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Commonwealth Of Kentucky

Court Of Appeals

NO. 2001-CA-002508-WC

ROBERTA SCHWARTZ — APPELLANT

v.

PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
CLAIM NO. WC-98-58570

APPALACHIAN REGIONAL HEALTHCARE;
IRENE STEEN, Administrative Law Judge;
and WORKERS' COMPENSATION BOARD — APPELLEES

OPINION

AFFIRMING

** ** ** ** **

BEFORE: BUCKINGHAM, GUIDUGLI and HUDDLESTON, Judges.

HUDDLESTON, Judge: Roberta Schwartz appeals from a Workers' Compensation Board opinion that affirmed an administrative law judge's finding that Schwartz's preexisting congenital condition is not related to nor was it aroused into a disabling reality by her work injury. In its opinion, the Board determined that the ALJ had complied with its directive on remand to provide an explanation for her conclusion "as it related to the 'erroneous' histories relied upon by the physician in light of available medical reports" and concluded that the evidence does not compel a result contrary to that reached by the ALJ.

Schwartz's entire occupational history consists of employment in the healthcare industry. Eventually, she obtained a masters degree in nursing administration. Beginning in 1993, Schwartz was employed by Appalachian Regional Healthcare as a director of nursing at its hospital in South Williamson, Kentucky. On November 1, 1998, while working in that capacity, she injured herself when lifting a box of copier paper. She has not worked since that time.

Schwartz testified that the pain she felt upon lifting the box felt as though "somebody struck [her] in the back of [her] neck with a knife" and also described it as radiating down her right side into her right arm, including her shoulder. Immediately thereafter, a nursing supervisor escorted Schwartz to the emergency room where she received pain medication and her arm was x-rayed and placed in a sling. Following the injury, she continued to experience pain in her neck and right arm as well as numbness in her right hand.

Two days after the incident, Schwartz met with her initial treating physician, Dr. Desingu Raja. At that time, she complained of pain at the base of her neck and in her right arm and shoulder. Initially, Dr. Raja felt that Schwartz had suffered an acute strain of the cervical spine with radiculopathy of the right upper extremity and an acute strain of the lumbosacral spine to mild degree. He treated Schwartz conservatively with outpatient physical therapy for approximately three weeks. However, when her symptoms persisted, he ordered a cervical magnetic resonance imaging (MRI) scan which suggested a cystic lesion in the spinal

cord and degenerative changes. Based on these findings, Schwartz underwent additional MRIs (thoracic and head) on December 21-22, 1998. Both the cervical MRI scan and the thoracic MRI scan revealed a large syrinx (cavity) which began in the upper cervical region and extended into the upper thoracic spine. The MRI scan of the head showed an Arnold-Chiari Type II malformation[1] with associated hydrocephalus. In response to these results, Dr. Raja recommended that Schwartz seek further evaluation. He did not specifically address the possibility that Schwartz's malformation may have been aroused by her work injury.

Dr. Raja referred Schwartz to Dr. Richard Mortara, a neurosurgeon, who examined her on November 14, 1998, at which point he diagnosed her as having an Arnold-Chiari malformation and

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[1] Exhibit A, a report from the National Organization for Rare Disorders, Inc., defines Arnold-Chiari Syndrome as "a rare malformation of the brain that is present at birth. Abnormalities at the base of the brain include the displacement of the lower portion of the brain (cerebellum) and/or brain stem through the opening in the back of the skull (foramen magnum). A developmental defect of the central nervous system may occur in some infants with Arnold-Chiari Syndrome. A sac (myelomeningocele or herniated pouch) may bulge through an abnormal opening in the spinal column and may contain portions of the spinal cord, spinal membranes, and/or cerebrospinal fluid. Some infants may also have abnormal accumulations of cerebrospinal fluid in the skull (hydrocephalus)." Chiari Type I is used to describe individuals who have an extension into the spinal canal without a myelomeningocele. Chiari Type II refers to this brain malformation along with myelomeningocele. Synonyms include ACM, Arnold-Chiari Malformation and Cerebellomedullary Malformation Syndrome.

