BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE DEPARTMENT OF ADMINISTRATION

In the Matter of:

S.S.

OAH Nos. 05-0707-PER
Div. R&B Nos. 100-003

DECISION

I. Introduction

S.S., an employee of the State of Alaska, filed an application for non-occupational disability benefits on August 22, 2001 and made a formal request for disability retirement benefits on November 20, 2002. On March 21, 2003, the administrator of the Public Employees' Retirement System found that Ms. S. was eligible for non-occupational disability benefits, effective January 1, 2002, but was not eligible for occupational disability benefits. On April 18, 2003, Ms. S. appealed the denial of occupational disability benefits.[1] On September 16, 2005, her appeal was referred to the Office of Administrative Hearings, pursuant to AS 44.64.030(a)(37).[2]

The administrative law judge conducted a hearing on March 15 and 16, 2006. Ms. S. and her husband testified, as did Claire Siggurdson, Ms. S.'s supervisor in her former position with the State of Alaska. In addition, Dr. Michael Smith, Dr. Paul Blocher and Dr. Joella Beard offered expert medical testimony. Based on the evidence in the record and the testimony at the hearing, the administrative law judge concludes that Ms. S. did not prove by a preponderance of the evidence that her employment was a substantial factor in her disability.

[1] Following the award of non-occupational disability benefits, Ms. S. applied for Social Security disability benefits. Her application was denied, and her non-occupational disability benefits were terminated. Ms. S. appealed that action. Subsequently, she was granted Social Security disability benefits, her non-occupational disability benefits were reinstated, and her appeal on that issue was dismissed. Ms. S.'s disability is not disputed.

[2] Sec. 131, Ch. 9 FSSLA 2005, eff. July 1, 2005. The hearing in this case before the Public Employees Retirement Board was continued and was transferred to the Office of Administrative Hearings pursuant to Sec. 139, Ch. 9 FSSLA 2005, eff. July 1, 2005. Procedural regulations governing the hearing process before the Public Employees Retirement Board continue in effect only to the extent not modified by AS 44.64, but the prior provisions of substantive law governing this case continues to control. *Id.*

II. Facts

S.S. was 22 in 1984 when, after receiving an abnormal PAP test, she was referred by her primary care physician to Dr. Hendric Hanson for examination. The examination revealed "carcinoma-in-situ with gland involvement and severe dysphaxia with gland involvement," leading Dr. Hanson to perform a fractional dilation and curettage and cone biopsy on November 15, 1984.[3]

The procedure resulted in damage to the nerves in Ms. S.'s groin area.[4] The next day, Ms. S. experienced weakness, stiffness, and pain within her lower extremities. These symptoms persisted through her post-operative examination on January 15, 1985.[5] With time, the symptoms subsided in severity, but they continued to intermittently recur over the next eight years.[6] During that period, Ms. S. was able to continue a fairly normal life. For most of that time, she was working for Alaska USA Federal Credit Union in a variety of positions, where her job duties included some strenuous lifting[7] and did not restrict her to a desk for the entire work day.[8]

Ms. S. reported her symptoms to her family physicians, Dr. Charles Thrush and later Dr. Alexander Baskous, on numerous occasions from at least early in 1987 and continuing into the early 1990's.[9] In mid-1988, Dr. Baskous referred Ms. S. to an orthopedist, Dr. Jay Garner, who found no obvious orthopedic problem and suggested further tests.[10] When she was

[3] S2. [References are to S. Exhibit (S#) or Agency Exhibit (A#)].

[4] From the time of her earliest complaints of pain, Dr. Thrush had the impression of some traumatic injury in the right ilioinguinal area or thigh. S5 (April 17, 1987). The first diagnosis of ilioinguinal neuralgia was by Dr. Slocumb, in 2001. Nerve damage was not one of the "significant complications" that Dr. Hanson informed Ms. S., prior to the procedure; his operative reports do not indicate that there were any problems or complications in performing the procedure. S3.

[5] S3.

[6] Tr. 264:6-266:17 [References are to Transcript page #: line #].

[7] Dr. Garner noted that Ms. S. had "started a new job about 4 yrs ago involving heavy lifting." A24 (June 16, 1989). Ms. S. reported to Dr. Fraser that she "lugged heavy cash boxes around vault." S8 (October 1, 1998).

[8] Tr. 353:9-356:4.

