No. 13-109393-A

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# IN THE COURT OF APPEALS OF THE STATE OF KANSAS

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**LINDA SPIVEY**
**Claimant/Appellant**

**v.**

**BREWSTER PLACE**
**Respondent/Appellee**

**and**
**KANSAS ASSOCIATION OF HOMES FOR THE AGING INSURANCE GROUP, INC.**
**Insurance Carrier**

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# BRIEF OF APPELLANT

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**Appeal from the Kansas Workers Compensation Appeals Board**
**Docket No. 1,025,309**

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## BRIEF OF CLAIMANT/APPELLANT, LINDA SPIVEY

Claimant, Linda Spivey, hereby submits here brief concerning the Petition for Judicial Review filed by her on February 14, 2013.

## I. STATEMENT OF NATURE OF THE CASE.

This is an original proceeding requesting review of the Order of the Kansas Workers Compensation Appeals Board entered in this case on January 28, 2013. The Claimant, Linda Spivey, was represented before the Administrative Law Judge (ALJ) and the Appeals Board by Paul D. Post. The Respondent and its Insurance Carrier were represented throughout the case by Michael Entz, of Entz and Entz, P.A.

Ms. Spivey contends that she met with accidental injury in the performance of her duties with the Respondent on or about March 29, 2005. She claims injury to her head and neck, and also psychological injuries directly resulting from the physical injury. She also seeks work disability. In the alternative, she alleges that she is now permanently and totally disabled. The parties agreed that Ms. Spivey is covered by the Kansas Workers' Compensation Act. The Respondent first denied that Claimant was injured by an accident arising out of and in the course of her employment with Brewster Place, but later stipulated in writing that the Claimant met with personal injury by accident on the date alleged, admitted that the alleged accidental injury arose out of and in the course of employment, admitted timely written claim, and admitted timely notice (Stipulation filed with the Director on November 10, 2011, stating that the sole issue to be decided was nature and extent of disability, including functional impairment, work disability, and permanent total disability,

Vol. 1, pp. 301,302). The Respondent admitted that the relationship of employer and employee existed on the claimed accident date. There is was agreement on the Claimant's average weekly base wage made at the regular hearing in the amount of $442.83. The November 11, 2011 Stipulation, at paragraph 2, also stipulated that the fringe benefits were $65.08, making the total average week wage $507.91 (Vol. 1, p. 422).

The ALJ appointed Dr. James Eyman, a psychologist, to evaluate Ms. Spivey. He did not perform a "one time" evaluation, but saw Ms. Spivey on two occasions in November and December 2008, two times in December 2010, and once in January 2011. Dr. Eyman diagnosed Ms. Spivey as suffering from a Delusional Disorder, a type of psychosis, which he felt originated as a result of the work accident. Dr. Eyman believed that her functional impairment attributable to this illness was 65% under the *AMA Guides, Fourth Edition.* Dr. Eyman also opined that Ms. Spivey is not capable of gainful employment.

In her Award, the ALJ found that the psychological injury was work-related. She agreed with Dr Eyman that the Claimant's functional impairment was 65%. Dr. Stein, who had also performed an IME, had opined that the physical injury resulted in a 2% whole body impairment. Judge Sanders adopted that opinion as part of her findings on functional impairment. The ALJ found that Claimant had work disability, with a task loss equal to 44% based upon the average of the three physician opinions on task loss. Wage loss was assigned based upon episodic periods of employment following the work injury. Certain medical bills were ordered paid. Future medical ordered. The claim for permanent total disability was denied.

In its January 28, 2013 Order, the Appeals Board found that the Claimant suffered

a work-related injury on March 29, 2005, but found that the Claimant suffered no permanent disability as a result of this accident. The Board found that the Claimant failed to prove that her psychiatric illness was directly related to the work-related physical injury. Accordingly, the Board reversed the decision of the ALJ. Claimant timely appealed from that decision and requested judicial review.

## II. ISSUES PRESENTED

A. Whether Claimant suffered a permanent disability in light of the record as a whole.

B. Whether Claimant's psychiatric illness was directly related to the work-related physical injury in light of the record as a whole.

C. Whether Claimant was entitled to an award of work disability.

D. Whether Claimant is permanently and totally disabled as a result of her work injury.

## III. FACTS OF RECORD

The parties stipulated that the claimant met with accidental injury on March 29, 2005 during the course of her employment with the respondent, and with the other stipulations in the affirmative (Vol. 1, pp. 301-303). At the time of the regular hearing, respondent denied that the accident occurred and that it arose out of and in the course of employment with Brewster Place, which had been respondent's position from the outset of this case (Vol 6, p. 4). However, the testimony of Brenda Phillips, a co-worker who witnessed the accident, forced respondent to change its position on this issues. Ms. Phillips completely corroborated claimant's testimony concerning the accident, testifying that a piece of steel six to twelve

inches long and three to four inches wide fell from the top of a door and struck Ms. Spivey on her head (Vol. a, pp. 7, 13). Ms. Phillips observed the top of Ms. Spivey's head and stated that "She had a really big goose egg instantly from it." (Vol. 9, p. 8). Ms. Phillips stated the prior to this accident, Ms. Spivey had gotten along well with other employees (Vol. 9, p. 14). After the accident, Ms. Spivey had difficulty doing her work and "kept getting headaches "(Vol. 9, p. 13).

On January 2, 2005, a few weeks before this accident, claimant had received a letter from Angela Dailey, Director of Human Resources with respondent, providing Ms. Spivey with a copy of her recent performance evaluation. Ms. Dailey commended Ms. Spivey for the good evaluation, noting that "Your Performance Appraisal indicates that you work well independently; you are always looking for work to be done; and you are dependable. **Your are truly an asset to Brewster Place.**") (Vol. 10, pp. 42-45, emphasis added, and also appended to this brief as Appendix I). The performance report, itself, under "Accomplishments," reflected that Ms. Spivey was capable of "Working through times when [there were] difficulties with staff relations **with a positive outcome.**" Also included was a commendation for Ms. Spivey's ability "To identify residents as individuals and to give them **the respect they deserve**, resident centered care." (Vol. 10, pp. 42-45, emphasis added). Ms.. Spivey received a pay raise on account of her good evaluation. Yet less than six months after the accident in question, Ms. Spivey was terminated for "unacceptable activities" which included allegedly threatening another employee (which Ms Spivey vehemently denied). (Vol. 10, pp 46-48). After her termination from employment, Ms. Spivey filed a discrimination suit against Brewster Place in the U.S. District Court for the

District of Kansas, in case number 06-CV-04041-RDR, alleging employment discrimination. Brewster Place ultimately paid Ms. Spivey $33,000.00 to settle that claim in April 2011 (Vol 11 pp 14, 68-71; Vol. 11 pp 96-98). The statement by Angela Dailey that the suit was dismissed was incorrect to the extent that it implied that Ms. Spivey did not prevail. (Vol. 10, pp 23-24).

After Brewster Place, claimant went to work for McCrite Plaza, but ultimately quit there because she thought other employees were abusive towards her (Vol. 11, p 42; Ex 12). She only worked there for about seven months. In her claim for unemployment against McCrite, Ms. Spivey stated that "I was discriminated, harassed, humiliated, verbally and physically abused by Rita Davenport (DON) [Director of Nursing]. I could no longer subject myself to that type of treatment" (Vol. 11, pp, 133-134).

After working for McCrite Plaza, Ms. Spivey worked for Topeka Adult Care, but was terminated twice from that employment, because "The employment didn't work out. I kept having flashbacks. There was a lot of things that was [*sic*] going on with my psychologically at this time which maybe I shouldn't say anything right now, but –" (interrupted by Mr. Entz) (Vol. 11, p. 35).

