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**IN THE
COURT OF APPEALS OF INDIANA**

ANNA GREENE,)
)
 Appellant-Plaintiff,)
)
 vs.) No. 93A02-0511-EX-1096
)
 R.R. DONNELLEY & SONS COMPANY,)
)
 Appellee-Defendant.)

APPEAL FROM THE FULL WORKER'S COMPENSATION BOARD OF INDIANA
The Honorable G. Terrance Coriden, Chairman
Cause No. C-155348

September 7, 2006

MEMORANDUM DECISION - NOT FOR PUBLICATION

FRIEDLANDER, Judge

Anna Greene appeals from a decision of the Worker's Compensation Board (the Board) in favor of her former employer, R.R. Donnelley & Sons Company (R.R. Donnelley), on her application for benefits for a work-related injury. She presents the following restated and consolidated issues for review:

1. Was a report by John McLimore, M.D., improperly admitted into evidence in violation of Ind. Code Ann. § 22-3-3-6 (West 2005)?
2. Did the Board abuse its discretion in failing to give weight to the reports of Todd Midla, D.O., and a certified rehabilitation counselor?

We affirm.

Greene was employed by R.R. Donnelley from July 1995 until November 2000. While working on an auto-punch machine on or about March 14, 2000, Greene reported to her employer that she was suffering right hand and wrist pain and swelling. Thereafter, R.R. Donnelley provided medical care and treatment for her with Osvaldo Acosta-Rodriguez, M.D. At the initial exam, Dr. Acosta-Rodriguez noted right hand swelling of unknown etiology. X-rays of her hand were taken, which came back normal. He sent her back to work with restrictions, provided her with a splint, and directed her to ice and elevate her hand. The following day, Dr. Acosta-Rodriguez proscribed Lodine, a nonsteroidal anti-inflammatory drug, and opined that Greene might have a ganglion cyst.

At a follow-up appointment on March 24, Greene continued to complain of right-hand pain and also began complaining of symptoms consistent with carpal tunnel syndrome in her left hand and wrist. Dr. Acosta-Rodriguez directed her to wear wrist splints on both hands and take Celebrex instead of Lodine. At an appointment on April 10, the doctor noted pain and carpal tunnel syndrome symptoms with regard to Greene's

right hand and wrist. At this time, an EMG and nerve conduction studies were ordered. The results of these tests of Greene's upper extremities, performed on April 14, were essentially normal, with no evidence of carpal tunnel syndrome or ulnar neuropathy. Thereafter, on April 20, Dr. Acosta-Rodriguez diagnosed Greene with bilateral hand pain and dysfunction, instructed her to continue taking Celebrex, and referred her to a specialist at The Indiana Hand Center.

By summer, Greene had begun seeing James Creighton, Jr., M.D., at The Indiana Hand Center for bilateral wrist and forearm pain. Dr. Creighton ordered physical therapy for strength and conditioning of Greene's upper extremities. During physical therapy in July and early August, Greene consistently complained about her sore wrists and hands and noted on several occasions that she believed her condition would not improve as long as she was doing her same job. After nearly a month of physical therapy, her strength had increased, but there had been no decrease in her subjective complaints.

Dr. Creighton ordered a functional capacity evaluation (FCE) of Greene to assess her current level of physical capacities in order to determine her ability to perform her present job. At the time, her primary complaint was pain in both hands. The FCE, which was performed on August 9, revealed that Greene did not demonstrate a full and consistent effort during the evaluation and indicated that she "may be physically able to do more". *Exhibits* at 35. Upon reviewing the report, Dr. Creighton observed that the FCE "demonstrated inconsistencies and, therefore, no specific work restrictions could be recommended from th[e] report." *Id.* at 41. When Dr. Creighton attempted to review the results of the FCE with Greene on August 11, Greene became upset and accused Dr.

Creighton of being “one of the plant doctors being paid a lot of money.” *Id.* After further discussion regarding Greene’s lack of confidence in the care she was receiving, Dr. Creighton recommended that she seek care at another facility.