[9] A24 (March 23, 1987 ["Pt. has some low abd. Upper thigh tenderness from time to time"]; March 30, 1987 ["She still has some low back and/or hip pain, possibly from position on table during pelvic"]; April 17, 1987 ["Cont'd low back pain...impr[ession] Traumatic...rt. Inguinal area, thigh"]; February 12, 1988 [need to "investigate further longstanding complaint of right leg pain"]; April 23, 1988 ["low back pain increasing"]; June 6, 1988 ["Continues to have pain in legs"]; June 11, 1988 ["Constant ache in legs - relieved when she sits or takes a hot bath"; "S. ...saying that the aching in her legs has continued, somewhat relieved with hot bath, gets worse with menstrual cycle...Seems to be getting worse."]; May 2, 1989 ["Pt. called. Legs hurting &cramping again."]; June 16, 1989 ("[right] thigh pain/cramping"); July 7, 1989 ["some discomfort over the right trochanter"]; July 3, 1990 ["Her old leg problem which was worked up by Dr. Garner has flared up"]; June 25, 1991 [reporting a "five year history of pain in the right buttock into the right posterior thigh resembling a sciatica-like picture"]).

[10] A24 (J. Garner, June 16, 1989).

examined by Dr. Gamer, Ms. S. traced the onset of her symptoms to her 1984 procedure, and stated that the pain was "quite severe at times especially when she's been working at a Crisis Center lifting children, or working in the yard."[11]

In July of 1993, at a time when she was still conducting a relatively normal life, Ms. S. took a job with the State of Alaska, working as an eligibility technician in the Department of Health and Social Services, Division of Public Assistance. For the first time, her job duties required prolonged periods of sitting at a desk, essentially for the entire work day. Over the course of the next five years Ms. S. continued to regularly report pain symptoms to Dr. Baskous.[12] By 1997 or 1998, her symptoms were more pronounced, and she was in more or less constant pain.[13] She began propping up her foot and using pillows to sit on to provide relief from the pain at work.[14] She sought and obtained pain medications to deal with her condition.

Beginning in mid-1998, Ms. S. began an intensive and prolonged search for medical relief from the pain she was feeling. She was examined by Dr. Shirley Fraser, a neurologist, in the summer of 1998. Ms. S. told Dr. Eraser that she had first experienced her symptoms after the 1984 procedure, and that "[over the years, ...[the] pain has increased in frequency and severity," and was exacerbated by physical activity. Dr. Fraser opined that her symptoms could be the result of a nerve injury, endrometrium, or an orthopedic problem, and suggested that she "reconsider the possibility of [an orthopedic] disease rather a neurological problem".[15] That fall, Ms. S. consulted Dr. Declan Nolan, an orthopedist, to whom she reported that she was still "reasonably functional, but the pain bother[ed] her a lot and limit[ed] her activities moderately."[16] She did not report any "significant aggravating or alleviating factors."[17] Dr. Nolan diagnosed trochanteric bursitis in the right hip.[18]

[11] A24 (June 16, 1989).

[12] A24 (November 1, 1995 ["continuing to experience leg pain"]; July 18, 1996 ["R low bk pain. "]; April 11, 1997 ["She mentions has had back pain into her rt bttk & leg for many years"]; June 2, 1998 ["She does have flares of her back pain"]; September 23, 1998 ["Rt low back pain with radiation to right leg"]).

[13] Tr. 287:19-288:2.

[14] Tr. 285:2-6 (1997-1999); Tr. 290:19-291:22 (prior to end of 1999); Tr. 62:12-23 (C. Siggurdson)..

[15] Dr. Fraser found that there could be "an injury to the peroneal or the nerve root supplying it" (August 28, 1998); she suggested that the problem could be "secondary to a sketch (wrenching) injury in [the] past or to endrometrium on the sciatic nerve." S8 (July 31, 1998). Dr. Fraser also suggested, however, that the problem could be orthopedic in nature. S8 (August 3, 1998).

[16] S9 (November 6, 1998).

[17] *Id.*

[18] S9 (November 8, 1998). The trochanter is one of two bony prominences (the greater and lesser trochanter) toward the upper end of the thigh bone (the femur). The trochanters are points at which hip and thigh muscles attach. www.medterms.com (accessed February 2, 2007). Bursitis is an inflammation of a bursa; a bursa is a "sac or saclike

In February and March, 1999, Ms. S. consulted Dr. Susan Klimow. Ms. S. reported that "there [did] not seem to be a pattern" to her pain, but that it was at times much more severe with physical activity.[19] Dr. Klimow recommended physical therapy and bio-feedback. Dr. Klimow noted that Ms. S. had a mild limp,[20] and diagnosed chronic back pain, leg pain, and trochanteric bursitis in the right hip.[21] The bursitis may have been the result of the limp, secondary to her pain symptoms.[22] Ms. S. received cortisone injections from Dr. Nolan in late 1998 and early 1999,[23] but although these provided temporary relief, he advised her that continuing injections over the long term was not advisable.[24]

Since September, 1999, Ms. S.'s primary treating physician has been Dr. Leon Chandler at AA Pain Clinic, to whom she was referred by Dr. Baskous.[25] Dr. Chandler and Dr. Borrello, another physician at the pain clinic, using a working diagnosis of degenerative disc disease, provided additional epidural steroid injections, along with pain-relieving drugs. Again, these afforded some temporary relief from her leg and back pain.[26]

