BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of:	)	
	)	
E E-T	)	OAH No. 10-0082-PER
	)	Div. R&B No. 2010-001

DECISION

I. Introduction

E E-T filed an application for occupational disability retirement benefits in 2000. She last worked in 2001 and she was terminated from employment due to disability in 2002. On April 3, 2003, the administrator of the Public Employees' Retirement System issued a decision granting her non-occupational disability benefits but denying occupational disability benefits. Ms. E-T filed an appeal.

The administrative law judge conducted a hearing on March 29-31, 2011.[1] Ms. E-T and the administrator were represented by counsel. Ms. E-T testified. Expert medical testimony was provided by Dr. Stephen Fuller, an orthopedic surgeon, for the administrator, and by Dr. T N, a chiropractor, for Ms. E-T.

It is undisputed that Ms. E-T is disabled and that she suffers from chronic pain. At issue is whether on-the-job injuries which she allegedly incurred in 1992 (blow to the head), 1993 (back injury), 1996 (back injuries; fall from a standing position), and in 1998-2000 (back injury) were a substantial factor in her disability. The administrator contends that the work injuries were not a substantial factor in her disability, in light of other non-work-related factors (other blows to the head and falls, fibromyalgia, pre-existing degenerative joint disease).

Based on the evidence in the record and the testimony at the hearing, the administrative law judge concludes that Ms. E-T did not prove by a preponderance of the evidence that her on-the-job injuries were a substantial factor in her disability.

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[1] Ms. E-T's appeal was held in abeyance pending proceedings before the Alaska Workers' Compensation Board. Ms. E-T's workers' compensation claim was resolved by settlement, and her claim for occupational disability benefits was referred to the Office of Administrative Hearings in 2010. Following the submission of post-hearing briefs, the record closed on July 15, 2011.

II. Facts

E E-T was born and raised in No Name.[2] As a young woman she worked in the private sector in a variety of positions, eventually gravitating to real estate sales and appraisal.[3] For about a month and a half in 1979, Ms. E-T experienced lower back pain that radiated down into her left leg.[4] In 1983, when she was 29, Ms. E-T was mooring a boat when she slipped and fell, breaking her ankle.[5] She was hospitalized and had ankle surgery. The ankle injury resolved: she was able to shovel snow and walk up to five or six miles a day in her work capacity,[6] but in later years the ankle injury was occasionally a source of ankle pain.[7] In 1986, she had a stiff neck, which she believed was due to stress.[8] In 1987, she reported she strained a muscle in her back while gillnetting.[9]

In the mid-1970's, Ms. E-T was diagnosed with a seizure disorder.[10] On several occasions, these seizures had caused her to fall, sometimes striking her head.[11] In February, 1981, she fell and hit her head against a plant stand, resulting in an abrasion on her scalp;[12] in 1986, she fell in the kitchen, injuring her nose and breaking a tooth;[13] in 1988, she sustained a nasal fracture when she had a seizure while showering;[14] in May, 1989, she had a seizure and

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2 Deposition of E E at page 8, lines 10-17 [hereinafter, DD pp:ll] (Administrative Record [hereinafter, R.], p. 1819. Pages 1-61 of the Administrative Record were included with the initial referral, and are numbered at the bottom center of each page. Pages 62-1316 are also numbered at the bottom center. Beginning with page 1317, page numbers are at the bottom right corner of each page.

3 DD 10:12-12:1 (R. 1820); DD 37-71 (R. 1827-1835); Div. Ex. 1; Div. Ex. 10, p. 81; R. 35, R. 395.

4 R. 85 (Dr. B; diagnosis back strain). *See* R. 66 (x-ray negative).

5 R. 93.

6 R. 121.

7 *See, e.g.*, R. 145 (12/4/1989; left ankle pain); R. 213 (10/9/92; left ankle pain, "No accident.").

8 R. 114 (Dr. B, 10/10/1986; reported as "probably from nerves").

9 R. 118 (Dr. B, 8/22/87); DDS #3 0:22.

10 R. 35 (" I have had grand mal and partial complex seizures since my 20's."); R. 111, Div. Ex. 10, p. 5 ("She does…know about a seizure disorder which extends back at least to '79 when she was evaluated at Harborview."). The record includes a 1981 Harborview report, but none dating from 1979. *See* R. 88. Apparently, Ms. E-T's parents had observed a seizure for the first time about then, and they referred her to Harborview for an evaluation. *See* R. 144 ("About 10 years ago [1979] she had a seizure which her parents actually witnessed (previous to that the parents had never seen one[)]. She was sent to Harborview…").

11 *See, e.g.*, R. 85 (abrasion on forehead, February 13, 1980); R. 87 (December 8, 1980); DDS #1 1:17 (hit head on wrought iron bookcase in 1980).

12 R. 87 ("8 sutures removed from posterior-top of scalp"), R. 88 ("In 2/81, she hit her head on a plant stand and had loss of consciousness for an unknown period of time.").

13 Testimony of E E-T, Digital File No. 1 at 1 hour, 11 and 17 minutes [hereinafter, DDS #n hour:minute].

14 R. 1335 ("she does report that she had an epileptic attack in her shower and fractured her nose"); R. 266; DDS # 1 1:12, 1:17, 1:34.

struck her forehead.[15] Epilepsy was diagnosed in 1989.[16] Since the mid-1990's, medication has generally controlled, but not entirely eliminated, her seizures.[17]

Beginning in 1989, Ms. E-T was employed full time as a right of way agent for the Alaska Department of Transportation and Public Facilities.[18] Most of that job was office work, and did not place significant physical demands on her; however, a significant portion of the work involved the on-site inspection of real estate.[19] On-site inspections involved substantial travel, with the transport of luggage and other baggage, including trips in small aircraft; walking over rough terrain; stooping; and climbing up and down stairs. The job required substantial physical mobility. For the first few years after she was hired, Ms. E-T had no difficulty in performing her work duties.[20]

On June 25, 1992, Ms. E-T was in No Name examining a building as part of her duties with the Department of Transportation and Public Facilities. She was standing outside the premises when a plumber, working above her and carrying a lengthy metal pipe, turned in a manner that caused the pipe to strike her on the top of her head.[21] The force of the blow knocked Ms. E-T to her knees.[22] She did not lose consciousness and she drove herself to the hospital. While there, she vomited twice. She incurred a "minimal abrasion and contusion of the parietal scalp" and otherwise showed no evidence of trauma to the head, eyes, ears, nose or throat.[23] She was diagnosed with a scalp contusion, concussion and strained cervical muscles.[24] On her return to No Name the next day Ms. E-T's head was x-rayed and no sign of a skull fracture was found.[25] She reported right side neck pain.[26] She did not miss any work days.[27]

Beginning some eight months after the No Name injury, in February, 1993, Ms. E-T began visiting Dr. T N, a No Name chiropractor, for treatment of pain in her shoulder and lower

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15 R. 128.
16 R. 128, 143.
17 R. 248. *See* notes 80, 105, *infra*.
18 Div. Ex. 1; R. 35.
19 Ms. E-T testified that only 30% of the work was office work, and 70% involved investigations and field work. DDS #1 1:02. However, the position description shows field work as within the 30% of the job involving investigations (some of which was not in the field), and that the remainder was office work. *See* R. 56.
20 DDS #1 1:04.
21 R. 204, 207, 209.
22 DDS 1:34.
23 R. 207, 209.
24 R. 207, 209.
25 R. 210.
26 R. 209.
27 DDS #1 1:41.

back.[28] She reported that her back had been painful since the 1983 fall when she broke her ankle.[29] She reported having a tingling sensation in her left arm for about six to eight months.[30] Dr. N took a lumbo-sacral (lower back) x-ray series on February 10, 1993. The x-rays showed diminished disc space at L5-S1, with minimal bone spurring[31] throughout the lumbar (lower back) spine and degenerative joint changes throughout the lumbar spine; Dr. N's impression was of degenerative joint changes.[32] Ms. E-T did not report pain in the cervical (neck) spine area during this visit, and she did not reference the June, 1992, No Name injury.[33] She had normal neck rotation and full neck muscle strength.[34]

On September 23, 1993, Ms. E-T experienced pain while carrying bags.[35] She visited Dr. N, who took cervical and thoracic x-ray series. These x-rays were "essentially normal."[36] They showed some disc space height loss with minimal bone spurring and degenerative changes. Dr. N found no evidence of a fracture or dislocation; his impression was of "degenerative joint changes in the cervical spine" and other features that "appear to be slightly more advanced than a patient of this age should demonstrate." His diagnosis was of "advancing cervical and thoracic spondylosis DJD [degenerative joint disease]."[37] Ms. E-T experienced pain at C7-T1 with

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[28] R. 35, 172-173, 216-217. *See* DDS #1 1:46 (lower back was "screaming at me").

[29] R. 35, 172-173, 216-217, 866 (intake history); Testimony of Dr. T N, Hearing Recording #2 at 3 hours, 39-40 minutes [hereinafter, SM #n hr:min]). Counsel for Ms. E-T argues that the reference to pain since 1983 is to pain in the ankle, not in the lower back. DDS Post-Hearing at 5-6, citing Dr. N's testimony. However, Dr. N's notes in the record, which are difficult to read, appear to state that the main complaint is "low back" with a duration since 1983, and that the cause of the pain was a slip on an icy dock. In particular, the note for "previous injuries" appears to say: "ankle frac 1983/low back pain followed." At his deposition, Dr. N confirmed this reading. R. 1541.

[30] R. 173 (Div. Ex. 10, p. 28); SM #2 3:40.

[31] Dr. N's report refers to "osteophytic changes." Dr. Fuller testified these are bone spurs. SF #3 2:30.

