same date, the trial judge ordered that Dr. A. Robert Buonanno conduct an impartial medical examination of the employee.

After receiving Dr. Buonanno's report, the trial judge entered a pretrial order on May 16, 2018 denying the employee's original petition, and the employee filed a timely claim for trial.

Laurie Cairone ("the employee") testified that she was employed as a nurse case manager at Coastal Medical, Inc. ("the employer") since September of 2012. Utilizing a keyboard, laptop, and headset, the employee would update patients' electronic medical records in her computer after speaking with the patients by telephone. The employee stated that she worked eight (8) to ten (10) hours a day, always sitting. In order to copy and paste the patients' care plans into the electronic health record, she would use her left hand to press the control keys, moving her left arm back and forth about six (6) inches for each entry. The employee, who is right-hand dominant, operated the mouse with her right hand and typed with both hands. Occasionally, she would need to lift or carry office items, but she specifically denied any overhead use of her left arm on a repetitive basis.

The employee initially complained of left shoulder pain on July 14, 2016 when she saw her primary care physician, Dr. Frank Fraioli, for her annual physical. She thought the pain may be related to her computer work. Dr. Fraioli administered a steroid injection into her left shoulder, which the employee found helpful. The employee did not notify her employer of her shoulder pain at this time.

In November of 2016, the employee's workstation was moved to a different location. This change was unrelated to any complaints made by the employee. Within two (2) weeks of this move, she complained to her immediate supervisor that reaching for her keyboard led to discomfort. The employee never specifically mentioned left shoulder pain to her supervisor, nor did she mention her previous treatment in July of 2016. In response, the employer arranged for an ergonomic assessment which was conducted in December of 2016 with the employee present.

During the ergonomic assessment, the keyboard tray of the employee's desk was removed to enable her to move closer to the desk and provide more leg room, and the keyboard was placed on top of the desk. In addition, the height of the employee's chair was raised. These alterations made the employee more comfortable but did not entirely alleviate her shoulder complaints.

Due to increasing discomfort, on June 8, 2017, the employee began email correspondence with the person in the human resources office who had arranged the ergonomic assessment, requesting a second ergonomic assessment and a new chair. The employee explained that her current chair did not stay raised up at a level where her arms and shoulders were comfortable. At times, the employee would take the keyboard off her desk and place it on her lap to relieve the discomfort in her left shoulder. The employee acknowledged that she did not state that she was having left shoulder problems in the emails she exchanged with the human resources office.

On August 10, 2017, the employee sought treatment with Dr. Jack Goldstein, an orthopedic surgeon. X-rays were taken and Dr. Goldstein advised her to do certain exercises using two (2) pound weights. When the employee did not experience any relief, an MRI was ordered and subsequently Dr. Goldstein administered a steroid injection, which provided no relief. After the employee complained of severe pain, Dr. Goldstein advised her to rest the shoulder and provided the employee with a note to stop working as of September 28, 2017. The employee participated in physical therapy for about a month, from October to November of 2017, which also provided no relief.

The employee denied any previous injuries to her left shoulder. She has not returned to work in any capacity since September 28, 2017.

The medical evidence presented in this matter consists of the records of Dr. Frank Fraioli, and the depositions with attached records of Drs. Jack Goldstein, Michael Hulstyn, and A.

Robert Buonanno.

The records of Dr. Fraioli, the employee's primary care physician, reflect that he saw the employee on July 14, 2016 for an annual physical examination. At that time, the employee complained of left shoulder pain that she believed was related to computer work. In his examination findings, Dr. Fraioli noted the presence of a tender left acromion and positive impingement. His diagnoses included left shoulder tendinitis. Dr. Fraioli administered an injection into the employee's left subacromial bursa.

Dr. Goldstein, an orthopedic surgeon, first saw the employee on August 10, 2017. The employee related to Dr. Goldstein that her left shoulder pain commenced one (1) "month ago with no known injury or cause." Ee's Ex. 8, Dr. Jack Goldstein Dep., Pet'r's Ex. 1 (attached report dated 8/10/2017, page 1). X-rays "demonstrate[d] a type III acromial morphology with limited space for the rotator cuff anteriorly." Ee's Ex. 8, Dr. Goldstein Dep., Pet'r's Ex. 1 (attached report dated 8/10/2017, page 2). Dr. Goldstein diagnosed the employee with impingement syndrome of the left shoulder as well as AC joint arthritis. The August 10, 2017 medical record does not indicate that the employee mentioned her work activities or the physical requirements of her job duties to Dr. Goldstein.