By that time, Ms. S.'s discomfort was apparent to co-workers.[27] By 2000, Ms. S. was spending her much of her non-work hours lying down, in hot baths, and avoiding prolonged periods of sitting or standing.[28] In May, 2000, Dr. Chandler referred Ms. S. to Dr. Jan Whitfield, an obstetrician/gynecologist, who believed that her chronic pain was not a gynecological problem and that although a hysterectomy might alleviate her pre-menstrual pain,

bodily cavity, especially one containing a viscous lubricating fluid and located between a tendon and a bone or at points of friction between moving structures." *The American Heritage Dictionary of the English Language, Fourth Edition.* Houghton Mifflin Company, 2004. Thus, trochanter bursitis is an inflammation of the hip cavity into which the trochanter sits.

[19] A26 (S. Klimow, February 15, 1999).

[20] S12 (March 11, 1999) ("mildly antalgic gait pattern"); S70 at 3 (L. Miller, February 11, 2004) ("Her gait is antalgic"). An antalgic gait is a limp. Although Ms. S's limp was not always observed by her examining physicians, it was obvious to her co-workers. *Compare* Tr. 55:11-14, 63:4-8 (C. Siggurdson) *with* S55 (J. Ravits, May 2, 2002) ("Gait is essentially normal."). Ms. S. responding to Dr. Gavaert's report, found it "interesting" that he had not mentioned her limp. Dr. Smith's evaluation indicates that Ms. S.'s gait was normal. S69 at 10 (M. Smith, February 11, 2004).

[21] S12 (March 11, 1999); A27 (April 8, 1999).

[22] S 47 (August 20, 2001); S70, pp. 2,4 (February 11, 2004).

[23] S9 (November 6, 1998; April 16, 1999 [reporting a third injection by Dr. Nolan].

[24] S9 (July 30, 1999).

[25] A5(E).

[26] S13 (September 15); S 60 (M. Borrello, September 30, 1999 [reporting injection on September 15, 1999]; October 27, 1999; February 4, 2000; May 2, 2000).

[27] Tr. 55:7-23 (C. Siggurdson).

[28] Tr. 285:1-2 (1997-1999); Tr. 295:17- 296:2..

it would not help with her chronic pain.[30] Dr. Chandler also referred Ms. S. to Dr. John Slocumb, a pelvic pain specialist. In December, 2000, Dr. Slocumb diagnosed ilioinguinal neuralgia[31] (the first physician to do so) and recommended nerve blocks as treatment.[32]

In the summer of 2001, Ms. S. took personal leave from her job while she explored treatment options. Her scheduled personal leave ended on July 11, 2001, and Ms. S. returned to work on July 12, 2001. On July 17, 2001, Ms. S. was disabled by pain and was unable to return to work. She took extended leave and continued to seek treatment.

On July 17, 2001, Ms. S. obtained a nerve block from Dr. Dale Trombley, a family practitioner, which provided temporary relief.[33] On July 27, 2001, Dr. Chandler performed a second nerve block, which again provided temporary relief.[34] An additional nerve block was performed on August 2, 2001, again providing temporary relief.[35]

On August 22, 2001, while she was still on extended leave, Ms. S. submitted an application for non-occupational disability benefits.[36]

On August 28, 2001, Dr. Trombley noted that prolonged sitting or standing caused the pain to increase.[37] That fall, Dr. Slocumb also noted that prolonged sitting or standing were pain triggers.[38] Ms. S. obtained trigger point injections from Dr. Slocumb as treatment for her symptoms, but discontinued that treatment after two sessions.[39] On October 1, 2001, Ms. S. obtained a disability evaluation from Dr. Joella Beard, a specialist in physical medicine and rehabilitation,[40] who opined that Ms. S. could "tolerate light duty work for at least two hours a

[30] A5(B), A9.

[31] "Ilioinguinal" means "relating to the inguinal region and the groin." Stedman's Medical Dictionary, accessed at vvww.dictionary.com (February 2, 2007). The same source reveals that "inguinal" means "groin," and "neuralgia" means a sharp pain in a nerve or group of nerves. Thus, "ilioinguinal neuralgia" **means a** sharp pain **in** the nerves in the groin area.

[32] S14 (December 16, 2000; October 1, 2001).

[33] S15 (July 17,2001).

[34] S17.

[35] S17, S18. Ms. S. has received nerve blocks since that time, with similar results. *See* S73 (C. Kahn, September 16, 2004) ("The patient states she got very good relief from her injections performed September 9."), S74 (C. Kahn, September 23, 2004) ("She feels that she is making some progress and getting control of the pelvic pain."), S75 (C. Kahn, September 30, 2004) ("The patient states that she gets three to four days of excellent relief before her symptoms begin to return).