Thereafter, Dr. Acosta-Rodriguez referred Greene to John McLimore, M.D., at OrthoIndy for a second opinion. Dr. McLimore evaluated Greene on August 31. In his written report, Dr. McLimore detailed the history of Greene’s injury and her subsequent medical treatment. As in the past, Greene reported that the initial onset of pain and swelling was in her right hand. Dr. McLimore noted that Greene’s description of the pain was “somewhat ill-defined and nonspecific but may perhaps have been in the right dorsomedial hand/wrist region.” *Id.* at 105. Dr. McLimore noted that Greene eventually began experiencing pain in the bilateral forearms and left-hand region. The doctor also noted Greene’s negative x-rays and negative/normal EMG. With respect to the FCE, Dr. McLimore observed that Greene “apparently did not demonstrate full or consistent effort during the testing.” *Id.*

After detailing the results of his physical examination of Greene, Dr. McLimore concluded his report as follows:

IMPRESSION: Reported work related incident 3/14/00 with residual myalgias in predominately the bilateral forearm region.

At this point, I reviewed the case with the patient in detail as well as her clinical examination. She is neurologically intact. She has full range of motion. She does not have any palpable myofascial band or trigger areas or tenderness. With detailed examination of her entire upper extremities, there is no evidence of vascular compromise and no evidence of thoracic outlet signs or symptoms or radicular complaints. She has a negative Spurling sign. She does tend to have some embellishment of symptomatology with description of her pain. She describes a gripping pain in her hand and

forearm region whereby at times she feels that it swells so that the veins look like they are about ready to “blow up”.

She repetitively questions me regarding the swelling in her hand, however, there is no appreciable at all today on examination. She also describes that her muscles get so tight that the muscle actually sticks out of her arm and looks like it is “coming out of the arm”. She states this occurs quite frequently.

She states that nothing to date has been of benefit to her, including medication, icing modalities, splinting, anti-inflammatories and physiotherapy.

RECOMMENDATIONS: At this point in time, I do feel that indeed she has reached maximum medical improvement and is at a quiescent state. There is nothing further from a medical or therapeutic standpoint, in my opinion, that would dramatically change her outcome. I feel she has received appropriate treatment to date with lack of benefit. Her subjective complaints are disproportionate with her rather benign examination. Her exam is essentially within normal limits without neurologic compromise, restrictive range or myofascial patterns or vascular compromise or evidence of thoracic outlet syndrome.

She does have, interestingly, some give-way weakness suggestive of possible functional overlay as well as non-anatomic sensory deficits of her hands in a rather diffuse inconsistent pattern.

I was able to review the [FCE] which for the most part deemed to be invalid. I did not see, based on her examination as well as review of her record and her [FCE], why she cannot return to full duties without restriction. Again, I feel she is at maximum medical improvement. She does not merit a PPI rating (0% PPI rating).

She can return to full duty status with no restrictions. No further medication is required. However, if she gets some discomfort with work activities, she can take over the counter Advil or Tylenol p.r.n. Otherwise she is formally discharged from my care.

Id. at 107-08.

Greene returned to Dr. Acosta-Rodriguez on October 9, “with similar signs and symptoms of right hand dorsum pain.” *Id.* at 43. She exhibited some tenderness and some

soft-tissue swelling in an area of her right hand and wrist. Dr. Acosta-Rodriguez diagnosed possible enthesistis/second dorsal compartment tendinitis. He started her on a Medrol dose pack, provided her with a new splint, and directed her to ice the affected area. Greene was to return to work with restrictions of a wrist splint, no lifting of over five pounds, and limited use of her right hand. Dr. Acosta-Rodriguez also referred Greene to her third orthopedic specialist, Louis Metzman, M.D., to evaluate her hand pain and dysfunction and a right carpal boss.

Dr. Metzman examined Green on October 25, at which time Greene reported that both of her wrists and arms hurt, with the right hurting more than the left. In particular, Greene reported that whenever she was doing her regular job, her right hand swelled, a bump popped up on the back of her hand, and veins bulged out. Greene described pain in a different location on her left hand and explained that a bump did not pop out on that side when working. Upon examination of Green's upper extremities, Dr. Metzman noted:

She has full motion at the hands, wrists, elbows, and shoulders. Grip strength is good, perhaps a bit weak on the right as compared to the left.... Sensation is intact. The fingers are warm and well perfused. Radial pulses are intact. There is no specific tenderness to palpation anywhere about either upper extremity. Finkelstein's test for De Quervain is negative. Tinel's at the medial nerve is negative as well. There is a palpable carpal bossing at the right side a little bit larger and symmetric as compared to the left side. This area, however, is not tender at this point. The lateral epicondyles are not tender. Resisted extension does not cause pain at the lateral epicondyle.

