OFFICE OF SPECIAL MASTERS

(Filed: July 11, 2005)

BRUCE STEARNS,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 04-1082V
	)	
SECRETARY OF HEALTH AND HUMAN SERVICES,	)	
	)	
Respondent.	)	
	)	

ORDER TO SHOW CAUSE[1]

Petitioner, Bruce Stearns (Mr. Stearns) seeks compensation under the National Vaccine Injury Compensation Program (Program).[2] In a petition that he filed on June 30, 2004, Mr. Stearns alleges that he "suffered the 'Table Injury' known as brachial neuritis" after he received a diphtheria-tetanus (DT) vaccination on July 30, 2003. Petition (Pet.) at 1. Mr. Stearns claims that he "continues to experience pain and numbness" from the brachial neuritis. Pet. ¶ 9.

[1] Because this order contains a reasoned explantion for the special master's action in this case, the special master intends to post this order on the United States Court of Federal Claims's website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2913 (Dec. 17, 2002). Therefore, as provided by Vaccine Rule 18(b), each party has 14 days within which to request redaction "of any information furnished by that party (1) that is trade secret or commercial or financial information and is privileged or confidential, or (2) that are medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of privacy." Vaccine Rule 18(b). Otherwise, "the entire" order will be available to the public. *Id.*

[2] The statutory provisions governing the Vaccine Program are found in 42 U.S.C. §§ 300aa-10 *et seq.* For convenience, further reference will be to the relevant section of 42 U.S.C.

THE LEGAL STANDARD

Mr. Stearns may pursue potentially three legal theories. Mr. Stearns may present what is commonly referred to as a Table case. The Act contains the Vaccine Injury Table that lists vaccines covered by the Act and certain injuries and conditions that may stem from the vaccines. *See* § 300aa-14; 42 C.F.R. § 100.3(a). If Mr. Stearns establishes by the preponderance of the evidence that following his DT vaccination, he suffered the onset of an injury listed on the Table for the DT vaccine, within the time period provided by the Table for the injury, then Mr. Stearns is entitled to a presumption that the vaccine caused the injury. §§ 300aa-11(c)(1)(C)(I); 300aa-13(a)(1)(A).[3] Respondent may rebut the presumption of causation if respondent establishes by the preponderance of the evidence that the injury was "due to factors unrelated to the administration of" a vaccine. § 300aa-13(a)(1)(B); *Knudsen v. Secretary of HHS*, 35 F.3d 543 (Fed. Cir. 1994).

Brachial neuritis is listed on the Table for DT vaccine. 42 C.F.R. § 100.3(a)(I)(B). The first symptom or manifestation of onset of brachial neuritis must occur within "2-28 days" after the administration of a DT vaccination for the injury to qualify for a presumption of causation. *Id.* The qualifications and aids to interpretation (QAI) that apply to the Table define brachial neuritis as a "dysfunction limited to the upper extremity nerve plexus . . . without involvement of other peripheral . . . or central nervous system structures." 42 C.F.R. § 100.3(b)(7)(i). According to the QAI, "[a] deep, steady, often severe aching pain in the shoulder and upper arm usually heralds onset" of the injury. *Id.* The QAI require specifically that "weakness" be present "before the diagnosis" of brachial neuritis "can be made." 42 C.F.R. § 100.3(b)(7)(ii). In addition, the QAI require specifically that "[m]otor, sensory, and reflex findings on physical examination *and the results of nerve conduction and electromyographic studies* must be consistent in confirming that dysfunction is attributable to the brachial plexus." 42 C.F.R. § 100.3(b)(7)(ii) (emphasis added).