[32] R. 215. Dr. N's typed report states he suspected "spondlyoslysis." R. 215. That is a spelling error, as there is no such condition as "spondlyoslysis." Dr. N suspected either "spondylosis" or "spondylylosis." Spondylosis is "a general term for degenerative changes due to osteoarthritis[.]" Dorland's Medical Dictionary, p. 1239 (26th Ed. 1985) (Administrator's Prehearing Brief, Attachment B); SM #2 2:54 (another term for degenerative disc disease). "Spondylylosis" is something very different, and relatively specific. It is a defect in the vertebra that can lead to slippage of that vertebra, typically at L5, a condition known as spondylolisthesis. *Id.* *See also* note 189, *infra*. Dr. Fuller, in reviewing Dr. N's report, believed the reference was to spondylosis. *See* SF #3 2:31. Dr. N's handwritten note appears to diagnose spondylosis, which is the condition he subsequently noted in the cervical and thoracic spine in September. *See* R. 174, 224. Ms. E-T did, in any event, eventually exhibit spondylolisthesis at L5. *See generally infra* at notes 188-189.

[33] *See* R. 1541 (SM Depo, p. 100); R. 173. Ms. E-T testified, however, that the pain had not gone away. DDS #1 1:42.

[34] R. 173. *See* SF #3 2:25.

[35] R. 217. The handwritten note is largely illegible.

[36] R. 224.

[37] R. 224.

cervical compression.[38] About a month later, on October 19, 1993, Ms. E-T sprained an ankle while moving office furniture.[39]

On October 10, 1994, Ms. E-T visited Dr. N and reported she had experienced low back pain while sitting in a class.[40] Dr. N took another x-ray series of the lumbar spine, with results consistent with the prior (February, 1993) series, essentially showing degenerative changes.[41] Based on his observation, he released her from work for the week, with a diagnosis of intervertebral disc syndrome.[42]

On April 3, 8 and 9, 1996, Ms. E-T had three on-the-job injuries. On April 3, in No Name, she lifted a bag with electronic gear and "felt something give";[43] on April 8, in No Name, while lifting baggage, she strained her back and felt lower back pain.[44] The next day, also in No Name, an embankment gave way and Ms. E-T slipped and fell, wrenching her back.[45] Ms. E-T missed a few days of work.[46] She visited Dr. N, who provided chiropractic treatment, and by Friday, April 12, the pain from these incidents had gone away.[47] Over the weekend, however, it returned.[48] Ms. E-T was released to return to work on April 15.[49]

Over the course of the next two years, Ms. E-T periodically experienced back pain, triggered by stress or by activities such yard work or a rough transportation ride.[50] Despite

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[38] R. 217; SM #2 1:41.

[39] R. 225 (Workers' Compensation Board Physician's Report, date of injury 10/19/93); R.214 (10/20/93 B note "pt having ankle pain from moving office"); 224-227.

[40] R. 240.

[41] R. 237.

[42] R. 238.

[43] E E Deposition Exhibit Ex. 10 [hereinafter, DD Ex. #] (4/10/96 Report of Injury). *See* DD 105:2-17 (R. 1844) (bag of environmental documents; hurt "[b]etween the shoulders and up"); DD 163:14-19 (R. 1858) (clarifying it was "electronics gear").

[44] DD Ex. 19 (4/10/96 Report of Injury). *See* DD 159:17-160:23, 163:1-7 (R. 1857-1858) ("pulling the bag…and turning at the same time"; "my back twisted very badly and it hurt for weeks"); R. 274, 278. Ms. E-T described this incident to Dr. Fuller (in 2006) as "lifting heavy bags of public information material after a hearing." R. 1336.

[45] R. 278. Ms. E-T testified that she fell to the ground. DDS #1 2:01, DDS #3 0:31. Ms. E-T testified at her deposition that she fell against a boulder, striking her lower back. DD 105:223-107:4 (R. 1844). *See also R.* 1576 (K C, OTR; 6/6/2006).

[46] Ms. E-T asserted she missed five days of work as a result of "severe back pain that immediately shot to her knees." R. 1336. Her last day of work was April 10. R. 278.

[47] R. 274, 275, 277 (Div. Ex. 10, pp. 44-46).

[48] R. 279 (Div. Ex. 10, p. 48).

[49] R. 278.

[50] R. 309 (12/26/96 Dr. N note: "traveling on rough aircraft and high stress with the job. Low back pain into the left buttock and hip."); 339 (5/30/97, S. J, physical therapist: "has had flare of DJD since...April as a result of increasing activity with gardening and spring cleaning and painting the house"); R. 348 (7/7/97, Dr. N: "has been working in the yard"); R. 325, 345, 348-350] (7/7/97 "back cramping up, between shoulder blades"; "middle back pain into the left scapula"; breathing difficulty); R. 380 (12/8/97, Dr. N "Lower back soreness over the last two

periodic pain from her various ailments, Ms. E-T, through at least mid-1997, was active, playing golf and getting regular exercise.[51] A July, 1997 radiological study of her lower thoracic area showed degenerative changes.[52] She also reported pain in her knees that had persisted for about two years, and was diagnosed as having degenerative joint disease in the knees.[53] She did not, however, report neck pain, even after she was tested for it by Dr. N.[54]

In the fall of 1997, Ms. E-T reported numbness and tingling in her hands.[55] Dr. T J-K, a neurologist, performed nerve conduction studies and an electromyography[56] (EMG) which, to Dr. J-K' surprise, indicated C8 radiculopathy (a diseased nerve)[57] on both sides.[58] Magnetic resonance imaging (MRI)[59] on November 18[60] indicated degenerative changes at C5-6.[61] An x-

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weeks. Back pain at the l.sjc. into the left leg at the buttock and outside of the upper leg."); R. 406 (1/9/98, Dr. N "Lower back soreness today…Upper dorsal spine, right upper arm soreness").

[51] *See* R. 339; R. 348 (7/7/97, Dr. N: "has been working in the yard"); R. 373 (11/13/97 Dr. F: "still having pain in all of her fingers on the left hand, particularly after activities such as golfing"); R. 424-425 (1/27/98 No Name Physical Therapy: reporting gradual onset, with "1st hospitalization care 7/97" and previously "normal kinda' life – working, gardening, fishing, care-taking etc.").

[52] R. 350 (7/7/97, Dr. N notes "degenerative joint changes consistent with thoracic spondylosis and traumatic epiphysitis"). Dr. Calzaretta, referencing the same imaging study, identified the finding as "degenerative joint changes consistent with thoracic spondylosis and traumatic epihysitis." R. 1242. Dr. Fuller, commenting on Dr. Calzaretta's observation, stated that the doctor had described "slight scoliosis." R. 1734; SF #3 0:55.

[53] R. 296-300 (8/26/96, noting history of "sprained back in April 96"); R. 333, 339 [Div. Ex. 10, pp. 54, 63] (5/29/97 No Name Urgent Care "knees flaring up again"; 5/30/97 S. J diagnosis "DJD [degenerative joint disease] of the knees" noting, "since approximately the third week of April as a result of increasing activity with gardening and spring cleaning and painting the house").

[54] *See* Div. Ex. 10, pp. 44 (4/9/96), 48 (4/15/96), 54 (12/26/96), 65 (7/7/97); R. 329 (4/1/97); DDS #2 1:11-1:17; SM #2 1:58, 3:04-3:18, 3:58.

[55] R. 365-367 (Dr. J-K, 11/12/97).

[56] The National Institute of Health's online medical library states that an "[e]lectromyography (EMG) is a test that checks the health of the muscles and the nerves that control the muscles." It is performed by inserting a thin needle with an electrode into the muscle, and recording the electrical activity generated when the muscle is activated. www.nlm.nih.gov/medlineplus/ency/article/003939.htm (accessed December 7, 2011).

[57] "Radiculopathy" has been defined as "a disease of the nerve roots." Carter v. B & B Construction, Inc., 199 P.3d 1150, 1152 (Alaska 2008), *citing* DORLANDS ILLUSTRATED MEDICAL DICTIONARY at 1404 (28th Ed. 1994). Dr. Fuller stated: "Radiculopathy is a very specific medical term, which means that there is actually a pathological interruption of the nerve root or nerve in question." SF 19:15-18. It is, as Dr. Fuller explained, an organic condition, not simply a sensation of numbness or tingling. *See* SF 19:13-20:16 (R. 1698-1699). According to Dr. Fuller, a valid diagnosis of radiculopathy is based on pain, weakness, sensory loss, or reflex loss in the nerve distribution. SF #3 1:58.

[58] R. 362-373 (10/6/97 Dr. F: "for the last 2 years…occasional numbness and tingling, as well as pain of the left hand"; 11/12/97 Dr. J-K: "The EMG was positive for a C8 radiculopathy on both sides"; "This one really blew me away. Nothing on NCV or exam pointed to neck x the numbness extending slightly up the forearm"); R. 408.

[59] "Magnetic resonance imaging" has been defined as: "a noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves—called also MRI." www.merriam-webster.com/medlineplus (accessed November 30, 2011).

[60] R. 380 .

