ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

SHANNON K. PATTERSON, Employee, Claimant, v. MATANUSKA SUSITNA BOROUGH SCHOOL DISTRICT, Self-Insured Employer, Defendant.	)	FINAL DECISION AND ORDER AWCB Case No. 201416158 AWCB Decision No. 19-0103 Filed with AWCB Anchorage, Alaska On October 9, 2019

Shannon Patterson's (Employee) July 8, 2019 petition for a second independent medical evaluation (SIME) and her July 9, 2019 petition for an order requiring mediation were heard in Anchorage, Alaska, on September 11, 2019, a date selected on August 16, 2019. An August 7, 2019 hearing request gave rise to this hearing. Attorney Richard Harren appeared and represented Employee who appeared and testified. Attorney Nora Barlow appeared and represented Matanuska Susitna Borough School District (Employer). Susan Magestro appeared telephonically the record remained open to receive her statement.

Patterson v. Matanuska Susitna Borough School District, AWCB Case No. 18-0111 (October 26, 2018) (*Patterson IV*) denied Employee's claim and found she had neither a work-related physical-mental injury nor a mental-mental injury. Employee appealed *Patterson IV* to the Alaska Workers' Compensation Appeals Commission; the Commission stayed its proceedings and temporarily returned jurisdiction so this decision could consider Employee's petitions. The record remained open to receive the *Patterson IV* hearing transcript to which Employee referred in her hearing brief but did not file. The record closed on September 12, 2019.

Patterson v. Matanuska-Susitna Borough School District, AWCB Decision No. 17-0029 (March 16, 2017) (*Patterson I*) made comprehensive factual findings and ordered sanctions for Employee's failure to attend and participate at her deposition, granted her request for a protective order and outlined terms and restrictions for Employee's deposition. *Patterson v. Matanuska Susitna Borough School District*, AWCB Decision No. 17-0055 (May 16, 2017) (*Patterson II*) declined to strike Employer's late filed brief and granted in part and denied in part Employee's request for production and remanded to a designee to make rulings required under AS 23.30.108. *Patterson v. Matanuska Susitna Borough School District*, AWCB Decision No. 18-0005 (January 12, 2018) (*Patterson III*), denied Employer's petition to exclude Employee's late filed evidence and granted its petition to strike her late filed attorney fee affidavit. Upon investigation by the panel and division, the panel learned Employee's attorney fee affidavit was not filed late and the panel reconsidered its decision to strike it. (*Patterson IV*).

Prior to commencing the September 11, 2019 hearing, Employee withdrew her petition for mediation, which Employer opposed. Employee wanted to be placed, through mediation, in an open position with Employer in which she would not have to perform school nurse duties and actively treat children. The position was open only to Employer's current employees and had been filled through a standard recruitment process prior to September 11, 2019. Because the position was no longer available, Employee withdrew her mediation petition.

ISSUES

Employee contends there are medical disputes among various medical providers regarding "a controversial and subjective area of medicine," psychology. She contends if an SIME is not ordered, it is likely her case will be remanded months in the future for an SIME to reconcile disputed opinions between her psychologists and employer medical evaluator (EME) psychiatrist, Keyhill Sheorn, M.D., who offered opinions in her case. Employee contends an SIME is necessary to determine if *Patterson IV*'s determination was wrong.

Employer contends Employee did not petition for an SIME before the hearing, which would have been the appropriate time to do so, and provides no explanation why an SIME should now

be ordered, long after Employee's claim has been litigated and denied. Employer admits Dr. Sheorn's and Paul Wert, Ph.D.'s reports created a medical dispute. It contends had Employee desired an SIME, she could have petitioned for a continuance under 8 AAC 45.074(b)(1)(F). Instead, Employee made a tactical decision to not pursue a continuance and an SIME after Dr. Sheorn's opinion was filed and proceed to hearing using her existing evidence. Employer contends Employee provides no good explanation for her delay and has waived her right to an SIME. It contends, regardless of Employee's diagnosis, an additional opinion will not change the determination Employee failed to prove work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in comparable work environments. It opposes an SIME.

Should an SIME be ordered?

FINDINGS OF FACT

The factual findings and conclusions of law in *Patterson I*, *II*, *III* and *IV* are incorporated here. The factual findings relevant to whether an SIME should be ordered will be reiterated. A preponderance of the evidences establishes the following relevant facts and factual conclusions:

1) Employee was a school nurse working for Employer when she was required to assist the assistant principal to provide mouth-to-mouth resuscitation and chest compressions to a student on September 23, 2014. (*Patterson IV*.)

2) On October 2, 2014, Employee began treatment with Kevin O'Leary, Psy.D., and continued to treat with him until he terminated his relationship with her on February 1, 2017. (*Patterson IV*.)

3) On October 14, 2014, Employee's psychiatric and systems exams were completely normal. Employee was restricted from work until October 20, 2014, due to "situational stress at work." (WC Return to Work Authorization Form, Duane Odland, D.O., October 14, 2014.)

4) On December 9, 2014, EME S. David Glass, M.D., administered a MMPI-2 evaluation. He determined Employee's testing did not reinforce an Axis I psychiatric disorder, nor did it indicate Employee has posttraumatic stress disorder (PTSD). Dr. Glass noted Employee displayed "no evidence of exaggerated startle response or hypervigilance." He "considered" diagnosing Employee with dysthymic disorder "in view of [Employee's] longstanding history of

a mood disorder with the waxing and waning of depressive symptomatology beginning in childhood and the use of antidepressant agents - Wellbutrin." Dr. Glass opined Employee does not have a formal DSM-IV disorder caused by her employment as an elementary school nurse. He noted Employee reported feeling frustration and stress working with elementary students in the past and had discontinued that work in 2007, and returned to elementary school duties in the 2014 school year. Dr. Glass opined the cause of Employee's dysthymic disorder was multidimensional and included both constitutional and developmental components, but work stress did not contribute to her dysthymic disorder diagnosis, which is not a true psychiatric disorder. He said, "While the tragedy in September can be considered unusual - fortunately not a common occurrence - aspiration crises with small children would not be as extraordinary or unusual in a comparable work environment (small children aspirating)." Dr. Glass indicated Employee's perception of the September incident was accurate; however, despite the emotionally traumatic nature of the event, psychosocial factors, including personality psychodynamics and Employee's prior psychiatric issues along with past and ongoing dissatisfaction with elementary school nursing "are the reason for her remaining off work and reporting symptoms." He said any continuing need for psychotropic medication or counseling "involves her pre-existing psychiatric issues / diagnosis and personality psychodynamics," which preexisted her work injury. Dr. Glass believed Employee should have dealt with the distress generated by the incident after a few counseling sessions and returned to work. He determined her past and current dissatisfaction with elementary school nursing were the reasons for Employee remaining off work and reporting symptoms. Dr. Glass acknowledged Employee continued to report insecurities and apparent distress with elementary school nursing. Despite that, he found Employee was able to return to work as an elementary school nurse and any psychiatric disorder caused directly by the September 23, 2014 incident was medically stable without a ratable permanent psychiatric impairment. (EME Report, Dr. Glass, December 9, 2014.)