Prior to her accident, claimant had never had any psychological treatment. She was not treated for depression on an ongoing basis Years earlier, around 1995, when going through a divorce, she talked to a counselor two or three times, because she was depressed going through the divorce, but after that decided to proceed on with the divorce. Whatever problems she was experiencing resolved when the divorce was concluded (Vol 6, p. 27). Prior to the accident, she was able to perform all of her job duties that were required by her

employers (Vol 6, p. 28).

Dr. James Eyman, a psychologist, performed a court-ordered IME of claimant, with the evaluation beginning on November 11, 2008, and continuing with follow-up meetings with claimant on December 3, 2008, and January 8, 26, and 29, 2009. (Vol 1, pp. 166-174). Dr Eyman had extensive work records and medical records which he reviewed as part of his evaluation process. His medical records included a report from Dr. Lynn Curtis, who diagnosed the claimant with occipital neuralgia, ligamentous instability, and depression on March 2, 2006, less than one year after the accident. Jeanne Frieman, Ph.D., conducted a psychological examination on July 17, 2006, and concluded that Ms. Spivey suffered from "Major Depression, **severe with psychotic features** and Generalized Anxiety Disorder with Agoraphobia." (Emphasis added). Dr. Frieman described Ms. Spivey as "being depressed and hopeless about her future as well as believing that 'others are out to get her.'" Dr. Eyman noted in his report that Dr. Frieman thought the depression preexisted the work accident, but increased after the accident. (Vol 1, p. 169).

Dr. Eyman stated that claimant saw Dr. Ziad Haddad, a neurology resident at the K.U. Medical Center on October 12, 2005, less than six months after the accident, who diagnosed her with tension headaches due to a head injury, and possible depression. Dr. Olivia Fondable, Ms. Spivey's primary care physician, and Dr. Jonson Huang, a neurologist, diagnosed claimant as having blurred vision and headaches due to her head trauma. In September 2007, claimant was referred to Dr. Joseph Sankoorikal, who diagnosed myofascial pain disorder due to her head injury (Vol 1, p. 170).

Dr. Eyman concluded that Ms. Spivey was currently suffering from a Delusional

Disorder, persecutory type (DSM-IV 297.1), in that "she has a systemic delusional (false) beliefs that Brewster Place is conspiring against her and has the power to enlist doctors, and other individuals to harm her and thwart her medical care." (Vol 1, p. 174).

Dr. Eyman conducted a follow-up court-ordered IME with Ms. Spivey, with evaluations occurring on December 28 and 30, 2010, and January 5, 2011. He described her as continuing to insist that she has "brain damage" as a result of her work injury, and that she also experienced flashbacks, anxiety, depression, pain, and dizziness. The flashbacks included her belief that a small man had been standing behind her when she was injured, and that he hit her over the head, attempting to "ambush" her on the job. She thought Brewster Place had surveillance cameras which captured her injury, but that the film in the camera was destroyed by Brewster Place to leave no evidence of the attack. She thought Brewster Place had attempted to murder her. Ms. Spivey also experienced physical pain in her shoulders and neck which she related to the accident. She continued to ruminate on the accident "all the time." (Vol 1, p. 270).

Dr. Eyman concluded that claimant continued to suffer from a Delusional Disorder, which she did not have prior to the accident. Dr. Eyman stated that such a disorder is "extremely difficult to treat, and most individuals, even with treatment, do not become less delusional because they have such poor insight into the nature and severity of the illness." (Vol. 1, p. 272). Dr. Eyman opined that Ms. Spivey has a 65% impairment as a result of her psychological injury. He based this on the *AMA Guides,* 2nd Edition, noting that the 4th Edition does not give percentage impairments to classes of mental impairment. Using the 4th Edition, Dr. Eyman found that claimant fell into the "marked impairment" class, which

translated into the 65% if the 2nd Edition is consulted (Vol. 1, P. 279). As to work disability, Dr. Eyman thought that Ms. Spivey is not capable of gainful employment, and is thus permanently and totally disabled (Vol. 13, p 109).

Dr. Lynn Curtis evaluated the claimant on several occasions over the years, the first being on September 18, 2005, less than six months after the accident, and with subsequent evaluations on March 2, 2006, July 3, 2008, February 8, 2010, and October 1, 2010. Although Dr. Curtis never thought that Ms. Spivey was at MMI, he did provide a rating in his March 2, 2006, which found that she should be awarded 5% impairment for occipital neuralgia, 25% for ligamentous instability in the area of C1-2 of the cervical spine using the DRE Category IV, and 15% for mild to moderate depression. (Vol. 8, p. 86).

Respondent did not hire its own physician to conduct an evaluation to determine what physical impairments resulted from the injury. Dr. Patrick Hughes, a medical doctor, was not asked to conduct a physical examination. He limited his evaluation to a psychological examination (Vol. 14, pp. 62-69). Rather, respondent relied upon the opinion of Dr. Paul Stein, who had conducted a court-ordered IME on July 24, 2009, and concluded in his report to the court that Ms. Spivey had a 2% whole body impairment as a result of her work accident, using the *AMA Guides,* Fourth Edition. (Vol. 1, pp. 191-199). In his deposition, he changed his mind and said that Ms. Spivey had no impairment (Vol. 16, p. 15). However, Dr. Stein was not asked to reevaluate Ms. Spivey. He only saw her on the one occasion, which was July 24, 2009. He has not seen her since then (entire Stein depo, Vol. 16). He reviewed no new medical records. His original IME report, (Vol. 1, p. 199), also states that Ms. Spivey is psychotic. He also testified that the constellation of other symptoms he

described in his report could be the result of a delusional disorder (Vol.16 p. 27). Dr. Stein also conceded that there were no medical records prior to this accident which showed that Ms. Spivey was complaining of headaches (Vol. 16, p. 30). Dr. Stein also admitted that he could have stated in his report that there was no impairment, or that any impairment was not related to the work accident, but he did not do so (Vol. 16, p. 31).

Dr. Hughes testified that in his opinion, Ms. Spivey suffered from major depression with psychotic features (Vol. 14, p. 18). He testified that a major depressive disorder "means the person who has more than one episode of pretty well full-blown major depression symptoms and then gets well and then they come back later in life" (Vol. 14, p. 18). However, Dr. Hughes had no medical records at all pre-dating the Claimant's work-related injury in March 2005 (Vol. 14, p. 33). Rather than relying on medical records, Dr. Hughes testified that her employment records showed that Ms. Spivey "got sick again in 2004" in that she was developing paranoia then (Vol. 14, p. 36). The employment records he was looking at were two evaluations, one in February 2004 (her first evaluation) where she received an overall satisfactory report that included comments describing Ms. Spivey as "dependable and resourceful, open and sharing." Dr. Hughes contrasted this to her December 2004 evaluation (which was also satisfactory) wherein the evaluator stated that Ms. Spivey "needed to be more of a team player, be more cooperative" with other employees" (Appendix I). Dr. Hughes stated that this noted change in her evaluation "was strongly suggestive to me that she was developing paranoia during the course of the year: (Vol. 14, p. 38). He later acknowledged that Ms. Spivey received a satisfactory report for both February and December 2004, but that the November report was "just not as good as

her first one." He also admitted that the reports "wouldn't in and of themselves . . . indicate that [paranoia]" (Vol. 14, pp. 39-40).

