BEFORE THE STATE OF ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
K. S.	)	OAH No. 05-0709-PER
______________________________	)	Div. R&B No. 100-002

DECISION

I. Introduction

K. S. appealed the Public Employees Retirement System (PERS) Administrator's decision of July 21, 2003, denying her application for nonoccupational disability benefits. A hearing was held on January 9, 2006. Ms. S. appeared by telephone. She was represented by her attorney, William Erwin. Assistant Attorney General Virginia Ragle represented the PERS Administrator. Ms. S. was the only witness to testify at the hearing. The documentary record consists of over a thousand pages of documents, including extensive medical records and results of psychological and psychiatric evaluations.

The preponderance of evidence shows that Ms. S.'s employment was not terminated because of a total and apparently permanent nonoccupational disability. With one exception, all of the medical professionals whose reports are in the record, indicated that Ms. S. could work at her old job or at the least a similar job with lighter duties. The evidence shows that Ms. S. has both physical and mental conditions, but that these conditions are not disabling. The administrator's decision to deny Ms. S.'s application is therefore affirmed.

II. Facts

At the beginning of 1997, Ms. S. was working at an A. P.s' H. as a Certified Nurse Aide (CNA). Ms. S. enjoyed a history of good evaluations by her employer, got along well with her co-workers, and found her job enjoyable and fulfilling.[1]

Ms. S.'s job at the P. H. involved frequent lifting of residents and moving of lifts, wheelchairs, and various kinds of equipment. Ms. S. is a petite woman of just over 100 pounds who stands 5'2". On January 25, 1997, Ms. S. and two other employees were lifting and dressing a double amputee resident. At some point, the resident started to fall, panicked, and grabbed onto Ms. S.'s arm or shoulder. Ms. S. reports that at this time she suddenly felt a sense of numbness and pain in her right arm and shoulder.[2]

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[1] Testimony of K. S. at January 9, 2006 hearing (Testimony of Ms. Stack).
[2] Testimony of Ms. S.

In spite of her injury, Ms. S. continued to work. Ms. S. later reported that she kept working because she thought she would get better, and also because she had a root canal done, had taken some time off work for that reason, and had been distracted from her shoulder injury by pain from the dental surgery. In February, 1997, Ms. S. had a repeat pelvic ultrasound for an earlier problem with right upper quadrant pain.[3] In early April of 1997 she was treated for bronchitis. Ms. S. apparently did not complain of shoulder pain on either of these visits.[4] In April of 1997, Ms. S. went to a chiropractor because of pain. On April 25, 1997, Ms. S. filed a Workers' Compensation Report of Occupational Injury.[5] The chiropractor that Ms. S. went to in April of 1997 took x-rays, and then referred Ms. S. to Dr. Stacy Schultz, an internist.[6]

Dr. Schultz examined Ms. S. on April 28, 1997. Dr. Schultz found tenderness over the rotator cuff musculature, over the AC joint, and over the biceps tendon.[7] Dr. Schultz stated that "[i]t's really difficult to try and distinguish where the pain is actually originating from, however most of the pain seems to be coming from the posterior aspect of the shoulder." Dr. Schultz noted that Ms. S. had complained of tingling in the fourth and fifth fingers, which could be reproduced with palpation over the ulnar groove; Dr. Schultz stated that this tingling appeared to be "separate from the acute shoulder injury." Dr. Schultz stated, "will need to have her see the orthopedic physicians because she has multiple problems going on."[8]

Dr. Schultz referred Ms. S. to Dr. Bruce Schwartz, an orthopedic physician. Dr. Schwartz first saw Ms. S. on April 30, 1997.[9] Dr. Schwartz diagnosed impingement syndrome of the right shoulder. He discussed with Ms. S. various treatment alternatives, including time, physical therapy, exercises, and steroid injection. Ms. S. chose to have a steroid injection, which produced immediate pain relief. Dr. Schwartz wrote that "she will return next week for reevaluation, and we may send her back to work depending upon the response to the injection."