[61] R. 376 (11/18/97, Dr. W); R. 408 (1/14/98, Dr. M: (mild"); R. 378 (12/2/97, Dr. X); R. 533 (3/29/200, Dr. M: "degenerative changes C4 to C6").

ray of the cervical spine on November 18 showed "normal alignment but with minimal loss of vertical disc height at C5-6."[62] When examined by Dr. N on December 10, Ms. E-T reported the hand symptoms had been ongoing for about three years (*i.e.*, since late 1994 or early 1995), and had seemed to get worse in July.[63] Dr. N sent the November 18 MRI out for review, and received a report of spinal canal narrowing at C4-5 and C5-6, with encroachment upon the anterior margin of the cord, but "no unusual findings" at C8.[64]

Ms. E-T was referred to Harborview Medical Center in Seattle,[65] and on January 14, 1998, she was diagnosed with mild cervical spondylosis at C5-6, with symptoms "far beyond" what the observed spondylosis would cause.[66] She reported her upper back and neck pain and pain across the shoulders had persisted for about three years (*i.e.*, since late 1994 or early 1995).[67] Aggressive physical therapy was recommended, with surgery if no improvement followed.[68] Dr. N referred Ms. E-T to No Name Physical Therapy for aggressive therapy.[69] Her workstation was evaluated by a physical therapist, who recommended a number of changes.[70] Dr. N opined that absent changes in the ergonomics of her work station, her condition would not improve.[71] After ten sessions of physical therapy,[72] Ms. E-T elected to undergo surgery.[73]

On April 10, 1998, Dr. M. Sean Grady (neurosurgeon) and Dr. Jens Chapman (orthopedic surgeon) performed discektomies at C4-5 and C5-6,[74] followed by a bone graft and fusion at C4-6.[75] The surgery went well and Ms. E-T's recovery was unremarkable.[76] Dr. Grady deemed Ms. E-T able to return to work on July 10.[77] Dr. N authorized a part-time, limited duty return to work for two weeks pending re-evaluation and noted that a "return to 'pre-injury' status is

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62 R. 375 (11/18/97, Dr. W).

63 R. 384 (12/10/97, Dr. N). A similar report was provided to Harborview at her admission. R. 450, 462.

64 R. 395 (12/22/97, Dr. Q).

65 R. 397 (12/23/97 referral by Dr. X, who had apparently been consulted by Dr. M).

66 R. 408 (1/14/98, Dr. M).

67 R. 408 (1/14/98, Dr. M).

68 R. 411 (Dr. Grady).

69 R. 422 (1/22/98).

70 R. 430-431 (2/26/98 No Name Physical Therapy). The record does not indicate whether any changes were implemented at that time.

71 R. 432-433 (3/3/98 Dr. N).

72 R. 437 (3/11/98 No Name Physical Therapy).

73 *See* R. 438 (3/11/98 request for medical leave); R. 439 (3/16/98 recommendation for "appropriate procedure" (C5/6 corpectomy with a C4-C6 anterior fusion) by Dr. Grady).

74 A "diskectomy" has been defined as the "surgical removal of an intervertebral disk." www.merriam-webster.com/medlineplus (accessed November 30, 2011).

75 R. 453-456 .

76 *See* R. 479 (5/8/98 Dr. Grady).

77 R. 491.

remote as the biomechanics have been altered and the probability of advanced DJD [degenerative joint disease] in the cervical spine is high."[78]

Ms. E-T returned to work in mid-July, 1998. Upon her return her duties were changed and she was given a job managing a long-term, multi-year project in No Name involving the disinterment, transport and reburial of human remains that had been stored in a bunker at the airport.[79] Ms. E-T immediately experienced difficulty performing her duties; she had two seizures before the end of the month, likely resulting from the stress of returning to work.[80] On July 28 Ms. E-T requested additional leave and accommodations in the workplace.[81] As an accommodation, in August, 1998, she was provided a hands-free telephone headset and a new chair.[82] She continued to report soreness and fatigue.[83]

In January, 1999, Ms. E-T's employer's workers' compensation insurance carrier asked Dr. Jon Reiswig (orthopedist) to evaluate her condition. Dr. Reiswig examined Ms. E-T and reviewed her medical records. He concluded that Ms. E-T had incurred a disability, which he rated as 25% of the whole person, as a result of a cervical neck impairment caused by the on-the-job injury in 1992. He found no evidence of any pre-existing condition that would have contributed to that impairment, but did not rule out such a condition.[84] Her cervical range of motion was significantly reduced as a result of the fusion surgery.[85] Dr. Reiswig reviewed thoracic and lumbar films dating from 1993-1997 and observed some spurring but normal disc spacing; he concluded that her thoracic and lumbar spine condition was not disabling and was not substantially work-related.[86]

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78 R. 492 (7/13/1998).

79 DD 72:11-73:19 (R. 1835-1836); R. 1277.

80 R. 495- 497; R. 532. She had additional seizures in June and July, 1999. R. 592 (3/8/2000, Dr. X). In 2002, Ms. E-T reported that she had gone back to working 18-hour days, "because no had told her to reduce her work activities." R. 918 (7/23/2002; Dr. Chaplin). This report is seems inconsistent with the record, which states she herself requested reduced hours before she returned to work, and that her release was initially limited.

81 R. 444-445.

82 R. 573; DD Ex. 7 (4/4/2001 letter, D. E-T to B. N).

83 R. 511, 513 (8/13/98, 9/8/98 Dr. N).

84 R. 522-523, 527 (1/7/99); 539 (3/4/99).

85 R. 529 (Dr. Reiswig, 1/7/99: "Cervical spine - limited movement in all directions, approximately 50% of normal, except for left rotation, which is about 75% of normal.").

86 R. 522-523 (1/7/99); 539 (3/4/99). Dr. Reiswig noted she had "excellent movement in forward flexion" and that discomfort "was not felt at the low back." R. 539.

Ms. E-T continued to visit Dr. N periodically, with complaints of pain in various areas. Work on the No Name project involved lengthy work hours;[87] it was emotionally draining and involved substantial travel to and from No Name.[88] In February, 2000, Dr. N referred Ms. E-T to Dr. L M (orthopedist) for another cervical MRI and review of her status.[89] The MRI showed some minor spurring (as would be expected post-surgery),[90] but no cord compromise.[91] Ms. E-T reported that the surgery had "helped her tremendously" in using her hands, but that with exertion she was still experiencing "severe cramping pain in the arms and neck" as well as "some low back pain" and was "considering disability."[92] Dr. M, like Dr. Reiswig, considered the back pain (which he suspected was due to degenerative spondylolisthesis at L4-5) to be of less concern than the neck, but felt that "her neck pain is probably soft tissue in origin."[93] Dr. Chapman, too, was of the view that her "symptoms are myofascial in nature."[94] Dr. N, reviewing the consultation, was of the view that the findings were "consistent with post-surgical mechanical reaction to the fusion above and below the fusion with DJD and increase[d] stress to the surrounding joints."[95] Ms. E-T's physical therapist anticipated "minimal success unless she has her stress, depression, and other medical problems under control."[96]

On September 24, 2000, Ms. E-T filed an application for occupational disability retirement, attributing her disability to the full range of the manifold symptoms she was experiencing.[97] That fall, on several visits to Dr. N, she reported that she had pain "all over."[98]

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87 Ms. E-T testified at her deposition that she spent long hours typing in connection with the project, but did not know if that aggravated her condition, although her symptoms did worsen during that period of time. DD 111:2-112:19 (R. 1845).

88 *See* R. 1287.

89 R. 579 (2/17/20).

90 R. 595 (3/29/20, Dr. M: "postop changes C4 to C6 with fusion and plating").

91 R. 584 (3/28/20, Dr. C); R. 602 (3/30/02, Dr. R; "no cord or root compression"); R. 602 (3/30/00, Dr. Chapman; "we see no evidence of a transfer lesion or residual mild cord compression or root compression.").

92 R. 595 (3/29/00, Dr. M). She reported to Dr. J that, with respect to her cervical spine, she was "doing well except for some chronic neck pain". R. 598 (3/29/00). Ms. E-T did not identify lower back pain as an issue for Dr. J. R. 598-599. Ms. E-T reported that pain was interfering with her everyday activities, and largely preventing her from vigorous activity. R. 604. She noted lower back pain on her pain drawing. R. 605. The level of pain was described as between "discomforting" and "distressing." R. 606.

93 R. 595 ("Lumbosacral xray 2/23/00 shows a mild degree of L4-5 degenerative spondylolisthesis about 5%."; "Back pain probably due to L4-5 spondylolisthesis."). The referenced xray has not been located in the record.

94 R. 603 (3/30/00).

95 R. 610 (4/5/00).

96 R. 613 (5/1/00, D. P, L.P.T.).

97 R. 1318.

98 R. 639 (10/12/00, Dr. N: "sore all over"); R. 641 (10/17/00, Dr. N).

Dr. N referred her for a complete systems review at a pain management clinic.[99] An x-ray of her lumbar spine in November, 2000, showed "trace L4-5 spondylylisthesis" and "bilateral facet degenerative changes at L4-5 and L5-S1", but "no definite arthritic changes."[100] By this time, she had been diagnosed with fibromyalgia,[101] although other possible diagnoses were considered.[102] Electrodiagnositic testing indicated right wrist carpal tunnel syndrome, but no other abnormalities.[103] Ms. E-T was diagnosed with chronic pain syndrome, with possibly in large part a myofascial component.[104] The frequency of her seizures increased.[105]

Ms. E-T did not work after April 1, 2001.[106] In May, 2001, she was evaluated and approved for participation in a fibromyalgia study in Seattle, but declined to participate.[107] In October, 2001, she visited Dr. N for treatment of pain resulting when she slipped and fell to her left buttock.[108] An MRI of the cervical spine in March, 2002, revealed no significant cord or foraminal compromise.[109] An MRI of the lumbar spine in August, 2002, revealed moderate facet arthropathy, most prominently at L4-5.[110] Dr. N, reviewing that study, referred Ms. E-T to Dr. M, suspecting that the nerves in her spine were being constricted.[111] In September, 2002, she complained that back pain over the last two years had become "excruciating" over the last sixth months.[112] Dr. M diagnosed "L4-5 spinal stenosis [narrowing of a nerve corridor] with back pain with superimposed fibromyalgia."[113] Decompression, via a laminectomy,[114] rather than

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99 R. 646

100 R. 663 (11/17/00, Dr. H).

101 R. 643 (10/20/00, Dr. B).

102 *See, e.g.*, R. 676 (1/18/01, Dr. B: "inflammatory arthritis neuritis undifferentiated connective tissue dz").