Symptoms include vomiting, muscle weakness in the head and face, difficulty swallowing (dysphagia) and varying degrees of mental impairment. Paralysis of the arms and legs can also occur. Adults and adolescents with the syndrome who previously exhibited no symptoms may begin to do so as they mature including involuntary, rapid, downward eye movements, dizziness, headaches, vomiting, double vision, deafness, leg muscle weakness, an impaired ability to coordinate movement and episodes of acute pain in and around the eyes. The cause is unknown.

cerebromalcia. During her examination with Dr. Mortara, Schwartz relayed that she had experienced an episode in the past consisting of numbness under her left breast area and was told that she had swelling in the spinal cord.[2] Dr. Mortara suspected that the November injury was an event that caused her condition to "be brought into reality." His examination of Schwartz revealed "no particular limitation of movement at this time." However, he felt that Schwartz's symptoms were progressive and recommended immediate surgery.[3]

Pursuant to a request from the workers' compensation carrier, Schwartz consulted Dr. Phillip Hylton, another neurosurgeon, for a second opinion. Having reviewed the MRIs of Schwartz's brain, cervical spine and thoracic spine, he concurred with Dr. Mortara as to the diagnosis[4] and urgent need for surgery, noting that once the malformations become symptomatic they can produce progressive neurological loss. Dr. Hylton indicated that, although she initially denied having previously experienced direct

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[2] ARH submitted records from Dr. Henry Altman, Schwartz's family physician, which indicate that she saw him in October 1989 at which time she indicated that she had recently seen a neurologist concerning numbness on the left side of her thorax and been diagnosed with syringomyelia. Syringomyelia is a rare, slowly progressive neurological disorder characterized by a syrinx (cavity) in the spinal cord. It is often associated with craniovertebral abnormalities such as Arnold-Chiari syndrome. ARH also submitted hospital records indicating that Schwartz was admitted there in December 1996 for several conditions, including the syringomyelia which was considered stable at that time but could lead "to parasthesias in the upper limbs."

[3] Apparently, some adults with the syndrome may benefit from a procedure which enlarges the opening in the back of the skull, relieving intracranial pressure in the area.

[4] "Chiari malformation associated with the syrinx and hydrocephalus due to obstruction at the fourth ventricular flow."

symptoms, upon extensive questioning, Schwartz said that she had experienced numbness around her left thorax in the past and noted painful, "shock-like" sensations radiating into her arms with valsalva[5] or sneezing. At the time, she noted some difficulty with urinary urgency but no incontinence.

With regard to causation, Dr. Hylton determined that the condition was clearly a pre-existing one but indicated that valsalva such as Schwartz may have experienced with the lifting accident can "acutely arouse this condition into disabling reality." Dr. Hylton also acknowledged that it is possible Schwartz had undiagnosed and unexplained symptoms prior to the accident which were not apparent to her and were not disabling. He did not assess an impairment rating.

On July 26, 1999, Dr. James W. Templin, a specialist in occupational medicine, evaluated Schwartz pursuant to a request from her attorney. At that time, Schwartz complained of chronic neck, shoulder and arm pain coupled with generalized upper body weakness. Dr. Templin completed a medical history and his report indicates that her symptoms "were said to be the result of injuries she sustained in a work-related accident." Schwartz informed Dr. Templin that she had begun to notice a clumsiness when attempting to use her right hand several days after the accident as well as a decreased level of sensation in both arms, the right more so than the left. She also reported that she had developed dysesthesia

[5] As defined by the Board, a Valsalva maneuver is an attempt to force air from the lungs while closing off the throat.

involving her left chest wall and breast area and an overall balance disorder and had noticed a decrease in mental acuity.

Dr. Templin reviewed the various MRIs taken in December 1998, confirming the large syrinx which originated in the upper cervical region and extended into the upper thoracic spine, degenerative changes of the cervical spine, and the Arnold-Chiari Type II malformation and associated hydrocephalus. The results of Schwartz's neurological examination were essentially normal with the exception of some noticeable motor ataxia, particularly with respect to her right hand. It was Dr. Templin's opinion that the November 1998 injury was the source of Schwartz's problems as it had aroused a preexisting, dormant condition into a symptomatic state. Although there was a notation on the MRI reflecting degenerative changes of the cervical vertebrae with some osteophyte formation and bulging at the C2-3 and C6-7 level, Dr. Templin did not assign a percentage of impairment to the natural aging process. Instead, he assigned an overall impairment of 21% in accordance with the American Medical Association (AMA) Guides to Evaluation of Permanent Impairment, apportioned equally between the dormant condition and the work injury. Dr. Templin imposed numerous restrictions on Schwartz's movement, i.e., lifting, bending, walking, standing, sitting, . . . , finding that she could not return to the type of work performed at the time of injury.