On May 7, 1997, Dr. Schwartz stated that

> K. states she's somewhat better after the injection I gave her last week. She states the heavy feeling is gone and her shoulder 'popped' two days ago and now she can reach better. She states the pain that went all the way down her arm is gone. She still has some

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[3] Record 712.
[4] Record 712.
[5] Record 49.
[6] Record 16.
[7] *Id.*
[8] *Id.*
[9] Record 13.

> shoulder discomfort and feels like it gets worse as the day goes on. She's been seeing a chiropractor for some manipulations.[10]

Dr. Schwartz stated that "on examination shoulder motion appears to be complete. She has no swelling. Impingement signs are slightly positive, and no evidence of instability." Dr. Schwartz recommended that Ms. S. "should go to physical therapy and stay off work." [11] A week later, on May 14, 1997, Dr. Schwartz examined Ms. S. again and found her condition unchanged. Ms. S. complained that her physical therapist "wasn't listening to her complaints and wasn't helping her very much, although this is more of a communication problem. She thought the therapy seemed to be helping her shoulder." [12] Dr. Schwartz noted that "she is a little difficult to communicate with because of her tendency to not stay on track, and her answers sometimes can be vague and somewhat rambling."[13]

On May 21, 1997, Dr. Schwartz saw Ms. S. again and reported that "K. seems a little better."[14] In spite of her apparent improvement, at this point Dr. Schwartz questioned whether Ms. S. would ever work again: "I am concerned that she is going to need some sort of lighter duty than normal work as an aide if and when she goes back to work. I will see her in one month."[15] It was less than two weeks before Ms. S. was back in Dr. Schwartz' office on June 2, 1997, complaining of pain, a pulling sensation, and knots. Dr. Schwartz's physical examination revealed only that "she has positive impingement signs. Motion appears to be complete." Without further explanation, Dr. Schwartz stated, "I have concerns that she may have an extended disability as a result of this injury and will be off work for some time. She says there is no light duty where she works."[16]

Dr. Schwartz examined Ms. S. again on June 27, 1997.[17] His examination showed that Ms. S. "appears to have full active and passive range of motion of her shoulder. Impingement signs continue to be positive. She has no effusion. Motor strength is probably normal. She has give-way weakness is isolating the supraspinatus."[18] Dr. Schwartz reported that besides Ms. S. having continuing difficulty with her shoulder, "she has a myriad of complaints. She states that the 'methylprednisolone' and 'lidocaine' have caused her to have pouring night sweats and

[10] Record 10.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] Record 9.
[15] *Id.*
[16] *Id.*
[17] Record 8.
[18] *Id.*

sometimes in the daytime as well. This involves the backs of her hands, her nose, and her neck."[19] Ms. S. also complained of headaches, late period, pain in her elbow from bumping her should into a doorway, discomfort unrelated to the doorway bump going from her forearm to her hand, charley horses in her upper arm if she rotates her arm, inability to write, veins on her hands sticking up when she tries to write, and something "doing the bop" on her forearm underneath her skin. In his recommendations, Dr. Schwartz wrote,

> She is making very little progress. She has not done well at Physical Therapy, and obviously hasn't reacted well to the steroid injections…The rehab specialist has recommended that she go south for another opinion, and I would recommend that that occur. K. was advised that she may not return to her previous type of employment. I will see her again in one month.[20]

On July 29, 1997, Ms. S. was seen by Dr. Bruce Bradley in Seattle for an independent medical evaluation.[21] Dr. Bradley diagnosed Ms. S. with "strain/tendonitis with mild impingement syndrome of the right shoulder which seems to be spontaneously resolving with relative rest and gentle range of motion exercises performed by the claimant on her own."[22] Dr. Bradley found this diagnosis to be directly related to the January 25, 1997, injury, but he also noted that Ms. S. had other complaints that appeared unrelated:

> The claimant has diffuse subjective complaints and they do outweigh the objective findings and produce some inconsistency. She seems to have diffuse symmetric pain complaints about the right shoulder, although I do think she strained the right shoulder and has a mild impingement syndrome at this point which seems to be spontaneously resolving.[23]

Despite the other "diffuse subjective complaints," Dr. Bradley did not think Ms. S. had a pre-existing condition that combined with the January 25, 1997 injury. Although Dr. Bradley thought Ms. S. would need another two months before she was fully medically stationary, he felt that Ms. S. could return to light duty work immediately:

> I thinks she should continue to relatively rest the shoulder, although I think she could do light work with the restrictions I have noted, not lifting or carrying greater than 25 pounds and not using the arm in an overhead position while working for the next 2 months. I think in another 2 months, the worker would be medically stationary and probably able to return to work as a CNA at that time.[24]

[19] *Id*.
[20] *Id*.
[21] Record 317-320.
[22] Record 319.
[23] *Id*.
[24] *Id*.

Just a week after seeing Dr. Bradley in Seattle, Ms. S. returned to Dr. Schwartz for another examination on August 5, 1997. Although Ms. S.'s condition had not changed substantially, Dr. Schwartz began to take the position that Ms. S. was permanently disabled. His notes for that day read:

> SUBJECTIVE: K. is essentially the same. She states that she is somewhat better, meaning that she can do certain maneuvers and not others. She has had some discomfort in her forearm, and she points to the snuff box.[25] She states that it swells there, and she has discomfort at the trapeziometacarpal joint.
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> PHYSICAL EXAMINATION: She has no swelling or tenderness in the snuff box. The trapeziometacarpal joint appears to be normal. Grind test is negative. Finkelstein's test is negative. Forearm motion is complete. Shoulder motion is complete with the exception of internal rotation (her thumb reaches her belt).
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> RECOMMENDATIONS: She is not getting anywhere fast. Probably in another six weeks she will have reached a medically stationary point. I would not recommend surgery or therapy, but only continued observation. I will see her back at that point. I think we should rate her permanent impairment.[26]

On November 10, 1997, psychologist Keith Youngblood evaluated Ms. S.[27] Dr. Youngblood found no indication of malingering, somatization disorder, or psychogenic pain. Dr. Youngblood noted that there had been a previous diagnosis of chronic pain disorder, and he recommended an evaluation by a clinic specializing in pain management. Ms. S. did not seek pain management therapy, but in the middle of 1998 she returned to Dr. Youngblood for ongoing therapy.[28] Dr. Youngblood concluded that Ms. S. had no pre-existing mental or personality disorder contributing to her medical condition. He later stated in 1999 that Ms. S. suffered from Adjustment Reaction related to a disabling injury with chronic pain, inability to work, loss of income, uncertainty about future income and medical support, and secondary stress to her family and personal life.[29] Dr. Youngblood opined that Ms. S.'s psychological condition would probably resolve itself with removal of the stressors, and that she therefore had no permanent impairment.

By February of 1998, Dr. Schwartz determined that Ms. S. was medically stationary, and stated that "she agrees that she is medically stationary. She would like a disability from the

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[25] The anatomical snuffbox, or radial fossa, is a triangular deepening on the radial, dorsal aspect of the hand. The name originates from the use of this surface for placing and then snorting powdered tobacco, or "snuff."
[26] Record 7.
[27] Record 99.
[28] Record 786.
[29] Record 787.

state."[30] Dr. Schwartz stated that "I think this upper extremity is totally and permanently impaired." He discussed surgery, but determined that it would be "problematic." Dr. Schwartz concluded,

> As I read the AMA "Guides to the Evaluation of Permanent Impairment," Fourth Edition, she does not have a ratable disability. This is in contrast to a severe functional disability manifested by inability to do any type of work. She is discharged from care.[31]