In the alternative, Mr. Stearns may show based upon traditional tort standards that his DT vaccination caused actually a condition that is listed on the Table for DT vaccine, but that occurred outside the period provided in the Table, § 300aa-11(c)(1)(C)(ii)(II); or that his DT vaccination caused actually a condition that is not listed on the Table for DT vaccine. § 300aa-11(c)(1)(C)(ii)(I). While "[t]he Act relaxes proof of causation for injuries satisfying the Table," the Act "does not relax proof of causation in fact for non-Table injuries." *Grant v. Secretary of HHS*, 956 F.2d 1144, 1148 (Fed. Cir. 1992). Indeed, the United States Court of Appeals for the Federal Circuit has described Mr. Stearns's burden under the actual causation standard as "heavy." *Whitecotton v. Secretary of HHS*, 81 F.3d 1099, 1102 (Fed. Cir. 1996). The mere temporal relationship between a vaccination

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[3] The preponderance of the evidence standard requires the special master to believe that the existence of a fact is more likely than not. *See, e.g.*, *Thornton v. Secretary of HHS,* 35 Fed. Cl. 432, 440 (1996); *see also In re Winship,* 397 U.S. 358, 372-73 (1970) (Harlan, J., concurring), *quoting* F. James, CIVIL PROCEDURE 250-51 (1965). Mere conjecture or speculation will not meet the preponderance of the evidence standard. *Snowbank Enter. v. United States,* 6 Cl. Ct. 476, 486 (1984); *Centmehaiey v. Secretary of HHS*, 32 Fed. Cl. 612 (1995), *aff'd*, 73 F.3d 381 (Fed. Cir. 1995).

and an injury, and the absence of other obvious etiologies for the injury, are patently insufficient to prove actual causation. *See Grant*, 956 F.2d at 1148; *Wagner v. Secretary of HHS*, No. 90-1109V, 1992 WL 144668 (Cl. Ct. Spec. Mstr. June 8, 1992). To prevail under an actual causation theory, Mr. Stearns must demonstrate by the preponderance of the evidence that (1) "but for" the administration of his DT vaccination, he would not have been injured, and (2) his DT vaccination was a "substantial factor in bringing about" his injury. *Shyface v. Secretary of HHS*, 165 F.3d 1344, 1352 (Fed. Cir. 1999). The actual causation standard requires Mr. Stearns to present "a medical theory," supported by "[a] reliable medical or scientific explanation," establishing "a logical sequence of cause and effect showing that the vaccination was the reason for the injury." *Grant*, 956 F.2d at 1148; *see also Knudsen v. Secretary of HHS*, 35 F.3d 543, 548 (Fed. Cir. 1994)(citing *Jay v. Secretary of HHS*, 998 F.2d 979, 984 (Fed. Cir. 1993)). "The analysis undergirding" the medical or scientific explanation must "fall within the range of accepted standards governing" medical or scientific research. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 43 F.3d 1311, 1316 (9th Cir. 1995). Mr. Stearns's medical or scientific explanation need not be "medically or scientifically certain." *Knudsen*, 35 F.3d at 549. But, Mr. Stearns's medical or scientific explanation must be "logical" and "probable," given "the circumstances of the particular case." *Knudsen*, 35 F.3d at 548-49.

According to the Federal Circuit, "causation can be found in vaccine cases based on epidemiological evidence and the clinical picture regarding the [injured person] without detailed medical and scientific exposition on the biological mechanisms." *Knudsen v. Secretary of HHS*, 35 F.3d at 549. However, in most actual causation cases in the Program, petitioners are not able to adduce epidemiological evidence regarding a vaccination and an injury. As a result, many special masters have struggled over the years to articulate the proper method of analyzing actual causation cases that lack epidemiological evidence regarding a vaccination and an injury. *See e.g.*, *Stevens v. Secretary of HHS*, No. 99-0594V, 2001 WL 387418 (Fed. Cl. Spec. Mstr. Mar. 30, 2001); *see also Pafford v. Secretary of HHS*, 64 Fed. Cl. 19 (2005), *appeal docketed*, No. 05-5105 (Fed. Cir. Apr. 12, 2005). A judge of the United States Court of Federal Claims has advanced recently a "rule of reason." *Pafford*, 64 Fed. Cl. at 31. The judge posits that in appropriate circumstances, proof of biologic plausibility between a vaccine and an injury; proof that an injury occurred within a medically-acceptable time period following vaccination; and proof eliminating other potential causes for the injury may satisfy a petitioner's burden. *See id.*