[36] S20.

[37] S15. It appears that Dr. Trombley was reporting what Ms. S. had told him, rather than independently identifying this as a trigger.

[33] S24 (October 1, 2001). As with Dr. Trombley, it appears that Dr. Slocumb was reporting what Ms. S. had told him.

[39] S24-S26.

[40] Tr. 110:5-7, 118:12-18.

day."[41] Subsequently the surgical emplanting of an epidural stimulator was recommended as a treatment option, but Ms. S. did not wish to undergo a surgical procedure.[42] Ms. S.'s extended leave benefits terminated,[43] and she was finally terminated from state service on December 10, 2001.[44] She filed a formal claim for occupational disability benefits on November 20, 2002.

On March 21, 2003, based on Dr. Cole's conclusion that Ms. S. is disabled by chronic pain caused by neuropathy initiated by the medical procedure in 1984,[45] the administrator awarded her disability benefits effective January 1, 2002, but denied occupational disability benefits on the ground that her employment was not a substantial factor in the disability.[46]

III. Discussion

A. Legal Standards

An employee is eligible for occupational disability benefits if the employee's physical condition prevents the employee from performing her usual duties and "the proximate cause of the condition [is] a bodily injury sustained, or a hazard undergone, while in the performance and within the scope of the employee's duties."[47] A bodily injury or hazard in the course of employment is the "proximate cause" of a condition if it aggravates, accelerates, or combines with a pre-existing condition[48] and is a substantial factor in the disability, regardless of whether a non-occupational injury could independently have caused the disability.[49] An injury or hazard may be a substantial factor in a disability if it aggravates the symptoms of a pre-existing condition *(e.g.,* pain), even if it does not aggravate the underlying condition.[50]

B. Summary of Testimony and Evidence

While the medical record in this case is voluminous, the dispute between the parties is relatively narrow. Most of the physicians who have examined Ms. S. since 2001 concur that

[41] A17, p. 6.
[42] A18 (September 6, 2001); S28, S31. Ms. S. was not a good candidate for the procedure. S41.
[43] S30.
[44] S32.
[45] A4.
[46] S65.
[47] AS 39.35.680(27).
[48] Hester v. Public Employees' Retirement Board, 817 P.2d 472, 475 (Alaska 1991) (adopting test identical to that applied in workers' compensation cases).
[49] State, Public Employees' Retirement Board v. Cacioppo, 813 P.2d 679.683 (Alaska 1991).
[50] Hester v. Public Employees' Retirement Board, *supra,* 817 P.2d at 476, note 7. *See* Lopez v. Administrator, Public Employees' Retirement System, 20 P.3d 568, 573-574 (Alaska 2001);

she is disabled,[51] and both parties agree that the primary cause of her disability is a neurological injury incurred in 1984 that became disabling during the time Ms. S. was working for the State of Alaska.[52] Finally, the evidence also establishes that Ms. S.'s working conditions included prolonged periods of sitting. The dispute concerns whether the prolonged periods of sitting were a substantial factor in her disability.[53]

1. Medical Opinions

Ms. S. has consistently been reporting pain in her leg, hip, groin or abdomen since the 1984 medical procedure. She has undergone a variety of tests to determine the source of her pain, but none has identified the source of the pain. Although Ms. S. has never been provided a formal electrodiagnostic study,[54] the preponderance of the evidence is that she suffered some form of injury to her ilioinguinal nerve in the course of the 1984 procedure, resulting in long-term unresolved ilioinguinal neuralgia. Her disabling condition is chronic pain syndrome, primarily resulting from the nerve injury in 1984, and referred and secondary pain related to that injury.

For the most part, the physicians who have examined Ms. S. have not offered an opinion as to whether the prolonged periods of sitting while employed by the state were a substantial factor in her disabling chronic pain syndrome. Only Drs. Cole, Blocher, Beard, and Smith provided clear opinions regarding the effect of Ms. S.'s working conditions on her disability.[55] Drs. Blocher, Beard and Smith all provided written reports and testified at the hearing; Dr. Cole provided written reports but did not testify.

Dr. Cole, retained by the administrator, reviewed the medical records and concluded that "there has not been an adequate case made for her employment with the State of Alaska as being a significant aggravating factor in the causation [of her disability]."[56] His conclusion rests on these observations: (1) the ordinary activities of daily life would also have contributed to her disability; (2) only one doctor (Dr. Blocher) specifically identified employment as "a causative

[51] *See, e.g.,* A5(L) (April 23, 2002, Dr. Slocumb); S70 (February 11, 2004, disability rating by Dr. Lawrence Miller; no work related component noted).

[52] Administrator's Post-Hearing Brief at 1; A4, A13, A16.