5) On January 12, 2015, Dr. O'Leary generally agreed with Dr. Glass' opinion Employee "can and should return to work fairly soon." However, he also found "highly questionable" the logic Dr. Glass used to draw his conclusion and stated:

> Dr. Glass' opinion that the pt suffers with no Axis I diagnosis and should have been able to deal with her distress after Kenneth's death in a few sessions' seems inaccurate. Neither Dr. Glass nor I knew the pt prior to the incident with

> Kenneth, so we have few baseline data markers on which to go beyond the pt's report of previous functioning. Per that, the pt has been very consistent in reporting anxiety and depressive sxs greatly heightened by and after watching Kenneth choke and (later) die. She seems to clearly meet clinical criteria for an Adjustment Disorder, and may also meet criteria for Acute Stress Disorder, PTSD, and/or Specific Phobia. The symptoms inherent in these constellations are easily traced back to her involvement in the Kenneth incident. Given this, it seems inaccurate to posit that [Employee] only needed ''a few sessions" of treatment related to the Kenneth trauma. Even the most aggressively managed care coordination models could not possibly deny the appropriateness of a course of therapy for such disorders that would usually be measured in months (and maybe years), not a few sessions. If [Employee] had attempted to return to work after a few sessions, it is my opinion that there would have been an extremely high likelihood she would not have been able to function, leaving the school, the children, and [Employee] in the extremely problematic position of having a nurse on duty regressing, panicking and emoting inappropriately. There should be no doubt that [Employee] needed the treatment she received.
>
> I concur with Dr. Glass' test findings and related conclusions that a pre-existing tendency toward histrionic reactions may be present in the patient; that tendency does not mitigate the legitimacy of her need for treatment of the Axis I disorders discussed above, presumably created and exacerbated by the trauma she faced on the job.

Dr. O'Leary concurred with Dr. Glass that benzodiazepines should be reduced or eliminated. He did not, however, concur with Dr. Glass' recommendation for future treatment with antidepressant medications only. Dr. O'Leary, "in alignment with well-established standards of care" recommended Employee comply with her medication regimen but also seek ongoing outpatient psychotherapy to further reduce her symptoms. Based upon Dr. O'Leary's work with Employee, he found she had proven herself amenable and responsive to psychotherapy. He agreed with Dr. Glass that once Employee successfully returned to work, her continued psychotherapy should "presumably be financed by [Employee] and her insurance company." (Review of Dr. Glass' Report, Dr. O'Leary, January 12, 2015.)

6) Employer served Dr. Glass's December 9, 2014 report and Employer's controversion on January 15, 2015. Dr. O'Leary's January 12, 2015 opinions reflect a dispute with Dr. Glass's opinions. Sixty days from January 15, 2015, is March 16, 2015. (Controversion Notice, January 15, 2015; Judgment; observations.)

7) On February 6, 2015, Dr. Odland did not agree Employee was medically stable or ready to return to work full time. Dr. Odland acknowledged Employee had improved; however, he believed further measurable improvement could be achieved with continued medical treatment and transition back to the work place over time. His plan was for her to return to work on a part-time basis starting with the mornings in February 2015, and then transitioning to full-time duties starting in March 2015. He said she would need to take Wednesday afternoons off for the remainder of the school year to complete her treatment with Dr. O'Leary. (Letter from Dr. Odland, February 6, 2015; Return to Work Authorization, Dr. Odland, February 6, 2015.)\

8) Dr. Odland's February 6, 2015, disagreement with Dr. Glass's December 9, 2014 opinions reflect a medical dispute. Sixty days from February 6, 2015, is April 7, 2015. (Judgment; observations.)

9) On February 10, 2015, Employee filed a claim and requested an SIME. She claimed temporary total and partial disability, medical and transportation costs, a compensation rate adjustment, penalty, interest, and a finding of unfair or frivolous controversion. Employee's claim was not filed together with a completed SIME form listing the medical dispute, nor copies of the medical records reflecting a dispute. (Workers' Compensation Claim, February 9, 2015; observations.)

10) On February 27, 2015, Dr. Odland reviewed Employee's school nurse job description, predicted she would not have an impairment rating from the September 23, 2014 work injury and had physical capacities to perform the school nurse position's physical demands. He approved her to perform the job and released her to return to work with no restrictions. Dr. Odland noted Employee was to continue her appointments with Dr. O'Leary. Based on Dr. Odland's responses, rehabilitation specialist Forooz Sakata determined Employee not eligible for reemployment benefits. (Return to Work Authorization, Dr. Odland, February 27, 2015; Response to Job Description, Dr. Odland, February 27, 2015; Reemployment Benefits Eligibility Evaluation,

Ms. Sakata, March 10, 2015.)

11) On October 16, 2015, Dr. Odland said Employee's September 23, 2014 injury occurred "while performing mouth to mouth resuscitation on a student and got exposed to vomit, blood tinged foam, nasal and mouth secretions and post-incident stress, anxiety, depression, grief, PTSD." Her mental status was normal. (Physician's Report, Dr. Odland, October 16, 2015.)

12) On November 11, 2015, Dr. O'Leary gave Employee the adjustment disorder diagnosis with mixed anxiety and depressed mood, and PTSD, unspecified. He reviewed with Employee "professional/psychic boundaries for 'not taking the bait' for drama and contention with principal, coupled with hopefully anxiety reducing self-validation strategies to reduce agitation and self-doubt." (Progress Note, Dr. O'Leary, November 11, 2015.)

13) On October 18, 2016, Dr. Odland said he was providing medication management for Employee's mental health disorder. "She maintains adequate compliance with follow-up and her mental health issues in no way impact her ability to practice nursing." (Letter To Whom It May Concern, Dr. Odland, October 18, 2016.)

14) On February 1, 2017, Employee filed a petition requesting three actions: (1) to compel discovery; (2) an SIME; and (3) "to establish facts admitted." The petition's attachment states Employee requested "a ruling that Employer has admitted, by its failure to deny, informal requests for discovery that:

A. For ruling that Employer has admitted, by its failure to deny, informal requests for admission that:

    1. The substantial cause of Shannon Patterson's current mental injury/malady, consisting of PTSD, depression, and/or anxiety, which requires her present use of prescription medication is a combination of related events which occurred between the initial choking of a student at Iditarod elementary school on September 23, 2014, and the present time. (That combination of related events includes Ms. Patterson's perception of the emergency, efforts to assess and/or update the student choking, Ms. Patterson struggle to resuscitate him, Ms. Patterson's exposure to multiple bodily fluids, the child's evacuation, hospitalization and death, and, the persisting memories, dreams and flashbacks of the above); and

    2. The combination of Ms. Patterson's perception of the emergency, efforts to assess and/or abate the student choking, Ms. Patterson struggles to resuscitate him, Ms. Patterson's exposure to multiple body fluids, the child's evacuation, hospitalization and death, and, the persisting memories, dreams and flashbacks of the above is an extraordinary and unusual exposure for elementary school nurse working in an elementary school environment.

B. For ruling compelling production requests informally need to employer and hereto for ignored. See Informal Requests for Production 1 through 6 attached as Exhibit A.

Employee's petition was not filed together with a completed SIME form listing the medical dispute, nor copies of the medical records reflecting a dispute. (Petition, February 1, 2017; observations.)

15) On March 1, 2017, Employee requested a hearing on her February 1, 2017 petition and a prehearing held on March 28, 2017 identified the issue for hearing as Employee's petition filed on February 2, 2019, requesting an order stating the requests for admission submitted to Employer be deemed admitted. The prehearing conference summary does not identify Employee's request for an SIME as an issue for hearing. (Affidavit of Readiness for Hearing, March 1, 2017; Prehearing Conference Summary, March 28, 2017; observations.)