103 R. 680 (1/19/00, Dr. T).

104 R. 696-697 (2/5/01, Dr. W). "Myofascial" has been defined as "of or relating to the fasciae of muscles." www.merriam-webster.com/medlineplus (accessed November 30, 2011). The "fascia" are connective tissues. *Id.*

105 R. 723 (4/18/01, Dr. X); *see* R. 747 (six seizures from December, 2000 through April, 2001).

106 R. 1322.

107 R. 704, 709-716, 733-741, 754. Ms. E-T at one point explained that "she did not enroll because her neurologist could not endorse an aerobic exercise program thinking it might cause further seizures". R. 1058. However, in fact, her neurologist, Dr. X, had informed the fibromyalgia study team that an aerobic exercise program would not increase her risk of seizures, and had encouraged her to join the program. R. 744, 746.

108 R. 816 (10/17/01; Dr. N).

109 R. 855-856 (Dr. C). Dr. N had referred Ms. E-T to Dr. Q, an associate of Dr. C, looking for signs of post-surgical scarring. R. 849.

110 R. 942 (8/1/02; Dr. Y, No Name Regional Hospital).

111 *See* R. 943 (8/5/02; Dr. N) ("Confirm hypertrophic changes and stenosis lumbar spine.").

112 R. 972 (9/24/02, Dr. M).

113 R. 972 (9/24/02; Dr. M).

114 A "laminectomy" has been defined as the "surgical removal of the posterior arch of a vertebra." www.merriam-webster.com/medlineplus (accessed November 30, 2011). The lamina has been defined as "the part of the neural arch of a vertebra extending from the pedicle to the median line." *Id.* In light of these definitions, it

fusion, was recommended as a surgical option for treatment, "knowing that this [might] not relieve all of her pain."[115] On October 7, a laminectomy at L4-5 was performed, confirming "marked stenosis" at L4-5, but no other stenosis.[116] The surgery was complicated by a small tear of the dura, which was repaired during the procedure.[117] Following the surgery, Ms. E-T reported weakness in the right foot and an MRI revealed a hematoma at the site of the tear in the dura.[118] The hematoma was removed in an operation performed on October 7.[119] On discharge, Ms. E-T was provided a walker and a drop foot splint to alleviate symptoms caused by damage to the L5 nerve root during the surgery.[120]

Ms. E-T was terminated from employment due to disability on November 30, 2002.[121] Her foot drop symptoms did not abate, and she continued to experience substantial low back pain. Dr. Chapman recommended surgery,[122] and on January 28, 2004, he performed a revision diskectomy and fusion at L4-5,[123] intended to improve her quality of life.[124] The surgery did not resolve her disabling conditions.

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."[125] A work injury is the "proximate cause" of a

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would appear that "decompression" refers to a lessening of the compression of bone on a nerve, by the removal of the lamina; the intended result, presumably, is to lessen pain emanating from that nerve.

115 R. 972 (9/24/02, Dr. M).

116 R. 974 (10/7/02, Dr. M).

117 R. 974.

118 R. 976.

119 R. 976 (10/7/02; Dr. M). *See also* R. 981 (10/15/02; Dr. M). The L4-5 nerves, according to a demonstrative chart provided by the administrator at the hearing, extend to the calf and ankle area, and thus to have foot drop following surgery at the L4-5 area would suggest (to a layperson) damage to the nerves exiting that site, associated with the surgery. In his discharge report, Dr. M states "[t]here was no significant hematoma to press on the nerve." He viewed the foot drop as "difficult to explain based on the circumstances."

120 R. 981 (10/15/02, Dr. M). *See* DDS #1 2:29; R. 104, R. 108, R. 1079 (3/17/03, Dr. G); SF 32:11-14.

121 R. 1322.

122 R. 1211-1212.

123 R. 2091-2093.

124 R. 2092.

125 AS 39.35.680(27).

disabling condition if it is a substantial factor in the condition.[126] A work injury may be a substantial factor in the disability if it aggravates, accelerates, or combines with a pre-existing condition,[127] even if the pre-existing condition could independently have caused the disability.[128] A work injury 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 physical condition.[129] The work injury is a substantial factor in the disability if (1) the disability would not exist but for the injury, and (2) a reasonable person would regard the work injury as a cause and attach responsibility to it.[130]

B. Summary of Contentions

The administrator and Ms. E-T agree that she is disabled. Furthermore, the administrator and Ms. E-T agree that she suffers from a variety of ailments, including degenerative joint disease, epilepsy, foot drop, and fibromyalgia. The issue to be determined is whether her work injuries were a substantial factor in causing her disability. Ms. E-T contends that they were. Her pre-hearing brief puts it this way:

> Ms. [E-]T will show that the enumerated injuries so disrupted the mechanics of her neck and back and/or so aggravated any [degenerative] joint disease she may have had, that her body responded with increasing and unremitting pain, which in turn made it impossible for her to continue doing the job she had.
> …
> In this case, the disability is unremitting pain, limited function of her right foot, and severely limited ability to move about, all of which are direct results of the cascading breakdown in Ms. [E-]T's spinal biomechanics and the surgical attempts to correct it. The breakdown in her spinal mechanics is directly related to the work-related injuries to her head, neck, and lumbar spine.[131]

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126 State, Public Employees' Retirement Board v. Cacioppo, 813 P.2d 679, 683 (Alaska 1991). *See generally*, Shea v. State, Department of Administration, Division of Retirement and Benefits, 267 P.3d 624, 631-634 (Alaska 2011) [hereinafter, "Shea"].

127 Hester v. Public Employees' Retirement Board, 817 P.2d 472, 475 (Alaska 1991) (adopting test identical to that applied in workers' compensation cases).

128 State, Public Employees' Retirement Board v. Cacioppo, 813 P.2d 679, 683 (Alaska 1991).

129 Hester v. Public Employees' Retirement Board, *supra*, 817 P.2d at 476, note 7. *See* Shea, 267 P.3d at 631, n. 18; Lopez v. Administrator, Public Employees' Retirement System, 20 P.3d 568, 573-574 (Alaska 2001).

130 The "but for" and "attach responsibility" features of the "substantial factor" test, which are derived from the common law test for causation in the tort context, had been adopted for purposes of workers' compensation cases before the court's decision in Cacioppo. *See* Doyon Universal Services v. Allen, 999 P.2d 764, 770 note 26 (Alaska 2000), *citing* Fairbanks North Star Borough v. Rogers & Babler, 747 P.2d 528, 532 (Alaska 1987); State v. Abbott, 498 P.2d 712, 726-727 (Alaska 1972). Those features of the substantial factor test were not specifically adopted in Cacioppo for purposes of occupational disability cases. In Shea, the court expressly clarified that the "but for" and "attach responsibility" elements apply in occupational disability cases arising under AS 39.35. Shea, 267 P.3d at 633.

131 Prehearing Brief on Behalf of E E-T, pp. 11-12, 13 [hereinafter DDS Prehearing].

Ms. E-T's pain is real and it is disabling.[132] The administrator has not argued that Ms. E-T did not suffer from disabling chronic pain in 2002, or that her loss of mobility resulting from surgeries intended to relieve her pain, including cervical and lumbar fusions and a surgical complication in the form of foot drop, was not disabling. Rather, he argues that Ms. E-T did not prove that her work injuries were a substantial factor in her disabling pain and loss of mobility. In the administrator's view, the contribution that the work injuries made to her disabling loss of mobility and chronic pain is insubstantial or non-existent.

C. Work Injuries

At various times, Ms. E-T has identified different alleged work injuries as contributing to her disability. For purposes of this appeal, however, her primary focus has been on (1) the 1992 incident in which she was struck on the head.[133] She has also mentioned (2) incidents involving back injuries allegedly incurred in 1993 and April, 1996.[134] Ms. E-T has also emphasized (3) an injury to her lower back resulting from a fall from a standing position, also in April, 1996,[135] and (4) an injury allegedly incurred in connection with her work on the No Name project, which lasted from 1998 until she stopped working in 2001.[136] To prevail, she must prove by a preponderance of the evidence that (1) these injuries occurred, and that (2) but for the injuries (individually or collectively) she would not be disabled, and (3) a reasonable person would regard the injuries as a cause of her disability and attach responsibility for her disability to the injuries.

1. 1992 Blow To The Head

That Ms. E-T incurred a work injury in 1992 is undisputed. The facts relating to that injury are essentially undisputed, albeit somewhat sketchy. In short, she was struck on the top of the head by a heavy metal pipe as it was maneuvered by a nearby worker. The size and weight of the pipe, the speed with which it was moving at the time of impact, and the precise direction

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132 Dr. Fuller and Dr. Bell were "in no doubt that she has a chronic pain syndrome which is secondary to fibromyalgia and/or myofascial pain syndrome or somatization disorder." R. 1427 (6/29/06). *See* LB 28:4-12.

133 *See* DDS Prehearing at 5-7, Post-Hearing Brief On Behalf Of E E-T at 9-10 [hereinafter, DDS Posthearing].

134 Ms. E-T's pre- and post-hearing memoranda are somewhat inconsistent with each other and the record with respect to some of these incidents. *See* DDS Prehearing at 2, 7 (referencing October, 1992, injury to back and ankle while moving office furniture to new office location; two injuries in April, 1996, "in conjunction with moving office equipment"); DDS Posthearing at 11 (September, 1993 office furniture move; no mention of April, 1996 incidents other than the fall). The record establishes that the office move that resulted in an ankle injury occurred in October, 1993, and that the April, 1996, incidents did not involve furniture moves.

