FINAL AWARD DENYING COMPENSATION
(Affirming Award and Decision of Administrative Law Judge
with Supplemental Opinion)

Injury No.: 13-100429

Employee: Debbie A. Shanks

Employer: Heartland Regional Medical Center

Insurer: Heartland Regional Medical Center s/c/o Thomas McGee LC

Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence, read the briefs, and considered the whole record, we find that the award of the administrative law judge (ALJ) denying compensation is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, we affirm the award and decision of the ALJ with this supplemental opinion.

Preliminaries
The parties asked the ALJ to determine the following issues: (1) was there an injury sustained by employee by accident during the course of her employment; (2) was the accident the prevailing factor in any subsequent injury; (3) notice to the employer; (4) employer's liability for medical care; and (5) temporary total disability benefits. The parties agreed that the ALJ would not decide the issues of permanent partial disability or permanent total disability.

The ALJ determined as follows: (1) employee failed to prove she sustained an injury by accident on or about October 1, 2013, arising out of and in the course of employment; the ALJ acknowledged that he did not need to make additional findings since he found no compensable injury, however, he continued; (2) employee gave proper notice to the employer of the alleged injury; (3) the evidence does support that the employee needs additional treatment; and (4) employee is temporarily totally disabled since October 9, 2013, but employer is not liable for these benefits.

Employee filed a timely application for review to the Labor and Industrial Relations Commission alleging that the ALJ erred in finding: (1) employee did not suffer a physical reaction and sustain an injury arising out of and in the course of her employment, from the October 1, 2013 influenza vaccination; (2) employee failed to establish that as a result of physical reaction to the vaccination, she suffered additional compensable psychological injury; (3) employee was not temporarily and totally disabled as a result of the physical injury resulting in psychological and mental injury, for which the vaccination was the prevailing factor; (4) no additional medical benefits were awarded; and (5) no temporary and total disability benefits were awarded due to the October 1, 2013 injury.

For the reasons stated below, we affirm the award of Administrative Law Judge Robert Miner, to the extent it does not conflict with our supplemental findings and conclusions herein.

Discussion
Affirmative findings vs. summaries of the evidence
Section 287.460.1 RSMo tasks the ALJ in a workers' compensation case to issue an award "together with a statement of the findings of fact." Here, the ALJ did provide a thorough review of the evidence. However, the factual findings are interspersed throughout a 93 page decision that

includes lengthy summaries of the evidence (including many pages consisting entirely of block quotes from medical records and testimony). These passages were provided without the benefit of accompanying analysis or commentary from the ALJ as to how he viewed such evidence. The decision also provides an exhaustive recitation of numerous statutory, regulatory, and case law authorities applicable in Missouri Workers' Compensation proceedings.

The courts have strongly cautioned us against issuing or approving these kinds of decisions:

> Here, there are literally pages of testimony summarization. There are also pages of substantial discussion of abstract legal theory. The ALJ certainly diligently summarized all of the evidence as an impartial and uncritical scrivener. No doubt it was a useful reference tool for the ALJ's own use in understanding the facts. But because of the absence of findings (that is, the lack of critical evaluation and the failure to draw pertinent inferences from the evidence), the summaries, with all due respect, are of little value to this court. ... **We need to know what the Commission actually found to be operative and significant as it reviewed the testimony.**

Stegman v. Grand River Reg'l Ambulance Dist., 274 S.W.3d 529, 532 (Mo. App. 2008) (emphasis added).

In *Stegman*, the court concluded the award, as written, failed to comply with the requirements under § 287.460.1, and that the court was therefore constrained to vacate it and remand the case to the Commission to provide an appropriate statement of the facts. *Id.* at 537. Here, we believe the award ultimately contains findings of fact and conclusions of law sufficient to permit judicial review, should this matter be subject to further appeal. However, because the findings are interspersed throughout lengthy summaries and recitations of the type the courts have specifically cautioned us against, we discern a need to briefly summarize below the operative findings of fact and conclusions of law with respect to the issues identified at the hearing, which findings and conclusions we are hereby affirming and adopting as our own:

> *General Background*
> At the time of employee's Workers' Compensation hearing on January 24, 2017, she was 45 years old. Employee had achieved a G.E.D. after leaving high school.
>
> Employee worked for employer for nine years, in a full-time position beginning in 2004. Her job title was cardiac monitor technician. Her duties included working 12 hour consecutive shifts, paying close attention to heart monitors of patients to alert medical personnel of any problems, printing read-out strips, and inputting data into a computer. Her work location was in a room away from patients, with 30-40 monitors within view.
>
> The last day employee worked was October 9, 2013. Employee initiated the paperwork for Family Medical Leave in October 2013. She was on approved leave through December 16, 2013, and then resigned later that month. On January 13, 2014, employee filed a Report of an "event" with the employer, making a claim of injury resulting from her flu shot.[1]

[1] Neither party addressed the issue of proper notice in their briefs before the Commission. Employer appeared to have abandoned this issue at hearing, *Transcript*, page 13, but compare reference on page 14. In any event, based on our finding with regard to dispositive issue of causation, we deem the issue moot.

As of January 2014, employee has been receiving Social Security disability payments.

Employee filed her workers' compensation claim on July 22, 2015.

The ALJ found claimant credible, "unless otherwise discussed in this Award." *Award* page 15. We agree that claimant is credible in relating her impressions of her symptoms and events. However, her credibility is flawed because of memory issues and apparent limited understanding of medical terminology. We note several self-reports to doctors in the medical records, which report treatment, medical events, and diagnoses, which are not borne out by the records, as well as instances that are documented by physicians which employee denied.

Alleged Accident
On October 1, 2013, while at work around 11:00 a.m., employee received a flu shot, which was offered and encouraged by employer. She did not report any problems with her health on that day and finished her whole work shift ending at 7:00 p.m. Employee expressed her belief during the workers' compensation hearing that the shot was mandatory but she did not explore this belief with the employer or consider if there were options available to her. Employer required its employees to get a flu shot, but allowed for accommodations, as needed. The vaccine was not a live virus. Employee believes the shot has caused a series of conditions and symptoms which she finds disabling. Employee had received the flu immunizations annually for eight years prior to this date with no remarkable symptoms or reactions. In 2012, employee recalled a general achiness for about 5 - 7 days after the shot, but it did not cause her to alter her work or other activities. Employer's workers' compensation manager, Nurse Sarah Duin, (also responsible for the immunization program), researched the vaccine which had been administered. The vaccine batch had not been recalled by the manufacturer. She had not received other reports of reactions from any of the 3,000 vaccinated hospital employees.