On September 7, 2017, Dr. Goldstein ordered an MRI of the shoulder and recommended that the employee continue with her home exercise program. The MRI was interpreted by the radiologist to show "[m]ild supraspinatus and infraspinatus tendinosis." Ee's Ex. 8, Dr. Goldstein Dep., Pet'r's Ex. 1 (attached report dated 9/13/2017). Dr. Goldstein stated that this finding was expected and that it helped to reinforce his belief that his diagnosis was correct. A steroid injection was administered into the employee's left shoulder on September 21, 2017. Again, this provided a brief period of relief. On September 28, 2017, Dr. Goldstein

recommended that the employee remain out of work as her job duties were exacerbating her shoulder symptoms.

At her last appointment with Dr. Goldstein on September 27, 2018, the employee continued to complain of ongoing shoulder pain which disabled her from her work. Her physical examination showed mild AC joint compression as well as a positive impingement test. Dr. Goldstein's diagnosis remained simple impingement. While the employee was anatomically predisposed to this condition, Dr. Goldstein opined that her shoulder had "somehow" been aggravated by her work activities. Ee's Ex. 8, Dr. Goldstein Dep. 13:16. Dr. Goldstein recommended a surgical procedure that would provide more room for the rotator cuff.

Although Dr. Goldstein was aware that some modifications had been made to the employee's work area, he did not know what had been changed or when those changes were made. He stated that it was his understanding that the employee did some type of secretarial work, but he did not explain exactly what arm movements were required or the frequency of such movements. Dr. Goldstein stated that it was his understanding that the condition of adhesive capsulitis is a common consequence of shoulder impingement. He maintained that his causation opinion was not affected by the fact that the employee did not need to lift her left arm above shoulder level to perform her work activities.

The employee was examined by Dr. Michael Hulstyn, an orthopedic surgeon, on December 21, 2017, at the employer's request. Dr. Hulstyn reviewed the previous medical records and was told by the employee that she attributed her neck and left shoulder complaints to her repetitive work on her keyboard. The employee's physical examination revealed that she had both an active and passive restriction of motion in her left shoulder. Dr. Hulstyn diagnosed the employee with "left shoulder adhesive capsulitis, which is also known as frozen shoulder." Er's

Ex. C, Dr. Michael Hulstyn Dep. 6:21-23. He described adhesive capsulitis as a condition in which the capsule surrounding the shoulder joint becomes inflamed "for no good reason" and consequently becomes very painful and shrinks, causing loss of motion. *Id.* at 8:6-7. Dr. Hulstyn stated that this condition is not causally related to the employee's work activities or requirements.

Dr. Hulstyn believed the tendinosis found on the MRI was degenerative and that it preexisted the employee's employment. He described tendinosis as "degeneration of the rotator cuff tendons" due to wear and tear and the aging process. *Id.* at 9:23-24. He disagreed with the diagnosis of Dr. Goldstein and asserted that the employee did not have impingement syndrome. Dr. Hulstyn explained that, if the employee had full motion of her shoulder accompanied by pain or weakness and loss of function, the diagnosis could be impingement syndrome. He did not make that diagnosis for the employee as "she has adhesive capsulitis and restricted motion . . . ." *Id.* at 12:21-22. Dr. Hulstyn stated that adhesive capsulitis was an idiopathic condition that occurred "for no good reason." *Id.* at 17:10.

On April 17, 2018, Dr. A. Robert Buonanno, an orthopedic surgeon, conducted an impartial medical examination of the employee as ordered by the trial judge. Dr. Buonanno stated that, as a general orthopedic surgeon, he no longer performs shoulder surgeries, but he has treated shoulder injuries for more than forty-five (45) years. After his review of the medical records, his discussion with the employee, and his physical examination, Dr. Buonanno advised the trial judge that he did not agree with Dr. Goldstein's diagnosis of impingement syndrome nor his opinion that the employee's condition was caused by her work activities.