Id. at 45. Dr. Metzman further reported that x-rays of the bilateral wrists were requested by Greene and no obvious abnormalities were noted. He noted Greene's "fairly

complicated history” in that she had seen three doctors and had “no specific or discernable diagnosis other than the fact that she has soreness in both of her upper extremities”. *Id.* The doctor believed the soreness to be job related and recommended:

RECOMMENDATION: I explained to her that not everybody can do every job and her job at Donnellys, from what she tells me, it involves a lot of repetitive motion. She is 47-years of age now and perhaps this has just caught up with her and she will not be able to do that type of thing in the future. From what I can tell she has been on restrictions on several occasions and she gets better a bit while on the restrictions and when she returns to work the discomfort comes back. However, at this point, I think she needs to wear wrist splints at work and she needs to be on some anti-inflammatories. I wrote her a prescription for Flubuprofen[.]

Id.

On November 2 and 7, Greene returned to Dr. Acosta-Rodriguez for treatment, complaining of “numbness, tingling, and general aches throughout the hand.” *Id.* at 110. Dr. Acosta-Rodriguez noted some mild swelling to her right hand and tenderness to her metacarpal boss on her right wrist. On the later date, Dr. Acosta-Rodriguez informed Greene that he believed she had reached maximum medical improvement. He found her hand pain, tingling, and numbness to be of unknown etiology and concluded:

At this point in time I feel we have exhausted all known modalities and treatments to my knowledge. I told her it would be in her best interest to at this point in time to go on permanent restrictions until such time that she can go on long term disability....

A PPI rating has been requested and at this point the patient has reached maximum medical improvement and has no measurable loss in objective strength testing which is consistent and verifiable and has no sensory loss that is reproducible. She has no decrease in range of motion. She has complaints of pain and dysesthesias that are not limited to a known dermatomal or myotomal distribution. She is therefore not eligible for anything other than a Zero percent PPI rating.

Id. at 110-11. Dr. Acosta-Rodriguez then placed Greene on permanent restrictions of no repetitive wrist motions or lifting over three pounds with either hand.

Greene was subsequently laid off because R.R. Donnelley was unable to accommodate her permanent restrictions. She filed an application for adjustment of claim with the Board on November 9, 2000, claiming a “repetitive-use type injury.” *Appellant’s Appendix* at 5.

On December 29, Dr. Acosta-Rodriguez completed documentation to assist Greene in obtaining disability benefits, reiterating his diagnosis of “hand pain and swelling of unknown etiology.” *Exhibits* at 79. While the doctor noted several limitations regarding the use of Greene’s hands (such as, repetitive hand motions and gripping forcefully), he noted that her exam was “fairly benign” and that the results of prior nerve conduction studies, x-rays, and an EMG had been normal. *Id.*

Several months later on May 30, 2001, Greene underwent an MRI of her cervical spine.¹ The indicated reason for the MRI was neck and left shoulder pain. The MRI revealed a “small left paracentral soft disc herniation at C6-7.” *Id.* at 81. Albert Lee, M.D., who reviewed the MRI results and saw Greene in a neurology clinic for follow up, sent a report to a Mary Glass, M.D., who is not otherwise mentioned in the record. After detailing the exam, Dr. Lee provided the following impression/plan:

1. History of neck pain.^[2]
2. History of wrist pain.

¹ Contrary to Greene’s assertion on appeal, it is not clear who ordered this MRI. It is apparent, however, that Dr. Acosta-Rodriguez was not involved.

² The report indicated that Green’s neck was “still tender.” *Id.* at 97.

At this point her work up was fairly unremarkable. Nerve conduction study was negative for underlying pinched nerve. MRI scan of the neck showed a small disk at the left C6-7 level. MRI scan of the head was normal.

I have therefore elected to repeat injection therapy into the carpal tunnel and also neck muscles. We will continue to monitor her progress through the neurology clinic.