16) Employee did not object to the March 28, 2017 prehearing conference summary or seek to modify it. (Agency file).

17) On April 14, 2017, Paul Wert, Ph.D., noted Employee "was referred for the purpose of psychological evaluation by Wasilla, Alaska physician, Dr. Duane Odland. Shannon was also referred by Wasilla, Alaska attorney, Richard L. Harren." Dr. Wert administered the Millon Clinical Multiaxial Inventory-III (MCMI-III), which revealed Employee's "reported feelings of weakness, fatigability, and physical illness may represent the somatic expression of her underlying mood of depression. Simple responsibilities may at times demand more energy than she can muster." Her testing results also found Employee "appears to be experiencing symptoms . . . indicative of an anxiety disorder. She reports a growing apprehensiveness over trivial matters, an increase in a variety of psychosomatic signs, and psychological symptoms, such as restlessness, diffuse fears, catastrophic anticipations, and distractibility." It further revealed the "enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal functioning." Dr. Wert's report states,

> Related to, but beyond her characteristic level of emotional responsivity, this woman appears to have been confronted with an event or events in which she was exposed to severe threat, a traumatic experience that precipitated intense fear or horror on her part. Currently, the residuals of this event appear to be persistently re-experienced with recurrent and distressing recollections, such as in cues that resemble or symbolize an aspect of the traumatic event. Where possible, she seeks to avoid such cues and recollections, such as in cues that resemble or symbolize an aspect of the traumatic event. Where possible, she seeks to avoid such cues and recollections. Where they cannot be anticipated and actively avoided, such as in dreams or nightmares, she may become terrified, exhibiting a number of symptoms of intense anxiety. Other signs of distress might include

> difficulty falling asleep, outbursts of anger, panic attacks, hypervigilance, exaggerated startle response, or subjective sense of numbing and detachment.

18) Dr. Wert found Employee displays symptoms of both depression and anxiety, including fatigue, sleep disturbance, sweating and tension, and concentration difficulties. He found she has "habitual and maladaptive methods of relating, behaving, thinking and feeling." Dr. Wert interpreted the testing results to conclude Employee was dysphoric, insecure, and had abandonment fears, somatic symptoms, and diminished capacity for pleasure, grew anxious over trivial matters, claustrophobic anticipations, and had poor self-image. His evaluation identified Employee has passive dependency and becomes angry toward others who do not appreciate her need for affection and nurturance. He opined her presentation was suggestive of borderline personality disorder. Dr. Wert concluded Employee was affectively unstable and "continues to experience symptoms of posttraumatic stress disorder (PTSD), associated with incident which occurred on or around September 23, 2014." He based his conclusion on Employee's exposure to actual or threatened death when she witnessed the student choking. Dr. Wert recommended Employee receive outpatient mental health treatment and be medically assessed for use of Prasozin, originally a blood pressure medication that was helpful with veterans experiencing nightmares and troubling dreams as a result of PTSD. He diagnosed Employee under the DSM-5 with PTSD; major depression, recurrent, severe, without psychotic features; generalized anxiety disorder; R/O adjustment disorder with anxiety; dependent, avoidant (socially), and possibly borderline personality features or traits. (Psychological Evaluation, Dr. Wert, April 26, 2017.)

19) On May 11, 2017, Employee complained of "increased stress and anxiety since the incident at work involving the death of a student." Employee felt Employer's "staff was somewhat less than supportive." Dr. Odland determined Employee was not yet medically stable and it was undetermined if she could return to her job or if she would have a permanent impairment. He counseled Employee and moved her to "supportive care." (Physician's Report, Dr. Odland, May 11, 2017.)

20) On June 13, 2017, Employee filed Dr. Wert's April 26, 2017 report on a medical summary. (Medical Summary, June 13, 2017.)

21) Dr. Wert's April 26, 2017 opinions reflect a dispute with Dr. Glass's December 9, 2014 opinions. Sixty days from April 26, 2017 is March 13, 2015. (Judgment; observations.)

22) On October 24, 2017, Dr. Sheorn psychiatrically evaluated Employee at Employer's request. Prior to evaluating her, Dr. Sheorn administered the Structured Inventory of Malingered Symptomatology. Employee scored 27, which "was significantly above the cutoff score of 14. The score comes from the number of answers she gave that are atypical, improbable, inconsistent, or illogical for people with true mental disorders." An elevated score, such as Employee's, indicates concern for exaggeration of symptoms in a medico-legal complaint, and caution for multiple inconsistencies in the records and within the clinical interview. During Dr. Sheorn's interview, she noted Employee's behavior was remarkable. Employee "appeared" to sob, would stop suddenly, smile and make a comment or stop and appear ready for Dr. Sheorn to ask the next question. Employee reported she did not remember the period of time after the incident; however, she did recall a message issued by the principal providing notice a student had an incident and had been transported to the hospital. Employee was incensed because the hospital to which the student was transported was shared and Employee thought this was a HIPAA violation. She also recollected trying to find someone to cover for her after the incident so she could leave school and be seen by her family practice doctor. She recalled someone asking her why she needed to see her doctor "at that moment" and replying, "I had all that vomit and stuff in my mouth and I needed to go see my healthcare provider!" Employee shared she was vomiting and walking and throwing up trying to get "that taste" out of her mouth and she needed to be tested for tuberculosis, hepatitis and AIDS. Employee had already been vaccinated for hepatitis A and B, so she was only concerned about hepatitis C and HIV. Employee said when the blood tests came back negative her mind was cleared of those concerns. Dr. Sheorn attempted to elicit PTSD symptoms and asked Employee if she had nightmares or flashbacks. Employee replied she had nightmares two or three times a week and flashbacks at night that made it difficult to sleep; however, Dr. Sheorn said Employee was unable to describe either. After conducting an interview, administering evaluations, and reviewing Employee's extensive medical record and depositions, Dr. Sheorn 's diagnostic impression of Employee's psychiatric mental health condition is:

> [Employee] does not have, and did not, by the records or her own report, have Posttraumatic Stress Disorder. She does have a significant and pre-existing personality disorder that is manifest by periods of functioning and periods of decompensation. The records are replete with documentation of [Employee] being chronically malcontent - at times becoming suicidal, unduly angry, irritable,

> or intolerant of her job, her mother, mother-in-law, sister, husband, and the parents at the school. The incident on September 23, 2014 is the most recent focus of her therapeutic attention, and this has become a diversion from the real problem -- which is her underlying mental illness and maladaptive ways of coping with stress. There is no causal connection from the work-related incident to her ongoing presentation of dramatic symptoms.

Dr. Sheorn said there is enough evidence in her clinical exam of Employee and the records reviewed to diagnose borderline personality disorder. However, Dr. Sheorn also found strong histrionic personality disorder elements based on Employee's "pattern of attention seeking behavior, extreme emotionality, and appears to have difficulty sustaining herself when the focus is not on her." To be diagnosed with histrionic personality disorder under the DSM-5, an individual must display a pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present it in a variety of contexts, as indicated by five or more of eight criteria. Dr. Sheorn identified Employee has only three histrionic personality disorder criteria, which are: (1) Is uncomfortable in situations in which she is not the center of attention; (2) displays rapidly shifting in shallow expression of emotions; and (3) shows self-dramatization, theatricality and exaggerated expression of emotion. Dr. Sheorn concluded Employee shows stronger borderline personality disorder diagnostic elements and said:

> Her records document the typical long-standing history of unstable relationships, fear of perceived abandonment, irritable anger, chronic malcontent, and suicidality. The addition of the diagnosis 'Bipolar II' back in 2006 is a strong indicator that someone was thinking of borderline personality disorder. Dr. O'Leary has peppered his records with his concerns about Ms. Patterson's characterological structure and her character style. Dr. Glass stated that 'personality psychodynamics and psychosocial factors are involved past and present, and records reflect personality issues.' He stated that 'psychosocial factors including personality psychodynamics and her prior psychiatric issues along with past and ongoing dissatisfaction with elementary school nursing are the reason for her remaining off work and reporting symptoms.'