[53] There was some evidence that stress could trigger increased pain, and that Ms. S.'s job was stressful. However, Ms. S. did not show by a preponderance of the evidence either that (1) the stress of her job was more than might ordinarily be expected in an employment relationship, or that (2) stress on the job was a substantial factor in her disabling pain.

[54] A17 at p. 2 (J. Beard, October 10, 2001).

[55] Dr. Gevaert also expressed an opinion, but it is unclear what he meant to say. *See* note 82, *infra.*

[56] Memorandum, W. Cole to M. Millhorn, 8/23/2005 at 2.

factor," and that doctor did not examine Ms. S. and has limited medical experience;[57] (3) one doctor, Dr. Gevaert, allegedly "specifically stated that her work was not a causative factor."

Dr. Paul Blocher, retained by Ms. S., also reviewed Ms. S.'s medical records. He provided a written report and testified at the hearing. Based on his review, he concluded that Ms. S.'s sedentary working conditions were "the only plausible medical etiology" for her condition.[58] He testified that employment was "a major factor in aggravating her condition and creating or causing secondary conditions as well."[59]

Dr. Beard testified that Ms. S.'s "condition" (ilioinguinal neuralgia) was not "significantly aggravated by her employment."[60] Her view was that ilioinguinal neuralgia caused by stretching of the nerve *(e.g.,* by positioning during the course of a gynecological procedure) would not generally persist over an extended period of time.[61] She testified that prolonged periods of sitting would not aggravate (which she defined as "a permanent worsening or flare [up]") an ilioinguinal neuralgia of a person who was not immobile.[62]

Dr. Smith testified that prolonged periods of sitting, even with changes of position, would aggravate Ms. S.'s "symptoms" *(i.e.,* pain) from her pre-existing "condition" (ilioinguinal neuralgia), temporarily and over time permanently by 5-10%.[63]

[57] Ironically, Dr. Cole discounts Dr. Blocher's report, in part, on a ground that applies equally to his own: that the doctor had not examined the patient.

[58] S79.

[59] Tr. 246:10-17,252:5-253:3.

[60] Tr. 131:22-25.

[61] Tr. 128:13-129:22, 149:18-150:6. The medical journal relied upon by Dr. Blocher supports her view. Tr. 212:23-213:1; S79. *See* R. Cardosi, C. Cox and M. Hoffman, "Postoperative Neuropathies After Major Pelvic Surgery", 100 OBSTETRICS AND GYNECOLOGY 240 (August, 2002). The article describes a variety of neuropathies that are "well-recognized complication^] after pelvic surgery." Dr. Blocher's report quotes this sentence from the article: "These complications are often reversible, but may persist and result in permanent disability." *Id.,* at 240. However, the article distinguishes between different types of injuries, and concludes that only some will persist:

> Prognosis clearly depends on the nature and severity of the injury; this is supported by the outcomes observed in this series. The only patients with persistent symptoms were those with injury to the lumbosacral plexus and those with an unrepaired transection of the genito-femoral nerve. On the contrary, all patients with a repaired nerve transection, a stretch, or a compression injury had complete resolution of their symptoms within less than 10 months for an overall 73% recovery rate.

Id. at 244. The article noted only a single stretch injury to the ilioinguinal nerve; that patient, aged 80, resolved in six weeks. *Id.,* Table 2. The only persistent injuries occurred as a result of transection of the genitofemoral nerve, or transection or suture entrapment of the lumbrosacral plexus. *Id.,* Tables 3, 4. Ms. S. has claimed that her initial injury was caused by stretching of the ilioinguinal nerve; she has not asserted she has an injury of the type found in the article to persist.

[62] Tr. 163:13-164:14.

[63] Tr. 24:21-25:1,35:25-36:4,40:7-41:18.

2. Non-Opinion Evidence and Testimony

During the nine-year period before Ms. S. began working for the State of Alaska in 1993, and for several years thereafter, Ms. S. experienced intermittent pain from the ilioinguinal neuralgia but continued to live a substantially normal life. Ms. *S.* reported her symptoms to her family physician, Dr. Baskous, on numerous occasions, from at least early in 1987.[64] Finally, in mid-1988, she was referred to an orthopedist, Dr. Jay Garner, who found no obvious orthopedic problem and suggested further tests.[65] Ms. **S.** consistently traced the onset of her symptoms to her 1984 procedure, and she told Dr. Gamer that the pain was "quite severe at times especially when she's been working at a Crisis Center lifting children, or working in the yard."[66]

After she started working for the State of Alaska, from 1993 until mid-1998, Ms. S. continued to report this intermittent pain to Dr. Baskous. However, at no time did Dr. Baskous report that Ms. S. had told him that prolonged sitting was a pain trigger, or that her pain worsened during the time she was at work.[67] She did not mention sitting as a source of pain to Dr. Fraser in 1998,[68] and she told Dr. Nolan, later that same year, that "[t]he pain seems to have no significant aggravating or alleviating factors."[69] Nor did she report sitting as a source of pain to the Scripps Institute, when she was examined there on July 16, 1999.[70]

Ms. S. first reported sitting as a source of pain to Dr. Klimow, in February, 1999, but she did not identify it as any more of an aggravating factor than standing or climbing stairs.[71] Ms. S. noted sitting as an "aggravating, factor" to the pain clinic on October 21, 2000, but she did not refer to sitting as a pain aggravator on any subsequent visits until October, 2001, after she had stopped working.[72] When Ms. S. visited Dr. Trombley on July 17, 2001, shortly after she

[64] *See* notes 4, 9, *supra.*

[65] A 24 (J. Garner, June 16, 1989).