Id. at 97. There is no indication in the record that Greene sought medical treatment for her alleged neck, arm, hand, or wrist pain after this appointment in May 2001.

On July 29, 2002, Greene met with Michael Blankenship for a vocational rehabilitation assessment. Greene reported to Blankenship that she “experiences neck pain; pain in the right wrist, thumb, and forearm to the shoulder; and pain in the wrist and forearm of the left upper extremity.” *Id.* at 50. Regarding career alternatives, Blankenship opined: “Given the significant degree of impairment and limitation to Ms. Green’s [sic] upper extremities and neck,[³] I am unaware of any reasonable occupation for which she would be capable, qualified, and able to sustain herself during the traditional 8-hour work day.” *Id.* at 51. Blankenship ultimately concluded:

It is my opinion based on my interview with Anna B. Greene, my reviewing of her medical history, and my evaluation of her vocational and educational background,[⁴] that she is currently not a candidate for employment. Ms. Greene has sustained injuries to both upper extremities with a herniated disc in her cervical spine. Consequently, she is unable to resume any reasonable type of employment. Ms. Greene’s limitations affect her functioning with the upper extremities, and severe limitation have

³ Greene testified at the hearing in the instant case, however, that all of her restrictions in July 2002 were because of her hands.

⁴ Greene is a high school graduate who has held a variety of other jobs, such as housekeeper, switchboard operator, assistant retail manager, front desk clerk at a hotel, and concierge.

been imposed primarily by Dr. Acosta. As a result, she is not a candidate to engage in substantial gainful activity.

Id.

On June 3, 2004, more than three years after she had stopped working for R.R. Donnelley, Greene went to Todd Midla, D.O., for an independent medical evaluation for “pain and disability referable to her neck and bilateral arms.” *Id.* at 100. Greene reported to Dr. Midla that in March 2000 she was working at R.R. Donnelley when she started to experience “bilateral hand numbness and pain in her neck and pain down both of her arms with the right worse than the left.” *Id.* She further indicated that activity aggravates her neck and shoulders. Dr. Midla’s physical examination of Greene appears unremarkable, except that he noted she has “diffuse tenderness throughout her cervical spine.” *Id.* at 101. At the conclusion of his report, Dr. Midla provided in relevant part as follows:

DIAGNOSIS:

1. Herniated disc cervical spine with radiculopathy.
2. Tendonitis, possible carpal tunnel syndrome bilateral wrists, right worse than the left.

From the “Guidelines To Evaluation of Permanent Impairment”, 5th edition revised, I estimate her whole person impairment to be 7%.

I feel she is at a quiescent stage. I wouldn’t recommend any further diagnostic testing. She would benefit from therapeutic injections on occasion to her cervical spine and possibly therapy. It is my opinion that her impairment is due to her injury dated March 2000.

Id.

A hearing on Greene’s application for adjustment of claim was held before a single hearing member of the Board on June 7, 2004. The issues presented for

determination were whether Greene was entitled to permanent total disability benefits or any permanent partial impairment (PPI) benefits. On November 16, 2004, the single hearing member determined Greene should take nothing by her application for adjustment of claim and issued the following findings and conclusions:

1. On or about March 14, 2000 [Greene] reported to her employer that she was suffering right hand and wrist pain and swelling. [R.R. Donnelley] thereafter provided her with medical care and treatment for the right hand condition.
2. [Greene] later advised of left wrist pain which [R.R. Donnelley] also accepted as compensable and for which treatment was provided to [Greene].
3. No clear-cut diagnosis of her bilateral hand and wrist conditions appears in the medical record.
4. By November 7, 2000, her main treating physician, O.A. Acosta-Rodriguez, M.D., determined that [Greene] had reached maximum medical improvement with no measurable loss of strength and no sensory loss. Dr. Acosta-Rodriguez further noted that [Greene] had no decrease in range of motion and that her “complaints of pain and dysesthesias...are not limited to a known dermatomal or myotomal distribution.” Dr. Acosta-Rodriguez assigned a zero percent (0%) permanent partial impairment at that time.
5. [Greene] did not work for [R.R. Donnelley] after November 2000.
6. In May 2001 [Greene] was complaining of neck pain which may be related to a small left paracentral soft disc herniation at C6-7 identified in a May 30, 2001 MRI. This condition is unrelated to her work activities.
7. [Greene] has offered the reports of Michael L. Blankenship (with respect to vocational disability and dated July 30, 2002) and of Todd E. Midla, D.O. (with respect to permanent partial impairment and dated June 3, 2004). Neither of these reports has been given weight as they include reference to limitations placed by [Greene’s] neck pain, which has been found herein to be unrelated to her work.
8. [Greene] has not been rendered permanently and totally disabled as a result of her March 14, 2000 reported work injury to her right hand and wrist and her subsequently reported left wrist problem.
9. [Greene] has sustained a zero percent (0%) permanent partial impairment as a result of her March 14, 2000 reported work injury to her right hand and wrist and her subsequently reported left wrist problem.