Dr. Sheorn summarized Employee's extensive medical record and commented that Dr. Wert's report did not mention Employee had any prior mental health diagnosis or treatment. She did find, however, that "Dr. Wert's assessment was congruent with both Dr. O'Leary and Dr. Glass."

> His testing of Ms. Patterson showed the 'enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal functioning.' He highlighted her 'more habitual and maladaptive methods of relating, behaving,

> thinking, and feeling.' Specifically, the scoring noted her passive dependency and her anger toward others who 'fail to appreciate her need for affection and nurturance.' She was dysphoric, insecure, and had fears of abandonment. She would grow anxious over trivial matters, and had catastrophic anticipations. Dr. Wert saw her as affectively unstable, cited her poor self-image as suggestive of borderline pathology, and diagnosed her on Axis II with Borderline, Dependent, and Avoidant personality features or traits.

To receive a borderline personality disorder diagnosis, five of nine criteria must be met. Dr. Sheorn determined Employee met seven: (1) Frantic efforts to avoid real or imagined abandonment; (2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealism and devaluation; (3) Identity disturbance: markedly and persistently unstable self-image and sense of others; (4) Recurrent suicidal behaviors, gestures, or threats or self-mutilation; (5) Affective instability due to a marked mood reactivity; intense episodic dysphoria, irritability, and anxiety, usually lasting for only a few hours, rarely more than a few days; 6) inappropriate, intense anger or difficulty controlling anger (frequent displays of temper, constant anger, physical fights); and (7) Transient, stress-related paranoia ideas or severe dissociative symptoms. Dr. Sheorn said Employee's work incident "flashbacks" "do not do not fit the pattern of a traumatic flashback, and are instead the typical regressed psychotic illusions that occur in borderline personality disorder"; which fulfills the seventh criteria.

> Some of the other clinical signs of this disorder are Ms. Patterson's defense mechanisms (Dr. O'Leary mentioned the need to reduce projective identification), her inability to conjure up a visceral image, and a dramatic affective instability. As far back as 5/3/07, Mr. Grasser documented that Ms. Patterson's primary identified problem was mood instability. Newer research has shown that this pattern of such an unstable mood is predictive of borderline personality disorder, just as its absence is clear evidence that disorder is not present.

Therefore, Dr. Sheorn concluded Employee's diagnosis is borderline personality disorder with histrionic traits. She said, "Dr. Glass' use of the old DSM IV-TR is still consistent with the DSM-5 and these opinions are congruent." She also said, "Dr. Glass' overall testing did not indicate PTSD or any other Axis I disorder." Dr. Sheorn's diagnostic evaluation also clarified she could not make a PTSD diagnosis. Under the DSM-5, there are eight criteria that must be analyzed before making a PTSD diagnosis. The first, Criteria A, is a "stressor," and Dr. Sheorn acknowledged Employee's September 23, 2014 work incident was catastrophic and could qualify as a "stressor." However, Dr. Sheorn said, by Employee's own description, she did not respond

with intense fear, helplessness, or horror to the student's situation. "In fact, she has been consistent in describing, and bragging publically, that she was not helpless during the child's collapse and that she was able to provide her best first responder emergency care and deliver him to the EMTs. Therefore, Criteria A is not met." The second, Criteria B, involves "intrusion symptoms."

Dr. Sheorn also found Employee does not satisfy Criteria B because "she has not avoided the target incident. What she is avoiding is returning to work." Dr. Sheorn noted the reason Employee gave for resigning from her school nursing job is "she wants to avoid being put in a position to medically help a child because she does not want to expose herself again to someone else's body fluids." However, contact with the student's vomit, blood, and salvia while performing CPR did not cause Employee any "true harm or threat of harm." Dr. Sheorn said it merely caused a "what if" situation. "What if she contracted Hepatitis C? What if she contracted AIDS? These were future events of [Employee's] own imagination, and had nothing to do with the actual situation that had happened. PTSD is a disorder of memory, not of fantasy." Dr. Sheorn found Employee's stress, abhorrence, and over-reactivity symptoms fall into the hysteria category satisfying one of the borderline personality disorder criteria -- "transient, stress-related paranoia ideas or severe dissociative symptoms." The example Dr. Sheorn referred to was Employee's report she screamed at the child and God to leave her alone while kicking the child's head, which is a volleyball, under the bed. Dr. Sheorn said Criteria H, which requires the disturbance is not attributable to another medical condition, further clarifies Employee does not have PTSD. Dr. Sheorn identified "that other condition" in Employee's case is malingering. She said:

> [Employee's] score on the SIMS malingering inventory was quite elevated. She was quite careful not to present herself with limited intelligence or as psychotic, but she highly endorsed illogical symptoms of neurologic impairment, impaired memory, and a disturbed mood.
>
> Malingering can take several forms, the pure form which is simply making up symptoms. The second form is called partial malingering when the person has some symptoms but exaggerates them and the impact they have. The third form, the category of [Employee's] malingering, is called false imputation. This is when the person has valid symptoms but attributes them to a compensable cause, rather than to the true source. An example of this would be when [Employee] complained to Dr. O'Leary about being 'chastised' at work and that a secretary

> had been 'bitching at' her. Dr. O'Leary stated that [Employee] was now suffering 'secondary trauma' from a lack of emotional support from the school district. This illuminates the iatrogenic weight added to [Employee's] symptoms. She may, indeed, have some anxiety, disordered thinking, and behavior, but it is not causally related to the incident of September 23, 2014. Instead, her symptoms are related to her personality structure and to secondary gain.
>
> Ms. Patterson stated that her fears were assuaged when her blood test results were returned negative. And yet she still exhibits a visceral horror at the memory of having vomit and saliva in her hair, on her face, and in her mouth. Her affect and thought processes collapsed while she was describing her vision of the child's head as a soccer ball. While there is a large component of malingering in this case, this momentary psychotic deterioration would be difficult to manufacture for secondary gain. Even generating the thought requires a psychotic interface -- much less if [Employee] actually acts them out in the privacy of her bedroom late at night. This symptom is strongly related to the severity of her personality disorder.

AS 23.30.010(b) was quoted to provide Dr. Sheorn the criteria for determining if a mental injury caused by mental stress is compensable. Applying this standard, Dr. Sheorn opined the September 23, 2014 incident did not cause Employee to suffer a mental health injury, but stated, "[I]t must be remembered that [Employee] herself later alleged that she felt accused as negligent in the death of the student and this was a 'primary factor in causing her PTSD.' She also contended that the estate's litigation and the Employer's attempt to assign blame and culpability to her triggered PTSD symptoms. She contended that the attorney for the estate triggered her PTSD symptoms." Despite Employee's contentions, Dr. Sheorn indicated none of these factors meet PTSD Criteria A. Dr. Sheorn also said, "The requirement to perform CPR certainly would not be considered an extraordinary or unusual task for a licensed RN. She had been trained and certified in this skill. The skill itself and the requirement to perform this task should not be confused with the extraordinary or unusual calamity that befell the child." Dr. Sheorn opined the work stress occasioned by the September 23, 2014 events did not cause a work-related mental health injury. "[Employee's] personality organization and her poor coping skills are the cause of her symptoms." Determining Employee did not sustain a mental injury, Dr. Sheorn determined the question regarding mental stability was not applicable and Employee did not sustain an impairment.