Pursuant to Kentucky Revised Statutes (KRS) 342.315, the ALJ referred Schwartz to a university evaluator, Dr. Phillip A. Tibbs, a neurosurgeon and professor of neurosurgery and rehabilitation medicine at the University of Kentucky. Consistent

with the provisions of that statute, Dr. Tibbs was provided with all medical records pertinent to Schwartz's claim.[6] Schwartz saw Dr. Tibbs for a neurological consultation on December 8, 1999, at which time she complained of headaches, weakness in holding up her head, decreased balance, pain on sneezing and moving around, moderate difficulty with urinary retention and urinary tract infections, weakness and numbness in her right arm, sleep apnea, depression and a memory disorder. Dr. Tibbs found it medically probable that Schwartz suffers from an Arnold-Chiari Type I malformation that is congenital in nature. In addition, he diagnosed her as having hydromyelia, hydrocephalus and cervical disc disease with a right C6 radiculopathy.

With respect to causation, Dr. Tibbs found "within reasonable medical probability" that Schwartz's injury was responsible for the cervical radiculopathy but did not believe that the hydrocephalus or Arnold-Chiari malformation could properly be attributed to the work injury. He attributed 50% of her condition to the effects of the natural aging process, i.e., the cervical disc disease. Based on the cervical disc disease and related radiculopathy, Dr. Tibbs assessed a 10% impairment rating to the body as a whole, attributable to the injury in question. Dr. Tibbs clarified that this percentage excludes any impairment that is attributable to injury-related depression, deferring to the evaluating psychiatrist in that regard.

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[6] The referral order shows that Dr. Tibbs was provided with the records of Dr. Mortara, Dr. Templin, Dr. Raja, Dr. Weitzel, Dr. Altman and hospital records from Williamson ARH.

According to Dr. Tibbs: "One presumes that this was a dormant condition that became symptomatic as a consequence of this otherwise trivial injury." He also speculated that Schwartz appeared to be exaggerating the severity of the pain she was experiencing as it was "exacerbated by an associated affective disturbance of depression." Consistent with the previous recommendations, Dr. Tibbs recommended surgery, drainage of the cyst and possible ventricular shunting.[7]

In addition to the medical evidence summarized above, the ALJ considered the report and deposition of Dr. William Weitzel, a psychiatrist. In August 1999, Dr. Weitzel conducted a psychiatric evaluation (included psychiatric testing, a clinical examination and an interview) of Schwartz, ultimately assessing an overall psychiatric impairment of 15%. In his opinion, Schwartz's IQ placed her in the normal range but she engaged in some symptom exaggeration as reflected by her clinical scales which showed distress arising from perceptions of bodily dysfunction, obsessive compulsion, the need for control, hypochondriasis, hysteria and depression. Dr. Weitzel also felt that Schwartz's entire impairment stemmed from pre-existing, dormant, nondisabling conditions aroused by the injury. He expressed concern that Schwartz's cognitive functioning would become more impaired since her level of dementia will increase as the disease progresses.

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[7] In his letter to the ALJ, Dr. Tibbs noted that "The patient appears to be immobilized by anxiety regarding the potential complications of such a procedure, and it is her right to decline." This description is consistent with Schwartz's initial hesitation at the prospect of undergoing the procedure as documented by Dr. Hylton.

At the time of the evaluation, Dr. Weitzel felt that Schwartz was not occupationally disabled from a psychiatric standpoint alone. However, at his deposition, Dr. Weitzel attempted to clarify his position regarding the 15% impairment rating by explaining that he had addressed the emotional issues relating to Schwartz's condition while Dr. Robert Phillip Granacher, the neuropsychiatrist who examined Schwartz, had focused on the neurological components. According to his testimony, the ALJ should have combined both of their impairment ratings in order to arrive at an appropriate functional impairment rating for Schwartz. At times, however, he also indicated that Dr. Granacher had addressed both aspects in assessing a 25% impairment.

Dr. Granacher performed a neuropsychiatric examination on Schwartz in September 1999. According to his testimony, the numbness that Schwartz experienced in the area of her left thorax was at the level of her spinal cord where the syrinx is located. While he indicated that syringomyelia can remain static or cease to progress even if it does become symptomatic, he felt that in Schwartz's case the progression is obvious. He opined that her condition had existed long before 1989 when it was officially diagnosed. Upon reviewing her MRIs, Dr. Granacher concluded that her condition is in no way associated with the lifting incident as evidenced by the fact that the deterioration of her corpus callosa indicates that the pressure has been there for a long period of time causing destruction of the nerve fibers in her brain.