Appellant's Appendix at 136-37 (footnote omitted).

Greene subsequently filed an application for review by the full board. Following oral argument, the Board issued its order on September 26, 2005, unanimously adopting and affirming the decision of the single hearing member. Greene now appeals.

1.

Greene initially argues that it was prejudicial error for the Board to admit evidence over her objection when the evidence was inadmissible pursuant to I.C. § 22-3-3-6. In this regard, Greene challenges the admission of the August 31, 2000 report by Dr. McLimore in which he noted Greene's embellishment of symptomatology, assigned her a 0% PPI rating, and sent her back to work with no restrictions.

I.C. § 22-3-3-6(c) provides that a physician's written statement may be submitted by either party as evidence if the statement meets certain requirements. These requirements are set out in subsection (e) of the statute:

(e) All statements of physicians or surgeons required by this section, whether those engaged by employee or employer, shall contain the following information:

- (1) The history of the injury, or claimed injury, as given by the patient.
- (2) The diagnosis of the physician or surgeon concerning the patient's physical or mental condition.
- (3) The opinion of the physician or surgeon concerning the causal relationship, if any, between the injury and the patient's physical or mental condition, including the physician's or surgeon's reasons for the opinion.
- (4) The opinion of the physician or surgeon concerning whether the injury or claimed injury resulted in a disability or impairment and, if so, the opinion of the physician or surgeon concerning the extent of the disability or impairment and the reasons for the opinion.
- (5) The original signature of the physician or surgeon.

On appeal, Greene claims that Dr. McLimore's report does not contain the history of the injury as given by Greene or the doctor's opinion regarding causation.

We observe that Greene objected on statutory grounds to the admission of this report, as well as a report from Dr. Acosta-Rodriguez, before the single hearing member. On review by the full board, however, Greene objected only to the admission of "Dr. Acosta's Letter of November 07, 2000". *Appellant's Appendix* at 143. Thus, when before the full board, she evidently abandoned her objection to Dr. McLimore's report.

Moreover, we find no merit to Greene's cursory claim that Dr. McLimore's report is statutorily insufficient. Our review of the report, substantial portions of which are set forth above, reveals that Dr. McLimore specifically detailed the history of Greene's injury to her upper extremities as explained by Greene. In fact, this information is set forth in the initial section of the report. Moreover, while not as plainly stated, the report clearly implies that Greene's "residual myalgias in predominantly the bilateral forearm region" were caused by a work-related injury. *Exhibits* at 107. We find no error in the admission of Dr. McLimore's report.

2.

Greene also argues that the Board erred by expressly refusing to give any weight to the June 2004 report by Dr. Midla and the July 2002 report by Blankenship. Though not clearly articulated, it appears as though Greene is really challenging the Board's finding that her neck pain (that is, the disc herniation at C6-7 identified in May 2001) is unrelated to her work activities.

On review, we may not disturb the Board's factual determinations unless we conclude that the evidence is undisputed and leads inescapably to a contrary result. *See Bowles v. Gen. Elec.*, 824 N.E.2d 769 (Ind. Ct. App. 2005), *trans. denied*. Furthermore, it is the claimant's burden to prove a right to compensation. *Id.* In reviewing a decision made by the Board, we will neither reweigh the evidence nor assess the credibility of the witnesses. *Id.*; *see also Four Star Fabricators, Inc. v. Barrett*, 638 N.E.2d 792, 794 (Ind. Ct. App. 1994) ("in our review of the Board's factfindings we must disregard all evidence unfavorable to the decision and consider only the evidence and reasonable inferences therefrom which supports those findings").