135 DDS Prehearing at 2, 7, 9; DDS Posthearing at 11.

136 DDS Prehearing at 3, DDS Posthearing at 11-12).

from which it came are unknown. The force of the blow was sufficient to knock Ms. E-T to her knees, but did not cause her to lose consciousness. She had no skull fracture and only a "minimal abrasion and contusion of the parietal scalp." She was diagnosed with strained cervical muscles. Although she may have had some temporary pain in the neck and shoulders following this incident, the preponderance of the evidence is that she did not experience severe or long-lasting neck pain.[137]

2. 1993-1996 Back Injuries

The record includes evidence of a number of occasions on which Ms. E-T allegedly experienced back injuries at work and otherwise.[138] For purposes of this appeal, three of those incidents have been identified by Ms. E-T as substantial factors in her disability.[139] The first is an incident on October 19, 1993, when she was moving office furniture and sprained an ankle.[140] On that occasion Ms. E-T did not report any injury to her neck or back, but she has asserted she injured her back.[141] However, the preponderance of the evidence is that she did not.[142] The other two incidents occurred on April 3 and 8, 1996.[143] The preponderance of the evidence is that on these occasions Ms. E-T injured her back, once while lifting, on the other occasion while also twisting, but did not incur any fracture or disc herniation or displacement.

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[137] The No Name hospital records from the date of the injury do not mention a report of neck pain. R. 204, 207. However, Ms. E-T reported neck pain upon her return to No Name. R. 209. Ms. E-T testified that she had pain at the knob of the neck, and that it did not go away. DDS #1 1:38, 1:42. Ms. E-T also testified that she saw Dr. N for treatment of neck pain in 1993-1994. DDS #2 1:08. However, there is no indication in his records that he treated her for neck pain during this period of time.

[138] For example in her deposition testimony, Ms. E-T asserted that on one occasion, a filing cabinet fell on her, but no such incident has been identified in the medical records. DD 161:2-6 (R. 1858).

[139] There is evidence in the record regarding back injuries on September 23, 1993 (lifting a bag), and in October, 1994 (sitting at a conference table, twisted back). *See* notes 35-37, *supra* (September 23, 1993 incident); notes 40-42, *supra* (October, 1994 incident). Neither was identified in Ms. E-T's prehearing brief as a substantial factor in her disability, and her reports to doctors who examined her in connection with her disability claims generally do not refer to either incident. *See*, R. 918 (7/23/02, Dr. Chaplin); R. 1266 (9/28/04, Dr. G); R. 1276-1277 (10/10/04, Dr. Robertson); R. 1221 (10/6/04, Dr. Calzaretta); R. 1350 (6/29/06, Dr. Fuller).

Ms. E-T appears to have referenced a different October, 1994, injury in her report of the April, 1996, injuries, but there is no information in the record regarding that other event. *See* R. 278 (April 15, 1996, Workers' Compensation Physician's Report; Ms. E-T reports "10/94 lumbar sprain, intervertebral syndrome on the job – No Name, No Name Street").

[140] R. 225.

[141] R. 1336; DDS #1 1:55.

[142] There is no mention of a neck or back injury or complaint of neck or back pain in the records relating to that incident. *See* R. 214, R. 224-227. Ms. E-T did not visit Dr. N, who had previously treated her for her complaints of neck and back pain.

[143] *See* R. 274; R. 278 (April 15, 1996, Workers' Compensation Physician's Report; Ms. E-T reports "in No Name…went to lift electronics bag and felt something give w/ pain in legs & lower back (4/3/96); "in No Name 4/8 went to lift bag out of back of car and again felt a sharp back pain").

3. 1996 Fall

This incident involved a sudden fall from a standing position on April 9, 1996. It appears that an embankment gave way and Ms. E-T was thrown to the ground.[144] This injury, by itself or in conjunction with the immediately preceding instances in which she injured her back, resulted in a substantial period of disability, as Ms. E-T was out of work for 18 days.[145]

4. 1998-2001 No Name Project

Ms. E-T testified at the hearing that she incurred an injury as a result of handling heavy items in connection with the 1998 No Name project.[146] At her deposition she testified this occurred in the winter of 1999-2000, and that she reported the injury to Dr. N.[147]

Ms. E-T's testimony that she incurred a physical injury to her back while working on the No Name project is not persuasive. First, Dr. N's records (and other medical records) from October 1, 1999, through April 30, 2000, while occasionally mentioning back pain, do not report any specific back injury during that time, even though Ms. E-T stated she reported it to him.[148] Second, on multiple occasions prior to her deposition testimony, Ms. E-T mentioned the No Name project, but did not describe moving heavy objects or injuring her back.[149] Her first reference to moving heavy objects in connection with the No Name project was apparently in

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144 R. 275 (Div. Ex. 10, p. 45), R. 278 (Div. Ex. 10, p. 47) ("taking a picture of a culvert, stepped backwards and had small rock roll, it threw me off balance and I have very bad back pains, numbness and tingling upper arms"). Ms. E-T testified at her deposition that she fell against a boulder, striking her lower back. DD 105:223-107:4 (R. 1844). *See also* R. 1576 (K C, OTR; 6/6/06); DDS #1 2:01.

145 R. 278-285 (Div. Ex. 10, p. 50-51). Ms. E-T also received chiropractic treatment in December. R. 309 (Div. Ex. 10, p. 54); R. 223.

146 DDS #6 0:19, 0:28.

147 DD 109:3-21 (R. 1845). At that time, Ms. E-T testified that she "opened the packages up, checked the gravestones for the name and the years, and then put them back into the packing and moved them to stacks." DD 108:19-25 (R. 1844).

148 Ms. E-T testified at her deposition that she spent long hours typing in connection with the project, but did not know if that aggravated her condition, although her symptoms did worsen during that period of time. DD 111:2-112:19 (R. 1845). *See* R. 562 (10/6/99); R. 566 (1/5/00) ("Long hours sitting at a computer and feels like I have over done it"); R. 567 (1/6/00); R. 568 (1/7/00); R. 1/10/2000) ("While picking up a gallon of milk I felt a slashing pain into the neck"); R. 573 (2/15/00); R. 580 (2/21/00); R. 582 (3/1/00); R. 585 (3/8/00) ("the last three days hard at work"); R. 586 (3/16/00) ("under a great deal of stress…she is involved in some major work with transferring bodies"; no mention of physical injury); R. 589 (3/23/00) ("any activity makes it hurt"); R. 595 (3/29/00; Dr. M); R. 601 (3/30/00; Dr. Chapman) ("has…returned to work where she is primarily at a desk and involved in decision-making, some computer work, and other office tasks"); R. 609 (4/5/00); R. 611 (4/14/00).

149 *See* R. 613 (4/26/00; D. P, P.T.) ("presently working had a job that deals with chronic grief issues"; no mention of physical injury or heavy lifting); R. 667 (11/17/00; Dr. J) (No Name project was "emotionally wrenching"; no mention of a physical injury or heavy lifting); R. 918 (7/23/02; Dr. Chaplin) (No Name project reference; no mention of injury); R. 1266 (9/28/04; Dr. G); R. 1277 (10/10/04; Dr. Robertson) ("in charge of contacting the families and obtaining the numerous special permits for each body and orchestrating the special burials along with a national memorial"; no mention of heavy physical labor).

2006, more than five years later.[150] In the absence of a contemporaneous medical report of an injury to either Dr. N, another medical professional, or her employer, the preponderance of the evidence is that Ms. E-T did not incur a physical injury to her neck or back while working on the No Name project.[151]

D. Causation

1. Fibromyalgia

Fibromyalgia (myofascial pain) is a diagnosis that describes symptoms, rather than identifying a specific physical condition with a known cause.[152] Fibromyalgia is a condition whose essential symptom is pain in connective tissues, not pain that can be identified as radiculopathy in the form of a compressed or otherwise compromised nerve.[153] The diagnosis of fibromyalgia might be considered equivalent to a diagnosis of somatic pain disorder, or chronic pain syndrome: all three are terms that are applied to describe chronic pain absent objective physical signs.[154] Ms. E-T contends that her primary disabling condition is chronic pain. Fibromyalgia is the major contributor to that condition.

To say that Ms. E-T has fibromyalgia is to say nothing more than that she has pain in a variety of connective tissues: it does not explain or suggest why she has connective tissue pain.[155] In the view of the Dr. Fuller, the administrator's expert witness, which is supported as

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150 R. 1337 (6/29/06; Dr. Fuller) ("[l]ifting the heavy headstones caused pain in her neck and back").

151 Ms. E-T testified at her deposition that she did not make any work report of an injury to her lower back because she had been informed that to do so would jeopardize her employment. DD 108:4-11 (R. 1844). However, she also testified that she reported the injury to Dr. N. DD 109:3-21 (R. 1845). The thrust of her testimony is that she reported an on the job injury to Dr. N, but that she did not file any documentation of such an injury with her employer. However, Dr. N's records do not mention a physical on-the-job injury to her back at this time, and on multiple occasions after she terminated her employment and prior to her 2006 deposition she did not mention any such injury. *See* notes 148, 150, *supra*.

152 *See generally* R. 655.

153 *See* SF 32:2-4, 35:3-23, 36:8-112; SF #4 0:30-0:32.