The sources consulted by the employee's treating doctors with regard to symptoms of an adverse reaction to a flu vaccination, did not identify the types of symptoms employee described. Usually the site of the injection was a point of reference. There was no evidence that there was anything unusual about employee's injection site. The package insert to the vaccine indicated that reactions to the immunization could include transient malaise, symptoms like the flu, myalgia or localized muscle ache and pain. *Transcript* page 602-605.

Medical Causation – Physical Symptoms
There is extensive medical work-up by several different treating doctors over the course of several months after the date of the immunization. On October 2, 2013, employee left work mid-day for an appointment with Dr. Ronald S. Kempton, M.D., her primary care doctor. The doctor noted that she presented to him with "diffuse nonspecific symptoms," *Transcript,* page 129; however, the chief complaint was back pain like pins and needles and numbness. She complained of weakness and fatigue in lower extremities, neck pain, headaches and some blurred vision. There was no notation in the doctor's records of a recent flu shot or that employee's injection site was unusual in any way. Employee was not exhibiting or complaining of an inability to walk or any issues

with gait. Dr. Kempton's initial diagnosis settled on metabolic syndrome and his treatment discussion focused on diet.

Employee informed employer's representative in October 2013, that she was unable to return to work that week because of medical problems. It is not clear that she indicated at that time that she believed her symptoms were related to the flu shot, although employee believes that she did mention this.

Beginning October 2, 2013 and continuing through March 2015, employee reported various symptoms to her doctors. Employee's hearing testimony was that she began having muscle spasms in her arms and tremors in her hands[2] sometime in October 2013. After a visit on October 17, 2013, Dr. Byron Thornton noted employee's report to him that she sometimes had trouble forming words that begin with 's', that her brain felt "cloudy," and she was anxious that something ominous was occurring. *Transcript,* page 139. Among her complaints to doctors were balance problems, right knee pain, headache, rash, occasional dizziness, burning in her feet, memory issues, fatigue, weakness, and sleep disturbance. Many of these complaints are also recorded in employee's medical records prior to October 1, 2013.

Beginning October 17, 2013, she began seeing doctors (other than her primary care doctor) on her workplace campus, who referred her for tests. Several doctors noted employee's unusual gait. In November 2013, Dr. David Ewing, (a neurologist), described it as a "monster-like" gait. *Transcript,* page 161. All of her doctors found no identifiable physical cause for the gait alteration. Dr. Wendell Bronson (Heartland Arthritis and Osteoporosis Center) opined that it would seem that such an odd gait would require the individual to have good balance in order to remain upright and be able to "pull that off?" *Transcript,* page 266. Dr. Bronson found no signs of active connective tissue disease or an inflammatory arthritis as of November 1, 2013. Employee's doctors found no clearly identifiable physiological cause for employee's gait problems. Yet, employee was sometimes using a device to assist her in walking as of December 2013.[3]

The results of objective testing did not pinpoint a diagnosis of a physical nature. Dr. David Ewing performed extensive objective testing on employee in November 2013. He could find no neurological cause for her symptoms. A lumbar puncture was performed with no abnormality found. Dr. Ewing noted that the spinal fluid was negative for evidence of demyelination or inflammation, ruling out these conditions. Blood tests revealed no abnormal findings. Magnetic Resonance Imaging (MRI) of the brain and thoracic and cervical spine[4] performed in November 2013, were all negative. An echocardiogram with bubble study that same month was also negative. An electromyography (EMG) was performed in November 2013, with no positive findings. A copper elevation test was normal. Dr. Vernita Hairston, a neurologist, was consulted at the request of Dr. Ewing in January 2014. Dr. Hairston also found no neurologic cause and noted that she and her colleagues at the University of Kansas Medical School were unaware of

[2] Employee had experienced similar problems with her hands in 2012.
[3] Employee's testimony was that she started using the walker device she had at the hearing in October 2015, and that she uses it for longer walks outside the home.
[4] Dr. Vernita Hairston's December 23, 2013 Progress Note indicates there was diffuse cervical spine narrowing, indicated on the October 28, 2013 MRI (without contrast). However, she does not indicate any pathology based on this observation.

this set of symptoms ever being related to an adverse reaction to a flu shot. Dr. Hairston opined that employee's left-sided weakness was related to her history of prior strokes. Dr. Ewing opined that there was likely a psychological cause to employee's display of symptoms.

The treating doctors, individually, were able to identify a number of illnesses that could be ruled out or were unlikely – lupus, Guillian-Barre syndrome, a neurological cause, amyotrophic lateral sclerosis (ALS), neuropathy, encephalopathy, multiple sclerosis, muscular dystrophy, myopathy, myositis, connective tissue disease, or inflammatory arthritis. None of employee's doctors could diagnose an active connective tissue disease. No neurological cause could be attributed by the doctors to her gait issue. There was no sign of encephalopathy on the imaging studies. Inflammatory polyradicular neuropathies were ruled out by Dr. Ewing as of July 2014. The only abnormal finding identified in objective testing was elevated antinuclear antibodies (A.N.A.) in a homogenous pattern with a negative rheumatoid factor and a negative profile. Dr. Wendell Bronson indicated the findings were non-specific, and eliminated an autoimmune disorder as of November 1, 2013.[5]

As of January 3, 2014, Dr. Byron Thornton opined that employee was not able to perform work on a regular and continuing basis without an unusual number and length of rest periods relating to her medical condition.

Most doctors gave a qualified (*best-guess*) diagnosis, many noting that it was difficult to diagnose with precision.[6] Diagnoses included ataxia (Dr. Thornton January 3, 2014); fibromyalgia with muscle aches, headaches, depression fatigue, (Dr. Robert Stuber May 9, 2014), but the doctor noted the report of severe stiffness was contrary to that diagnosis; Nurse Practitioner Megan Ebbens assessed arthralgia, limb weakness and chronic major depression (March 13, 2014). Some of the doctors noted that employee's perception of her symptoms was not confirmed by the medical tests.

None of the medical doctors who treated or examined employee for the diagnostic work-up were of the opinion that there was any basis to say the immunization caused the symptoms described by employee. All of employee's treating doctors - Dr. Kempton, Dr. Thornton, Dr. Ewing, Dr. Bronson (rheumatologist), Dr. Hairston, and Dr. Stuber found there was no connection that could be established between the flu shot and a physical adverse reaction.

Employer presented Dr. Harold Barkman, the medical director of occupational health at Kansas University Medical School, who reviewed employee's extensive medical records and examined her on October 21, 2016. Dr. Barkman is in charge of the flu vaccination program for all of the KU Medical Center and was director of a community-based flu vaccine drive-through clinic. In these capacities, he has had significant involvement with vaccinations over

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[5] Although early on, Dr. Kempton suggested an autoimmune disorder, employee changed doctors at that point and other medical providers did not confirm an autoimmune disorder. *Transcript,* page 138.