At his deposition, Dr. Buonanno stated that the MRI revealed mild tendinitis and no evidence of impingement syndrome. He explained that Dr. Goldstein did not document the

results of any testing that was performed to show impingement, nor did he document the employee's range of motion or strength. Dr. Buonanno asserted that this information is essential for a diagnosis of impingement syndrome. Dr. Buonanno agreed with Dr. Hulstyn that the accurate diagnosis for the employee was a frozen left shoulder as well as mild rotator cuff tendinitis.

Furthermore, Dr. Buonanno stated that the employee's work activities did not aggravate any underlying shoulder tendinitis or rotator cuff disease as they did not involve the use of her left arm above shoulder level. He explained that the activities described by the employee as repetitive were a winging motion that involves the scapula, back, and rhomboid muscles, not the rotator cuff where impingement syndrome is found.

In his comprehensive twenty-four (24) page bench decision, the trial judge reviewed the testimony of the employee as well as the depositions with attached medical records of Drs. Goldstein, Hulstyn, and Buonanno. The trial judge also discussed the ergonomic assessment performed at the employee's request, as well as the functional job description that had been admitted as an exhibit and was reviewed by Drs. Hulstyn and Buonanno. Citing *Parenteau v. Zimmerman Eng'g, Inc.*, 111 R.I. 68, 299 A.2d 168 (1973), the trial judge stated that he was persuaded by the opinions of Drs. Hulstyn and Buonanno that the employee suffered from adhesive capsulitis which was idiopathic in nature and not caused by the employee's work activities. The trial judge specifically rejected the testimony of Dr. Goldstein, noting that Drs. Hulstyn and Buonanno stated that repetitive movements above shoulder level were required to cause impingement syndrome, which was Dr. Goldstein's diagnosis. The written job description and the testimony of the employee both indicated that such activities were not a part of her

regular employment. Consequently, the trial judge denied the employee's original petition, and the employee promptly filed a claim of appeal.

In reviewing the trial judge's decision, we must bear in mind that the trial judge's determination that the employee failed to meet her burden of proof is a finding of fact and shall not be overturned unless the trial judge was clearly erroneous, or overlooked or misconceived material evidence. R.I. Gen. Laws § 28-35-28(b); *Diocese of Providence v. Vaz,* 679 A.2d 879, 881 (R.I. 1996). Only after specifically finding that the trial judge was clearly wrong may we conduct our own *de novo* review of the evidence. *Vaz*, 679 A.2d at 881. After a careful review of the record, we conclude that the factual findings made by the trial judge are not clearly erroneous, and we therefore deny the employee's claim of appeal.

In the memorandum designated as her reasons of appeal, the employee asserts that the trial judge erred in denying the employee's petition when he chose to rely upon the testimony and opinions of Drs. Buonanno and Hulstyn rather than the testimony and opinions of the employee's treating physician, Dr. Goldstein. In support of her argument, the employee initially contends that the opinion of Dr. Buonanno should have been disregarded because he lacked sufficient knowledge of shoulder anatomy and diagnoses to provide a probative and persuasive opinion regarding the employee's condition. The employee contends that "Dr. Buonanno admitted that, as a knee surgeon, he was not familiar with the biomechanics of shoulder injuries." Ee's Reasons of Appeal at 5. However, the employee mischaracterizes Dr. Buonanno's testimony.

The employee's counsel asked Dr. Buonanno if he was "familiar with *any of the literature* on biomechanics and shoulder injuries" and computer work. Ee's Ex. 11, Dr. A. Robert Buonanno Dep. 34:25-35:1 (emphasis added). Dr. Buonanno replied that he was not

familiar with such literature as he presently specialized in knee replacement surgery. Dr. Buonanno explained that he previously performed open shoulder repair surgeries, but with the advent of arthroscopic shoulder surgery he now refers patients with chronic rotator cuff tendinitis or positive MRI scans to two (2) surgeons in his office who specialize in those procedures.