On February 1, 1999, Dr. Schwartz again saw Ms. S. and re-evaluated her. Dr. Schwartz concluded,

> She continues to be disabled. I have suspicions of impingement syndrome and carpal-tunnel syndrome symptoms, and there are chronic pain symptoms, but I'm not confident that surgery would be beneficial. I think she needs to stay off work and put up with this as best she can.[32]

Dr. Schwartz continued to see Ms. S. on a regular basis. As recently as September 26, 2002, he wrote,

> Kathy continues to have a myriad of complaints involving her upper extremities, neck and upper back. She states she got a computer and is unable to use the mouse because it causes increased problems with her right arm or left arm if she uses her left hand. She states it causes her to "slow down." She states her fingers don't function appropriately. She has increased numbness in her forearm and her 4th and 5th fingers. She complains of headaches, chronic shoulder pain and upper thoracic pain. She also describes a numbness on the left side of her face in the region of her cheek.[33]

Dr. Schwartz "advised her that I don't have any specific treatment for her. I filled out her disability form but I don't think that she would be a good candidate for surgery and I think just about everything else has been explored."[34] Dr. Schwartz continued to see Ms. S., who testified that on the day of the hearing she had canceled a scheduled appointment with Dr. Schwartz so that she could participate in the hearing.

On July 26, 1999, Dr. Douglas Smith, an orthopedic consultant, examined Ms. S. and reviewed all of the records available at the time, including diagnostic imaging studies.[35] In answer to the question, "what is the medical cause for each complaint or symptom of the left and right upper extremities," Dr. Smith stated:

> I am afraid that I cannot come up with a medical cause for the myriad subjective complaints that this lady has relative to her right upper extremity.

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[30] Record 115.
[31] *Id*.
[32] Record 182.
[33] Record 1024.
[34] *Id*.
[35] Record 167-175.

> The diagnosis of pain syndrome affecting the right hand and arm to the right shoulder was made by neurologist Patterson at Virginia Mason Clinic and seems to be as useful diagnosis as any other. This was done after he found no neurological abnormalities clinically.
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> * * * * *
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> What this boils down to then is that she has numerous subjective complaints which are not anatomically consistent with any particular disease process that I am aware of. Furthermore, all objective studies to this point have been negative….[36]

In answer to the question whether any symptoms were related to the January 27, 1997, injury, Dr. Smith commented that he could not answer the question:

> I am not sure what the injury was. It is noted the injury was reported in April of 1997 to have occurred three months prior, but there is no indication of medical care between January of 1997 and April of 1997 in the documents presented to me. Consequently, the remoteness of the injury to the first medical care makes definition of the injury itself somewhat difficult.[37]

In February of 2000 Ms. S. was given a psychiatric evaluation by Patricia Lipscomb, M.D., Ph.D. Dr. Lipscomb's review of Ms. S.'s medical, personal, and psychological history was thorough and comprehensive, and is described in a 34-page report.[38] Dr. Lipscomb summarized Ms. S.'s medical records back to 1979. Dr. Lipscomb diagnosed Ms. S. with the following clinical disorders: undifferentiated somataform disorder, pain disorder, nicotine dependence, and alcohol Abuse/Dependence, in remission.[39] Dr. Lipscomb did not rule out a somatoform disorder (as opposed to undifferentiated somatoform disorder), but could not confirm that diagnosis. [40]

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[36] Record 171-172.
[37] Record at 172.
[38] Record 195-227.
[39] Record 219-220.
[40] Apparently as an attachment to Dr. Youngblood's report, diagnostic criteria for somatization disorder are provided in the record at pages 842-843:

> A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and resulting in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.
> B. Each of the following criteria must have been met, with individual symptoms occurring ant any time during the course of the disturbance:
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> > 1. *four pain symptoms:* A history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)
> > (2) *two gastrointestinal symptoms:* a history of at least two gastrointestinal symptoms other than pain (e.g. nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)
> > (3) *one sexual symptom:* a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)