[6] F.N.P. Megan Ebbens noted "a very interesting case," considering that all diagnostic testing was mostly normal, and that there may be some type of conversion disorder. Dr. Robert Stuber described the illness as mysterious and admitted he was "struggling with a diagnosis." Dr. Byron L. Thornton observed employee's "symptom complex is quite perturbing," and was unable to "pinpoint any one focal diagnosis." *Transcript,* page 139. The doctor noted as of October 22, 2013, that conversion disorder was part of the differential to be explored. *Transcript,* page 142.

several years. In his opinion, there was no medical science to support the conclusion that employee's symptoms were indicative of an adverse reaction to a flu vaccination. He opined that employee had not suffered any temporary or long-term effect resulting from the flu vaccination and that it was not a prevailing factor in any of the symptoms she expressed. His opinion was the prevailing factor in any of the current medical conditions "was more related to her preexisting conditions." *Transcript,* page 591. We find that Dr. Barkman is the physician with the most expertise in this area and find his opinion most persuasive on this issue.

A single report was located in the U.S. Centers for Disease Control database of an alleged adverse reaction claimed by an individual in Kentucky in January 2014, who had received an injection from the same lot of vaccine. That individual reported muscle weakness, gait alteration and feeling "weird." The report indicated there was no acknowledgement that these symptoms were related to or caused by the vaccine. We find this hearsay evidence on a collateral matter is not persuasive of a causal connection of the immunization to employee's symptoms in the matter before us.

The only medical doctor who found a possible connection was Dr. P. Brent Koprivica who conducted an examination in January 2016, at the employee's attorney's request. Dr. Koprivica opined that employee was experiencing a conversion disorder of a psychological nature and that same was "a contributor to the disability presentation that both pre-dated October 1, 2013, and that which is attributable to the October 1, 2013, injury, in terms of response to that vaccination with new disability development." *Transcript,* page 346. Dr. Koprivica also opined:

> Ms. Shanks' work-related vaccination on October 1, 2013, and the adverse reaction to that vaccination is felt to represent the direct, proximate and prevailing factor in Ms. Shanks' development of physical symptoms. Unfortunately, flowing from this adverse reaction to the vaccination is the development of what I believe is a likely conversion disorder. *Transcript,* page 363.

We do not find Dr. Koprivica's premise that employee experienced an adverse physical reaction to the vaccine itself is supported by the evidence. Therefore, we are unwilling to credit his opinion that any psychological disorder identified by Dr. Koprivica and Dr. Claiborn, (employee's psychological expert), is causally connected to the October 1, 2013 flu vaccination at work.

Medical Causation – Psychological Symptoms

After exhausting a search for a physical cause to explain employee's diverse symptomology, the parties consulted doctors with expertise in psychological disorders.

Some of employee's treating physicians had questioned whether there may be a functional overlay, a psychological or a conversion disorder involved, considering employee's unusual display of symptoms. (See Dr. Ewing – July 17, 2014; Dr. Hairston – Jan. 2, 2014; Dr. Thornton – Oct. 17, 2013) We find the opinions of these several treating doctors to be persuasive in this respect.

However, since no clear link was shown between the flu vaccination and any of the physical symptoms, we find no causal link has been extended from those symptoms to any psychological symptoms.

Dr. Daniel Claiborn, Ph.D., a psychologist, evaluated employee on April 14, 2016, at the request of employee's attorney and following an examination by Dr. Koprivia. Dr. Claiborn diagnosed somatic symptom disorder (or somatoform symptom disorder) and major depressive disorder. He explained somatoform symptom disorder is "a psychological pattern or disorder that is characterized by physical symptoms that the person's displaying and also by an excessive amount of concern about the physical symptoms." *Transcript,* page 405-406. Dr. Claiborn opined that the "prevailing factor and kind of initiating event was her physical reactions to the vaccination," which then resulted in the psychological disorder. He described the disorder as manifesting in "[e]xcessive attention to the symptoms, the amount of distress she had about them, the way she looked at the way they affected her lifestyle." *Transcript,* page 421 The psychological diagnosis is based "not so much whether or not the physical symptoms have a definable medical underpinning, but rather whether the person is distress (sic) and excessively upset about the symptoms, whether they're interpreting the symptoms in a way that lead them to feel more restricted than they otherwise could." *Id.* He described the employee's physical symptoms as "either an exacerbation of the physical symptoms that she already was experiencing or some other symptoms that couldn't be explained by medical testing," *Transcript* pages 419-420, but which are a result of her depression. Dr. Claiborn further explained at his deposition that the timing of the symptoms after the vaccination affected his conclusion of causation, and in response to cross examination questions, he acknowledged that it wasn't the vaccination itself that triggered the somatoform and major depressive disorders, but rather the events thereafter. *Transcript* page 483. Because we do not find the physical symptoms related by the employee were proven to be causally related to the vaccine, we are not persuaded by Dr. Claiborn's opinion on the prevailing factor.

Dr. William Logan, a board certified physician in psychiatry and neurology, met with employee and reviewed her medical records in September 2016 at the request of the employer. He also administered several psychological tests. Dr. Logan noted a pre-existing psychiatric history of attention deficit disorder, social anxiety disorder and depression, along with numerous pre-existing physical complaints, prior to October 1, 2013. He diagnosed her with recurrent, moderate major depressive disorder and somatic symptom disorder. Dr. Logan could not confirm that any psychological conditions were caused by the October 1, 2013 flu vaccine. Dr. Logan explained that employee's symptoms did not follow any clear pattern that would indicate an illness and that typically illnesses have a certain set of symptoms that exist together and follow a typical course. Because of this, he attributed her symptoms to a conversion disorder or somatic symptom disorder.

Both of employer's experts, Dr. Logan and Dr. Harold Barkman, M.D., M.S.P.H.[7] opined that there was no physiological connection between employee's symptoms or conditions and the flu shot. Dr. Barkman's extensive expertise in vaccination programs was particularly persuasive regarding the potential effects

[7] M.S.P.H. identifies a Master's of Science in Public Health.

of vaccinations. Dr. Barkman credibly opined that there was no short term or long term illness resulting to employee from the flu vaccination. We adopt the ALJ's findings that Dr. Logan and Dr. Barkman's opinions were most persuasive that there was no causal connection established with the October 1, 2013 flu vaccination; and that the flu shot was not the prevailing factor in causing any of employee's conditions, either medical (Barkman) or psychological (Logan).

Preexisting Conditions

Prior to receiving the flu shot in 2013, employee had a number of preexisting medical conditions, including fibromyalgia. These various preexisting diagnoses further complicated the medical professionals' ability to accurately diagnose the current condition and cause(s). Employee had fibromyalgia since 1994, and had ongoing complaints and treatment for the condition since that time including hand and fingertip sensitivity. She had been experiencing fibromyalgia symptoms before the flu shot. In 2011 and 2012 employee sought treatment for fingertip sensitivity. Employee reported to Dr. Wendell Bronson in 2011, that this sensitivity had started 8-9 years ago. During visits to Dr. Bronson in March 2011, he notes impressions of fibromyalgia, paresthesia of fingers, 20 year history of back pain, anxiety and depression. *Transcript,* page 542.