A complete neurological examination revealed neurological deficits which were primarily affecting her right side but both

sides to some degree. Upon completing a battery of psychological testing to ascertain Schwartz's level of cognitive function, Dr. Granacher concluded that she suffers from a neurocognitive disorder caused by the Arnold-Chiari malformation. While he questioned the genuineness of her efforts during the examination, he was not prepared to say outright that she was exaggerating her symptoms given the diagnosis. Ultimately, he assessed an overall functional impairment rating of 25% with 75% apportioned to the active, pre-injury, neurological deformity and the remaining 25% to the work incident. He qualified that assessment by saying that the 25% would only be relevant if the neurosurgeons had found evidence of an actual work-related injury as Schwartz would not have a psychiatric impairment relative to the incident if they did not, explicitly relying on the opinions of Dr. Mortara and Dr. Hylton. When reviewing Schwartz's medical history, Dr. Granacher observed that she had failed to mention her previous loss of sensation and numbness to the neurosurgeons.

At the hearing before the ALJ, Schwartz testified that she has refused to undergo surgical intervention. As a consequence, her workers' compensation benefits were terminated on March 28, 1999. In her testimony, Schwartz indicated that she has experienced an increased number of headaches since the injury and continues to suffer from pain in her neck and right shoulder which radiates to her fingertips. She also suffers from memory loss, dizziness, loss of balance, numbness in her right arm, difficulties with her left arm and has even begun to experience problems with her feet. According to Schwartz, these symptoms are becoming

progressively worse and she is also suffering from depression now due to her inability to perform her prior job or even do household chores. Schwartz admitted that the numbness in her left thoracic region which persists today first occurred several years prior to her injury but indicated that she had continued to work as it had not bothered her in terms of performing her job. She denied having experienced similar symptoms prior to her injury, further testifying that she was unable to recall being diagnosed with syringomyelia and believes that the swelling in her breast area caused the numbness.

In a thorough and detailed opinion, the ALJ found that Schwartz's malformation and associated conditions, i.e., syringomyelia and hydrocephalus, were in no way caused by or aroused into disabling reality as a consequence of the minor work injury. In so finding, the ALJ said, in relevant part, that:

> It is very clear from the record that Plaintiff was not honest with the neurosurgeons who saw her for the injury sub judice, relative to her prior history of an actual diagnosis of this situation many years prior to the evaluation, by, especially, Dr. Tibbs who, in this instance, is afforded presumptive weight. As stated, Dr. Tibbs had "presumed" that this was a dormant condition, however, other evidence through especially Dr. Granacher, clearly reveals that Plaintiff had had complaints as a sequela of this disease already when she was in her forties. Unfortunately for this Plaintiff her condition appears to be one of the progressive types rather than

> the static type. I find the problems associated with her underlying disease to be merely coincidental with the sprain/strain which she suffered at the time she lifted the box of paper. She does have evidence of degenerative disc disease in her neck and the UK evaluator found that 50% of her problems were due to natural aging processes. In using the DRE model under which Dr. Tibbs assessed the 10% impairment, I do not feel that to exclude 50% as attributable to the natural aging process would be correct, as I believe this has already been taken into consideration when using the DRE model.

The ALJ also concluded that any emotional or psychiatric problems Schwartz suffers from are related to the serious nature of the underlying disease rather than the lifting incident. Ultimately, she determined that Schwartz has a 10% occupational disability.

On appeal to the Board, Schwartz argued that there is uncontradicted evidence confirming that the Arnold-Chiari malformation was aroused by the November 1998 injury, namely the opinions of Dr. Mortara, Dr. Hylton and Dr. Tibbs. She emphasized the fact that Dr. Granacher, the only other doctor to testify regarding this issue, explicitly deferred to their judgment regarding causation. Schwartz also took issue with the ALJ's characterization of the histories she provided to Dr. Templin and Dr. Tibbs, highlighting the fact that both doctors were given copies of the reports compiled by Dr. Mortara and Dr. Hylton, both of which noted her previous numbness in the left thoracic region. In significant part, the Board concluded as follows:

We cannot accept Schwartz's contention that the evidence compels a finding in her favor regarding the arousal of the Arnold-Chiari malformation. The opinions regarding causation given by Dr. Hylton and Dr. Mortara are equivocal at best. Dr. Hylton stated that it was possible for a Valsalva maneuver to arouse this condition into disabling reality, but did not state within reasonable medical probability that this is what he believed happened. Dr. Mortara stated he suspected that the injury aroused the malformation. Dr. Tibbs stated that "one presumes that the malformation was a dormant condition that became symptomatic as a result of the injury." It is unclear, however, whether this is a statement made within "reasonable medical probability."[8] While Dr. Granacher felt that Schwartz's current impairment was due, at least in part, to her work-related injury, he explicitly based this opinion on the opinions of Drs. Mortara and Hylton. Since the causation opinions of Drs. Mortara and Hylton are equivocal with respect to this workers' compensation claim, Dr. Granacher's causation opinion must also be regarded as equally equivocal. The only definite statement of causation was made by Dr. Templin who felt that the Arnold-Chiari malformation had been aroused by the injury. However, it is unclear from Dr. Templin's

[8] See Markwell and Hartz, Inc. v. Pigman, Ky., 473 S.W.2d 842 (1971).

report whether he was aware that Schwartz had manifested some symptoms prior to the injury.

Although the ALJ premised her opinion regarding arousal of the malformation largely on the fact that Schwartz failed to inform Dr. Templin and Dr. Tibbs about her previous numbness, it was unclear to the Board whether they relied on a faulty history as they had access to other medical records which did contain an accurate medical history. Accordingly, the Board remanded the case for further consideration with instructions for the ALJ to determine exactly what information Dr. Templin and Dr. Tibbs relied upon in forming their opinions before disregarding them.[9]

On remand, the ALJ emphasized Schwartz's extensive medical background and the fact that she had declined to undergo the proposed decompression surgery, reasoning that Schwartz might have declined since she did not view the situation as urgent because she had possessed knowledge of her condition since she was in her forties. In the ALJ's estimation, Dr. Mortara, Dr. Hylton and Dr. Tibbs were of the opinion that Schwartz's condition was in the acute stages because she insisted that she had experienced a completely new set of symptoms since the injury. Accordingly, the ALJ concluded that the doctors would have reported differently if

[9] An example of why further analysis was deemed necessary was correctly pointed out by the Board which observed that the ALJ said that Dr. Mortara did not address causation in any way. To the contrary, in his letter to Dr. Raja, Dr. Mortara did in fact say that he suspected that the November 1998 injury caused the malformation to be brought into reality.

they had been provided with an accurate history.[10] Based upon the totality of the evidence and her perception of Schwartz's testimony, the ALJ remained convinced that Schwartz had deliberately misstated the facts concerning her condition.

On review after remand, the Board found that the ALJ had complied with its directive in that, "[a]s she proceeded through an analysis of the evidence from Drs. Hylton, Tibbs and Mortara, she referred to statements contained in those reports which support what we believe to be a reasonable inference on the part of the ALJ, which is for the fact finder and not this Board." Acknowledging that there was evidence which would have supported a finding that there is a causal connection between the symptomatology from the Arnold-Chiari syndrome and the work injury, the Board also noted that there was equivocation on the part of the physicians as to that possibility. As such, the evidence did not compel a contrary result. In an opinion rendered on October 31, 2001, the Board affirmed the decision of the ALJ, and that opinion is the subject of the present appeal.

In a workers' compensation claim, the claimant bears the burden of proving each of the essential elements of her claim.[11] Where the party that bears the burden of proof before the ALJ is unsuccessful, the question on appeal is whether the evidence

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[10] "The lack of adequate review of medical records by the physicians is regrettable, although sometimes understandable based upon their time frames, however, physicians base their conclusions upon the medical history as they get it from the patient, and when that information is false everything thereafter becomes skewed."

[11] Snawder v. Stice, Ky. App., 576 S.W.2d 276, 280 (1979).

compels a different result.[12] Compelling evidence is defined as evidence that is so overwhelming no reasonable person could reach the same conclusion as the ALJ.[13] It is not enough for Schwartz to show there is merely some evidence that would support a contrary conclusion.[14] As long as the ALJ's opinion is supported by any evidence of substance, it cannot be said that the evidence compels a different result.[15]

The ALJ, as fact finder, has the sole authority to determine the weight, credibility, substance and inferences to be drawn from the evidence.[16] The ALJ may choose to believe parts of the evidence and disbelieve other parts, even when it comes from the same witness or the same party's total proof.[17] Furthermore, the Board may not substitute its judgment for that of the ALJ in matters involving the weight to be afforded the evidence on questions of fact.[18] The function of the Court of Appeals when reviewing the Board's decision is to correct it only where the Court perceives the Board has "overlooked or misconstrued

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[12] Wolf Creek Collieries v. Crum, Ky. App., 673 S.W.2d 735, 736 (1984).