[66] S79.

[67] *See* note 12, *supra.*

[68] A28 (July 31, 1998).

[69] A9 (November 6, 1998).

[70] A10.

[71] A27 (February 8, 1999 "lower back discomfort...coming and going but usually present...discomfort...increases with utilizing stairs or sitting or standing too long"; March 11, 1999; April 8, 1999 "no particular aggravating factors").

[72] A18 (October 21, 2000, "sitting" identified as aggravating factor, "pillows-heat walking" identified as relieving factors; October 30, 2000; November 27, 2000; December 27, 2000, "lifting 7.5 pounds" identified as aggravating factor; January 29, 2001; February 26, 2001; March 26, 2001; April 23, 2001; May 21, 2001; June 20, 2001; July 16, 2001; July 18, 2001; August 2, 2001; August 9, 2001; August 22, 2001; September 6, 2001; September 19, 2001; September 26, 2001; October 30, 2001, "sitting" identified as aggravating factor).

stopped working, Ms. S. reported that she felt stiff in the morning but improved during the day; she made no reference to prolonged sitting or any working conditions as having triggered pain or aggravating her condition.[73]

The first time that Ms. S. specifically identified her working conditions as an aggravating factor to one of her health care providers was two years after she had stopped working and after her application for occupational disability benefits had been denied, when she visited Dr. Gevaert on August 22, 2003, and reported that "sitting over the years has aggravated her conditions," particularly if the chair was hard, and stated that the cause of her condition was the 1984 surgery and "then working at a job that worsened condition."[74] By then, she asserted, she could sit for no more than ten minutes on a hard chair, twenty on a softer chair, or longer if her legs were elevated.[75] Ms. S. again specifically identified her work conditions as an aggravating factor when she was examined by Dr. Michael Smith on February 11, 2004.[76]

C. Evaluation of Testimony and Evidence

In this case, the evidence suggests that an initial trauma left Ms. S. with a vulnerable nerve, which intermittently flared up over the years as a result of the activities of everyday life, leading eventually to secondary bursitis and referred pain in a variety of areas. But Ms. S.'s bursitis is not disabling, and the chronic pain she suffers has many sources other than her working conditions: walking, standing, sitting, and physical activity in general, according to Ms. S. Her claim for disability benefits rests on whether, in light of the record as a whole, her employment was a substantial factor in a complex chronic pain syndrome. Beyond the ordinary activities of daily life, the only work-related activity identified as a possible contributing factor to her disabling pain was prolonged sitting. Thus, only if Ms. S. proved by a preponderance of the evidence that prolonged sitting was a substantial factor in her chronic pain syndrome is she entitled to occupational disability benefits.

1. Medical Opinions

Looking only to the basis for their opinions, rather than to the substance, Dr. Cole's and Dr. Blocher's opinions were less persuasive than the opinions of Dr. Smith and Dr. Beard: neither Dr. Cole nor Dr. Blocher had examined Ms. S., neither had special expertise beyond

[73] S15 (July 17, 2001).
[74] S63.
[75] *Id.*
[76] S69, p. 2.

their general medical training relevant*to Ms. S.'s condition and symptoms, neither was shown to have had substantial recent experience in direct patient care, and both were retained by the party offering their testimony for the purpose of this administrative proceeding.[77] By contrast, both Dr. Smith and Dr. Beard personally examined Ms. S1pt and had some degree of experience treating patients with conditions similar to Ms. S. In addition, although neither of them was retained by Ms. S. for purposes of providing treatment, Dr. Beard was seen on a direct referral from her treating physician[78] and Dr. Smith believed that Ms. S.'s consultation was in part for diagnostic puiposes, and was not solely for a disability evaluation or specifically for use in this proceeding.[79]

Beyond these factors, the substance of the opinions expressed was of varying persuasiveness. Dr. Cole's view that the ordinary activities of daily life "were in some way causative factors"[80] does not mean that Ms. S.'s employment was not a substantial causative factor: it simply means that other factors were involved as well.[81] In addition, Dr. Cole mischaracterized Dr. Gevaert's report. Dr. Gevaert specifically acknowledged that sitting could aggravate Ms. S.'s condition, and he did not specifically rule out employment as a substantial factor in her disability.[82] For these reasons, in addition to the factors mentioned previously, Dr. Cole's opinion was given less weight.