Further, even though he had no medical records prior to 2005, he saw one record of treatment after the accident which referenced the fact that Ms. Spivey had been seen at Valeo Mental Health Center in 1995 for a one-time treatment for depression. He did not ask to see that particular record. Despite never having seen it, Dr. Hughes testified that Ms. Spivey must have been prescribed medication for her depression. He did not know what sort of therapy Ms. Spivey underwent in 1995. Then, he testified that "whatever therapy she got in 1995 was not relevant" (Vol. 14, pp. 44-42). In his report as well as his testimony, Dr. Hughes also stated that Ms. Spivey's major depression that he claimed to have diagnosed was the result of a "depression gene" – an inherited gene that "is the most medically probable cause of Ms. Spivey's currently disabling, chronic Major Depression with psychotic features . . . " (Vol. 14, pp. 23-24, 68) (emphasis original). However, Respondent's other expert, Dr. Kathleen Keenan, a psychologist, testified that "most psychologists and most psychiatrists don't think that [depression] is gene related." She testified that Dr. Hughes' opinion as to depression being genetically caused was an "outlier" and that, "In my opinion major depression is not gene related." "I do not think major depression is a genetic disorder" (Vol. 15, pp.60-61, 110 Ex 4, "Misconceptions about gene-environment interactions in psychiatry").

In addition to the diagnosis made by Dr. Eyman that Ms. Spivey suffered from a delusional disorder, the Social Security Administration had Ms. Spivey evaluated for disability determination purposes. The findings and results of that report were the same as

that of Dr. Eyman, with the diagnosis made by the evaluator, Dr Carol Adams, being "delusional disorder persecutory type" (Vol. 15, pp. 91-100).

Dr. Keenan also admitted that she did not have complete medical records. She had no records from Ms. Spivey's current treater, Sheila Redmond, even though the treatment had been going on prior to Dr. Keenan's evaluation. She did not have any records from Dr. Gordon Parks, a psychiatrist who had also been treating Ms. Spivey. Dr. Keenan had no records from Dr. Jean-Daniel Policard, a psychiatrist with Woodbridge Counseling Services, who had also been treating Ms. Spivey and had evaluated her. Dr. Keenan did not have any records from Dr. Betsy Johns, Ms. Spivey's primary care physician. Dr. Keenan testified that it is important to have all medical records if one is going to accurately evaluate a patient: "The more records you have the more helpful it is." (Vol. 15, pp. 36-37). Dr. Keenan testified that Ms. Spivey told her that she was treating with these professionals, but Dr. Keenan never asked that the records be provided. She acknowledged that she could have requested these records (Vol. 15, p. 42). Even though Dr. Keenan diagnosed Ms. Spivey as suffering from depression, she, like Dr. Hughes, had no medical records at all prior to the work injury in 2005. She, like Dr. Hughes, only had employment records. (Vol. 15, p. 38). Again, parroting what Dr. Hughes stated, Dr. Keenan testified that the only evidence that she had to support her claim that Ms. Spivey suffered from depression prior to the accident was that the employment evaluations showed that "she had an argument with her supervisor and another nurse" and this, despite the fact that the both evaluations that Dr. Keenan reviewed rated Ms. Spivey at satisfactory or above satisfactory (Vol. 15. 43-44) Dr. Keenan testified that Ms. Spivey "had a major depressive episode in 1995" but had never looked at the

records concerning that alleged episode (Vol. 15, p. 39). Despite her testimony that Ms. Spivey suffered from major depression in 1995, she did not even include that finding in her written report (Vol. 15, p. 41, 90-92) but only added that opinion during her deposition testimony.

Dr. Keenan performed some testing on Ms. Spivey. One of those tests was the Beck Depression Inventory which Dr. Keenan testified was a tool to evaluate depression. Ms. Spivey's score on the Beck Depression Inventory was 23, which was "considerably below the indicator for severe depression (Vol. 15, p. 48). Dr. Keenan also testified that the Diagnostic and Statistical Manual (DSV IV-TR), which she considered authoritative, specifies at page 376 that if a delusional disorder better accounts for a patient's condition as compared to major depressive episodes, the preferred diagnosis to be used is a delusional disorder, which is exactly what Dr. Eyman found to exists (Vol. 15, pp. 50-52).

Respondent deposed Dr. Gordon Kelley, a neurologist with K.U. Medical Center, but he had not seen claimant since August 15, 2006, at which time he reported that she had been hit on the head at work in March 2005, and "has complained since of varying degrees of visual blurring, headaches, and dizziness." He thought there was "an element of paranoia in her history - she implies she has a belief her coworkers were trying to kill her and her initial thought when the bar hit her head was that someone was trying to take her life." (Vol. 17 p. 32). This was the same delusional thought process identified by Dr. Eyman three years later in his reports. Dr. Kelley was not asked to render any impairment rating at the time of his evaluation or later.

Respondent deposed Dr. Brian Gibson, a family medicine physician in Topeka, who

treated claimant in 2007 and 2008, having last seen her on June 3, 2008. The initial medical record reflects that Dr. Gibson was seeing her for a head injury occurring at work on March 29, 2005. She complained of problems with both ears and pressure in her head. She had lightheaded sensations and dizziness. She reported neck pain. She related all her symptoms to the work accident. (Vol. 12, p 37). Dr. Gibson testified that he does not generally treat psychological disorders, including schizophrenia, paranoia disorders, and personality disorders (Vol. 12, p. 7). He did treat Ms. Spivey for anxiety which he diagnosed and prescribed Xanax for that condition, but did not otherwise consult the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), in connection with this treatment (Vol. 12, pg. 18). Dr. Gibson did not obtain health care records from any other providers even though he knew that she had seen other treaters since the accident (Vol. 12., pp. 21-22). Dr. Gibson ended up referring Ms. Spivey to Dr. Michael Smith, an orthopedist (Vol. 12, p. 32). Dr. Gibson had was not asked to render an opinion on functional impairment.

## IV. ARGUMENTS AND AUTHORITIES

### A. Standard of Review as to all Issues.

Final orders of the Board are subject to review under the Kansas Judicial Review Act, K.S.A. 77-601 et seq. K.S.A. 2011 Supp. 44-556(a). The standard of review will vary depending on the issue raised. See K.S.A. 2011 Supp. 77-621. The Court may grant relief if the Court determines that the agency erroneously interpreted or applied the law. K.S.A. 2011 Supp. 77-621(c)(4). That issue is reviewed *de novo*. *Fernandez v. McDonald's*, 292 P.3d 311 ( 2013); *Tyler v. Goodyear Tire & Rubber* Co., 43 Kan. App. 2d 386, 388, 224 P.3d 1197 (2010). Moreover, the Court need not give deference to an agency's interpretation of a

statute; rather, the Court exercises unlimited review. *Kansas Dept. of Revenue v. Powell*, 290 Kan. 564, 567, 232 P.3d 856 (2010). Further, Claimant can obtain relief if the Board's action is otherwise unreasonable, arbitrary or capricious. K.S.A. 2011 Supp. 77-621(c)(8). A challenge under K.S.A. 2011 Supp. 77-621(c)(8) attacks the quality of the agency's reasoning. See *Kansas Dept. of Revenue v. Powell*, 290 Kan. 564, 569, 232 P.3d 856 (2010) (stating that agency may have acted arbitrarily when it fails to properly consider factors courts require it to consider to guide its discretionary decision). K.S.A. 2011 Supp. 77-621(c)(7). K.S.A. 2011 Supp. 77-621(d) statutorily defines "in light of the record as a whole" as:

> The adequacy of the evidence in the record before the court to support a particular finding of fact shall be judged in light of all relevant evidence in the record cited by any party and detracts from such finding as well as all of the relevant evidence in the record, compiled pursuant to K.S.A. 77-620, and amendments thereto, cited by any party that supports such finding, including any determinations of veracity by the presiding officer who personally observed the demeanor of the witness and the agency's explanation of why the relevant evidence in the record supports its material findings of fact. In reviewing the evidence in light of the record as a whole, the court shall not reweigh the evidence or engage in *de novo* review.

Under the secondary injury rule, an injured worker is entitled to compensation "for all of the natural consequences arising out of an injury, including any new and distinct injuries that are the direct and natural result of the primary injury. [Citation omitted.]" Casco, 283 Kan. at 515.