R.R. Donnelley has never denied that Greene's bilateral hand and wrist injury in March 2000 was work related, and the Board did not find otherwise. Rather, the Board simply found that Greene's alleged neck pain was not work related. This finding is supported by the evidence and reasonable inferences drawn therefrom. For more than a year, Greene's only documented medical complaints involved her bilateral extremities, in particular her hands and wrists. The first indication of neck pain did not arise until her MRI in May 2001, more than six months after she had filed her application for adjustment of claim and had stopped working. Dr. Lee's report following the MRI did not indicate that Greene's neck pain and wrist pain were related and expressed no opinion with regard to the cause of Greene's "small left paracentral soft disc herniation at C6-7." *Exhibits* at 81. Further, despite the "small" herniated disc, Dr. Lee described Greene's work up as "fairly unremarkable." *Id.* at 97.

Dr. Midla's independent medical examination of Greene was conducted more than four years after Greene's work-related injuries to her upper extremities in March 2000. At the examination in June 2004, Greene reported to Dr. Midla that she started to have neck pain (in addition to the pain in her bilateral upper extremities) while working in March 2000. This belated claim of neck pain is entirely unsupported by medical records that were created contemporaneously with her reported injury. For more than a year, Greene's sole complaints to her treating physicians and therapists concerned her bilateral upper extremities, with particular emphasis on her hands and wrists. Moreover, Dr. Midla made two separate diagnoses, one involving Greene's neck ("1. Herniated disc cervical spine with radiculopathy") and one involving her bilateral arms ("2. Tendonitis, possible carpal tunnel syndrome bilateral wrists, right worse than left"). *Exhibits* at 101. In his brief report, Dr. Midla did not explain if or how Greene's neck and arm pain were related, aside from apparently taking Greene's word that both originally occurred at the same time while working. Finally, Dr. Midla's PPI rating of 7% clearly took into account Greene's herniated disc.

As we have stated above, it is not our place to reweigh the evidence or assess the credibility of witnesses. *See Bowles v. Gen. Elec.*, 824 N.E.2d 769. Here, Dr. Midla's report was admitted in place of his testimony at the hearing. In light of the dubious nature of that report, it was entirely within the Board's discretion to disregard Dr. Midla's opinion regarding Greene's level of impairment.

Two of Greene's treating physicians, Dr. Acosta-Rodriguez and Dr. McLimore, opined that she had reached maximum medical improvement with respect to her bilateral

hand/wrist condition and that she had a 0% PPI rating. While the relevant medical records reveal that Greene experienced soreness in her upper extremities due to her work, the bulk of Greene's subjective complaints could not be proven by objective means and, even after seeing a number of doctors, no specific or discernible diagnosis had been made. Further, there are clear indications in the record that Greene's subjective complaints were often overstated and were disproportionate with her consistently benign exams. In fact, when issuing his 0% PPI rating, Dr. Acosta-Rodriguez explained:

[Greene] has no measurable loss in objective strength testing which is consistent and verifiable and has no sensory loss that is reproducible. She has no decrease in range of motion. She has complaints of pain and dysesthesias that are not limited to a known dermatomal or myotomal distribution.

Exhibits at 111. There is an abundance of evidence in the record to support the Board's determination that Green had sustained a 0% PPI as a result of her March 2000 work injury, and we reject Greene's invitation to reweigh the evidence.⁵

Judgment affirmed.

BARNES, J., and MATHIAS, J., concur.

⁵ We note that the Board did not abuse its discretion by disregarding the vocational rehabilitation assessment provided by Blankenship, as it relied in large part upon Greene's neck condition. Moreover, in light of the fact we have upheld the Board's determination that Greene is not entitled to permanent partial impairment benefits, it necessarily follows that she is not permanently totally disabled. *See Kanacs v. Walker*, 557 N.E.2d 670, 672 (Ind. Ct. App. 1990) ("[s]ince this form of disability is treated in the same section with other harms comprising threats to wage-earning power such as impairments and lost uses, total permanent disability must be taken to require a greater incapacity than that produced by any other of the scheduled harms"), *trans. denied*.