She described to Dr. Bronson during a visit in 1995 that she would experience sleepiness if she was standing for more than 15 minutes. *Transcript* page 523. Employee reported at that visit that she had fallen about four years prior and her back complaints had started then. She had one or more strokes in 2000, which resulted in left side weakness affecting her walking, and lingering weakness in her left arm. She had a prior knee problem. The past medical records documented frequent doctor visits for weakness and muscle ache, mid-low back pain and instances of inflammation over a period of years. Employee was involved in at least two car accidents, one in 2011, which caused some neck and back problems.

Employee had been treated on more than one occasion over several years for anxiety disorders and depression and was taking Paxil for many years. Past medications included BusPar, Zoloft, Prozac, Nistarel, Ativan, and Lyrica. Her history also included sleep apnea, attention deficit disorder, and a diagnosis of bipolar disorder by one provider. There was also a history of affective disorders in employee's family.

Conclusions of Law

Accident - Unexpected traumatic event resulting in objective symptoms of injury

Section 287.020.2 RSMo defines "accident" as:

> [An] unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor. (emphasis added)

Employee was given a flu vaccination at her place of employment on October 1, 2013. She asserts her alleged reaction to the shot was an "accident" i.e. an unexpected traumatic event. However, there is no persuasive evidence of objective symptoms of an injury caused by a

specific event in the workplace. Therefore, we conclude employee has not suffered an "accident," as defined by § 287.020.2. [8]

The ALJ found there was no compensable accident. We agree.

Medical Causation

The ALJ found that employee failed to prove causation of an injury, medical or psychological condition or disability. We adopt the ALJ's conclusions of law in this regard.

Section 287.020.3 RSMo provides as follows:

> (1) ... An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor in relation to any other factor, causing both the resulting medical condition and disability. (emphasis added)

We conclude employee has not shown that any work accident or event (the flu vaccination) was the prevailing factor in causing any physical injury to employee.

The remaining question raised is whether employee has proven that any psychological injury and disability resulted from the work event. In other words, was the flu shot the prevailing factor causing a psychological disorder?

In a matter before the Western District Court of Appeals,[9] an employee who slipped and fell at work, initially reported mild pain and was walking without much difficulty after the incident. Three days later she complained of pain in the left knee, hip and lower back and was observed to be walking with a left-sided limp, eventually resulting in a prescription for crutches to stabilize her gait. Yet, there were no anatomical problems found through any objective testing. Six weeks after the incident at work, employee was diagnosed with deep-vein thrombosis of the lower left leg, which was medically resolved shortly thereafter. Nevertheless, the employee continued to assert pain. She claimed that her leg was broken in two places and continued to assert that she was unable to walk. This was medically unfounded and the employee in that matter was diagnosed with a somatoform disorder. The issue before the court was whether the unquestionable work-related fall, resulting in the left leg/hip injury and thrombosis was a significant factor in causing a claimed psychological disability.

The Court adopted the Commission's findings that there was not a sufficient basis to find the physical injury was a substantial factor[10] in the subsequent psychological disorder. The Commission reasoned:

> We do find, based on the circumstantial evidence in this case, (i.e. the close

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[8] We have previously found that where the employer creates the need for the flu vaccine to prevent infection of patients and other employees, that the hazard or risk that may result from a flu vaccination is related to employment. *Karen Doyle v. Lakeland Regional Hospital,* Injury No. 05-141082, (LIRC, Dec. 8, 2011) A vaccination resulting in objective symptoms of injury may be considered an unexpected traumatic event. However, unlike the case of *Karen Doyle,* there are no objective symptoms of injury shown to have resulted from the employee's alleged accident in the matter before us.

[9] *Royal v. Advantica Rest. Group, Inc.,* 194 S.W. 3d 371 (Mo. App. 2006)

[10] The court in *Royal v. Advantica,* was using the test for medical causation found in an earlier version of § 287.020.2 which used the terminology 'substantial factor' in defining when an injury is "work-related."

> spatial and time relationship between the accident and the ensuing mental disorder focused primarily on the claimant's left leg), that the work-related accident and injury to the claimant's left leg was somehow and in some way a precipitating factor in causing her psychological disorder. However, [we] cannot find that work (in this case the October 15, 2000, fall, the injury she sustained at that time to her leg and low back, and the deep-vein thrombosis which developed or the medical treatment she received) was a substantial factor in causing her somatoform disorder. There simply was no expert testimony or evidence as to how a trauma or deep-vein thrombosis or anxiety about possible recurrences can be a substantial factor in causing a somatoform disorder.

Royal v. Advantica Rest. Group, Inc., 194 S.W. 3d 371 at 377, (Mo. App. 2006)

There is some evidence according to the opinions of Dr. Koprivica and Dr. Claiborn that employee's manifestation of physical symptoms are the result of a psychological, conversion or somatoform disorder. The theory appears to be that the psychological disorder was triggered by the physical injury (an adverse reaction to the flu vaccine on October 1, 2013). Dr. Claiborn described the physical reactions to the flu vaccine as the "initiating" event to her somatoform disorder. *Transcript, page 419-420.* First, the legislature has instructed that, "an injury is not compensable because work was a triggering or precipitating factor." § 287.020 RSMo. We do not mean to parse the doctor's words, but his meaning is somewhat unclear. If Dr. Claiborn's use of the word "initiating" was meant to suggest the vaccine was a triggering or precipitating event, the statute would not permit us to find the somatoform disorder as a compensable injury. If, however, he intended to declare the flu shot as the prevailing factor in the somatoform disorder, we have found this opinion unpersuasive.

Regardless of the nuances of the doctor's language, we are unable to conclude from the preponderance of the evidence that the flu vaccination (from which no physical injury or medical condition has been clearly diagnosed) was the prevailing, i.e. the primary factor, in relation to any other factors in causing a somatoform disorder. It is not "reasonably apparent, upon consideration of all the circumstances," that the work event is the prevailing factor in causing any injury – physical or psychological. § 287.020.3 (2) RSMo.

We adopt the reasoning expressed by Administrative Law Judge Robert Miner that:

> Claimant's symptoms after October 1, 2013 were similar to symptoms that she had prior to the shot. She had similar complaints and symptoms before she took the October flu shot. She had prior difficulty walking following her strokes. She had pins and needles feelings in 2012 according to Dr. Kempton's records. She testified that she had fingertip sensitivity in 2012. Dr. Bronson had diagnosed active problems in March 2011, including depression and anxiety.