Dr. Sheorn opined no treatment Employee received has been related to any mental injury from

the September 23, 2014 incident. However, she found a review of Employee's treatment necessary "because when a patient is not getting better, then either the diagnosis is wrong or the treatment is wrong." Dr. Sheorn believed Dr. Odland attempted to treat Axis II symptoms using Axis I techniques. She said:

> The mood and cognitive symptoms of a personality disorder rarely respond to antidepressants, antipsychotics, or anxiolytics. The use of benzodiazepines is contraindicated for use in someone who has borderline personality disorder in that it disinhibits someone who is already labile and disinhibited. The early records document her stimulated reaction to these drugs. The anticonvulsant can dampen some of the reactivity, but the providers' perpetuation of the addictive sleep agent Sonata is inappropriate. This drug is to be used only short-term and in the most minimal dose possible. Not only has it been continually prescribed for at least ten years now, the dose is escalating and has just again been doubled to 40mg. The maximum recommended dose is 20mg -- at which level it is to be tapered and discontinued if used for a long period of time. Rather than doing that, Dr. Odland has approved 40mg, according to [Employee]. [Employee's] 'diagnosis' of sleep fragmentation disorder is much more likely than not caused by the interruption of REM sleep by the benzodiazepines and Sonata. To continue to not only use, but increase the dose, of the very drugs that are causing the problem is circular and below the standard of care.

Dr. Sheorn opined treatment Employee received from Dr. O'Leary's was elective and in no way connected to a work event. Dr. Sheorn believed Dr. O'Leary should have had some sense of Employee's personality disorder and "been on high alert for her histrionic trait of assuming the relationship is more intimate than it was." While Employee "may have felt comforted by him, and he may have felt that his wish to have private communication with her *(no-notes-nothing-never)*; amend her chart and let her peruse the change; or collude with her to deceive the Board of Nursing was somehow in her best interest, he never-the-less violated her boundaries." Dr. Sheorn also found Dr. O'Leary's quick termination of the counselor patient relationship via email was below the standard of care, "especially after allowing such a disturbed patient who had issues with abandonment to have such personal contact with him. It is of concern that, in the abrupt termination, Dr. O'Leary used bullying tactics, manipulation, and outright threats to [Employee's] already impaired self-esteem in an attempt to coerce her to block the subpoena of his office records." Dr. Sheorn determined that, based upon Employee's own statements, "she is functioning at a level high enough not just to care for herself, but to care for fragile others 'like a regular nurse would.' She is able to intervene medically on an airplane, manage her household,

her parent's household, and keep up with friends and her children. She described no functional limitation and appears to be cognitively and neurologically intact. There is no indication that these skills could not be applied to the workplace." Dr. Sheorn based her opinions upon a reasonable degree of medical certainty. (*Id.*)

23) Dr. Sheorn's December 23, 2017 opinions, received by Employee on December 26, 2019, reflect a dispute with Dr. Wert's April 26, 2017 opinion, Dr. O'Leary's January 12, 2015 and November 11, 2015 opinions and Dr. Odland's February 6, 2015 opinion. Sixty days from December 26, 2017 is February 24, 2018. (Medical Summary, December 26, 2019; Judgment; observations.)

24) On January 11, 2018, a prehearing was held to simplify and clarify the issues for hearing and to record the parties' stipulations. The issues identified for hearing were: temporary total disability benefits from January 5, 2015 through February 6, 2015 and May 24, 2016, until Employee was medically stable; temporary partial disability benefits from February 9, 2015 through May 21, 2015, for every Wednesday afternoon Employee missed work while treating with Dr. O'Leary; medical costs; transportation costs; interest; attorney fees and costs. Other previously identified hearing issues included Employee's claim for a compensation rate adjustment. Mr. Harren stated he had not used the division's online benefits calculator and had not formulated a contention regarding what the compensation rate should be. He agreed to the designated chair utilizing the online benefit calculator with the evidence currently in the record to calculate Employee's compensation rate. Mr. Harren was going to confirm with Employee that the issues of penalty and unfair controversion could be withdrawn. An SIME dispute was not set for hearing. (Prehearing Conference Summary, January 11, 2018; observations.)

25) Employee did not request a continuance of the January 16, 2018 hearing or request an SIME at hearing. (Record; observations.)

26) Employee claimed two types of mental stress claims, each based upon PTSD. One was a physical injury that caused a mental disorder -- a physical-mental injury. She also claimed a mental-mental injury; in other words, a mental stimulus caused a mental disorder. Each was analyzed and it was determined Employee did not have either mental injury. *Patterson IV* determined Employee waived her physical-mental injury claim. Employee did not raise a physical-mental injury until the final minutes of the January 16, 2018 hearing. Further, when her April 3, 2017 deposition was taken, she was asked if she was claiming a physical-mental injury

and specifically stated she was not. It was determined Employer did not have sufficient notice of a physical-mental injury claim and had not been given fair notice or the grounds upon which a physical-mental claim rested. Alternatively, *Patterson IV* applied the presumption analysis and found Employee's exposure to the student's bodily fluids and receiving laboratory studies for hepatitis C and HIV raised the presumption for a physical injury since her mother-in-law's death was caused by hepatitis C and she was concerned her exposure caused her, too, to contract it. Without judging credibility, *Patterson IV* found Employer rebutted the presumption with Dr. Sheorn's report. Employee reported to Dr. Sheorn she was concerned about hepatitis C and HIV, but when the laboratory tests came back negative, her concerns no longer remained. Dr. Sheorn determined Employee does not have, and never did have PTSD. Dr. Sheorn stated, despite the September 23, 2014 incident providing the most focus for Employee's therapeutic attention, it is merely a diversion from Employee's real problem, which is her pre-existing mental illness and maladaptive methods of coping with stress. She opined there is no causal connection between the work incident and Employee's ongoing symptoms. *Patterson IV* found when viewed in isolation, Dr. Sheorn's opinion is substantial evidence Employee did not sustain a physical-mental injury. Employee was unable to prove a physical-mental injury by a preponderance of the evidence. *Patterson IV* found Dr. Wert's opinion did not serve as evidence to prove Employee sustained a physical-mental injury. He did not attribute any of Employee's diagnoses to Employee's exposure to the student's bodily fluids, nor did he opine Employee's mental health conditions were caused by her exposure to student's bodily fluids; nor did any other provider. *Patterson IV* gave Dr. Sheorn's report great weight; it was conscientious, reliable and credible. Employee's assertions during her evaluation with Dr. Sheorn that she no longer had concerns regarding her physical well-being after receiving non-reactive lab results for hepatitis C and HIV belie her assertions a physical injury caused her to have a mental disorder. *Patterson IV* found medical support for Employee's physical-mental claim was not found in the record; she was unable to prove by a preponderance of the evidence her employment with Employer is the substantial cause of a mental disorder caused by her exposure to the student's bodily fluids. To the contrary, *Patterson IV* found Employee's own statement contradicted her contention her physical-mental claim is compensable. (*Patterson IV*.)