B. **Whether Claimant Suffered a Permanent Disability in Light of the Record as a Whole.**

At the time of the pre-hearing settlement conference, and at the regular hearing, the Respondent denied that the Claimant met with injury by accident that arose out of and in the

course of her employment. By written stipulation dated November 10, 2011, which was filed with the Director (Vol. 1, pp. 351-52), Respondent stipulated that the Claimant met with injury arising out of and in the course of her employment with Brewster Place when she was struck on the head with a piece of steel which fell out of the top of a door. Thus, the Board was bound by the parties' written stipulation to find that Claimant did meet with injury by accidental means, and that the injury arose out of and in the course of her employment with Brewster Place.

The Board referenced the deposition testimony of Dr. Stein to support its conclusion that the Claimant had no physical functional impairment, stating that "Dr Stein testified that he did not relate the claimant's headaches to the work injury." (Vol 1, p. 623). Dr. Stein was appointed by the ALJ in 2009 to perform an independent medical examination (IME) of Ms. Spivey, which the doctor did on July 24, 2009 (Vol 1, pp. 191-199). First, Dr. Stein recommended additional testing in the form of "flexion/extension, rotary, and lateral bending x-rays of the cervical spine" which were never done (entire record). Second, Dr. Stein stated that "I cannot determine any symptomatology [of the neck] which would not be psychological in etiology." He also stated that "Ms Spivey appears to have a **psychotic paranoia** which is responsible for the predominance of her symptomatology." (Emphasis added.) (Vol. 1, pp. 173-174) Dr. Stein **did** conclude that Ms. Spivey had a ratable impairment as a result of the injury, which he found to be 2 per cent (Vol 1, p. 177). This is contrary to the Board's finding that Dr. Stein did not relate claimant's headaches to the work injury."

Several years later, without again having examined the Claimant or having reviewed

new medical records, including those of Dr. Eyman, Dr. Stein then changed his mind at his deposition. He claimed that he "didn't assign anything" insofar as a rating was concerned (Vol 16, p. 29). However, Dr. Stein conceded that he could have assigned 0 per cent impairment, which he did not do. Furthermore, prior to his 2009 IME of the Claimant, Dr. Stein was furnished with voluminous medical records from a number of treaters which he reviewed as part of his examination process. Ms. Spivey had complained of headaches from the onset of her accident in 2005 to every physician that treated her following that accident. Those physicians included a neurologist, a physiatrist, and an orthopedist (Vol 16, pp. 18-25). Dr. Stein acknowledged that "throughout all this period of time she was being seen and treated by various professionals . . . for headache." (Vol 16, p. 25). Dr. Stein had no records of any treatment or complaints of headache prior to Claimant's work-related accident on March 29, 2005 (Vol 16, p. 25). Dr. Stein testified that there was an internal consistency of Ms. Spivey's complaints to all of the treaters she had seen (Vol 16, p. 25). And while there was a constellation of other symptoms that Ms. Spivey described to Dr. Stein and other treaters, Dr. Stein thought that these symptoms were the result of her delusional disorder (Vol 16, p. 27).

The Board had to ignore this testimony and Dr. Stein's original IME report to reach the conclusion that Dr. Stein "did not relate claimant's headaches to the work injury." The ALJ had appointed Dr. Stein to conduct an IME in 2009 to determine whether Claimant's headaches or other symptoms were caused by her work injury, and to assign an impairment rating, if appropriate (Vol 1, p. 190). Dr. Stein could have assigned no impairment, or stated in his report that the headaches were pre-existing the injury and not the result of the injury.

He did not do this, but rather, stated that Ms. Spivey "can be provided 2% impairment to the body as a whole for headaches under the chapter on pain n the fourth edition of the AMA Guides to the Evaluation of Permanent Impairment." (Vol 1, p. 199). He then attempted to retract that finding in his deposition taken almost two and one half years after his examination without again seeing the Claimant or reviewing any new or different medical records, including the IME reports of Dr. Eyman.

Even if Dr. Stein's opinion is that Claimant has no *physical* impairment as a result of the work accident, this does not prevent a finding of a psychological impairment. According to the Court of Appeals case of *Love v. McDonald's Restaurant*, 13 Kan. App. 2d 397, the test for "traumatic neurosis was enunciated by the Supreme Court in 1984:

> In *Followill v. Emerson Electric Co.*, 234 Kan. 791, 674 P.2d 1050 (1984), a case not considered in *Ruse*, the Supreme Court explicitly held that traumatic neurosis is not compensable absent a physical injury because mental injury standing alone is not a "personal injury" as defined by the Workers' Compensation Act. 234 Kan. at 795-96. The court stated: "We hold, in accordance with an unbroken line of worker's compensation cases in this state, that the obligation of an employer under K.S.A. 44-501 *et seq.* does not extend to mental disorders or injuries unless the mental problems stem from an actual physical injury to the claimant." 234 Kan. at 796.
>
> As we read *Followill*, the possibility of a compensable traumatic neurosis absent physical injury -- as explored in *Jacobs* -- simply no longer exists in Kansas. As a result, we feel comfortable in returning to the clear statement of the rule as enunciated in the earlier cases such as *Morris* and *Barr*.

Here, the was without a doubt a physical injury when a piece of metal fell from a door and struck Claimant on the top of her head. Respondent has stipulated to this accidental injury. There is no requirement under the holding of *Love* and its progeny, as well as predecessors

(other than the *Ruse* case), that their be a functional impairment rating for the *physical* injury. Thus, even if the Board is correct that is no impairment to the "cervical neck" as the Board put it, that does not prevent a finding that Claimant sustained traumatic neurosis as a result of the blow to the head. It is also interesting to note that the Board rejected Dr. Curtis' impairment rating of 10 per cent for the cervical spine, finding that "there is insufficient evidence to support that Dr. Curtis' rating reflects the claimant's condition at the time of his deposition," when exactly the same thing could be said about Dr. Stein's change of heart from his 2009 report. Again, at the time of his deposition two and one half years later without having again examined the Claimant or reviewed any new medical records (all of the records of Drs. Eyman, Hughes, and Keenan were available at the time of Stein's deposition) Dr. Stein changed his rating from 2 per cent to 0 per cent.

Furthermore, Dr. Stein stated in his IME report that "I cannot determine any symptomatology which is not likely psychological in etiology". Put in a positive light, Dr. Stein stated that her symptoms where psychological. This is exactly what Dr. Eyman concluded, and went on to testify that the psychological problems were work related. Morever, Dr. Stein assigned the 2 per cent impairment to Claimant's chronic headaches, not the cervical pathology, as the Board incorrectly found.

There was also other evidence of functional impairment that the Board did not address. Claimant has a 65% functional impairment per Dr. Eyman's report (Vol. 1, p. 272). Dr. Curtis thought that Ms Spivey's impairment was 39%, with 15% of that being assigned for depression (Vo. 8, p. 86). The Board never discussed these ratings because it never reached the issue of functional impairment.

**C. Whether Claimant's psychiatric illness was directly related to the work-related physical injury in light of the record as a whole.**

The Board next relied upon the report and testimony of Dr. Patrick Hughes to support its finding that his diagnosis of the Claimant's illness was that she suffered "a major depressive disorder, severe, with psychotic features, which is stated **was not directly related to the work injury** (Vol 1, p. 624). (Emphasis added.) In this regard, Dr. Hughes had no medical records of anything prior to the 2005 work accident, even though he knew they existed (Vol 14, p. 33). He based his opinion on the existence of major depression by reviewing two employee performance evaluations in 2004, both of which rated the Claimant's job performance as satisfactory, with only suggestions for improvement in the second report, where no suggestions for improvement were even found in the first evaluation (Vol 14, p. 37; Appendix I). However, it was these suggestions for improvement in an otherwise satisfactory report that Dr. Hughes seized upon as demonstrating, without question as he put it, that Ms. Spivey was suffering from major depression with psychotic features prior to the work accident. The psychotic features of her supposed major depression were demonstrated, according to Dr. Hughes, by the employer's need to suggest that Ms. Spivey improve certain aspects of her job performance, even though the overall report was satisfactory. Dr. Hughes also claimed that Ms. Spivey had a "depression gene" which somehow magically turned on or off at will, and that this "depression gene" and not the work accident was responsible for Ms. Spivey's psychosis (Vol 14, p. 72). Of interest if the fact that the Respondent's other expert, Dr. Keenan, debunked Dr. Hughes' "depression gene" argument, stating that Dr. Hughes' opinion in this regard was an "outlier" and that the

majority of mental health professionals rejected the "depression gene" argument (Vol 15, p. 59).