We conclude the influenza vaccination of October 1, 2013, was not the prevailing factor in causing any subsequent medical condition, whether physical or psychological, or disability suffered by employee.

Because we have found no compensable injury has been proven, we must deny the claim. All other issues are moot.

Decision

We affirm and adopt the award of the ALJ as supplemented herein.

The award and decision of Administrative Law Judge Robert B. Miner, issued September 11, 2017, is attached and incorporated herein to the extent not inconsistent with this supplemental decision.

Given at Jefferson City, State of Missouri, this 18th day of October 2018.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

Robert W. Cornejo, Chairman

Reid K. Forrester, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: Debbie A. Shanks

Injury No.: 13-100429

Employer: Heartland Regional Medical Center

Additional Party: The Treasurer of the State of Missouri as Custodian of the Second Injury Fund

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri

Insurer: Heartland Regional Medical Center, s/c/o Thomas McGee LC

Hearing Date: January 24, 2017

Date Record Closed: June 8, 2017

Checked by: RBM

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No.

2. Was the injury or occupational disease compensable under Chapter 287? No.

3. Was there an accident or incident of occupational disease under the Law? No.

4. Date of accident or onset of occupational disease: Alleged: October 1, 2013.

5. State location where accident occurred or occupational disease was contracted: Alleged: St. Joseph, Buchanan County, Missouri.

6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.

7. Did employer receive proper notice? Yes.

8. Did accident or occupational disease arise out of and in the course of the employment? No.

9. Was claim for compensation filed within time required by Law? Yes.

10. Was employer insured by above insurer? Yes.

11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee alleges she was injured from taking a flu shot at work on October 1, 2013.

12. Did accident or occupational disease cause death? No.

13. Part(s) of body injured by accident or occupational disease: Alleged: Body as a whole including psychological injury.

14. Nature and extent of any permanent disability: Not determined.

15. Compensation paid to-date for temporary disability: None.

16. Value necessary medical aid paid to date by employer/insurer? None.

17. Value necessary medical aid not furnished by employer/insurer? Not determined.

18. Employee's average weekly wages: $526.35.

19. Weekly compensation rate: $350.92 for temporary total disability, permanent total disability, and permanent partial disability.

20. Method wages computation: By agreement of the parties.

COMPENSATION PAYABLE

21. Amount of compensation payable: None. Employee's claim against Employer and Insurer is denied.

22. Second Injury Fund liability: None. Employee's claim against the Second Injury Fund is denied.

23. Future requirements awarded: None.

Employee's claim is denied in its entirety. Employee's attorney is not allowed any attorney fee.

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Debbie A. Shanks

Injury No.: 13-100429

Employer: Heartland Regional Medical Center

Additional Party: The Treasurer of the State of Missouri as Custodian of the Second Injury Fund

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri

Insurer: Heartland Regional Medical Center, s/c/o Thomas McGee LC

Hearing Date: January 24, 2017

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Checked by: RBM

PRELIMINARIES

A non-section 287.203, RSMo hardship hearing was held in this case on Employee's claim against Employer on January 24, 2017 in St. Joseph, Missouri. Employee, Debbie A. Shanks, appeared in person and by her attorney, Daniel L. Smith. Self-insured Employer, Heartland Regional Medical Center, s/c/o Thomas McGee LC, appeared by their attorney, Mark Hoffmeister. The Second Injury Fund is a party to this case but was not represented at the hearing since the parties agreed to bifurcate the Second Injury Fund claim. Daniel L. Smith requested an attorney's fee of 25% from all amounts awarded.

STIPULATIONS

At the time of the hearing, the parties stipulated to the following:

1. On or about October 1, 2013, Debbie A. Shanks ("Claimant") was an employee of Heartland Regional Medical Center ("Employer") and was working under the provisions of the Missouri Workers' Compensation Law.

2. On or about October 1, 2013, Employer was an employer operating under the provisions of the Missouri Workers' Compensation Law, was duly self-insured under the provisions of said Law, and its self-insurance administrator was Thomas McGee LC.

3. Claimant's Claim for Compensation was filed within the time allowed by law.

4. The average weekly wage was $526.35, the rate of compensation for temporary total disability is $350.92 per week, the rate of compensation for permanent partial disability is $350.92 per week, and the rate of compensation for permanent total disability is $350.92 per week.

5. No compensation has been paid by Employer for temporary disability.

6. No medical aid has been paid or furnished by Employer.

7. Issues of Employer's liability for permanent partial disability and permanent total disability benefits were not submitted for determination at the January 24, 2017 hearing.

ISSUES

The parties agreed that there are disputes on the following issues:

1. Did Claimant sustain an injury by accident on or about October 1, 2013 arising out of and in the course of her employment for Employer?

2. Did Claimant give notice of her alleged injury to Employer as required by law?

3. What is Employer's liability, if any, for additional medical aid, including psychological counseling and medications?

4. What is Employer's liability, if any, for past and future temporary total disability benefits?

Claimant testified in person. In addition, Claimant offered the following exhibits. The exhibits were admitted in evidence without objection unless otherwise noted:

A—Notes made by Employee (Admitted over objection).
B—Employee's FMLA application and medical certification.
C—Letter from Human Resources Assistant at Heartland Health/Mosaic Life Care, January 28, 2014.
D—Comprehensive Family Care Center, Ronald Kempton MD, medical records, October 2, 2013 and October 9, 2013.
E—Specialist of Internal Medicine, medical records, October 17, 2013, October 25, 2013, January 3, 2014.
F—Heartland Neurology and Mosaic Life Care, David Ewing, MD, medical records, October 23, 2013 through July 17, 2014.

G—Heartland Arthritis and Osteoporosis Center, Wendell Bronson, DO, medical record from October 29, 2013.

H—Bridges Cytology, medical record from December 3, 2013.

I—Heartland Health Counseling, Louis T. Bein, psychologist, medical record from June 10, 2014, also identified as Claiborn deposition Exhibit 4.

J—University of Kansas Medical Center, Dr. Vernetta Hairston, medical records, December 27, 2013 and January 2, 2014.

K—St. Joseph Social Welfare Clinic, Dr. Robert Stuber, medical records, May 9, 2014 **March 13, 2014** to July 10, 2015.

L—Oliver G. Orth, MD, Curriculum Vitae and medical report of December 20, 2015, also identified as Claiborn Deposition Ex. 5.

M—Vaccine Adverse Event Reporting System (VAERS) report (Admitted over objection).

N—Brent Koprivica, MD, medical report of January 18, 2016.

O—Transcript of deposition testimony of Dr. Daniel Claiborn of January 12, 2017 (Exhibit O was admitted subject to any objections contained in the deposition).

P—Claiborn deposition Exhibit 1, Curriculum Vitae of Dr. Daniel Claiborn.