27) *Patterson IV* next analyzed if Employee suffered a compensable mental-mental injury. Employee claimed PTSD was caused by a mental-mental injury. Specifically, she claimed a mental-mental injury was caused by work-related stress, an unsupportive work environment and lack of immediate attention to her mental health needs after the September 23, 2014 incident. *Patterson IV* held a mental-mental injury is not entitled to the presumption analysis and Employee was required to prove by a preponderance of the evidence two criteria: (1) work-related stress resulted from extraordinary and unusual pressures and tensions in comparison to other persons in a comparable work environment and (2) work-related stress was the predominant cause of PTSD or other mental injury. *Patterson IV* analyzed both criteria. The first was work-related stress caused by extraordinary and unusual pressures and tensions in comparison to other school nurses. *Patterson IV* compared Employee's stress to that of other school nurses working for Employer. Employer's school nurses are expected to provide comprehensive health services for each student in a school, which includes providing emergency care to ill or injured students, crisis intervention and determining the need for emergency referrals. Employer's school nurses are also expected to provide on-going follow-up. *Patterson IV* found that on September 23, 2014, Employee faithfully and competently executed her school nurse duties when she provided emergency medical care to a choking student. It further found choking incidents and other incidents in which a student or staff member's life may be threatened were not continuous or the norm, but they were also not unusual. Several examples involving Employee existed in the record. On January 21, 2016, Employee reported to Dr. O'Leary a staff member had collapsed. Employee was ready to defibrillate and begin CPR, but the ambulance arrived and further intervention from Employee was not necessary. On January 22, 2016, Employee contacted Dr. O'Leary for an appointment after being called to a classroom when a student was choking. The student's teacher did abdominal thrusts and cleared the student's airway before Employee arrived. *Patterson IV* found when students are choking, school nurses are expected to respond and, in fact, other school staff may also respond. On September 23, 2014, the principal and Employee worked together to resuscitate the choking student. Dr. Glass acknowledged the student's choking was an "unusual" tragedy; however, he stated aspiration crises with small children is not extraordinary or unusual in a school environment. Susan Magestro, has a master's degree in teaching and is a criminologist who works with crime victims after they have received a psychiatric diagnosis. Ms. Magestro

considers it the school nurse's duty to respond if a student is choking, and calling 911 is a standard. *Patterson IV* found Ms. Magestro's master's degree in teaching gave credibility to her testimony stating it is a school nurse's job to respond to choking students. (*Patterson IV*.)

28) Dr. Johnson, a psychiatrist and Employee's friend, opined Employee's anxiety is increased when she is in situations where another child could choke and because she is hoping another person will not choke. He said this makes her "pretty much anxious all the time." *Patterson IV* found Dr. Johnson's testimony confirmed Employee is continually anxious, despite the absence of unusual or extraordinary pressures. (*Id.*)

29) *Patterson IV* found school nurses must be present in schools where there are students and staff who eat and are at risk of choking. School nurses intervene with actual and potential health concerns for both acute and chronic illnesses, injuries and emergencies. It found Employee presented no evidence the school environment, which placed her in a setting where another child could choke, created extraordinary and unusual pressure or tension for school nurses or staff. (*Id.*)

30) *Patterson IV* did not discount attempts to resuscitate the choking student were frightening and stressful for Employee, but to be compensable the stress must have resulted from "extraordinary and unusual pressures and tensions." *Patterson IV* found performing her duty to provide emergency care to a choking student by attempting resuscitation is not unusual or extraordinary; it is expected of all school nurses working for Employer. Likewise, choking incidents and other life-threatening emergencies are the types of incidents all Employer's school nurses and staff respond to when needed, as Employee did on more than one occasion. (*Id.*)

31) *Patterson IV* distinguished Employee's case from *Kelly v. State of Alaska Department of Corrections*, 218 P.3d 291 (Alaska 2009) and found that although it may have been unsettling for Employee to provide first responder medical care to a choking child, testimony showed the work stress was not unusual or extraordinary. It found in addition to the September 23, 2014 incident, Dr. O'Leary noted Employee experienced "secondary trauma" from Employer's lack of emotional support because her "debriefing" after the September 23, 2014 incident and after incidents when she responded to a collapsed staff member and another choking student was not provided and caused her stress level to go up. Employee contends she was subjected to "aftershock, after aftershock, after aftershock" and the series of shocks while working for Employer was unending. She expected Employer to offer her follow-up attention after she

performed her duty to provide emergency medical care to students and staff. However, *Patterson IV* found in addition to providing crisis intervention, Employee's school nurse duties required her to provide on-going follow-up after a crisis. Instead, Employee was dismayed because Employer did not provide her "debriefing." Historically, Employee has been dissatisfied with the emotional support she received from her parents, employers and others with whom she has had relationships. *Patterson IV* found Dr. Sheorn credibly testified Employee has a pattern of attention seeking behavior, extreme emotionality and difficulty sustaining herself when the focus is not on her; indicative of borderline personality disorder with histrionic traits. (*Id.*)

32) Although the event on September 23, 2014 while Employee performed her duties as a school nurse was a stressful experience, *Patterson IV* found Employee failed to prove her experience attempting to resuscitate the student on September 23, 2014, or Employer's failure to meet her emotional support needs was an extraordinary or unusual pressure or tension in comparison to other school nurses. *Patterson IV* conducted an alternative analysis. (*Id.*)

33) Because Employee was unable to prove her work stress resulted from extraordinary and unusual pressures and tensions, the analysis could have ended and Employee's claim would have not been found compensable; however, to make certain there was not more to Employee's evidence, that nothing was left unconsidered, and the decision was not wrong, *Patterson IV* analyzed the next element of a compensable mental injury. (Experience; judgment.)

34) Even had Employee been able to prove work stress resulted from extraordinary and unusual pressures and tensions, the next element she had to establish was that the work stress was the predominant cause of her mental illness. Employee asserted one of her mental illnesses caused by work stress was PTSD. (*Patterson IV*.)

35) In analyzing if work stress was the predominant cause of Employee's mental injury, *Patterson IV* relied most heavily on medical opinions to arrive at its legal conclusions. (Judgment.)

36) *Patterson IV* found Dr. Wert diagnosed PTSD; major depression, recurrent, severe, without psychotic features; and a generalized anxiety disorder. He indicated adjustment disorder with anxiety needed to be ruled out; and Employee had dependent, socially avoidant, and possibly borderline personality features or traits. He concluded Employee was "affectively unstable" and experienced PTSD symptoms "associated" with the September 23, 2014 work incident when

Employee witnessed the student choking. *Patterson IV* found Dr. Wert gave Employee the PTSD diagnosis without reviewing or considering any of her medical and mental health records or

Dr. Glass' report. His opinion was based primarily upon the social and medical history Employee provided. Finally, *Patterson IV* found although Dr. Wert's testimony recited the PTSD criterion, he was unable to describe what Employee's symptoms were or what signs and behaviors he observed and relied upon to diagnose PTSD. For all these reasons, Dr. Wert's report and testimony were not entitled to, nor given, weight. (*Patterson IV*.)