[77] The opinion of a non-treating physician who reviews medical records may not be automatically discounted on that ground. Rhines v. State, Public Employees' Retirement Board. 30 P.3d 621, 628-629 (Alaska 2001). However, in the absence of a finding of superior expertise, experience, knowledge, or other valid reasons, the opinion of a physician who has not examined or treated the patient may reasonably be afforded less weight than that of an examining or treating physician. *See generally* Lopez v. Administrator, Public Employees' Retirement System, 20 P.3d 568, 571 (Alaska 2001); Childs v. Copper Valley Electrical Association. 860 P.2d 1184, 1189-90 (Alaska 1993); Black v. Universal Services. Inc., 627 P.2d 1073, 1075 (Alaska 1981).

[78] Tr. 120:4-6.

[79] Tr. 30:13-31:2.

[80] Memorandum, W. Cole to M. Millhorn, 8/23/2005 at 2.

[81] *See* State, Public Employees' Retirement Board v. Cacioppo, 813 P.2d 679, 683 (Alaska 1991).

[82] Dr. Cole's report characterizes Dr. Gevaert's conclusion as "specifically stat[ing] that [Ms. S.'s] work was not a causative factor." In fact, Dr. Gevaert's jeport is open to interpretation. The report concludes: "…1 have a hard time state [sic] that her present condition is substantially aggravated by her work....It is my understanding that chronic pelvic pain is aggravated by sitting. Her present condition is a chronic irritation of the nerve. Sitting at work or at the home may increase the pain and additional [sic] necessarily substantially aggravate her condition." S63 at p. 5. The quoted language is inherently ambiguous, and is of little value for purposes of the relevant questions. Dr. Gevaert appears to say that sitting at work would aggravate the pre-existing condition, but at the same time he concludes that it is "hard" to state that her "present condition is substantially aggravated by her work." Working conditions may be a "substantial factor" in a disability, even if they do not "substantially aggravate" a physical condition. *See* note 50, *supra.* In the absence of testimony from Dr. Gevaert to clarify both his wording and the applicable legal standard, his report is of little value.

Dr. Blocher, like Dr. Cole, had not personally examined Ms. S. Furthermore, Dr. Blocher represents that his professional objective is to provide assistance to attorneys, from whom he solicits consultations to provide "persuasive medical summary reports to strengthen your client's claim."[83] In addition, Dr. Blocher's written report mischaracterizes one of the medical opinions offered by another physician.[84] For these reasons, Dr. Blocher's opinion that Ms. S.'s employment was a substantial factor in her disability was afforded less weight.

As previously described,[85] Dr. Beard's opinion was that Ms. **S.**'s condition was not aggravated by her employment. However, it does not appear that Dr. Beard applied the legal standard that applies in occupational disability benefit cases. She defined an "aggravation" as a "permanent worsening or flare [up]" of the underlying physical condition. However, for purposes of occupational disability benefits, an "aggravation" includes increased pain, even if there is no change in the underlying physical condition.[86] Notably, Dr. Beard did not testify that prolonged sitting would not have aggravated Ms. S.'s pain, which was the disabling symptom of her pre-existing condition. Dr. Smith, by contrast, specifically testified that prolonged sitting would have aggravated Ms. S.'s "symptoms":[87] Ms. **S**.'s chief symptom was pain.

Dr. Smith's medical opinion testimony supports the conclusion that for an individual with a pre-existing ilioinguinal neuralgia, prolonged sitting could increase the level of pain for that individual, even if there was no change in the underlying ilioinguinal neuralgia. Such an increase in pain may be a substantial factor in an occupational disability, even if there is no change in the physical condition that is the source of the pain. Dr. Beard did not opine that for a person with Ms. **S**.'s physical condition, prolonged sitting would not cause an increase in her pain. Thus, the preponderance of the more persuasive medical opinion testimony supports the conclusion that Ms. S.'s working conditions contributed to her pain. But Dr. Smith's opinion, while persuasive as an expression of medical opinion, offers only limited support for the claim that Ms. **S.**'s working conditions were a substantial factor in her disability: Dr. Smith testified that prolonged sitting could aggravate her symptoms, but only by 5 to 10 percent. While there is

[83] S80.

[84] S79. Dr. Blocher's report states that Dr. McDonald felt that Ms. S. "an occupational disability in that her ongoing condition was aggravated by her employment with the State." Dr. McDonald's report (S59) contains no such statements.

[85] *Supra,* at p. 8.

[86] *See* note 50, *supra.*

[87] Dr. Blocher's opinion, it appears, was substantially the same: he indicated that employment that triggered Ms. S.'s pain could be considered to have aggravated her condition. Tr. 241.

no requirement that any specific percentage threshold must be reached, it is not inherently unreasonable to conclude that 5 to 10 percent is not a substantia] proportion of a whole.