Q—Claiborn deposition Exhibit 2, witness' medical report, April 16, 2016.

R—Claiborn deposition Exhibit 3, witness' supplement to medical report, June 15, 2016.

S—Comprehensive Family Care Center, Ronald Kempton MD, medical records, June 25, 2012.

T—Heartland Arthritis Treatment Center, Wendell D. Bronson, DO, medical records, August 1, 1995, March 31, 2011.

U—St. Luke's Plaza Rehab Medicine and Neurological Consultants, Irene Bettinger, MD, medical records, February 2, 2009 to June 9, 2009.

V—St. Luke's Medical Group, Rebecca Baskins, MD, medical records, October 16, 2009.

W—Robert Seitzer, Ph.D., psychologist, medical record, May 31, 2001.

X—Family Medicine Associates of St. Joseph, Dr. Lill, medical records, 1992-1994.

Employer offered the following exhibits at the hearing that were admitted in evidence without objection:

Exhibit 4—Email from Sarah Duin to Claimant dated January 10, 2014.
Exhibit 5—Claimant's Employee Event Report dated 1/13/14.

During the January 24, 2017 hearing, the attorneys and Court agreed the depositions of Dr. Harold Barkman, Dr. William Logan, and Sarah Duin could be submitted after the hearing. The record in the case was left open to permit the depositions to be submitted to the Court. It was agreed at the hearing that the depositions, with

deposition exhibits, would be admitted in evidence subject to any objections contained in the depositions. It was agreed the deposition of Dr. Harold Barkman would be marked Employer's Exhibit 1, the deposition of Dr. William Logan would be marked Employer's Exhibit 2, and the deposition of Sarah Duin would be marked Employer's Exhibit 3. The depositions of Dr. Harold Barkman, Dr. William Logan, and Sarah Duin, with deposition exhibits, were received by the Court on March 15, 2017.

The deposition of Dr. Harold Barkman has been marked Employer's Exhibit 1, the deposition of Dr. William Logan has been marked Employer's Exhibit 2, and the deposition of Sarah Duin has been marked Employer's Exhibit 3. Employer's Exhibits 1, 2, and 3, with deposition exhibits, are admitted in evidence subject to any objections contained in the depositions.

The record in this case was reopened on June 8, 2017 to permit the attachment of six additional pages from the Social Welfare Board for dates 5/9/2014, 4/25/2014, and 3/13/2014 to Claimant's Exhibit K, pursuant to email from the Court to the attorneys dated June 8, 2017, stating:

> Thank you for your emails. Dan has agreed to add these additional pages to Claimant's Exhibit K and Mark has advised he has no objection to these additional pages being added to Claimant's Exhibit K. I am therefore reopening the record in this case today to admit these additional pages of records in evidence. I will attach these pages to the end of Claimant's Exhibit K.

Any objections not expressly ruled on during the hearing or in this award are now overruled. To the extent there are marks or highlights contained in the exhibits, those markings were made prior to being made part of this record, and were not placed thereon by the Administrative Law Judge.

The Post-Hearing Briefs have been considered.

Findings of Fact

General Background

Claimant began working for Employer on August 17, 2004 as a cardiac tech monitor. She worked as a cardiac tech monitor for Employer for nine years until December 16, 2013.

Claimant monitored patients' heart rhythms. Her job was primarily a sit-down job. She checked changes in heart rates and analyzed rhythms and heart rates. She watched

different screens of thirty to forty patients at a time, and if there was an issue, there were alarms. There were sometimes false alarms. Claimant had to be alert when she was on duty. She communicated with nurses and doctors. She needed to be able to run to check with a nurse if necessary. She had the same duties throughout her employment with Employer.

Claimant testified she loved her job with Employer. She said it was the best job she had. She understood her job. She got along well with her co-workers. They were like family. One co-worker, Dana Thompson, a cousin of Claimant, was a friend of Claimant. Claimant received positive feedback from her supervisor.

Claimant's work began at 7:00 o'clock a.m. She worked twelve-and-one-half hours on her shift. She was usually at work by 6:30 a.m. She parked in Employer's parking garage. It took about five minutes to get to her work station from her parking space. Her shift usually ended between 6:30 p.m. and 7:00 p.m. She ate lunch at her desk. She was normally scheduled to work three shifts per week. She sometimes took extra shifts for overtime.

Claimant testified that on October 1, 2013, she was not feeling sad or depressed. She was doing "great." She had a good job and a new boyfriend. She went out with friends and some co-workers to each other's houses. She went to Worlds of Fun and went to a bar for music. She enjoyed social activities outside of work. She and her cousin spent time together. She bowled. She has not bowled since October 2013.

October 1, 2013 flu shot

It was customary for staff at Employer to have flu shots in late September. Claimant had flu shots around October 1 before October 1, 2013.

Claimant worked for Employer on October 1, 2013. On October 1, 2013, about 11:00 o'clock a.m., at Employer's direction, Claimant was given a flu shot that was provided by Employer in Employer's cafeteria. She was going to lunch at that time. Dana Thompson was with Claimant at the time and Ms. Thompson had a flu shot then too.

Claimant was anxious on October 1, 2013 because she did not want to take the flu shot. However, she knew that she had to take it. Claimant testified she thought the flu shot on October 1, 2013 was mandatory and was a condition of her employment.

Claimant did not have any difficulty at the time she had her flu shot. She did not have an immediate reaction on the date of the shot. She performed all tasks at work on October 1, 2013 after she received the shot. She finished her work shift, and left work at

7:00 p.m. on October 1, 2013. She was scheduled to work a 12-hour shift on October 2, 2013.

Claimant went to bed on October 1, 2013 at 9:00 o'clock p.m. She had slept the night before. She felt exhausted when she woke up on October 2. She got up at 5:15 a.m. and felt like she was getting sick.

Claimant went to work on October 2, 2013. Later that day, the phone rang while she was at work. When she picked up the phone with her left hand, the phone felt like a brick. She testified she had never felt that before then. She had not had difficulty lifting with her left arm while at work before October 1, 2013.

Claimant's legs felt like jelly noodles when she attempted to stand later in the day on October 2. She testified she did not feel like that on October 1, 2013 before she had the flu shot or during the year before October 1, 2013. She did not have hives or swelling, difficulty breathing, or itching within 24-hours of receiving the shot.

Claimant had some difficulty reading strips on October 2, 2013. She had never had trouble doing that before October 1, 2013.

Claimant was alarmed at the way she felt on October 2, 2013. She told her co-workers that something was wrong. She tried to call her supervisor on October 2, 2013. She told her co-workers she had complaints. They said they would let the supervisor know.

Claimant called her primary doctor, Dr. Kempton, for an appointment. She left work on October 2, 2013 at 12:30 p.m. for a 1:00 p.m. appointment that day with Dr. Kempton. She did not return to work on October 2, 2013.