Dr. Buonanno is a board-certified orthopedic surgeon with over forty-five (45) years of experience examining, diagnosing, and treating shoulder injuries. Moreover, Dr. Buonanno fully addressed all the employee's questions regarding his diagnosis of a frozen shoulder rather than impingement syndrome or rotator cuff tendinitis during a vigorous cross-examination by counsel. He explained that the employee's job duties as described by the employee and as documented in the written job description provided to him by the trial court required only movements of her arm below shoulder level and did not involve the area of the shoulder that was damaged. Dr. Buonanno stated that impingement syndrome or rotator cuff tendinitis is generally caused by repetitive use of the arm above shoulder level and the employee acknowledged that her job did not involve such activity.

Dr. Buonanno was certainly qualified to testify as an expert medical witness based upon his credentials and experience. During his deposition, Dr. Buonanno provided detailed explanations of the foundation for his opinions as to the diagnosis and cause of the employee's condition. It was perfectly appropriate for the trial judge to rely upon the testimony of Dr. Buonanno, the court's impartial medical examiner, when arriving at his decision in this matter.

In her reasons of appeal, the employee also argues that the trial judge erred in relying upon the opinions of Dr. Hulstyn because he did not perform a test for impingement syndrome. This argument ignores the explanation of Dr. Hulstyn for his inability to test for impingement as well as the remainder of his testimony regarding his examination and his opinions. In his

decision, the trial judge noted that Dr. Hulstyn found a limited range of both active and passive motion in the left shoulder. Dr. Hulstyn rotated the employee's shoulder to test for impingement. Because the employee was unable to raise her arm fully overhead, she did not demonstrate the range of motion needed to reproduce the impingement sign. Dr. Hulstyn stated that this lack of motion was key to his determination that the accurate clinical diagnosis was adhesive capsulitis, or frozen shoulder, and not impingement syndrome.

Dr. Hulstyn is board-certified as an orthopedic surgeon and a sports medicine specialist. He had the opportunity to review the films from the MRI done on September 12, 2017 and noted that they revealed "increased capsular thickness and decreased axillary pouch volume consistent with adhesive capsulitis." Er's Ex. C, Dr. Hulstyn Dep., Resp't's Ex. A (attached report dated 12/21/2017, page 3). Dr. Hulstyn explained that adhesive capsulitis causes loss of motion, pain that interrupts sleep, and pain that limits the ability to rotate the arm, raise the arm overhead, or reach behind the back. The pain can quickly become severe over a short period of time. In contrast, Dr. Hulstyn stated that impingement syndrome would be indicated if the employee was able to raise her arm completely overhead and then experienced pain and weakness. The employee was not able to raise her arm overhead during Dr. Hulstyn's examination.

In reviewing the medical reports, the employee's complaints are consistent with Dr. Hulstyn's description of the symptoms of adhesive capsulitis, which Dr. Hulstyn classified as "an idiopathic condition that came on for no good reason" and is not related to the employee's work activities. Er's Ex. C, Dr. Hulstyn Dep. 17:9-10. When the employee initially saw Dr. Goldstein on August 10, 2017, she complained of pain when reaching, lifting, and carrying with her arm outstretched or overhead. On September 28, 2017, the employee complained of increased pain despite receiving a cortisone injection the week before. On December 18, 2017,

the employee told Dr. Goldstein that she was having difficulty reaching behind her back and overhead due to pain. A few days later, on December 21, 2017, after being out of work for almost three (3) months, the employee complained to Dr. Hulstyn of moderate to severe pain that she rated as an eight (8) to ten (10) out of ten (10). The employee also complained of pain at night that interrupted her sleep and difficulty performing daily activities such as dressing and washing her hair due to restricted motion of her shoulder. These complaints are consistent with Dr. Hulstyn's diagnosis of adhesive capsulitis.

Following her critique of the opinions of Drs. Buonanno and Hulstyn, the employee asserts that the trial judge "simply elected" to accept their opinions over those expressed by Dr. Goldstein. Ee's Reasons of Appeal at 5. Yet, the testimony of Dr. Goldstein revealed that he did not have a clear understanding of the precise left arm movements required by the employee's job duties, the arrangement of her workstation, or the modifications to that area made at her request. He did not document the employee's range of motion or her strength during any of his many examinations. Drs. Hulstyn and Buonanno both stated that these measurements are essential to any diagnosis of impingement syndrome. The trial judge thoroughly reviewed the testimony and opinions provided by Drs. Hulstyn and Buonanno and found them to be more probative and persuasive than the testimony and opinions of Dr. Goldstein. The trial judge committed no error in exercising his prerogative to accept the opinion of one (1) (or more) medical experts over the differing opinion of another expert.