2. Non-Opinion Evidence and Testimony

Beyond Dr. Smith's medical opinion, the evidentiary support for Ms. S.'s claim is limited. The primary non-opinion evidence regarding a causal link between prolonged sitting at work and Ms. S.s disabling pain is her own testimony, the testimony of her husband, and her own reports to physicians. At the hearing, Ms. S. testified that over the course of the last year or two at work, sitting was a "problem," and that "towards the end of my employment, I couldn't [sit like everybody else], and "[s]itting caused a lot of additional pain."[88] She added that in the last six months of employment the pain from sitting was "really severe."[89] Similarly, at the hearing Ms. S.'s husband testified that when she was still working, "she'd come home in tears sometimes at the end of the day because she'd just been sitting behind a desk all day...having to adjust herself."[90]

It is clear from the testimony and the medical records that Ms. S.'s symptoms substantially worsened during the time that she was employed by the state. But Ms. S. herself on a number of occasions has described her chronic pain syndrome as a progressive condition that became increasingly problematic over time as a result of the ordinary activities of daily life, such as sitting, standing and walking. A progressive condition that becomes disabling during a period of employment is grounds for an award of non-occupational disability benefits, but occupational disability benefits are only available if some bodily injury or hazard during employment was a substantial factor.

Ms. S.'s own reports of pain during the first five years of her employment were no more frequent than they had been previously,[91] and for the first five years that she was working for the state she there is no indication that she ever told a doctor that prolonged sitting was a pain trigger or aggravator. Ms. S. did not tell a doctor that sitting was triggering pain until 1999,[92] and she mentioned sitting only intermittently after that[93] until her claim for occupational

[88] Tr. 280:17-23,281:3.
[89] Tr. 270:18-25.
[90] Tr. 82:1-16.
[91] *See nn.* 4, 9, 12, *supra.*
[92] *See* notes 67-69, *supra.*
[93] *See* notes 70-72, *supra.*

disability benefits had been denied.[94] If prolonged sitting at the office was a substantial factor in her chronic pain syndrome, it is reasonable to expect that Ms. S. would have told at least one of her doctors that prolonged sitting was a trigger for her pain at some point prior to 1999 and would regularly have reported sitting as an aggravating factor after she began her extensive search for pain relief, before she quit working in 2001. That she was unaware of a medical explanation for the pain before she had to stop working does not mean that she was unaware of what she was doing when the pain was triggered or aggravated.

Taken as a whole, the medical records from both before and after Ms. S. became disabled indicate that prolonged sitting at work was simply one among many contributing factors, and that it was not of particular causal significance with respect to her chronic pain syndrome.[95] Typical of the medical reports is the comprehensive pelvic pain report prepared in November, 2002, by Dr. MacDonald, a gynecologist and pelvic pain specialist. At that time, Ms. S. reported that her pain is worst in the morning and that it increased with activity. She reported that her pain was made worse by sitting, standing, walking, and physical activity generally.[96] Nothing in that recitation or in the medical records generated before she had to stop working suggests that prolonged sitting at the office was a particular source of pain in comparison to other factors. To the contrary, the medical records both preceding and following the date of disability indicate that many of the ordinary activities of everyday life were pain triggers, and that if sitting at work was an "aggravating factor," it was no more or less so than anything else Ms. S. was doing during the period of her employment.[97]

IV. Conclusion

Ms. S. did not prove by a preponderance of the evidence that her employment was a substantial factor in her disability.

DATED April 6, 2007.

By: Andrew M. Hemenway
Administrative Law Judge

[94] *See* notes 73-75, *supra.*

[95] *See* notes 90-94, *supra; see also,* A17 (J. Beard, October 10, 2001: "The things that make her pain worse are sitting, standing, walking, exercise, bending forward or backward, climbing on stairs"; S9 (D. Nolan, November 6, 1998: "no particular aggravating factors"); S55 (Dr. Grissom, June 24, 2002: no mention of sitting as aggravating factor; impression of "multifactorial" chronic pain syndrome; Dr. Bryan, November 19, 2002: impression of "chronic multi-etiology pain," made worse by exercise, sitting, standing and walking); Dr. Ravil, May 20, 2002: pain "gets worse with standing, sitting, stress & during menses").

[96] S59.

[97] *See also,* A24 (June 16, 1989) (working "didn't help my condition"); A58 (Dr. Gambardella, November 20, 2002 ("job I had last didn't help my condition").

Adoption

This Order is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision and Order as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 21st day of May, 2007.

By: Andrew H. Hemenway
Administrative Law Judge

The undersigned certifies that this date an exact copy of the foregoing was provided to the following individuals:

Case Parties
5/21/07