When Claimant left work on October 2, 2013, she was able to walk one-half of the way to her car before she had to sit down. She did not have trouble driving to the doctor's office. It was a short walk into the doctor's office. She told Dr. Kempton her arms and legs felt very weak. Dr. Kempton asked her if she had had a vaccination. She told him she had had a flu shot. Dr. Kempton gave her a steroid shot and steroid pills. Blood work was done.

Claimant went home after 2:00 p.m. after she left the doctor's office, laid down, and went to sleep. She felt "really weak" when she awakened later. She did not return to work later that week. She told her supervisor she had problems with weakness since she had a flu shot on October 1. She testified she told her supervisor the vaccination was the problem. Claimant gave away all of her scheduled shifts.

Claimant started having tremors in her hands, muscle spasms, dizziness, and weakness during the week after October 1, 2013. She had difficulty walking. She felt like her legs would collapse and felt like she had balance problems.

Claimant testified she never felt rested that week. She slept most of the time. She got really depressed. Her symptoms did not go away. She knew she would not be able to do her job.

Claimant returned to Dr. Kempton on October 9, 2013. She felt Dr. Kempton took her seriously. She had confidence at that time that Dr. Kempton would get to the bottom of things. Claimant believes she had problems from the shot either on October 2, 2013 or on October 9, 2013 when she talked to Dr. Kempton.

Claimant testified on redirect that she suspected the flu shot may have been involved within the first day.

Claimant testified Dr. Kempton never said anything to her in October 2013 about her symptoms having anything to do with her fingertips.

Claimant testified she had ongoing dialog with her supervisor during October 2013 that she thought the flu shot may have caused symptoms. Claimant testified Dr. Thornton told her she had an adverse reaction to the flu shot. She testified she communicated that to her supervisor in October 2013.

Claimant did not work between October 2, 2013 and October 17, 2013. She filled out FMLA paperwork on October 10, 2013. Dr. Kempton had taken her off work.

Claimant's confidence in Dr. Kempton changed when she went to Dr. Thornton, a doctor on Employer's campus, on October 17, 2013.

Claimant identified Exhibit B, her FMLA application. It includes Dr. Thornton's Leave of Absence from Work form dated October 25, 2013. Claimant understands that FMLA is not Workers' Compensation.

Exhibit B was returned to Employer's leave coordinator either by Claimant or the doctor. Claimant's FMLA leave was approved. On the next to last page of Exhibit B, Claimant requested "wc" which is a wheelchair.

Dr. Thornton referred Claimant to Dr. Ewing, a neurologist, in October 2013. Claimant had tests from October through December 2013. Dr. Thornton also referred

Claimant to Dr. Hairston at KU. She saw Dr. Hairston in late December 2013 or early January 2014.

Claimant continued to have the same symptoms in December and January, but she also had new symptoms. She had balance issues and her walking was getting worse.

Claimant's mother had problems walking. Dr. Ewing asked Claimant to bring in her mother, but Claimant did not do that. Claimant testified Dr. Ewing told her that her mother's problem walking was not the same as her problem.

Claimant continued on FMLA until December 2013. She could not return to work in December 2013. She was using a walker or a wheelchair and she was having tremors and shaking in her hands. She was last employed by Employer on December 16, 2013. She was on leave from October 9, 2013 until December 16, 2013. She voluntarily resigned from Employer in December 2013.

Claimant lost her health insurance in January 2014. Claimant treated at the Social Welfare Board with Dr. Stuber when she did not have health insurance. Dr. Stuber prescribed medication for her. He diagnosed fibromyalgia.[1] She did not have health insurance until April, 2016 when she obtained health insurance with Medicare and Medicaid with a spend-down.

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[1] "Fibromyalgia" is defined in Stedman's Medical Dictionary (28th Edition):

> Fibromyalgia. A common syndrome of chronic wide-spread soft-tissue pain accompanied by weakness, fatigue, and sleep disturbances; the cause is unknown. CF. fibrosiitis. SYN fibromyalgia syndrome.
>
> Fibromyalgia is a disorder of unknown cause characterized by chronic widespread aching and stiffness, involving particularly the neck, shoulders, back, and hips which is aggravated by the use of the affected muscles. The American College of Rheumatology has established diagnostic criteria that include pain on both sides of the body, both above and below the waist, as well as in axial distribution (cervical, thoracic, lumbar spine, or anterior chest). Additionally, point tenderness must be found in at least 11 of 18 specified sites. Tender points are sharply localized and often bilaterally symmetric. Some points may correspond to sites of pain and others may be painless until palpated. Usually associated fatigue, a sense of weakness or inability to perform certain movements, paresthesia, difficulty sleeping, and headaches are found.

Claimant spoke with a person in Employer's Employee Health department in January 2014. She testified she discussed her FMLA with Employer's Employee Health Department. She told the person in Employee Health about weakness, not being able to concentrate, and her brain feeling foggy. She is not sure if she told the person in Employee Health that she had a flu shot when she was talking about FMLA.

Claimant testified about Exhibit A, a note she had made. Claimant contacted Employer's Employee Health in January 2014 regarding the ID number of the flu vaccine she received. She told Employee Health she was concerned her problems were related to her shot. The person in Employee Health provided the lot ID number for the vaccination to Claimant.

Claimant was not sure of the date on Exhibit A. She wrote Exhibit A when she got the lot number of the vaccination. Employee Health, probably Theresa Jones, gave her the insert that Claimant had requested that came with the flu shot. Claimant received the number before she saw her attorney, Dan Smith. Her Workers' Compensation claim was filed after she received the lot number for the vaccination.

Claimant acknowledged she received Exhibit 4, an email to her from Sarah Duin dated January 10, 2014. She did not recall receiving it. The email asked Claimant to complete the report and return it to Employers' Employee Health office.

Claimant acknowledged that Exhibit 5, Employee Events Report dated January 13, 2014, contains her signature. It is her writing and makes a claim for her flu shot.

Prior flu shots

Claimant testified that the last few times she took the flu shot before 2013, she did not have a serious problem. She took the shots to keep her job.

Claimant remembered taking the flu shot twice before 2013. She recalled on two occasions when she took the shot that she felt like she had been beaten up.

Claimant testified she believed she had a flu shot in 2012. She felt like she had been beaten up after that shot. It was hard for her to move. She had that feeling later that night and the next day. The feeling passed in five to seven days. She continued working in 2012. The 2012 shot did not prevent her from working in 2012.

Claimant testified she would not dispute a record showing that she took the shot every year for nine years while she worked for Employer.

Prior health conditions

Claimant saw Dr. Bronson in 1994 and 1995. Dr. Bronson diagnosed Claimant with fibromyalgia. She has had mild fibromyalgia for years. She had some fibromyalgia symptoms before the October 2013 flu shot, but they were not as severe then.