[13] REO Mechanical v. Barnes, Ky. App., 691 S.W.2d 224, 226 (1985).

[14] McCloud v. Beth-Elkhorn Corp., Ky., 514 S.W.2d 46, 47 (1974).

[15] Special Fund v. Francis, Ky., 708 S.W.2d 641, 643 (1986).

[16] Paramount Foods, Inc. v. Burkhardt, Ky., 695 S.W.2d 418, 419 (1985).

[17] Caudill v. Maloney's Discount Stores, Ky., 560 S.W.2d 15, 16 (1977).

[18] Ky. Rev. State. (KRS) 342.285(2).

controlling statutes or precedent, or committed an error in assessing the evidence so flagrant as to cause gross injustice."[19]

In the present case, there is evidence of substance which supports the ALJ's decision. In addressing the issue of causation, Dr. Mortara and Dr. Hylton used language which can only be categorized as equivocal, i.e., "suspect" that the injury was an event that caused the malformation to be brought into reality and "possible" to arouse this condition into disabling reality due to valsalva, respectively. While Dr. Granacher felt that Schwartz's injury was at least partially responsible for her current impairment, he explicitly based his opinion on those of Dr. Mortara and Dr. Hylton. It stands to reason that if their opinions are viewed as equivocal, Dr. Granacher's opinion must be as well. Similarly, Dr. Tibbs "presume[d]" that the malformation was a dormant condition that became symptomatic due to the injury. All of these statements reflect a lack of "reasonable medical probability." While the ALJ initially failed to consider Dr. Mortara's statement regarding causation, on appeal the Board specifically directed her attention to it, but the ALJ clearly did not find it persuasive in light of the evidence as a whole.

Dr. Tibbs further indicated that Schwartz's condition was "identified in the process of work up" of her current complaints, lending credence to the ALJ's finding that he was unaware of Schwartz's prior symptoms and diagnosis, regardless of the reason. Further support for the ALJ's conclusion that the physicians relied

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[19] Western Baptist Hospital v. Kelly, Ky., 827 S.W.2d 685, 687-688 (1992).

upon "erroneous" histories is found in Dr. Hylton's telling statement that Schwartz might have had "undiagnosed and unexplained" symptoms which were "unapparent" to her. While we are not convinced that Schwartz was intentionally deceptive, her initial failure to fully disclose her background to Dr. Hylton, her failure to report her previous numbness to Dr. Templin and her insistence that she had never experienced any of the symptoms she described to Dr. Tibbs prior to the incident in question could be interpreted as deceptive, particularly given Schwartz's education and employment history. Whatever her motivation, the inquiry is a factual one and the result is the same.

The only definite statement as to causation was made by Dr. Templin and it is unclear from his report whether he was aware that Schwartz had manifested symptoms prior to the injury. However, he did find within a reasonable medical probability that Schwartz's condition could not be attributed to her injury. His opinion is afforded presumptive weight under KRS 342.315(2).

There is no dispute that Dr. Templin and Dr. Tibbs had access to medical reports which contain the omitted information. Dr. Templin expressly referred to the reports prepared by Dr. Mortara and Dr. Hylton, both of which note the prior numbness. Likewise, the referral form attached to Dr. Tibbs's report indicates that he was given copies of those same reports in addition to the records of Dr. Altman which document the previous diagnosis of syringomyelia and related numbness in the left thorax. The ALJ possessed knowledge of all of these factors and remained of the opinion that Schwartz had misled the doctors, resulting in

inadequate medical histories which, in turn, led to incorrect medical opinions, either directly or indirectly. It is not the function of this Court to question the ALJ's wisdom with regard to factual determinations or the assessment of credibility. "The recitation of a history by a physician does not render it unassailable. If the history is sufficiently impeached, the trier of fact may disregard the opinions based on it."[20]

Because the evidence as to causation is ambiguous, it does not compel a finding in favor of Schwartz. The Board's opinion is affirmed.

ALL CONCUR.

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[20] Osborne v. Pepsi-Cola, Ky., 816 S.W.2d 643, 547 (1991).