BACKGROUND

The parties do not dispute apparently the relevant facts. Before July 2003, Mr. Stearns did not exhibit any difficulties with his left arm. Petitioner's exhibit (Pet. ex.) 6, ¶ 12. In July 2003, Mr. Stearns worked "at Bishop Manufacturing making store displays." Pet. ex. 2 at 1. On July 29, 2003, Mr. Stearns "was grinding high carbon steel." *Id.* He "felt that something got in his right eye." *Id.*

On July 30, 2003, Mr. Stearns presented to the Emergency Room at St. Croix Regional Medical Center. Pet. ex. 2 at 1. He reported "some ongoing irritation with slight photophobia" in

his right eye. *Id.* A physician observed "a superficial corneal abrasion with a small black fleck." *Id.* The physician "removed" the "small black fleck" from Mr. Stearns's eye "with a Q-tip." *Id.* Because Mr. Stearns had "not had a tetanus shot for over five years," *id.*, the physician administered "DT 0.5 cc." Pet. ex. 2 at 2.

On August 5, 2003, Mr. Stearns presented to St. Croix Regional Medical Center for a "[r]echeck of [his] right cornea." Pet. ex. 3 at 1. Wanda Brown, APRN (Ms. Brown), determined that Mr. Stearns's "[r]ight corneal abrasion" was "resolving." *Id.* However, Ms. Brown noted that Mr. Stearns complained "about severe pain where he had his tetanus shot." *Id.* Ms. Brown examined Mr. Stearns's "left deltoid." *Id.* Ms. Brown observed "no swelling, no redness and no erythema." *Id.* Ms. Brown advised Mr. Stearns to "use heat on his left upper arm as needed." *Id.*

On August 7, 2003, Mr. Stearns presented to St. Croix Regional Medical Center. *See* Pet. ex. 3 at 3. Mr. Stearns reported that his left extremity "pain" was "significantly worse." *Id.* Mr. Stearns explained that he felt "tingles down his arm." *Id.* In addition, Mr. Stearns explained that his "three middle fingers" on his left hand were "numb and tingly." *Id.* Further, Mr. Stearns explained that he experienced difficulty "with motion of the left arm." *Id.*

Ms. Brown examined again Mr. Stearns's "left deltoid." Pet. ex. 3 at 3. Ms. Brown observed again "no erythema or redness" and "no swelling." *Id.* Ms. Brown "consulted" an "Emergency Room physician." *Id.* Ms. Brown concluded that Mr. Stearns exhibited a "[l]ocal neuritis secondary to a diphtheria-tetanus vaccination in the left arm." *Id.* Mr. Stearns received a "[p]rescription for Bextra 20 mg daily." *Id.* Ms. Brown "encouraged" Mr. Stearns "to rest the arm to allow the muscle mass to lose the inflammation." *Id.*

On August 14, 2003, Mr. Stearns presented to St. Croix Regional Medical Center. *See* Pet. ex. 3 at 5. He was "concerned about his arm." *Id.* Ms. Brown examined again Mr. Stearns's arm. *Id.* Ms. Brown noted "still a slightly tender spot in the mid[-]deltoid muscle, most likely the point of injection." *Id.* Ms. Brown concluded again that Mr. Stearns exhibited a "[l]ocal neuritis secondary to DT vaccination." *Id.* According to Ms. Brown, Mr. Stearns exhibited "minimal progress of relief" from his pain. *Id.*

At some point, Ms. Brown referred Mr. Stearns for an electromyograph (EMG), *see* Pet. ex. 3 at 7; Pet. ex. 4 at 13-14, and to a neurologist for evaluation. *See* Pet. ex. 4 at 1-3, 25-28.