Contrary to Dr. Hughes' assertions, here is what the performance reports actually said. On January 2, 2005 (less than three months before the work injury), Angela Dailey, Director of Human Resources, wrote a letter to Claimant and stated that

> Your Performance Appraisal [of December 2004] indicates that you work well independently; you are always looking for work to be done; and you are dependable. You are truly an asset to Brewster Place. Your perfomance appraisal also indicates some opportunities for improvement which include being team oriented; and communicating with co-workers (Appendix I).

This positive report resulted in a raise in pay. The overall performance rating was "successful." The final commentary was:

> Linda is very resident oriented, and cares a great deal about her residents, always looking out for their needs. I do find some concerns for her ability to work with TEAM, but as of late she has been open with staff. Improvement in absences would be nice, but when she is here she works hard and is very dependable.

Despite having supposedly reviewed this performance evaluation, Dr. Hughes testified that Claimant "was certainly full-blown mentally ill again early in 2005." (Vol 14, p. 48). In discussing the performance report, Dr. Hughes testified that from this report he gleaned "an abrupt change in her previously seemingly pyschiatrically normal state." (Vol 14, p. 48). He stated that this report was "strongly suggestive to me that she was developing paranoia during the course of that year. Because when people get paranoid about their coworkers, the start being touchy, argumentative, uncooperative, don't cooperate with their team because they are beginning to think that the team is up to something no good to them."

(Vol 14, pp. 38-39). This was the same language used by Dr. Hughes in his written report, where he stated that the December 2004 performance evaluation showed that Ms. Spivey was "argumentative, touchy, and had difficult interactions with coworkers." However, there is absolutely nothing in that written report to support this assessment by Dr. Hughes. The report, itself, concerning interactions with coworkers states that she is "not always a team player." Suggested improvements were that Ms. Spivey should "work more on communication skills with the team, and to improve team relationships." "To work on being more team oriented." However, there is absolutely nothing in this report that describes Ms. Spivey as being "argumentative," "touchy," or having "difficult interactions with coworkers." It is obvious from the record that Dr. Hughes just made this up to fit his preconceived diagnosis. If an witness is going to give opinion testimony on causation, without obtaining prior medical records or current psychiatric treatment records, then one would hope that this witness would at least factually recite from the document that he is reviewing and which forms the main (and arguably only) basis for his opinion without misstating and adding his own gloss to that record.

Further, Dr. Hughes had no medical records for review prior to the work injury, asserting in his report that she had a 1995 "clinical depression episode" without having any medical records at all to support that conclusion. He agreed with the other professionals, including Dr. Eyman, that she had a severe mental disorder. Yet despite that fact that she had no history of any of this prior to the work injury of March 2005, Dr. Hughes seized upon two otherwise satisfactory employee performance reports given to Ms. Spivey by Brewster Place as proof that "her paranoia was pretty evident to me recurring" (Vol 14, p. 7). He then

stretched to the conclusion that her mental disorder must have pre-dated the work injury. The Board also made this stretch, when if found that the records which Dr. Hughes reviewed "showed claimant began developing symptoms of paranoid thoughts in 2004" (Vo. 1, p. 624). However, there are no medical records at all to support this finding, and the records Dr. Hughes based his opinion on, and in turn, the Board based its decision on, were employment evaluation records which showed that Claimant's performance was **satisfactory**. If Ms. Spivey "subsequently began to exhibit erratic behavior; illogical thinking; extreme fixation on her own belief that the head injury had severely injured her, ruined her health," as Dr. Hughes stated in his evaluation report (Vol 14, p. 67), the employee evaluations certainly do not support that position at all. It is also notable that on Dr. Hughes' handwritten notes from his review of records, next to the Delusional Disorder finding by Dr. Eyman, Dr. Hughes wrote and circled the word "perjury."

Dr. Hughes report also stated that Claimant "is currently seeing Dr. Gilbert Parks," but he did not have Dr. Parks' treatment record. Moreover, Dr. Hughes testified that Ms. Spivey reported that she was on medication prescribed by Dr. Parks, but had no idea what those medications were, again, because he did not bother to obtain Dr. Parks' records. **He tried to determine what those medications were by reading to Claimant a list of "contemporary typically used antipsychotic medications," but claimant couldn't recall that she had taken any of them**. (Vol 14, p. 66). One would think that correct diagnostic protocol would insist that the examiner determine from existing records what psychotropic medications a person was taking, rather than quizzing the patient with a list of drugs to determine which ones had been prescribed. Dr. Hughes also admitted that his diagnosis of

major depression is a Mood Disorder under the DSM IV-TR, and is not a psychotic disorder (Vol 14, p. 51), yet he testified that she was psychotic.

Turning to the testimony of Dr. Kathleen Keenan, a psychologist, concerning her opinions as to causation, that testimony actually helps Claimant. In the "Summary and Conclusions" section of her report, she found that Claimant "is suffering from severe, chronic, and progressive mental illness. She is psychotic, and everything in her presentation, her history, as well as the results of this evaluation support that conclusion." But then, Dr. Keenan, like Dr. Hughes, assumes that the psychosis first manifested itself in 2004 "when she filed the antidiscrimination lawsuit against her employer" (which the employer eventually settled by paying Ms. Spivey $33,000.00). Dr. Keenan goes on to state, "We know that she suffered a major depression in 1995." How Dr. Keenan "knows" this is unclear, since she, like Dr. Hughes, did not bother to obtain any medical records from Valeo Behavior Health concerning the two visits that Ms. Spivey had there to consult with a counselor regarding a pending divorce. Dr. Keenan then testified as follows:

> There are two possible conclusions that could be drawn. Here's a woman who got hit on the head and her problems just seemed to start multiplying and getting worse and worse. One could say that injury caused that to happen. In my opinion, when I look at the data, I look at what was going on beforehand. I look at what actually happened to her physically. I look at how she responded to it. **I look at the medical records.** I look at test results. In my professional opinion, it seems much more plausible to me that what happened **was that this injury became a focus, a way for her to externalize the craziness that she was feeling inside, to make sense of it, to justify it so to speak.** (Vol 15, p. 22) (Emphasis added).

First, Dr. Keenan admitted that she didn't look at medical records. She attempted to

diagnose Ms. Spivey's condition, but again without any records prior to the 2005 accident even though these existed and even though she was aware of their existence (Vol 15, p. 37-39). She, like Dr. Hughes, tried to argue that the second, less favorable but still satisfactory employment evaluation was firm evidence of the onset of major depression with psychotic features. The Board also accepted Dr. Keenan's testimony that Claimant suffered from psychotic depression, rather than a delusional disorder (Vol. 1, p. 624), even though Dr. Keenan admitted that the DSM IV-TR, which she considered an authoritative treatise on mental disorders and providing differential diagnosis for the same, states that a mental disorder should be assigned as a delusional disorder if it is better accounted for by the symptoms, as compared to major depressive disorder (Vol. 15, pp. 51-52). In other words, the more specific diagnosis of delusional disorder is favored by the DSM over the more general diagnosis of major depressive disorder. The condition "is better accounted for" as the DSM puts it, using this methodology. According to the DSM IV-TR, the diagnosis of Major Depressive Disorder is used unless "it is not superimposed on....Delusion Disorder.....(Vol. 14, p. 70) The Board got it exactly backwards, stating that "the broader diagnosis" of major depressive disorder is preferred over the diagnosis of delusional disorder (Vol I, p. 24). This may have been what Dr. Keenan testified to, but it is not what is required by the DSM IV-TR, a authoritative treatise recognized by Dr. Keenan, Dr. Hughes, Dr. Eyman, and Dr. Stein, who all testified in this case.