154 LB, pp. 26, 37, 41 (R. 1630, 1641, 1645); SF #4 0:30.

155 The testimony in this case to this effect is consistent with prior reported Alaska cases. *See* Brown v. Patriot Maintenance, Inc., 99 P.3d 544 (Alaska 2004) (discussion of differing opinions as to causal relationship between trauma and fibromyalgia); Safeway, Inc. v. Mackey, 965 P.2d 22, 25 n. 1 (Alaska 1998) ("Fibromyalgia is a disease in which the patient has musculoskeletal complaints of pain throughout the body, but does not exhibit any medically objective symptoms"); Black v. Universal Services, Inc., 627 P.2d 1073, 1074 n. 3 (referencing a 1973 source and noting that myofascial syndrome "may occur after acute injury to muscles, bones or joints. Certain areas in muscles or in muscular connective tissue become 'trigger areas,' which when stimulated may produce pain in parts of the body far removed from the trigger.").

well by Dr. Bell, the pain that Ms. E-T is experiencing is psychogenic pain: pain that has no physical basis at all, but that is nonetheless real because it is felt as pain.[156]

In light of the absence of any recognized organic basis for a diagnosis of fibromyalgia, other than the sensation of pain, it is a daunting task to show that the condition would not exist in a particular individual but for an injury incurred while working.[157] It is not, however, an impossible task. Medical uncertainty as to whether there is any causal relationship between traumatic injury on the job and fibromyalgia is not a bar to a finding that the traumatic injury was a substantial factor in disabling fibromyalgia, so long as there is medical opinion evidence to support such a finding in a particular case and a reasonable person could accept that opinion.[158]

In this case, there is evidence that fibromyalgia may become symptomatic following an illness, a traumatic injury, or stress.[159] But that Ms. E-T incurred traumatic injuries before her fibromyalgia was diagnosed does not establish that the injuries were a causal factor in the existence of fibromyalgia: it simply establishes that the temporal sequence is consistent with the injuries having played a causal role. There is also some expert medical opinion evidence in this case that the 1998 and 2002 surgeries were a possible cause of her fibromyalgia. In particular, Dr. Fuller, who testified for the administrator, conceded that the surgeries might have aggravated Ms. E-T's perception of pain even if it did not create any objective adverse physical condition.[160] But Dr. Fuller's opinion was that in this case, the work injuries were not a substantial factor in the existence of fibromyalgia.[161] Moreover, Dr. M, who performed the 2002 lumbar surgery, diagnosed "superimposed" fibromyalgia, which suggests he viewed it as unrelated to the back condition which the surgery was intended to treat.[162]

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156 *See* SF 36, 56. The distinction, if any, between psychogenic pain and fibromyalgia, it has been said, "remains a controversial medical topic." Brown, *supra*, 99 P.3d at 547 (referencing testimony at hearing). Psychogenic pain is quite distinct from pain that is imagined, or the product of malingering, which was at issue in Black. In Black, the claimant was alleged to not actually be suffering from pain at all: a psychiatrist had examined the claimant and expressed the opinion that the claimant "had fully recovered from her back injury and for psychological reasons was simply 'manipulating' those treating her." *Id.*, 627 P.2d at 1074.

157 In this regard, it is important to note that Ms. E-T did not argue that to the extent her pain is psychogenic, her perception of pain was itself caused by the work injuries: that is, she did not argue or attempt to prove that her work injuries were a substantial factor in creating psychogenic pain, that is, pain resulting from a disabling psychological response to the physical conditions caused by the work injuries. Ms. E-T presented no expert testimony from a mental health professional to support such a theory.

158 *See generally*, cases cited at note 155, *supra*.

159 *See* R. 655.

160 SF 87-88 (R. 1766-1767). In addition, Ms. E-T asserted that Dr. Chapman had stated that fibromyalgia and myofascial pain are common side effects of back surgery. DD 124:20-24 (R. 1848).

161 SF 18, ll. 19-22 (R. 1697).

162 R. 972.

None of the medical experts has provided an opinion that in this particular case, the onset of disabling pain from fibromyalgia is due to Ms. E-T's work injuries. Dr. N testified that she has pain as a result of bio-mechanical changes in the spine related to degenerative disc disease. But a "bio-mechanical" change is an organic condition, not, like fibromyalgia, a condition without an observed physical basis. Thus, Dr. N's testimony provides no support for the theory that the work injuries contributed to disabling pain from fibromyalgia. In the absence of any medical opinion evidence of a causal relationship between Ms. E-T's work injuries and the existence of fibromyalgia, Ms. E-T has not shown that the work injuries were a substantial factor in her disability, to the extent that fibromyalgia contributes to that disability.

2. Foot Drop

It is undisputed that Ms. E-T has foot drop as a result of nerve damage during her lumbar spinal surgery October 7, 2002.[163] Foot drop is a condition in which the patient is unable to lift the toes and ankle up while walking.[164] At the time of Ms. E-T was terminated in 2002, it was not clear whether that condition would be permanent, or how disabling it might be. However, with the passage of time it appears that the condition is permanent.[165] Ms. E-T asserts that she is disabled, in part, due to a loss of mobility, and it is clear that foot drop was a substantial factor in her disabling loss of mobility.

This leaves the question as to whether the work injuries were a substantial factor in the foot drop. Because the foot drop would not have occurred but for the lumbar surgery,[166] the relevant question is, were the work injuries a substantial factor in the lumbar spinal condition that led to the surgery. If so, then work injuries were a substantial factor any disability resulting from the foot drop.[167] If not, then the work injuries were not a substantial factor in any disability resulting from the foot drop.

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163 *See supra*, at p. 11.

164 SF 37:12-17; 38:8-9.

165 SF 37:11 ("This [the foot drop] is permanent."); LB 49:19-21 (R. 1653).

166 Dr. Fuller explained that the medical records show that the dura was torn during the 2002 surgery; in his view, this tear likely occurred with some trauma to the L5 nerve, which caused the foot drop. SF 84-85 (R. 1763-1764). However, there is no evidence as to why the tear occurred, other than that it was a complication of the surgery. SF 86 (R. 1765). *See also* R. 1120 ("This Pt demonstrates classic foot drop following a lumbar surg.").

167 If the injury to the nerve that caused the foot drop was the result of the surgeon's negligence, the chain of causation would remain, because negligence in a surgical procedure is a foreseeable consequence. *Cf.* General Motors Corporation v. Farnsworth, 965 P.2d 1209, 1217-1218 (Alaska 1998) (tortfeasor is liable for injury resulting from treating physician's negligence as a matter of law). If the injury was the result of an occurrence sufficiently unforeseeable to constitute a superseding cause, the chain of causation would be broke, but Ms. E-T did not need to disprove the existence of a superseding cause. *Cf.* Keogh v. W.R. Grasle, Inc., 816 P.2d 1343, 1347 (Alaska 1991)

3. Degenerative Joint Disease

It is undisputed that Ms. E-T has degenerative joint disease in her knees and in her cervical and lumbar spine, and that she is disabled by a loss of mobility and chronic pain. Ms. E-T has not asserted that work injuries were a substantial factor in the existence of any disability arising from the degenerative joint disease in her knees. To establish that she is entitled to occupational disability due to a loss of mobility and chronic pain resulting, in part, from degenerative joint disease in the cervical and lumbar spine, she must show that work injuries created degenerative joint disease, or aggravated or accelerated pre-existing degenerative joint disease, in her cervical or lumbar spine, and were a substantial factor in a disabling loss of mobility and chronic pain. To do the latter, she must show that but for work injuries to her cervical and lumbar spine, she would not have had a disabling loss of mobility and chronic pain at the time she terminated her employment in 2002.

a. Cervical Spine

Ms. E-T contends 1992 pipe incident created degenerative joint disease, or aggravated or accelerated pre-existing degenerative joint disease, in her cervical spine.[168] The administrator contends that Ms. E-T's degenerative joint disease in the cervical spine was pre-existing and genetic in nature, that it was aggravated or accelerated by blows to the head incurred in falls during epileptic seizures prior to 1992,[169] and that the pipe incident caused only a temporary muscle strain that fully resolved.[170]

The medical opinions as to whether the 1992 incident contributed to the existence of degenerative joint disease, or aggravation of pre-existing degenerative joint disease, in the cervical spine are mixed. Dr. Jon Reiswig, an orthopedic surgeon, examined Ms. E-T in 1999 on behalf of her employer's insurance carrier and expressed the opinion that the 1992 pipe incident had aggravated "and most likely caused her cervical spine problem."[171] Dr. N concurred.[172]

(in strict product liability tort case, defendant has burden of proof to show benefits of design outweigh risks). The administrator did not assert that the foot drop was an unforeseeable consequence of the surgical procedure.

168 Ms. E-T did not identify the 1993-1996 back injuries as substantial factors in the degenerative condition of her cervical spine, and the preponderance of the evidence is that they were not. Those injuries she linked to the lumbar spine.

169 There is some evidence, furthermore, that even without a traumatic injury in a fall, an epileptic seizure can cause injury to the cervical, thoracic or lumbar spine. SM #2 3:26; SM 15:22-16:7 (R. 1542-1543 ("neck or back problems"); SF #3 2:57; SF 16, ll. 16-19 (R. 1695) (thoracic spine).

170 Administrator's Post-Hearing Brief at 18-19.

171 R. 539. Previously, Dr. Reiswig had stated that "[a]ll of her symptoms regarding the neck and upper extremities are related to work incidents." R. 522. He identified those symptoms as "Cervical spinal stenosis, C4-5,

Two other experts, both orthopedic surgeons, Dr. Fuller and Dr. Chaplin, also examined Ms. E-T on behalf of her employer's insurance carrier, and were of the contrary opinion.[173] Their opinion was that Ms. E-T had pre-existing degenerative joint disease and that the 1992 injury caused a temporary aggravation but did not permanently aggravate, accelerate or combine with her pre-existing condition.[174]

The persuasive weight of these opinions varies. Dr. Chaplin's opinion is not persuasive because, in addition to not being subject to cross-examination, Dr. Chaplin concluded that Ms. E-T was not even disabled, and yet the administrator has conceded, and the preponderance of the evidence is, that she was disabled. Dr. Reiswig's opinion is also not persuasive. Although his opinion was adverse to the party that solicited it, which (other factors being neutral) might enhance its persuasiveness, Dr. Reiswig was not subjected to cross-examination and the document containing his opinion did not explain the basis for it and was initially so confusing that he was asked to clarify it.[175]

Both Dr. Fuller and Dr. N, the two expert witnesses who testified at the hearing, agreed that a traumatic injury could initiate, or permanently aggravate or accelerate pre-existing degenerative joint disease.[176] The central difference of opinion between them concerned the nature of a traumatic injury that is sufficient to initiate the onset of degenerative joint disease or to permanently aggravate that condition if it is pre-existing. Dr. Fuller asserted that for a traumatic injury to initiate or permanently aggravate degenerative disc disease, the injured

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C5-6, with bilateral upper extremity radiculopathy." *Id.* The basis for his assertion that Ms. E-T had bilateral upper extremity radiculopathy is unclear. Dr. Alan Greenwalt examined Ms. E-T and the medical records on behalf of the Worker's Compensation, focusing on the 1996 incidents. R. 1265-1274. He noted, in passing, that he did not disagree with Dr. Reiswig's conclusion. R. 1273. Dr. Greenwalt's view provides only marginal additional weight to Dr. Reiswig's.