In electing to rely upon the testimony and opinions of Drs. Buonanno and Hulstyn, the trial judge cited the decision of the Rhode Island Supreme Court in *Parenteau*, in which the Court stated "[t]he important factor here is that the trial commissioner, faced with conflicting medical opinions, chose to rely on the opinion of Dr. Berk and Dr. Stoll on the issue of

causation. *This he had a right to do.*" 111 R.I. at 78, 299 A.2d at 174 (emphasis added). The employee argues that because all the physicians in the present matter testified by deposition rather than live before the trial court, the Appellate Division should not afford any deference to the trial judge's assessment of the credibility of the medical witnesses and should conduct its own *de novo* review of the evidence.

Initially, we would point out that the employee erroneously asserts that in *Parenteau*, "[i]t is manifest from the Supreme Court's opinion that all of these doctors testified live before the Commissioner." Ee's Reasons of Appeal at 6. The Rhode Island Supreme Court states in that decision "*[h]aving read Dr. Osgood's deposition*, we cannot fault the trial commissioner's interpretation of Dr. Osgood's testimony or his decision not to give great weight to Dr. Osgood's opinion." *Parenteau*, 111 R.I. at 78, 299 A.2d at 174 (emphasis added). Consequently, it appears that at least one (1) of the physicians in the *Parenteau* case testified by deposition rather than live before the court.

Second, the Appellate Division has addressed and rejected this same argument in *Osmara Vasquez v. HV Industries, Inc.*, W.C.C. No. 2015-01253 (App. Div. January 17, 2020) and in *William W. Kittila v. Petro Holdings, Inc.*, W.C.C. No. 2016-00869 (App. Div. May 26, 2020). The Appellate Division is bound by the constraints of Rhode Island General Laws § 28-35-28(b) requiring an initial determination that the trial judge's findings of fact are clearly erroneous, before undertaking an independent review of the evidence. Expert testimony by way of deposition does not affect the ability of the trial judge to "accurately cite[] *Parenteau v. Zimmerman Eng'g, Inc.*, for the proposition that when a trial judge is confronted with conflicting medical opinions, they have the right to choose to rely upon one expert opinion over the other."

Osmara Vasquez, W.C.C. No. 2015-01253 at 8 (citing *Parenteau*, 111 R.I. 68, 78, 299 A.2d 168, 174 (1973)).

The employee simply asserts that the trial judge committed clear error by failing to accept the testimony and opinions of her treating physician, Dr. Goldstein. She argues that the trial judge's failure to find Dr. Goldstein's opinion more credible than the opinions expressed by Drs. Hulstyn and Buonanno provides the necessary rationale for a *de novo* review of the evidence by this appellate panel. We disagree.

The Rhode Island Supreme Court has unequivocally rejected the contention that the testimony and opinions of the treating physician should be afforded greater weight and probative value than the testimony and opinions of any other examining physicians. *Grimes Box Co. v. Miguel*, 509 A.2d 1002, 1004 (R.I. 1986). Furthermore, in his twenty-four (24) page bench decision, the trial judge thoroughly reviewed the employee's testimony and the depositions and records of all the physicians, as well as the workstation photographs and other documentary evidence in the record. In reviewing that decision, we find no grounds to conclude that the trial judge overlooked or misconceived any material evidence in arriving at his determination that the employee failed to prove that her shoulder problem is work-related. Consequently, we deny and dismiss the employee's appeal and affirm the decision and decree of the trial judge.

In accordance with Rule 2.20 of the Rules of Practice of the Workers' Compensation Court, a final decree, a proposed version of which is enclosed, shall be entered on July 21, 2022.

Pepin Fay, J., and Cardoza, J., concur.

ENTER:

/s/ Olsson, J.

/s/ Pepin Fay, J.

/s/ Cardoza, J.