Dr. Lipscomb determined that the 1997 lifting incident did not cause or aggravate any of the conditions she diagnosed, which were preexisting. Dr. Lipscomb observed that the somatoform disorder and pain disorder were more severe than they had been in the past, but Dr. Lipscomb attributed this to natural progression of the conditions, not the lifting incident:

> I believe that apparent worsening reflects a natural progression of those conditions, in which a person with a Somatoform Disorder or Pain Disorder is likely to focus on any physical event that occurs and to use it to explain decreased functioning, even after the medical consequences of such an event are long since resolved. A patient's attribution should not be confused with an actual causal relationship.[41]

Dr. Lipscomb did not recommend any specific psychiatric treatment for Ms. S., opining that "her problems are so chronic that she is unlikely to benefit in a lasting way from any further psychotherapy."

Dr. Lipscomb concluded that Ms. S. probably does sincerely believe that she is disabled and unable to work, but Dr. Lipscomb did not attribute this belief to a psychological illness. Asked whether Ms. S.'s mental condition would render her unable to work, Dr. Lipscomb responded, "Ms. S.'s psychiatric diagnoses do not render her unable to work as a CNA. However, her belief that she is totally disabled would certainly interfere. This belief is best understood as an attitude and not a psychiatric illness." [42]

On January 30, 2001, psychiatrist Peter Roy-Byrne interviewed Ms. S. and reviewed all of the medical and psychiatric records available to date. Dr. Roy-Byrne diagnosed Ms. S. with undifferentiated somatoform disorder, mixed personality disorder with histrionic and paranoid

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(4) *one pseudoneurological symptom:* a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures: dissociative symptoms such as amnesia: or loss of consciousness other than fainting)

C. Either (1) or (2):

(1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

(2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairments are in excess of what would be expected from the history, physical examination, or laboratory findings

D. The symptoms are not intentionally produced or feigned (as in a Factitious Disorder or Malingering).

In contrast to Somatization Disorder, Undifferentiated Somatization Disorder is "a residual category for those persistent somatoform presentations that do not meet the full criteria for Somatization Disorder or another Somatoform Disorder. Symptoms that may be seen include the examples listed for Somatization Disorder. There may be a single circumscribed symptom, such as nausea, or, more commonly, multiple physical symptoms. The chronic unexplained physical complaints often lead to medical consultation, typically with a primary care physician." Record at 843.

[41] Record 226.

features, chronic right shoulder impingement syndrome, and financial and marital stress.[43] Dr. Roy-Byrne also suspected somatization disorder, providing details of Ms. S.'s early history that would be consistent with such a diagnosis. While Dr. Roy-Byrne generally agreed with Dr. Lipscomb's diagnoses, he took exception to Dr. Youngblood's diagnosis of adjustment disorder: "It should be noted that Dr. Youngblood accepted virtually everything that the patient told him at face value. These included a report on August 11th by the patient that 'the most recent medical tests have confirmed damage in her arm,' something that is entirely false."[44] Dr. Roy-Byrne concluded that "there is no psychiatric condition that would prevent [Ms. S.] from working currently."[45]

Dr. Roy-Byrne's review of Ms. S.'s medical records noted "an impressive number of medical visits from 1978 to 1981 for a young woman without any major medical problems."[46] The record shows that the incident on January 25, 1997, was not the first time Ms. S. had complained of a shoulder injury. Records from March 12, 1986, show that Ms. S. saw an orthopedic surgeon,

> …regarding her left shoulder on a referral from Dr. Salness. What she says is that she was arrested for DWI, was handcuffed, and with her hands behind her back someone grabbed her left arm pulling it forward and in essence incurring an anterior force to her left shoulder. She said there was a pop and a searing pain which apparently lasted for several weeks. She is convinced it was dislocated although she said she saw Dr. Bloom who felt that she had an A-C joint problem. She now complains of pain in the left shoulder…. Of interest is the fact that that she saw Dr. Lindsay here in the office in January of 1985 regarding C-Spine and shoulder difficulties associated with an altercation apparently with her boyfriend New Years Eve. She says she got over those symptoms. Dr. Lindsey found no objective findings relative to her A-C joint….[47]