Second, Dr. Keenan's pronouncement that the physical injury became the **focus** is exactly what Dr. Eyman found to exist. He concluded that her "delusion is the central focus of her life." (Vol. 1, p. 172). Dr. Eyman testified that Ms. Spivey's "employment at

Brewster Place and subsequent to that, where she had other work difficulties, was more related to her delusional disorder. By the time she was terminated at Brewster Place, she was adamant about insisting that they were conspiring against her and had hurt her." (Vol. 13, pp. 16-17). Of interest is the fact that Dr. Keenan apparently did not have the December 29, 2004 employee evaluation which gave Ms. Spivey an overall satisfactory rating. Dr. Keenan's written report, at page 1, states that, "There is one performance review report in the chart which is dated 02/15/2004." This would have been Ms. Spivey's first report, given at the end of 90 days. Dr. Keenan apparently did not have nor did she review the December 2004 report, which was the first annual report. This was the same report that according to Dr. Hughes showed that Claimant was "argumentative," "touchy," or having "difficult interactions with coworkers, " none of which, as previously demonstrated, is contained within that report. Therefore, rather than having this report in her file and looking at it, herself, Dr. Keenan relied upon Dr. Hughes' incorrect assertions as to what the report contained. Dr. Keenan is clear from her report that she reviewed the Brewster Place employment records that had been provided, which contained "one performance review." She was never provided with the December 2004 report.

Finally, Dr. Keenan debunked Dr. Hughes' central tenant, which was that Ms. Spivey suffered from a "depression gene" that was capable of switching on and off. Said Dr. Hughes in his report:

> Ms Spivey has Major Depressive Disorder with psychotic features, which is widely regard in contemporary psychiatry as most likely caused by an inherited "depression" gene turning on at times in a person's life & generating the known malfunction in a person's biochemical brain functioning. (Underline original) (Vol. 14, p. 80).

Dr. Keenan testified that "I do not think it is gene related." She also testified that "most psychologists and most psychiatrists don't agree that it is gene related." (Vol 15, pp. 60-61).

Dr. Eyman's court-ordered evaluation concluded that Ms. Spivey suffered from a delusional disorder which he believed was caused by the head injury which occurred at Brewster Place (Vol 13., p. 59). This is also the same diagnosis that Dr. Carol Adams, a psychologist who examined the Claimant for the Social Security Administration, found to exist (Vol 15, pp. 94-108).

**D. Whether Claimant is entitled to work disability.**

The 1972 Supreme Court case of *Jackson v. Stevens Well Service*, 208 Kan. 637, 493 P.2d 264, established the principal that when a primary injury under the Workmen's Compensation Act is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury, including a new and distinct injury, is compensable if it is a direct and natural result of a primary injury. The parties stipulated that Ms. Spivey met by personal injury arising out of and in the course of her employment with Brewster Place when she was struck on the head by a falling metal bar. Claimant has previously argued that she is entitled to the 2 per cent functional impairment rating for the head injury, as originally assigned by Dr. Stein. Claimant has also shown that under the applicable case law, even if there is not a ratable physical injury, if there is a ratable condition, i.e., traumatic neurosis as it is often called, that arises as a result of the physical injury, he claim remains compensable. All testifying experts agree that Claimant now has a severe and permanent mental disorder. This disorder manifested itself after the physical

injury, and Ms. Spivey's condition has deteriorated since then, to the extent that she can no longer work. Prior to her 2005 injury, she received satisfactory or better job reviews, which resulted in increase in pay. Claimant has shown that the testimony of Drs. Hughes and Keenan is based upon speculation, at best, and at worst as to Dr. Hughes, complete misstatement of what the key employee reports that he relied upon in making his diagnosis actually said. Dr. Keenan, in turn, made the same mistake, not by misreading and misquoting the report, but rather, not reading it at all, and relying wholesale on Dr. Hughes' statements concerning what he claimed the evaluation said.

If, as Dr. Stein first opined, Ms. Spivey has a 2 per cent functional impairment, then she has a work disability regardless of whether the mental illness emanated from the physical injury. On the other hand, even absent a physical impairment, Claimant still has a work disability claim if the evidence from the record as a whole demonstrates that the psychosis arose out of the physical work injury. Claimant has shown above that it did.

After leaving Brewster Place, Ms. Spivey worked elsewhere intermittently. Respondent's counsel submitted a spread sheet based upon evidence concerning Ms. Spivey's employment after she left Brewster Place. Claimant objected to the rendition in that spread sheet, because it incorrectly showed that Ms. Spivey worked at both Topeka Adult Care Center and Autumn Home at the same time, apparently based upon a statement contained in the report by vocational expert Dick Santner concerning post-injury employment. First, the Santner report, at page 2, has a question mark after the end date for Topeka Adult Care Center. The report does, however, note that claimant was terminated at Autumn Home for psychiatric reasons (Vol 7, p. 33). The Santner report also states that

Topeka Adult Care Center job began the same month after the McCrite employment ended. Ms. Spivey also testified that she was hired twice and twice terminated from Topeka Adult Care, saying: "It just didn't work out. I kept having flashbacks. There was a lot of things that was going on with me psychologically at this time which I shouldn't say anything about right now." (Vol 11, p. 36). Thus, there is no overlap of these employments as assumed by Mr. Entz in his spread sheet (Vol. 1, p. 469). As evidenced in the employment records attached to the stipulation on employment after Brewster Place, R.N. Care and Topeka Adult Care were owned by the same person, so likewise, there is no overlap there as contended by Mr. Entz in his spreadsheet. The testimony of Mr. Santner, wherein he stated that the information in his report is correct, is evidence in this case (Vol 7, p. 33). The spreadsheet prepared by Mr. Entz is nothing more than argument by counsel and is not evidence. Thus, there being no overlap in employment, Ms. Spivey always had a wage loss after leaving Brewster as her income at any of these subsequent jobs was always less than 90% of her Brewster Place earnings. Finally, counsel for Ms. Spivey prepared a spreadsheet which correct shows the employment post-Brewster, and the resulting work disability periods and percentages (Vol 1, p. 486).

The parties stipulated to claimant's employment and earnings following her termination at Brewster Place. That stipulation, dated May 2, 2011, shows the following: Claimant worked for RN Care Services (Topeka Adult Care Center) from October 7, 2007, to February 18, 2008; Autumn Home from March 15, 2008 to February 23, 2009; apparently one day at Rose Villa earning $60.00 in 2009; and approximately eight weeks at Kansas Call Center in 2009. Claimant also testified that she worked at McCrite Plaza from March 31,

2006 to November 15, 2006, and as also shown on Mr. Entz' spreadsheet. Ms. Spivey also testified that she worked "in a different area for Topeka Adult Care Center. I was terminated twice from there." (Vol 11, p. 35).

What is evident by the clamant's employment after Brewster is that not only was she making less money, but her employment with any one employer was erratic. She was not able to hold a job for long periods of time. This tracks with Dr. Eyman's testimony that Ms. Spivey's mental status continued to deteriorate over time. Prior to the injury at Brewster Place, the undisputed testimony is that Ms. Spivey sought counseling for a brief period of time many years before to deal with a divorce situation, but other than that, she was never treated for any mental condition. Following the March 2005 injury, as her mental illness worsened, Ms. Spivey was required to seek more and more treatment for that condition, and was less and less able to hold down meaningful employment. The 2009 Social Security Award was based upon a finding of the existence of a delusional disorder, exactly the diagnostic conclusion reached by Dr. Eyman (Vol 13, p. 76).