On August 29, 2003, Mr. Stearns underwent an EMG. *See* Pet. ex. 4 at 13-14. The EMG revealed that "left median and left ulnar distal motor latencies and motor nerve conduction velocities" were "normal." Pet. ex. 4 at 14. However, the EMG revealed "borderline prolongation of the left median orthodromic distal sensory latency." *Id.* According to the physician who interpreted the EMG, the "finding can be seen in early/mild carpal tunnel syndrome affecting sensory fibers only." *Id.* Yet, the physician who interpreted the EMG described the "degree of abnormality" as "so mild as to be nondiagnostic." *Id.* The physician who interpreted the EMG stated that "clinical correlation" was "necessary." *Id.*

On September 2, 2003, Mr. Stearns presented to David L. Webster, M.D. (Dr. Webster), a neurologist associated with the Minneapolis Clinic of Neurology, Ltd. *See* Pet. ex. 4 at 1-3, 25-28. Dr. Webster evaluated Mr. Stearns for "a complaint of discomfort in his left shoulder and numbness in his left hand which began several days after a tetanus injection in his left deltoid." Pet. ex. 4 at 1. Dr. Webster reviewed Mr. Stearns's medical history. *See id.* at 1-2. In addition, Dr. Webster performed a physical examination. *See id.* at 2-3. Although Dr. Webster characterized Mr. Stearns as "mildly focally tender over the lateral left deltoid," Dr. Webster observed "no swelling in the vicinity of the deltoid muscle" and "no erythema." *Id.* at 2. Dr. Webster noted "some pain" upon "[a]bduction of the shoulder" greater than "90 degrees." *Id.* In addition, Dr. Webster noted "subjective sensory loss" spanning possibly "several dermatones." *Id.* at 3.

Dr. Webster commented that "brachial neuritis is occasionally reported after intramuscular injections." Pet. ex. 4 at 3. However, Dr. Webster declared that Mr. Stearns's "symptoms" were "not classic for brachial neuritis." *Id.* Dr. Webster elaborated that brachial neuritis often "hurts more diffusely in the shoulder and not just the deltoid region." *Id.* In addition, Dr. Webster elaborated that brachial neuritis often "is associated with some motor and reflex changes." *Id.* Although Dr. Webster acknowledged that Mr. Stearns's possible "type of sensory loss may occur in brachial neuritis," Dr. Webster believed instead that Mr. Stearns had "a 'frozen shoulder.'" *Id.* Dr. Webster recommended a magnetic resonance imaging (MRI) "scan of" Mr. Stearns's "shoulder" to identify any "structural abnormalities." *Id.* Nevertheless, Dr. Webster offered that Mr. Stearns's "differential diagnosis include[d] cervical radiculopathy, brachial plexus lesion, or even demyelinating disease." *Id.*

Mr. Stearns underwent an MRI on September 11, 2003. Pet. ex. 3 at 8. The MRI was "minimally abnormal." Pet. ex. 4 at 5. The radiologist who interpreted the MRI suggested that certain aspects of the MRI represented an "impingement syndrome." *Id.*; *see also* Pet. ex. 3 at 8.

On September 19, 2003, Mr. Stearns began physical therapy. *See generally* Pet. ex. 8.

On September 30, 2003, Mr. Stearns presented to Dr. Webster for "follow up on left shoulder discomfort and left hand and arm tingling numbness." Pet. ex. 4 at 4. Dr. Webster reviewed Mr. Stearns's medical history. *See id.*[4] In addition, Dr. Webster reviewed Mr. Stearns's "interval medical history." *See id.* Further, Dr. Webster reviewed Mr. Stearns's EMG and MRI. *See id.* at 5. Dr. Webster described Mr. Stearns's EMG as "negative," except for "borderline slowing of the right median nerve distal latency at the wrist." *Id.* Indeed, Dr. Webster stated specifically that the EMG showed "no sign of acute denervation in any of the EMG-studied muscles in the left upper