172 SM #2 2:31 (agrees with Dr. Reiswig as to causation); #2 22:36, 2:42; #3 3:37-3:50. *See also* SM #2 2:10 (blow to the head can alter biomechanics and accelerate degenerative disc disease).

173 Dr. Calzaretta (chiropractor) examined Ms. E-T on behalf of the Workers' Compensation Board in connection with the 1996 injuries. He stated that in his opinion her cervical complaints were not "industrial related." R. 1234. However, in view of the fact that he was asked to address only the 1996 events, in context it does not appear this was intended as an opinion regarding the relationship between the 1992 event and her cervical condition. Dr. Marilyn Robertson (neurologist), who also examined Ms. E-T on behalf of the Board, expressed similar opinion that also, in context, appears limited to the 1996 injuries. *See* R. 1298-1302.

174 *See, e.g.*, R. 928-929 (Dr. Chaplin), R. 1361, 1426 (Dr. Fuller). Dr. Linda Wray, a neurologist, participated in the examination with Dr. Chaplin and concurred in his opinion.

175 R. 359.

176 Ms. E-T was diagnosed with degenerative joint disease of the cervical spine in September, 1993. R. 224. The timing of the diagnosis is consistent with Dr. Fuller's view that traumatic degenerative joint disease manifests about a year after a sufficiently traumatic event. SF 101-102 (R. 1780-1781). However, a temporal relationship does not in itself establish causation, and in any case Ms. E-T had not been provided diagnostic testing for degenerative joint disease prior to September, 1993.

person's symptoms at the time of the traumatic event would have to be more pronounced than Ms. E-T's were following the 1992 pipe incident.[177] By contrast, Dr. N asserted that even minor trauma can lead to degenerative joint disease in the spine, as bleeding can lead to bone spurs, and the biomechanical function of the spinal joints may be affected.[178] The conflicting medical opinions of Dr. Fuller and Dr. N regarding the effect of minor trauma in the form of injury to soft tissues on the progression of degenerative joint disease are equally persuasive. In summary, the weight of the medical opinions as to the causal role of the 1992 pipe incident does not tilt the balance in favor of Ms. E-T.

Moreover, Dr. N's opinion that even minor traumas can lead to degenerative joint disease means that other injuries to Ms. E-T that impacted her cervical spine, such as her falls during seizures that resulted, on separate occasions, in a broken tooth and a nose fracture,[179] also contributed to her degenerative joint disease, and the cumulative effects of those other injuries lessens the significance of any single event, such as the 1992 pipe incident, as a causal factor in the condition of her cervical spine at the time she terminated her employment.

Moreover, the relationship between the physical condition of Ms. E-T's cervical spine and her disabling loss of mobility and chronic pain is unclear. With respect to a loss of mobility, it is undisputed that Ms. E-T has limited range of motion in her cervical spine as a result of her 1998 cervical spine surgery.[180] However, that particular condition was not in itself disabling (because Ms. E-T continued to work),[181] and Ms. E-T did not establish that but for the cervical fusion, she would not have a disabling loss of mobility. With respect to chronic pain, although Ms. E-T suffers from chronic pain due to fibromyalgia, the preponderance of the evidence is that degenerative joint disease in the cervical spine is not a substantial factor in the existence of her disabling chronic pain. In particular, the preponderance of the evidence is that the degenerative

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177 SF #3 1:51-1:55, 2:41; SF 100 (R. 1779).

178 SM #2 2:16.

179 SM #2 1:43; 2:15.

180 *See, e.g.*, R. 786, 789 (total 39% range-of-motion impairment).

181 For purposes of the Workers' Compensation Act, Dr. Reisweg found that Ms. E-T had a permanent partial impairment rating of 25% of the whole person. Such a rating established the amount of Ms. E-T's benefit under AS 23.30.190, but was unrelated to the extent or existence of a disability within the meaning of AS 39.35. *Cf.* Rydwell v. Anchorage School District, 864 P.2d 526, 531 (Alaska 1993) ("Alaska's statutory scheme does no use [impairment ratings] to establish *disability*, which requires a discretionary analysis considering incapacity in relation to employment potential." [italic in original]).

joint disease in Ms. E-T's cervical spine did not result in any nerve damage,[182] and that her pain symptoms were not the result of an organic condition of her cervical spine.[183] Dr. N asserted that degenerative joint disease could cause pain in the cervical spine itself, particularly in the facets, but Ms. E-T's complaints of pain extend far beyond the facet joints or any other part of the spine, to include pain all over the body. In light of the widespread chronic pain symptoms reported by Ms. E-T, and the absence of an organic condition of the cervical spine as a causal factor, Ms. E-T has not shown that degenerative joint disease in her cervical spine is a substantial factor in her disabling chronic pain.

b. Lumbar Spine

Prior to her 2002 surgery, Ms. E-T had no finding of significant nerve compromise in the lumbar spine, notwithstanding the existence of lower back pain and spondylolisthesis,[184] but she did have a loss of mobility attributed to the lumbar spine.[185] Following the 2002 surgery the clear preponderance of the evidence is that she had a disabling loss of mobility from her foot

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[182] *See* R. 690-695, R. 697 (2/5/01, Dr. W) ("no obvious evidence of nerve root impairment"); R. 532 (3/28/00, Dr. K C; "mild bilateral foraminal stenosis…without cord compromise"); R. 594 (3/28/00, Dr. K C; MRI shows "minimal flattening of the cord and mild hypertrophic foraminal stenosis at C5-6, with minimal hypertrophic foraminal stenosis at C6."); R. 595 (3/29/00, Dr. L M; Review of 3/20/00 MRI scan shows "No significant stenosis or disk herniation."); R. 601 (3/30/00, Dr. R; "Magnetic resonance imaging reveals no cord or root compromise."); R. 603 (3/30/00, Dr. Jens Chapman; reviewing radiographs and 3/20/00 MRI, "I find no concerning neurologic symptoms and no signs of myelopathy."); R. 680 (1/19/01, Dr. D T; EMG consistent with right wrist carpal tunnel syndrome, but "no other abnormalities appreciated on today's exam. Specifically, there is no evidence of an ulnar neuropath on either side…, left upper extremity neuropathy, or any apparent abnormality in neural sensory conduction on either side. There was no electrodiagnostic evidence appreciated of mononeuropathy multiplex or peripheral neuropathy."); R. 697 (2/5/01, Dr. G. B W (neurologist); reviewed recent "C-spine films as well as CT monogram"; "In my opinion there is no significant evidence of 1) pseudoarthrosis, 2) ongoing neurocompression of either her cord or nerve roots."); R. 855-856 (3/13/02, Dr. K C; "no compromise of the cord or neural foramina" at C7-T1).

[183] As Dr. M put it, her symptoms were "far beyond" what any observed organic condition would suggest. Note 66, *supra*. The only substantial evidence of an organic basis in the cervical spine for her pain symptoms is an anomalous finding of radiculopathy at C8 in 1997. *See* note 58, *supra*. That finding, apparently, was relied upon by Dr. Scott Calzaretta (chiropractor), who in 2004 ascribed Ms. E-T's pain symptoms as, in part, "a combination of cervical radiculopathy, particular the C7 and C8 nerve bilaterally." R. 1232. But that finding was not confirmed. *See, e.g.*, R. 395 (12/22/97, Dr. Bruce Q; review of 11/18/97 radiology report from No Name Hospital shows "diffuse mild prominence of the disks at C4-5 and C5-6", but "without specific focal nerve root or cord impingement", "No unusual findings" at C7-T1); R. 407 (1/14/98, Dr. M) ("She does not have any, at least radiologically, significant nerve impingement other than some narrowing of the foramen on both sides…Electrically, she has bilateral C8 radiculopathy [based on the prior finding] but no other findings to substantiate that either."). R. 1077 [Div. Ex. 10, p. 180] (3/13/03, (Dr. G; EMG showed "no evidence of C8 radiculopathy in either upper extremity on a limited study"). *See generally*, SF #3 1:59-2:03; #4 1:32. Dr. S, in 2001, found "residuals in the left upper extremity that are consistent with an old C-7 radiculopathy." R. 736.

[184] *See* R. 736 (5/9/01, Dr. J S; "I do not see any evidence of a major syndrome such as a lumbar radiculopathy.").

[185] *See* R. 736 (5/9/01, Dr. K S; "significantly restricted range of motion of the lumbar spine"). The record includes a spine evaluation summary from August, 2001, which identifies a significant loss of mobility of the cervical spine, but does not identify the degree of impairment to the lumbar spine. *See* R. 786-790.

drop, as well as chronic pain, both as a result of the 2002 surgery.[186] Accordingly, if the 2002 surgery was performed in order to alleviate symptoms attributed to her work injuries, then those injuries were a substantial factor in her disability.