At the hearing, Ms. S. described some additional ailments with which she is currently afflicted. Ms. S. testified at the hearing that she did not quit her job at the P.s' H.; rather, she had been ordered not to go to work by Dr. Schwartz. Ms. S. testified that around the time she stopped working in April of 1997 there had been a change of administration going on at the P. H. Ms. S. stated that the nursing director had been replaced, and after she stopped working at the P. H. she did not know anyone there anymore. Ms. S. testified she never called the P. H. to discuss her job, and that the P. H. never contacted her, although she did get letters from the state. Ms. S.

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[42] Record 227.
[43] Record 714.
[44] Record 712.
[45] Record 715.
[46] Record 710.
[47] Record 462.

testified that she considered herself an employee of the P. H. between 1997 and 2005, and that "I've tried other doctors, I've tried everything you can think to try to get myself to where I would be able to go back to work in any capacity." Ms. S. stated that during this period she did not believe she was totally disabled, but she did not make any effort to contact the P. H. or to go back to work in any capacity because "she had not been released to go back to work." She explained that in May of 2005 she received a letter stating that her job was being terminated with rehire rights because she had not been working.

Ms. S. testified that she knew what an undifferentiated somatoform disorder was and that she had not sought treatment for such a disorder nor did she intend to. She stated that Dr. Youngblood had concluded that she did not have such a disorder. Ms. S. incorrectly asserted that Dr. Lipscomb had "left it open in her report that if there was any further medical information that she would be willing to reevaluate." She discounted Dr. Roy-Byrne's conclusions because "I think I spent probably five minutes in his office, and anyway that was a pretty quick, a pretty quick thing and he wasn't all too friendly."

Ms. S. originally filed her workers' compensation claim for the January 25, 1997, injury on April 25, 1997. On July 21, 1997, the Alaska Workers' Compensation Board heard the case and concluded that "the preponderance of the evidence demonstrably shows that the employee has not suffered any type of permanent disability because of her work injury…the board is persuaded by the substantial evidence that the employee has been suffering an Undifferentiated Somatoform Disorder, which preexisted her 1997 work injury."[48] The Alaska Workers' Compensation Board found that the undifferentiated somatoform disorder was unrelated to, and not aggravated by, the January 25, 1997, incident and it denied the claim.

The Public Employees Retirement Board found that it was collaterally estopped from hearing Ms. S.'s claim for occupational disability based on the workers' compensation decision, but it determined that Ms. S. was not barred from applying for nonoccupational benefits.[49] Ms. S. applied for nonoccupational disability benefits on February 22, 2002, and the administrator denied the application on July 21, 2003.[50]

III. Discussion

An employee is eligible for a nonoccupational disability benefit if the employee's employment is terminated because of a total and apparently permanent nonoccupational

[48] Record 277.
[49] Public Employee's Retirement Board decision 02-02 at page 4; Record 306.
[50] Record 923-924.

disability, as defined in AS 39.35.680 . . ."[51] A "nonoccupational disability" is a physical or mental condition that, in the judgment of the administrator, presumably permanently prevents an employee from satisfactorily performing the employee's usual duties for an employer or the duties of another position or job that an employer makes available and for which the employee is qualified by training or education, not including a condition resulting from a cause that has been excluded by regulation.[52] The issues in this case are whether Ms. S. suffers a total and apparently permanent nonoccupational disability, and if so whether that is the reason she terminated her employment. The employee has the burden of proving that the requirements of the statute have been met.[53]

With the exception of Dr. Schwartz, all of the physicians, psychologists, and psychiatrists who have examined Ms. S. or reviewed her case opined that she could work at her old job or at the least a similar job with lighter duties. Multiple qualified professionals have concluded that the principal condition preventing Ms. S. from working is chronic pain disorder or undifferentiated somatoform disorder. Ms. S. has declined to seek treatment for these diagnoses, and she does not claim a disability based on these diagnoses. Ms. S. has not sought her previous job or a similar job with lighter duties or accommodations from her previous employer. Ms. S. has not tried to work anywhere else in any other capacity.