[4] According to Dr. Webster, Mr. Stearns "developed some redness and erythema" following "a tetanus injection in his left arm on July 27, 2003," before developing "tingling down his left arm" and "some discomfort in the shoulder." Pet. ex. 4 at 4. However, Dr. Webster's September 30, 2003 recitation of Mr. Stearns's medical history is clearly not consistent with Dr. Webster's September 2, 2003 recitation of Mr. Stearns's medical history, *see* Pet. ex. 4 at 1-3, or with Ms. Brown's contemporaneous examination records. *See* Pet. ex. 3 at 1, 3.

extremity." *Id.* Thus, Dr. Webster commented that the EMG was "reassuring." *Id.* Dr. Webster noted that an aspect of Mr. Stearns's MRI was "consistent with tendinopathy." *Id.*

Dr. Webster concluded that Mr. Stearns suffered "very mild carpal tunnel syndrome." Pet. ex. 4 at 6; *see also id.* at 5. However, Dr. Webster offered that the carpal tunnel syndrome was "not directly related to" Mr. Stearns's "chief complaint" of pain in the left shoulder. *Id.* at 5. Indeed, Dr. Webster remarked that he was not able to find "a specific identifiable or treatable explanation for" Mr. Stearns's "tingling rather diffusely throughout his lower arm and hand on the left." *Id.*

On October 28, 2003, Mr. Stearns presented to Dr. Webster. *See* Pet. ex. 4 at 7-9. Dr. Webster reviewed Mr. Stearns's medical history. *See id.* at 7. Dr. Webster related that "[e]xcept for" a "frozen shoulder," his evaluation of Mr. Stearns yielded "no real definite 'hard' neurological findings such as altered reflex or muscle atrophy, etc." *Id.* Dr. Webster offered that he "postulated that Mr. Stearns might have a mild brachial neuritis." *Id.* But, Dr. Webster acknowledged that Mr. Stearns's "EMG did not confirm the presence of brachial neuritis." *Id.* Instead, according to Dr. Webster, Mr. Stearns's EMG "showed a mild left carpal tunnel syndrome." *Id.*; *see also id.* at 8.

On February 17, 2004, Mr. Stearns presented to Dr. Webster "to follow up on what we *presume* to be a post[-]tetanus injection brachial plexitis of his left upper extremity." Pet. ex. 4 at 10 (emphasis added). According to Dr. Webster, Mr. Stearns reported "minimal interval improvement in his left upper extremity." *Id.*; *see also id.* at 11. Dr. Webster observed "some limitation of abduction of the left shoulder," representing likely "a partially frozen shoulder." *Id.* at 11. Dr. Webster desired "to repeat the EMG" for comparison "with the one done" in August 2003. *Id.* However, Dr. Webster indicated that Mr. Stearns lacked "health insurance," so he could not "afford" recommended "testings or therapies." *Id.*

MEDICAL OPINION

Mr. Stearns submitted with the petition an affidavit from Dr. Webster. *See* Pet. ex. 5. Dr. Webster opines that Mr. Stearns exhibits "most likely" a "brachial neuritis which has left him with some subtle weakness, limited abduction, and sensory changes in his left arm extremity." Pet. ex. 5, ¶ 6. Dr. Webster attributes Mr. Stearns's condition to Mr. Stearns's July 30, 2003 DT vaccination. Pet. ex. 5, ¶ 8.

RESPONDENT'S REPORT

Respondent denies that Mr. Stearns is entitled to Program compensation. *See generally* Respondent's Report (Report), filed November 30, 2004. Respondent contends that Mr. Stearns cannot gain a presumption of causation afforded by the Vaccine Injury Table (Table), *see* § 300aa-14; 42 C.F.R. § 100.3(a), and by § 300aa-13(a)(1)(A), because he has not adduced evidence demonstrating that his condition comports with the regulatory definition of brachial neuritis

contained in the QAI, 42 C.F.R. § 100.3(b)(7), that apply to the Table governing his petition. Report at 6. In addition, respondent contends that Mr. Stearns has not adduced sufficient evidence demonstrating that his July 30, 2003 DT vaccination caused actually his condition. *Id.* at 6-9.