The 2002 surgery was a laminectomy at L4-5, performed to address spinal stenosis (narrowing of the nerve canal) attributable to degenerative joint disease.[187] The surgery did not abate the degenerative condition of other areas of her lumbar spine and did not address her degenerative (*i.e.*, neither congenial nor traumatic) spondylolisthesis,[188] which had been diagnosed in 2000.[189]

Whether the three back injuries that Ms. E-T incurred in April, 1996 were a substantial factor in the degenerative condition of the lumbar spine as it existed in 2002 was hotly disputed.[190] Long before any on-the-job injury, Ms. E-T occasionally had lower back pain relating to the 1983 fall and subsequent muscular strains or other transitory conditions,[191] and on

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[186] *See* R. 972 (9/24/02, Dr. M) (noting complaints of "excruciating" back pain; diagnosis "L4-5 spinal stenosis with back pain with superimposed fibromyalgia); R. 1080 (3/17/03; Electromyography Report, Dr. G) ("profound right L5 radiculopathy"); R. 1197-98 (10/27/03; Dr. C); R. 1200 (10/29/03; Dr. N); SF 32:11-14 (foot drop).

[187] *See* R. 972 (9/24/02, Dr. M) (noting complaints of "excruciating" back pain; diagnosis "L4-5 spinal stenosis with superimposed fibromyalgia").

[188] *See generally*, R. 1036 (1/27/03, Dr. K C); R. 1057-1065, 1080 (3/13, 17/03, Dr. B G); R. 1126-1128 (Dr. E M; "sacroiliac arthrosis", "facet arthrois, L4/L5, L5/S1", spondylosis at L2 through L5"); R. 1197-1198 (10/27/03, Dr. K C; MR of lumbar spine, apart from synovial cyst at L4-5, "no other evidence of central or foraminal-compromising pathology or of nerve root compromise", "moderate degenerative disease"); R. 1211-1212 (12/9/03, Dr. Jens Chapman; "significant facet arthropathy with foraminal and central stenosis", "grade 1 spondylylistheses of a degenerative nature"); R. 1214-1215 (12/9/03, Dr. Dalley; at L4-5, "severe bilateral facet degenerative joint disease", "moderate bilateral neural foraminal stenosis").

[189] R. 663 (11/17/00; Dr. H). *See also* R. 630 (8/23/00, Dr. N); R. 595 (3/29/00, Dr. M) ("Lumbosacral xray 2/23/00 shows a mild degree of L4-5 degenerative spondylolisthesis about 5%."). Spondylolisthesis is a condition in which a vertebra slips over an adjacent vertebra due to a defect of the pars, a bony structure on the vertebra. *See generally* SF 44-45. Ms. E-T had additional surgery in 2004 in an attempt to deal with the "consequences and residuals" from the 2002 surgery. SF 91 (R. 1770). The 2004 surgery included a fusion that stabilized the lumbar spondylolisthesis, further restricting her lumbar range of motion. R. 1425; R. 1230; 1300-1301. Dr. Robertson, a neurologist, rated her as 41% impaired due to her lumbar condition. However, as previously noted, that rating is not equivalent to a finding of disability for purposes of this case. *See* note 181, *supra.*

[190] Minor back injuries in September, 1993, and later were not identified as a substantial factor in her disability. *See* note 139, *supra*. Furthermore, there is no persuasive evidence that the 1992 pipe incident was a substantial factor in the existence of degenerative joint disease in the lumbar spine. *See* DD 102:13-15 (R. 1843) (1992 injury did not cause lower back pain). Dr. N opined that a blow to the head could affect the thoracic and lumbar spine, but did not opine that the 1992 blow in fact contributed to the degenerative condition of Ms. E-T's lumbar spine.

[191] *See* notes 4, 9, *supra;* R. 85 (Dr. B); R. 118 (Dr. B, 8/22/1987). *See also* DDS Post Hearing Brief at 5 ("[S]he complained of back pain a few times" noting occurrences relating to her ankle fracture, pregnancy and constipation).

February 10, 1993, prior to any reported on-the-job back injury, Dr. N diagnosed degenerative joint disease in the lumbar spine.[192]

Dr. Robertson expressed the opinion that the lumbar condition reflected "an age-related degenerative process", *i.e.*, pre-existing degenerative joint disease, and that the work incidents, as she had described them to her, did not play "any significant role in the evolution of her disability".[193] Dr. Fuller, based on Ms. E-T's description to him of the incidents and on her symptoms, was of the opinion that the three April, 1996 injuries caused only transient strains.[194] Dr. Chapin, also based on Ms. E-T's description to him of the incidents and on the objective findings, expressed the opinion that the April, 1996 injuries had not contributed to her disability.[195] Similarly, Dr. Greenwalt was of the opinion that the April 9 work injury was not substantial factor in her disability.[196] Even Dr. Reiswig, who supported Ms. E-T's claim as it related to the 1992 event, was apparently of the opinion that the 1996 work injuries only temporarily aggravated her symptoms.[197] Dr. Calzaretta observed that it was "possible" that the 1996 injuries had aggravated and accelerated pre-existing lumbar conditions, but did not state an opinion that they did.[198]

The only medical opinion that Ms. E-T's work injuries in 1996 aggravated or accelerated the pre-existing degenerative condition of the lumbar spine was provided by Dr. N in his hearing testimony.[199] But Dr. N had twice examined Ms. E-T's lumbar spine in 1993 and 1994, identifying degenerative changes that, he pointed out on the latter occasion, "may lead to facet

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192 R. 215. The condition was again observed in 1994. R. 237-238.

193 R. 1299. Dr. Robertson expressed her opinion as to whether two 1992 incidents, the pipe incident and the office move, together with the April 9, 1996, fall (stated as having occurred on April 3) contributed to her disability, based on Ms. E-T's assertion that those three injuries had been combined for purposes of the evaluation. There is no reference to the April 3 and April 8, 1996, incidents as found to have occurred. Dr. Robertson characterized the April 9 (stated as April 3), 1996, injury as a "lumbosacral sprain strain injury" and that "was not a substantial factor in producing a disability." *Id*.

194 R. 1336, 1350, 1428, 1430-1431, 1433 (6/29/06; Dr. Fuller). In discussing her condition with Dr. Fuller, Ms. E-T did not mention her complaints of back pain as early as 1983. *See* R. 1336 ("Her first memory of low back pain occurred in 1994. She was simply sitting in a conference and 'twisted funny.'").

195 R. 918, R. 928 ("Subjective complaints out of proportion to physical findings with elements of chronic pain syndrome, not related to the injury of June 1992 or other work-related injuries."), 929.

196 R. 1273 (Dr. Greenwalt) ("In my medical opinion…the 4/3/96 injury caused a temporary aggravation of her preexisting lumbar disc condition necessitating treatment for several months."). Like Dr. Robertson, Dr. Greenwalt's opinion was based on Ms. E-T's reference to the 1992 pipe incident, an office move, and the April 9, 1996 fall. *See* R. 1266.

197 R. 522 ("The thoracic and lumbar spine are partially related to her employment"; "I do not believe [tripping and wrenching her back] led to any permanent change leading to her present symptoms in her thoracic and lumbar spine."). *See* R. 539 (providing new answer for paragraph III that is silent regarding lumbar spine)

198 R. 1232-1233.

199 SM #2 2:38. 2:42.

syndrome or facet capsilitis."[200] His impression at that time, it appears, was that the condition he was observing was a degenerative condition of the lumbar spine that would continue to become more problematic over time, without regard to any future injuries. Ms. E-T did not provide an expert medical opinion specifically connecting her work injuries to aggravation or acceleration of degenerative spondylolisthesis, and Dr. Fuller testified that degenerative spondylolisthesis typically becomes symptomatic in middle-aged women, and that Ms. E-T did not incur a pars fracture (which could have caused traumatic spondylolisthesis) in any of her work injuries.[201] Viewed as a whole, the clear preponderance of the expert medical opinion evidence is that the 1996 work injuries involved transient muscle strains that had fully resolved by 2002, and thus those injuries were not a substantial factor in her need for surgery in 2002, or in any disability existing at the time of her termination.

IV. Conclusion

It is undisputed that Ms. E-T is disabled and that a variety of conditions are contributing to her disability, through chronic pain and reduced mobility. Ms. E-T's argument that her work injuries were a substantial factor in her disability rests on her ability to show, first, a link between the on the job injuries and a physical condition, and second, a link between the physical condition and disabling pain or a disabling loss of mobility.

As to the first link, Ms. E-T did not show a link between her on the job injuries and the existence of fibromyalgia. Ms. E-T had degenerative joint disease of the lumbar spine (unrelated to the 1992 pipe incident) in February, 1993, before the on the job injuries she incurred beginning in September, 1993, and the condition of her cervical spine when it was first x-rayed in September, 1993, was consistent with degenerative joint disease that pre-existed the 1992 pipe incident. She had degenerative joint disease in her knees, without any on the job injury to those joints, and she had incurred multiple blows to the head prior to the 1992 pipe incident. The preponderance of the expert medical opinion is that her on the job injuries did not create or permanently aggravate or accelerate the degenerative spinal conditions that contributed to her disabling chronic pain and loss of mobility.

As to the second link, with respect to the cervical spine, in the absence of a showing that her fibromyalgia is the product of degenerative joint disease, or an organic basis for her chronic

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200 R. 237. Dr. N testified that 70% of complaints of pain in the lower back are generated in the facet joints.

201 SF #4 0:05-0:06.

pain, the preponderance of the evidence is that Ms. E-T's cervical spine condition was not a substantial factor in her disabling loss of mobility and chronic pain. With respect to the lumbar spine, the physical condition of Ms. E-T's lumbar spine was substantial factor in her disabling loss of mobility (foot drop) and in her chronic pain (L5 radiculopathy), but the preponderance of the evidence is that work injuries did not create, or aggravate or accelerate, degenerative joint disease in the spine.

For these reasons, Ms. E-T's claim for occupational disability benefits is denied.

DATED December 17, 2012.

Signed
Andrew M. Hemenway
Administrative Law Judge

Adoption

The order is issued under authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060(e)(1), adopts this Decision 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 1st day of February, 2013.

By: *Signed*
Signature
Andrew M. Hemenway
Name
Administrative Law Judge
Title

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