37) *Patterson IV* found Dr. O'Leary initially diagnosed Employee with adjustment disorder with mixed anxiety and depression. Eventually, Dr. O'Leary also diagnosed Employee with PTSD; however, he noted Employee's "egocentric trauma defenses" made the student's trauma and death all about Employee, even when these issues obviously were not. (*Id.*)

38) *Patterson VI* found Employee's discontent, because she perceived Employer did not provide her support, has a long history. Employer's lack of support hurt Employee's feelings and, because of that, she quit her school nurse job with Employer in 2007. Historically, Employee also complained about her parents' uncaring nature, including emotional deprivation and anger she carried since childhood. Her psychological diagnoses and bouts of psychological disorders frequently stemmed from others' failures to meet Employee's desire for some form of support, care and concern. *Patterson IV* found that when Employee does not receive the support she desires, she loses emotional control. There is no medical dispute between Drs. O'Leary, Glass and Sheorn on this point; they agree Employee has a preexisting tendency toward histrionic reactions. (*Id.*)

39) Dr. Glass' testing indicated Employee did not have PTSD or any other Axis I disorder. Dr. Sheorn's evaluation, which was given great weight in *Patterson IV*, confirmed Employee does not meet the PTSD diagnostic criteria. *Patterson IV* reviewed PTSD's various diagnostic criteria and how Dr. Sheorn analyzed those criteria. Additionally, Dr. Sheorn administered the Structured Inventory of Malingered Symptomatology. An elevated score indicates the examiner should be concerned the examinee's symptoms are exaggerated in a medico-legal complaint and that there may be multiple inconsistencies in the records and within the clinical interview. Employee scored 27, which was significantly above the cutoff score of 14. Employee's elevated score was derived from the number of atypical, improbable, inconsistent or illogical answers for

people with true mental disorders. *Patterson IV* found in both her report and hearing testimony, Dr. Sheorn provided many examples of inconsistencies in Employee's reports to Dr. Sheorn and her behavior, inconsistent with a PTSD diagnosis. (*Patterson IV*.)

40) *Patterson IV* found Employee was not credible and her failure to vest in her Employer-provided retirement and health care plan was the secondary gain motivating her claim. The evidence *Patterson IV* considered was voluminous and included testimony and reports from medical and mental health professionals including Drs. Odland, Johnson, O'Leary, Wert, Glass and Sheorn and Debra Haynes. *Patterson IV* made credibility determinations, discounted the weight given to Dr. Wert's opinions and testimony, gave great weight to Dr. Sheorn and relied upon her opinions in reaching its conclusions. (*Id.*)

41) Medical disputes have existed in this case since Dr. Glass issued his report on December 9, 2014. The most recent medical dispute occurred between Dr. Wert's April 26, 2017 report and Dr. Sheorn's December 23, 2017 report. (Experience; observations; judgment.)

42) Considering the medical disputes, an additional evaluation was not necessary. Additional investigation and evidence was not needed to decide *Patterson IV*. (Experience; judgment.)

43) Employee referred to M. Scott Peck, author of *The Road Less Traveled*, for the assertion psychoanalysis must be lovingly administered and Employee felt under attack by Dr. Sheorn. Employee felt unable to defend herself after her evaluation by Dr. Sheorn because she was denied permission to record the interview and evaluation. Employee asserts *Patterson IV* will harm her until the day she dies and harms her reputation. She contends if an SIME with an objective psychiatrist and a "touchy feely" psychologist were ordered, she would go into the evaluations knowing they were fair and unbiased. As support for her request for an SIME, Employee asked, "What if there is more to this?" and "What if the board was wrong?"

PRINCIPLES OF LAW

AS 23.30.001. Intent of the legislature and construction of chapter

It is the intent of the legislature that

> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter. . . .

The board may base its decision not only on direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.005. Alaska Workers' Compensation Board.**
> . . . .
>
> (h) The department shall adopt rules for all panels, and . . . shall adopt regulations to carry out the provisions of this chapter. The department may by regulation provide for procedural, discovery, or stipulated matters to be heard and decided by the commissioner or a hearing officer designated to represent the commissioner rather than a panel. If a procedural, discovery, or stipulated matter is heard and decided by the commissioner or a hearing officer designated to represent the commissioner, the action taken is considered the action of the full board on that aspect of the claim. Process and procedure under this chapter shall be as summary and simple as possible. The department, the board or a member of it may for the purposes of this chapter subpoena witnesses, administer or cause to be administered oaths, and may examine or cause to have examined the parts of the books and records of the parties to a proceeding that relate to questions in dispute. . . .
>
> **AS 23.30.007. Workers' Compensation Appeals Commission.** (a) There is established in the Department of Labor and Workforce Development the Workers' Compensation Appeals Commission. The commission has jurisdiction to hear appeals from final decisions and orders of the board under this chapter. Jurisdiction of the commission is limited to administrative appeals arising under this chapter. . . .
> **AS 23.30.008. Powers and duties of the commission.** (a) The commission shall be the exclusive and final authority for the hearing and determination of all questions of law and fact arising under this chapter in those matters that have been appealed to the commission, except for an appeal to the Alaska Supreme Court. The commission does not have jurisdiction in any case that does not arise under this chapter or in any criminal case. On any matter taken to the commission, the decision of the commission is final and conclusive, unless appealed to the Alaska Supreme Court, and shall stand in lieu of the order of the board from which the appeal was taken. Unless reversed by the Alaska Supreme Court, decisions of the commission have the force of legal precedent. . . .
>
> **AS 23.30.095. Medical treatments, services, and examinations**.
> . . . .
>
> (k) In the event of a medical dispute regarding issues of causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional

capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. The cost of an examination and medical report shall be paid by the employer. . . .

AS 23.30.110. Procedure on claims.

. . . .

(g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require. The place or places shall be reasonably convenient for the employee. The physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation may be payable for a period during which the employee refuses to submit to examination.

AS 23.30.155. Payment of compensation.

. . . .

(h) The board may upon its own initiative at any time in a case . . . where right to compensation is controverted . . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.

8 AAC 45.065. Prehearings.

. . . .

(c) After the prehearing the board or designee will issue a summary of the actions taken at the prehearing, the amendments to the pleadings, and the agreements made between the parties or their representatives. The summary will limit the issues for hearing to those that are in dispute at the end of the prehearing. Unless modified, the summary governs the issues and the course of the hearing.

(d) Within 10 days after service of a prehearing summary issued under (c) of this section, a party may ask in writing that a prehearing summary be modified or amended by the designee to correct a misstatement of fact or to change a prehearing determination. The party making a request to modify or amend a prehearing summary shall serve all parties with a copy of the written request. If a party's request to modify or amend is not timely filed or lacks proof of service upon all parties, the designee may not act upon the request.

. . . .

8 AAC 45.074. Continuances and cancellations. (a) A party may request the continuance or cancellation of a hearing by filing a

(1) petition with the board and serving a copy upon the opposing party; . . .

(b) Continuances or cancellations are not favored by the board and will not be routinely granted. A hearing may be continued or cancelled only for good cause and in accordance with this section. For purposes of this subsection,

(1) good cause exists only when

(K) the board determines that despite a party's due diligence in completing discovery before requesting a hearing and despite a party's good faith belief that the party was fully prepared for the hearing, evidence was obtained by the opposing party after the request for hearing was filed which is or will be offered at the hearing, and due process required the party requesting the hearing be given an opportunity to obtain rebuttal evidence;

8 AAC 45.092. Selection of an independent medical examiner.

. . . .