PROCEDURAL HISTORY

The special master convened the informal, yet substantive, Rule 5 conference on January 3, 2005. He discussed comprehensively the posture of the case. He announced that he agrees fundamentally with respondent's Report. In particular, the special master stated that Mr. Stearns's medical records refute a presumptive causation claim because electromyographic (EMG) study results do not confirm that Mr. Stearns's "dysfunction is attributable to the brachial plexus," as required by 42 C.F.R. § 100.3(b)(7)(ii). *See, e.g.*, Pet. ex. 4 at 7 ("[T]he EMG did not confirm the presence of brachial neuritis."). Therefore, the special master directed Mr. Stearns to develop further the medical basis for an actual causation claim. In particular, he required Mr. Stearns to file a supplemental affidavit from Dr. Webster. *See Stearns v. Secretary of HHS*, No. 04-1082V, Order of the Special Master (Fed. Cl. Spec. Mstr. Jan. 4, 2005). The special master provided:

> In the supplemental affidavit, Dr. Webster shall explain fully:
>
> 1. his impression that Mr. Stearns suffers brachial neuritis; and
>
> 2. the causal association between Mr. Stearns's July 30, 2003 DT vaccination and Mr. Stearns's condition.
>
> Dr. Webster shall supply copies of medical texts or literature supporting his opinion.

Id.

The special master convened an informal, yet substantive, status conference on May 24, 2005. He discussed comprehensively the posture of the case. He reviewed particularly Mr. Stearns's progress in obtaining a supplemental affidavit from Dr. Webster. Again, the special master directed Mr. Stearns to develop further the medical basis for an actual causation claim. In particular, he required Mr. Stearns to file a supplemental affidavit from Dr. Webster. *See Stearns v. Secretary of HHS*, No. 04-1082V, Order of the Special Master (Fed. Cl. Spec. Mstr. May 25, 2005). The special master provided:

> In the supplemental affidavit, Dr. Webster shall explain fully:
>
> 1. his impression that Mr. Stearns suffers brachial neuritis; and

2. the causal association between Mr. Stearns's July 30, 2003 DT vaccination and Mr. Stearns's condition.

Dr. Webster shall supply copies of medical texts or literature supporting his opinion.

Id.

On July 1, 2005, Mr. Stearns filed a status report. *See* Petitioner's Status Report, filed July 1, 2005. Mr. Stearns represented that he "is unable to provide the court with a supplemental affidavit of Dr. Webster." *Id.* at 1.

DISCUSSION

Congress prohibited special masters from awarding compensation "based on the claims of a petitioner alone, unsubstantiated by medical records or by medical opinion." § 300aa-13(a). Numerous cases construe § 300aa-13(a). The cases reason uniformly that "special masters are not medical doctors, and, therefore, cannot make medical conclusions or opinions based upon facts alone." *Raley v. Secretary of HHS*, No. 91-0732V, 1998 WL 681467, at *9 (Fed. Cl. Spec. Mstr. Aug. 31, 1998); *see also Camery v. Secretary of HHS*, 42 Fed. Cl. 381, 389 (1998).

The special master convened an informal, yet substantive, status conference on July 8, 2005. He expressed firmly his view that on the record before him, Mr. Stearns is not entitled to Program compensation.[5] The special master reiterated that Mr. Stearns's medical records refute *absolutely* a presumptive causation claim because electromyographic (EMG) study results do not confirm that Mr. Stearns's "dysfunction is attributable to the brachial plexus," as required by 42 C.F.R. § 100.3(b)(7)(ii). *See, e.g.*, Pet. ex. 4 at 7 ("[T]he EMG did not confirm the presence of brachial neuritis."). Mr. Stearns said that he understands.