At the hearing, Ms. S. acknowledged the many different providers she has seen and the variation in conclusions that have been reached regarding her case. Through her attorney, Ms. S. argued that the greatest deference should be given to the opinion of Dr. Schwartz, because he is the only medical professional that has seen Ms. S. on a regular ongoing basis. Dr. Schwartz has been declaring Ms. S. disabled and unable to continue her previous kind of work since June 1997.

In order to be nonoccupationally disabled, the employee must show that the disability prevents the employee from "satisfactorily performing the employee's usual duties for an employer or the duties of another position or job that an employer makes available and for which the employee is qualified by training or education." Thus, if the P. H. had made available, and Ms. S. had been able to perform, a light-duty job suitable for a qualified CNA, Ms. S. would not be nonoccupationally disabled, even if she could not perform the kinds of work she used to do.

[51] AS 39.35.400(a).
[52] AS 39.35.680(24).
[53] *Rhines v. State*, 30 P.3d 621, 628 (Alaska 2001).

Ms. S. did not show that she made any attempt to determine if the P. H. would make light duty available to her.

Dr. Schwartz examined Ms. S. many times and repeatedly declared her unable to work. He essentially advised her that she would never be able to work again. But it is significant that even Dr. Schwartz concluded that Ms. S. did not have a ratable disability, which he contrasted with "a severe functional disability manifested by inability to do any type of work." Dr. Schwartz did not explain what he meant by "severe functional disability."

According to Dr. Schwartz, he asked Ms. S. if there was lighter duty work she could do at the P. H.; when she told him there were no such positions available, Dr. Schwartz then concluded that Ms. S. could no longer work as a CNA. According to Ms. S.'s testimony, it was her belief that Dr. Schwartz had contacted the P. H. to inquire if there was light duty work available, and the P. H. told Dr. Schwartz that no light duty work was available. There is no evidence in the record, however, that shows that Ms. S., Dr. Schwartz, or anyone else ever contacted the P. H. at any time to ask if there was some kind of light duty or part-time work that Ms. S. could do. The P. H. wrote to the division on February 19, 1998, that "the reason Ms. S. was not assigned to light duty was because we were never given a release from her doctor for her to return to work."[54] Ms. S. testified at the hearing that after she stopped working, she never went back to or called the P. H. to talk about her job or to discuss returning to work in any capacity at all, though she did often visit with her old coworkers.

While Dr. Schwartz focused on Ms. S.'s physical complaints and the possible medical reasons, it does not appear that he gave extensive thought to the question of whether there might be some kind of productive work that Ms. S. could do, or whether working in at least some capacity might even have a positive therapeutic effect. In the spring and summer of 1997 Sue Roth, a disability management specialist, met extensively with Ms. S., attended one of her appointments with Dr. Schwartz, and discussed Ms. S.'s case with Dr. Schwartz. According to Ms. Roth's summary,

> Specialist discussed with [Dr. Schwartz] her non-participation in physical therapy and the guarding regarding her concern for capsulitis. Dr. Schwartz replied that if a patient did not want to get better that there wasn't anything he could do….Dr. Schwartz did not have an aggressive approach with Ms. S. He seemed to just feel that it did not matter that she was not trying to get better or that other psychosocial factors may be the primary reason for her ongoing pain.[55]

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[54] Record 134.
[55] Record 32.