Claimant is now exhibiting a 100 per cent wage loss, and therefore, has at least a 50 per cent work disability. One issue raised by Respondent before the Board was whether Dr. Eyman, a psychologist, could express an opinion on task loss (despite the fact that Respondent asked Dr. Keenan, a psychologist, for her task loss opinion). The Board never answered that question, because it found that there was no nexus between the work injury and the psychosis, and also found that the injury was only temporary (despite the fact that the genesis of Dr. Stein's 2 per cent opinion was intractable headaches, for which Claimant had complained of and treated for from 2005 on, by seeing numerous physicians for this

condition).

Even if a psychologist is not a physician and cannot render a task loss opinion, the record in this case contains such an opinion from a physician, namely, Dr. Curtis. Dr. Hughes was not asked about nor did he offer a task loss opinion. None of the other physicians deposed by Respondent did so either. That leaves the task loss opinion of Lynn Curtis, M.D. as the only opinion of task loss by a physician, and thus uncontroverted. That opinion was a loss of 6 out of 12 tasks, or a 50 per cent task loss (Vo. 8, p. 24).

**E. Whether Claimant is permanently and totally disabled as a result of her work injury.**

Dr. Eyman was also of the opinion that Ms. Spivey was permanently and totally disabled (Vol 13, p. 121). The Board rejected Dr. Eyman's testimony and IME report, for the apparent reason that "claimant refused to participate in psychological testing for Dr. Eyman" (Vol 1, p 624). The records shows that only one test was offered by Dr. Eyman, the MMPI or Minnesota Multiphasic Personality Inventory, which Claimant declined. Dr. Eyman stated that "her lack of participation did not interfere with the process"(Vol 13, p. 23). However, Dr. Eyman, who had seen the Claimant over a period of time on several appointments, opined that the work injury did result in her delusional disorder, which contrasted with Dr. Keenan's one time visit with Ms Spivey which resulted in opinions being based upon absent medical records which Dr. Keenan could have acquired but did not care to do so.

Under K.S.A. 77-621(d), which was amended effective July 1, 2009 this Court must look to the whole record, and can no longer ignore portions of the record that detract from

the agency's findings. *Redd v. Kansas Truck Center*, 291 Kan. 176, 182, 239 P.3d 66 (2010). In some situations, though, testimony that would otherwise support an agency's findings may have "been so undermined by cross-examination or other evidence that it is insufficient to support the agency's conclusion." *Herrera-Gallegos*, 42 Kan. App. 2d at 363. Under the new test, the Court has a new filter: evidence that has been so undermined that a reasonable person would no longer accept it as substantial to support a particular conclusion is filtered out. If the remaining evidence is substantial, i.e., if the remaining evidence is sufficient that a reasonable person might accept it as supporting the agency's decision, then the Court must uphold the agency's factual findings.

In the case, the Appeals Board accepted the testimony of Drs Hughes and Keenan wholesale, even though neither of these doctors had any medical records that predated the accident in question. Dr Hughes diagnosed a supposed 1995 episode of depression without seeing any medical records on that situation at all. The actual occurrence, as testified to by Ms. Spivey, was that she was going through a divorce, and saw a counselor on two occasions for support in getting through the divorce process (Vol 6, p. 27). Ms. Spivey talked to the counselor about the divorce "to make sure it was the right thing to do" (Vol. 6, p. 28). There was no evidence that the counselor who saw Ms. Spivey in 1995 was even a mental health professional or had reached a diagnosis of depression or for that matter, any diagnosis at all. Yet Dr. Hughes was sure that Claimant had experienced her first episode of major depression in 1995. In its best light, Dr. Hughes' opinion concerning that 1995 counseling is guesswork and in its worst light, disingenuous. Likewise, Dr. Keenan did not bother to obtain medical records prior to the 2005 accident. Both doctors formulated their diagnosis of major

depression of review of employee evaluations in 2005, which were before the accident, and which characterized the Claimant's work abilities and work ethic in positive terms. There was also some evidence that Dr. Hughes latched onto the fact that Claimant had filed an employment discrimination claim in December 2004 as some supposed evidence of major depression, even though the claim was eventually settled **in Claimant's favor** with a rather substantial monetary award. In other words, there is no logical basis, in reviewing non-medical employment records, for these two doctors to reach the conclusion that the records supported a diagnosis of major depression which predated the work accident. Medical records would have been a much superior source upon which to base such a diagnosis, but they were not used by them precisely because they **did not** support the theories of Drs. Keenan and Hughes.

The medical evidence of record demonstrates that Claimant **was not** suffering from any form of mental disorder prior to the March 2005 work accident. That is a fact which the Board failed to discuss, instead relying on medical testimony which ignored that very absence of mental illness before 2005, and instead conjured up a diagnosis based upon employments reports and records which were nothing but satisfactory. Whether the evidence is substantial is itself a question of law. *Redd*, 291 Kan. at 182. Kansas courts give no deference to the Board on such questions, which include the interpretation of statutes. 291 Kan. at 187-88.

The Board decision also misstated the testimony of Dr. Eyman on whether Claimant had prior mental disorders. Dr. Eyman stated in his 2011 report that "although Ms. Spivey has been depressed in the past, there is **no evidence in the medical records that she was**

**depressed, psychotic, or delusional just prior to the work incident**" (Vol 1, pp. 266-272). (Emphasis added.) Further, Ms. Spivey denied that she had ever had any mental health treatment prior to the work accident (Vol 1, p. 170). The Board also incorrectly stated that Dr. Eyman "cited at least one episode where claimant told him she was scared she might kill herself" (Vol. 1, p. 634). However, this incident, as reported by Dr. Eyman, occurred **after** the work accident, not before as the Board attempted to suggest, when on January 8, 2009, Dr. Eyman directed Claimant to go to the St. Francis Hospital emergency room when she reported that she had a gun and was suicidal (Vol 1, p. 267).

The Board also found that Dr. Curtis had diagnosed pre-existing depression. This is totally incorrect and not supported at all by the record. Dr. Curtis in his testimony talked about "subsequent depression" which he opined was the result of "a direct blow to the head" (Vol 8, p. 10). The Board got this testimony completely wrong. Dr Curtis examined Claimant on several occasions after 2005, and in his first report discussed her past medical history, with no mention of treatment for depression (Vol 8, p. 79). There is no discussion of past medical history in subsequent reports.

As noted above, Dr. Eyman was of the opinion that Ms. Spivey "is not able to perform adequately over a consistent period of time that would allow for gainful employment." (Vol. 13, p. 121). This conclusion is supported by the Claimant's work activities following her tenure at Brewster Place was she was less and less able to function in an employment setting. This conclusion is also supported by the Social Security Administration's finding that the Claimant was totally disabled.

## V. CONCLUSION

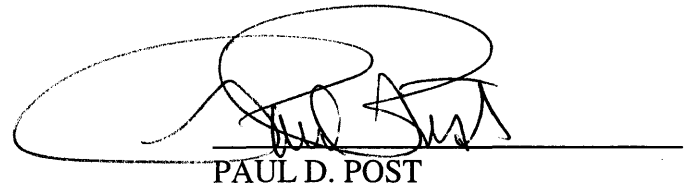
Claimant met with accidental injury arising out of and in the course of employment with the Respondent on or about March 29, 2005. Claimant's average weekly wage was $507.91 per week. Claimant sustained an injury to her head, which resulted in a psychological injury in the form of a delusional disorder. There was no medical history of any significant mental illness prior to the injury in question. There is a history of satisfactory work evaluations demonstrating Ms. Spivey's overall abilities as an employee.