(g) If there exists a medical dispute under AS 20.30.095(k),

. . . .

(2) a party may petition the board to order an evaluation; the petition must be filed within 60 days after the party received the medical reports reflecting a

> dispute, or the party's right to request an evaluation under AS 23.30.095(k) is waived;
> . . . .
>
> (3) the board will, in its discretion, order an evaluation under AS 23.30.095(k) even if no party timely requested an evaluation under (2) of this subsection if
> . . . .
>
> (B) the board on its own motion determines an evaluation is necessary.

The following, general criteria are typically considered when ordering an SIME, though the statute does not expressly so require:

> (1) Is there a medical dispute between Employee's physician and Employer's EME?
> (2) Is the dispute "significant"?
> (3) Will an SIME physician's opinion assist the board in resolving the disputes?

Deal v. Municipality of Anchorage (ATU), AWCB Decision No. 97-0165 at 3 (July 23, 1997). Considering the broad procedural discretion granted in AS 23.30.135(a) and AS 23.30.155(h), wide discretion exists under AS 23.30.095(k) and AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME.

The Alaska Workers' Compensation Appeals Commission (commission) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008), addressed the authority to order an SIME under AS 23.30.095(k), when there is a medical dispute, and AS 23.30.110(g), when there is a gap in the medical evidence. With regard to AS 23.30.095(k), the commission referred to its decision in *Smith v. Anchorage School District,* AWCAC Decision No. 073 (February 27, 2008), at 8, in which it said:

> [t]he statute clearly conditions the Employee's right to an SIME . . . upon the existence of a medical dispute between the physicians for the Employee and the employer.

The commission further noted that before ordering an SIME, the board traditionally finds the medical dispute "significant or relevant" to a pending claim or petition, and the SIME will assist in resolving the dispute. *Bah*, at 4. Under either AS 23.30.095(k) or AS 23.30.110(g), *Bah* noted an SIME's purpose is to assist the board in resolving a significant medical dispute; it is not intended to

give Employee an additional medical opinion at Employer's expense when Employee disagrees with his own physician's opinion. "[T]he SIME physician is the board's expert." *Bah*, at 5, citing *Olafson v. State, Dep't of Trans. & Pub. Facilities,* AWCAC Decision No. 061, at 23 (October 25, 2007).

> **Alaska Evidence Rule 401.** Relevant evidence means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.

ANALYSIS

Should an SIME be ordered?

The Alaska Workers' Compensation Act must be interpreted to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers. AS 23.30.001(1). Regulations have been adopted to establish clear procedures to avoid confusion and protracted litigation. AS 23.30.005(h).

Patterson IV was issued on October 26, 2018, and denied Employee's claim for benefits and found she did not sustain a physical-mental or mental-mental injury on September 23, 2014. Employee appealed the decision's denial of her claim for benefits and its determination she did not sustain a compensable injury on September 23, 2014. Employee petitioned for an SIME on two occasions. The first time Employee had a record that reflected a medical dispute was Dr. Odland's February 6, 2015 chart note. It disagreed with EME Dr. Glass's opinions regarding medical stability, Employee's need for additional medical treatment and ability to return to work. Employee did not file a petition for an SIME; however, she did request an SIME in her February 10, 2015 claim. She never filed an affidavit of readiness for hearing for this SIME request. On February 1, 2017, Employee filed a petition for an SIME, to compel discovery and "to establish facts admitted." This petition did not meet the regulatory requirements for an SIME request. 8 AAC 45.092(g). It was not filed with a completed SIME form, did not list the medical disputes, nor were the medical records reflecting the dispute filed. *Id*. When the February 1, 2017 petition's hearing was scheduled, the prehearing conference summary included the two discovery disputes as hearing issues. Employee's SIME petition was not identified as a hearing issue. She

never sought to modify or correct the prehearing conference summary to include the SIME. 8 AAC 45.065.

There continued to be disputes in the medical record. On April 17, 2017, at Dr. Odland and Attorney Harren's request, Dr. Wert conducted a forensic psychological evaluation and concluded Employee was "affectively" unstable and continued to experience PTSD symptoms associated with the September 23, 2014 incident. Dr. Wert's and Dr. Glass's opinions created a medical dispute. Giving Employee the benefit of the doubt, she knew at the very latest of a medical dispute, on December 26, 2017, when Dr. Sheorn's EME report was served. Sixty days after Employee received Dr. Sheorn's report was February 24, 2018. *Rogers & Babler*.

Employer obtained Dr. Sheorn's opinion after Employee filed her affidavit of readiness for hearing. This created the last medical dispute and had Employee felt a continuance was necessary to provide her an opportunity to obtain rebuttal evidence and request an SIME she should have filed a petition for a continuance. 8 AAC 45.074. She did not.

On July 8, 2019, after *Patterson IV* was issued and Employee appealed the determination, she requested an SIME, which Employer opposed. Employee waived her right to an SIME by making an untimely request. 8 AAC 45.092(g)(2). Nevertheless, the fact a party waives her right to request an SIME does not mean one will not occur. An SIME is a discretionary medical examination. AS 23.30.095(k). Despite a party's failure to timely request an SIME, if a medical dispute exists and an SIME is necessary, one can be ordered. 8 AAC 45.092(g)(3)(B).

An SIME can be ordered if it will assist in determining the parties' rights when there is a significant dispute between an attending physician and an EME. AS 23.30.095(k); *Deal*; *Bah*. In this case, had Employee properly requested one, an SIME would not have been ordered because, a multitude of physicians, psychiatrists, psychologists and counselors, offered a host of opinions, and additional opinions from a psychologist and psychiatrist would not have assisted in determining the parties' rights. AS 23.30.095(k); AS 23.30.155(h). *Patterson IV* was decided without an SIME because despite medical disputes, there was sufficient medical evidence and no gaps.

AS 23.30.110(g); *Bah*. Further medical opinions would not have assisted to resolve the disputes. *Deal*; *Bah*. Employee contends an SIME should be ordered to answer the questions, "What if there is more to this?" and "What if the board was wrong?" If *Patterson IV* was wrong, Employee's recourse is her appeal to the Commission. AS 23.30.007; AS 23.30.008.

Patterson IV considered extensive medical, psychological and psychiatric medical opinions and made credibility determinations. No additional evidence will make the existence of any factual findings of consequence to *Patterson IV* more probable or less probable than they would be without additional evidence from an SIME. Alaska Evidence Rule 401. Granting Employee's request for an SIME would be giving Employee an additional medical opinion at Employer's expense while an appeal is pending. Interpreting the Act to provide quick, efficient, fair and predictable delivery of compensable benefits at a reasonable cost to Employer, requires Employee's petition be denied. AS 23.30.001. If on appeal it is found *Patterson IV* is not supported by substantial evidence, it shall be remanded for additional findings. Until then, there is no basis for an SIME.

CONCLUSION OF LAW

An SIME should not be ordered.

ORDER

Employee's petition for an SIME is denied.

Dated in Anchorage, Alaska on October 9, 2019

ALASKA WORKERS' COMPENSATION BOARD

/s/
Janel Wright, Designated Chair

/s/
Robert Weel, Member

/s/
Rick Traini, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of Shannon K. Patterson, employee / petitioner v. Matanuska Susitna Borough School District, self-insured employer / respondent; Case No. 201416158; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on October 9, 2019.

/s/
Nenita Farmer, Office Assistant