Thus, the special master proclaimed that Mr. Stearns pursues necessarily an actual causation claim. However, the special master deemed Dr. Webster's opinion to be woefully insufficient to satisfy the legal standard required in Program cases. In advancing his opinion, Dr. Webster does not articulate a medical theory that is "logical" and "probable," given "the circumstances of the particular case." *Knudsen*, 35 F.3d at 548-49. In fact, he proposes no theory at all. Rather, even though Dr. Webster recognizes that Mr. Stearns's "symptoms" were "not classic for brachial neuritis," Pet. ex. 4 at 3, Dr. Webster presumes merely that Mr. Stearns suffers brachial neuritis. *See, e.g.*, Pet. ex. 4 at 10. Pet. ex. 5, ¶ 6. And, Dr. Webster relates apparently Mr. Stearns's condition to Mr. Stearns's DT vaccination simply because Mr. Stearns's condition followed Mr. Stearns's DT vaccination and because "brachial neuritis is occasionally reported after intramuscular injections."

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[5] The statute and the Vaccine Rules do not require the special master to afford Mr. Stearns a hearing, particularly when the evidence is so infirm, as it is in this case. *See* §§ 300aa-12(d)(2)(E) & 12(d)(3)(B)(v); Vaccine Rule 8(d).

Pet. ex. 4 at 3; *see also id.* at 7. The mere temporal relationship between a vaccination and an injury is patently insufficient to prove actual causation. *See Grant*, 956 F.2d at 1148; *Wagner v. Secretary of HHS*, No. 90-1109V, 1992 WL 144668 (Cl. Ct. Spec. Mstr. June 8, 1992). Moreover, "[s]imple similarity to conditions or time periods listed in the Table is not sufficient evidence of causation." H.R. Rep. No. 99-908, Pt. 1, at 15 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6344, 6356; *see also Lee v. Secretary of HHS*, No. 03-2479V, 2005 WL 1125672, at *4. Further, "jurisprudence" does not constrain the special master "to credit" an expert's unrebutted "summary opinion." *Rohm and Haas Co. v. Brotech Corp.*, 127 F.3d 1089, 1092 (Fed. Cir. 1997).[6]

The special master has granted Mr. Stearns a full, fair opportunity to supplement Dr. Webster's opinion. However, Mr. Stearns acknowledges now that he "is unable to provide" anything further from Dr. Webster. During the July 8, 2005, Mr. Stearns requested an opportunity to submit an affidavit regarding his symptoms and his current condition.[7] The special master questioned frankly the relevance of any affidavit. The special master explained carefully that he cannot base a decision solely upon Mr. Stearns's belief that he has suffered a vaccine-related injury. *See* § 300aa-13(a). And, the special master stated that the medical evidence in the record does not establish that Mr. Stearns suffered a vaccine-related injury. The special master is not confident that Mr. Stearns understands.

Nevertheless, the special master allows Mr. Stearns to file an affidavit regarding his symptoms and his current condition. By no later than **July 20, 2005**, Mr. Stearns shall:

1. file any supplemental fact affidavit; and

2. show cause why the special master should not dismiss the petition. *The special master expects Mr. Stearns's response to reflect a solid grasp of Program precedent.*

[6] This case is distinguished easily from *Dickerson v. Secretary of HHS*, 35 Fed. Cl. 593 (1996). In this case, the special master issued several orders requiring Mr. Stearns to submit from Dr. Webster a supplemental that contained his "full underlying analysis." *Id.* at 602.

[7] The special master notes that Mr. Stearns has proffered already an affidavit regarding his symptoms and his current condition. *See* Pet. ex. 6.

The clerk of court shall send Mr. Stearns's copy of this order to show cause to Mr. Stearns by overnight express delivery.

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John F. Edwards
Special Master