The injury Ms. Spivey suffered is permanent, contrary to what the Board found, and equals 65 per cent to the body as a whole under the *AMA Guides,* 4th Edition. Dr. Stein performed an IME in 2009 and assigned a 2 per cent impairment for Claimant's chronic headaches. He changed his opinion to no impairment almost three years later, without again seeing Ms. Spivey or reviewing any subsequent medical records. Even if there is no functional impairment for the headaches resulting from a physical blow to the head, Claimant is entitled to compensation in that the traumatic neurosis arose out of the work injury. Opinions of Drs. Hughes and Keenan to the contrary are not supported by any medical records prior to the accident, as none were reviewed by them, and are thus only supported by employee evaluations of Ms. Spivey, which Dr. Hughes misread and mischaracterized and which Dr. Keenan did not read herself, at least as to the supposedly negative evaluation (Appendix I). Dr. Eyman's extensive evaluations, consisting of several sessions over an extended period of time (as compared to a one-time evaluation by both Drs. Keenan and Hughes) found that Ms. Spivey suffers from a delusion disorder, which is a psychotic condition, and which resulted from the work injury. Dr. Eyman's opinion in this regard is

supported by the evidence of the record as a whole.

Claimant is entitled to work disability equal to 75 per cent, from August 30, 2005 to March 14, 2006, when she went to work for McCrite Plaza. While there, she had a 40% wage loss, which should be averaged with a 50% task loss (Dr. Curtis). After leaving McCrite, claimant worked at Topeka Adult Care Center and had a 21% wage loss. Topeka Adult Care Center has the same owner as RN Care, where claimant also worked. However, there was no overlap in employment. When claimant switched over to the RN Care facility, he earnings were $360 per week, for a 30% wage loss. After leaving RN Care in July 2008, claimant worked for Autumn Home for seven months, until March 2009, earning between $186.00 (seven weeks), then $360.00 (three weeks), then $463.50 (two week) and $481.00 (for two weeks), for an average of $305.00 per week, or a 40% wage loss. She worked at Topeka Call Center making $140.85 per week for 10 weeks for a 73% wage loss. After August 5, 2009, claimant had no further employment, and thus had a 100% wage loss, equal to a 75% work disability. In the alternative, Claimant is permanently and totally disabled as a result of her delusional disorder. For these reasons, the decision of the Workers Compensation Appeals Board should be reversed and remanded.

Respectfully submitted,



PAUL D. POST
Attorney for Claimant

# APPENDIX I: CLAIMANT'S ANNUAL PERFORMANCE REVIEW

BREWSTER PLACE
RETIREMENT COMMUNITY

January 2, 2005

Linda Spivey
2505 SE Monroe
Topeka, Kansas 66605

Dear Linda:

I have enclosed a copy of your Annual Performance Appraisal. Based on your performance evaluation, you have earned an increase in base pay from $10.42 per hour to $10.62 per hour effective November 5, 2004. This pay increase will be reflected on your January 7, 2005 paycheck. Due to the timeliness of your appraisal, you will also be receiving a one-time back payment of $44.98.

Your Performance Appraisal indicates that you work well independently; you are always looking for work to be done; and you are dependable. You are truly an asset to Brewster Place. Your performance appraisal also indicates some opportunities for improvement which include being team oriented; and communicating with your co-workers.

Please contact Julie Kuestersteffen for your annual uniform order and free to talk with me if you ever have any questions.

Thank you again for your service to Brewster Place.

Sincerely,

Angela S. Dailey
Director of Human Resources

Enclosure




1205 SW 29TH ST. TOPEKA, KS 66611 (785) 267-1666 FAX: (785) 267-9355

BREWSTER PLACE PERFORMANCE APPRAISAL

| | |
|---|---|
| Employee Name Linda Spivey | Title CMA |
| Department Nsg | Review Period 11-04-03 — |
| Date of TB Completion | Date of Annual Inservice Completion |
| Type of Appraisal (Check Box) 90-Day ☐ | Annual Appraisal ☑ |

**Job Responsibilities**
*Please briefly describe*

To see that medications & treatments are given to residents correctly and at the correct times, to care for residents ADL'S and overall case, reporting to nurses of changes and or incidents in residents.

**Accomplishments**
*Please list this individual's top three accomplishments this year.*

1. Working through times when difficulties with staff relations with a positive outcome.
2. Working independently in giving medications, treatments, and resident care.
3. To identify residents as individuals and to give them the respect they deserve, resident centered care.

**Strengths**
*Please list this individual's top three strengths, and after each, give a specific example of an instance where this strength was exemplified.*

1. Self direction & When E. Stearns was actively dying Linda spent the time to feed & care for this with out direction from nursing, her care & concern for the individual was apparent.
2. Good use of time: When here she is always on the floor, her job is always done, never idle.
3. Punctual up until recently: Always early to work until recently usually ready to start the day.

(Over)

Opportunities for Improvement

*Please list three areas where this individual ...ld improve and develop performance*

1. To work when scheduled, fewer absences.
2. To work on communication skills with the team, and to improve the team relationships.
3. To work on being more team oriented

Organizational Guiding Principles

*Please review the Organization's Guiding Principles. Indicate how well this employee has been exhibiting the values and provide comment and/or examples.*

| | Comments/Examples |
|---|---|
| Customer Focused | Relates well with residents and their needs, worked well with E. Stearns during active phase of death. |
| Trustworthiness | Able to leave her with jobs that need to be done and not have to worry or follow up. |
| Teamwork | She is aware of Bregwsters ideals on TEAM work, but she is not always an active team member. |
| CQI – involvement within | Aware of her work environment, willing to clean up or fix what is necessary to keep it safe & home. |
| Integrity | She upholds Brewsters Places integrity and the residents integrity at all times. |
| Fiscal Responsibility | Doesn't abuse the time clock, charges the residents correctly for items. |

Goals/Objectives for the coming year:

1. Become more TEAM oriented and to work with the TEAM members.
2. To improve communications skills with the staff.
3. Return to a consistency of coming to work when scheduled.

| Overall Performance Rating | | Please comment on the rating given: |
|---|---|---|
| Outstanding | | Linda is very resident oriented, and cares a great deal about her residents, always looking out for their needs. I do have some concerns with her ability to work with the TEAM, but as of late she has been open with staff. Improvement in her absences would be nice, but when she is here she works hard and is very dependable. |
| Exceeds Expectations | | |
| Successful | ✓ | |
| Needs Improvement | | |
| Unsatisfactory | | |

Employee Comments

I do not understand what they mean about not being a team member, I thought I got along & everyone I work &.

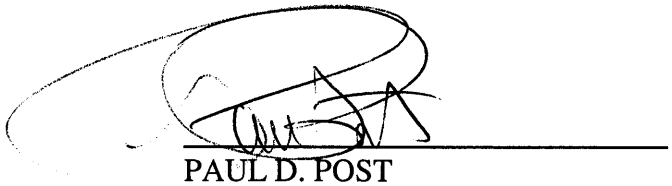
| | |
|---|---|
| Employee Signature | Date 12/28/04 |
| Supervisor Signature | Date 12/28/04 |
| Director, Human Resources Signature Angela S. Daily | Date 12/31/04 |

*To be completed by Human Resources:*

| |
|---|
| Date Uniforms Issued (if applicable) |
| % Increase 2 |

## CERTIFICATE OF MAILING

I hereby certify that I deposited two (2) copies of the foregoing Claimant's Brief in the United States Mail, postage prepaid, on April 26, 2013, addressed to: Michael Entz, Entz and Entz, P.A., Attorneys for Respondent/Appellee, 1414 SW Ashworth Place, Ste 201, Topeka Kansas 66615



PAUL D. POST