Throughout the medical records in this case compiled by an array of professionals, there is a recurring suggestion that Dr. Schwartz has stated that Ms. S. is unable to work because she says so, and Ms. S. states that she is unable to work because Dr. Schwartz says so. There may be more truth than was intended in Ms. S.'s statement about Dr. Schwartz at the hearing that "he totally disabled me in 1998." Other physicians have agreed with Dr. Schwartz's opinion, at least initially, that Ms. S. does have some impingement. But Dr. Schwartz's focus seems to be on treating Ms. S.'s physical complaints. His conclusion that she cannot work appears to be in large part based on Ms. S.'s opinion, not on a comprehensive evaluation of Ms. S.'s employability.

Dr. Lipscomb's and Dr. Roy-Byrne's discussions indicate that a person with a somatoform disorder, which an orthopedic physician might be less likely to recognize or deal with, the advice that she may never be able to return to her former work could provide her with the validation that prevents her from ever going back to work, in spite of the patient's physical ability to do so.

Dr. Roy-Byrne's suspicion of somatization disorder, particularly in light of Dr. Lipscomb's opinion that psychiatric treatment is unlikely to be productive for Ms. S., suggests the possibility of a genuinely disabling psychiatric condition with no avenue for treatment. Sufferers of somatization disorder are likely to continue seeking treatment for an array of pain and other physical symptoms, while refusing to acknowledge the true disorder. Ms. S.'s statements and behavior up to the time of the hearing are consistent with the patterns that Drs. Lipscomb and Roy-Byrne predicted in their earlier evaluations.

Finding that Ms. S. honestly believes that she cannot work and has not been persuaded otherwise, would not be enough to support a finding that she is disabled. In spite of his diagnosis of undifferentiated somatoform disorder and suspicion of somatization disorder, Dr. Roy-Byrne concluded that Ms. S. does not suffer an illness or disorder that would prevent her from working. Dr. Lipscomb's conclusion that "this belief [that she cannot work] is best understood as an attitude and not a psychiatric illness" shows that Ms. S. is not disabled. An attitude is not a disability.

The evidence in the record does not show that, in May of 2005, or even by the date of record closure, Ms. S. suffered a physical or mental condition that prevents her from satisfactorily performing her former usual duties. The evidence shows that Ms. S. has both physical and mental conditions, but that these conditions are not disabling. The evidence indicates that it was Ms. S.'s attitude that prevented her from returning to work, and that it is her

attitude that prevents her from seeking treatment that would help her improve these conditions. Ms. S. simply failed to meet her burden of showing by the preponderance of the evidence that her employment was terminated in May of 2005 because of a physical or mental condition that would have permanently prevented Ms. S. from working in her usual duties as a CNA or in another job that could be provided for her that is suitable for a person with her training and skill.

IV. Conclusion

Ms. S. has not met her burden of proving that she suffers from a nonoccupational disability or that her termination was the result of a nonoccupational disability. The PERS administrator's decision to deny Ms. S.'s application for nonoccupational benefits is AFFIRMED.

DATED this 17th day of April, 2009.

By: *Signed*
MARK HANDLEY
Administrative Law Judge

Adoption

The deadline for filing a proposed action in this case was extended to May 17, 2009. Ms. S. filed a proposal for action requesting that the case be remanded to take additional evidence. Ms. S. enclosed additional and updated medical records with her proposed action. Having reviewed the proposal for action filed in this case, and the records provided by Ms. S., I have determined that the proposed order should be adopted.

As it does not appear that Ms. S. copied the Division with her proposed action or the records that she provided, the Division may make an appointment with the Alaska Office of Administrative Hearings to review and copy these documents for its records.

This Decision 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 Rule of Appellate Procedure 602(a)(2) within 30 days of the date of this decision.

DATED this 22nd day of May, 2009.

By: *Signed*
MARK HANDLEY
Administrative Law Judge

[This document has been modified to conform to technical standards for publication.]