Claimant had strokes in 2000 that affected her left side.

Claimant had a knee problem before 2013. She dragged her leg for a time because she was paralyzed from strokes. Claimant testified she did not have any unusual walking prior to October 1, 2013, except when she had strokes before 2004. Claimant testified she did not have problems walking when she worked for Employer.

Claimant received treatment in the past for feeling anxious. She had taken Paxil before October 1, 2013 for depression. She had counseling in the past regarding a prior boyfriend. She may have had counseling before October 2013, but she did not recall.

Claimant has had past back and neck issues with two prior motor vehicle accidents. One accident was in 2011. She received a small settlement. She has had prior treatment with a chiropractor for back problems.

Claimant had fingertip sensitivity before she received the October 2013 flu shot. Her fingertips hurt when she touched papers in 2012. She used fingertip rubber devices. Dr. Kempton treated her fingertip sensitivity in 2012. Claimant testified the condition went away entirely and when she saw him the next time in December 2012, the fingertip sensitivity was gone.

Claimant started taking Paxil in her early twenties. She took the same dose except when she had her strokes. The doses were upped, but were lowered later. Claimant testified she had not missed work for depression except when she had issues with her daughter and when Claimant took FMLA time. She had anxiety and depression when she had issues with her daughter.

Prior FMLA

Claimant requested Family Medical Leave Act twice in the nine years she worked for Employer. The first time was in 2006 when she had a hysterectomy. She was off work for six weeks. The second time was in 2012 when she was off work for six weeks mostly for her daughter. She was not off work other times, except for rarely calling in sick for a day at a time.

Current condition

Claimant testified she got up about 9:30 a.m. on January 23, 2017. She walked to the door and let her dogs out. She did not use a walker. She was stiff. She went to the bathroom after letting out her dog. She then walked to her living room. Her son gave her coffee and she sat in a recliner and drank it. She took ibuprofen. She got dressed at 9:55 a.m. She finished her coffee and then slept from about 10:45 a.m. until 11:50 a.m. when she got up to go to the doctor. She described her house as "tiny".

Claimant testified that she sometimes gets up at night and walks. She feels unsteady on her feet at times for ten or fifteen minutes. Heat and humidity make her feel weaker. People have told Claimant that she walks funny, and she can feel that she does. She testified she continues to feel like her legs will collapse and that she had balance problems. She uses a cane at times. She has used a walker since October 2013 to go outside of the house for longer walks and as needed to stand. She does not use assisted devices to walk unless she is very weak.

Claimant testified her ability to concentrate has changed. She naps one or two times a day. She sometimes naps for two and one half or three hours in addition to sleeping eight hours at night.

Claimant does not do most activities. She does not take vacations, ride four-wheelers, do photography, or go to theme parks.

Claimant testified fibromyalgia was not causing gait problems before October 1, 2013. Claimant testified her fibromyalgia worsened after the flu shot. She testified her pain and weakness on both sides is worse now.

Claimant's mother has fibromyalgia. Her mother bought a walker one year before October 2013. Claimant did not use a walker every day before the October 2013 flu shot.

Claimant received Social Security Disability in March 2015. She saw Dr. Bein for Social Security. She did not see Dr. Orth.

Claimant has not been employed anywhere since October 9, 2013.

Claimant testified that she could not work as a monitor. She has trouble concentrating. She has weakness and tremors. Her head is in a fog. She could not sit at a monitor for four hours. She has a lot of pain. Dr. Thornton provided her with restrictions in January 2014 that prevented her from going back to work.

Claimant received a GED, and then received a computer tech degree from Vatterott College. She had worked in the mortgage business as a mortgage processor before she worked for Employer. She did not think she could do that work because of problems with attention to detail. She had also worked as a computer tech before she worked for Employer. She has not tried to find work in those areas.

Claimant saw Dr. Koprivica in January 2016. She saw a psychologist in June 2016.

Claimant saw Dr. Logan on September 13, 2016. They talked and she took tests. Claimant saw a doctor at KU, Dr. Barkman, in October 2016. She was with him for thirty to sixty minutes. She answered questions and he performed a short physical examination.

Claimant testified on cross-examination that she had three prior marriages and three dissolutions of marriage. Her second husband was verbally abusive. Claimant had been on Paxil since age 21 or 22 when she was getting her first dissolution of marriage.

Claimant still has ongoing weakness in her left arm since her strokes. That weakness never went away. Her sense of tiredness has improved.

Claimant testified she did not remember discussing with Dr. Hairston that he could not coordinate the gait problems with the flu vaccination.

Claimant was suspended once because a friend clocked her out after she had worked several days in a row and was tired. She tried to go out to bowl, but she did not bowl. She only got her shoes. She was never suspended for an entire week.

Claimant testified her Paxil helps with depression and anxiety. She stated she recently came off Paxil. She stated she had quit smoking and soda pop. She drank a lot of soda pop before the October 2013 flu shot.

Claimant has not been receiving any unemployment benefits. She receives Social Security in the amount of $1,025.00 per month. She received it back to January 2014.

Claimant is seeing doctors. She saw a psychiatrist for the second time on January 23, 2017. He is referring her for cognitive behavioral therapy. She is willing to see a psychologist. She is asking for a psychiatric referral for psychological treatment.

Exhibit C sets out the dates of employment with Employer.

Claimant was 45-years-old at the time of the hearing.

Claimant did not appear to be in pain during the hearing. The hearing commenced at approximately 1:30 p.m. She first stood at approximately 3:36 p.m. and stood during the recess from 3:36 p.m. until 3:49 p.m.

I find Claimant's testimony to be credible unless otherwise discussed in this Award.

Testimony of Sara Duin

The Deposition of Sarah Duin taken on February 13, 2017 was admitted as Employer Exhibit 3. Sarah Duin is a registered nurse in Employer's Employee Health department. She manages Employer's workers' compensation claims. (Duin deposition, page 5). Ms. Duin has had that position with Employer for eight years. She is familiar with the orientation process for new Employees. In that process, employees are advised to report an accident or injury to their team leader as well as to Employer's Employee Health Department. Once her department is notified, they follow up with the employee and have the employee fill out an Event Report if they have not already done so. (*Id.* at 7).

Ms. Duin testified that Claimant first notified her or reported to her an accident or injury on January 10, 2014. (*Id.* at 8). They spoke by telephone and Ms. Duin took a note and typed it up. Deposition Exhibit Number 6 is the note she typed up regarding her conversation with Claimant on January 10, 2014. Ms. Duin corrected the date 2013 from 2014 in two places on Exhibit 6 shortly after making the statement. (*Id.* at 9).

On January 10, 2014, Claimant told Ms. Duin she had received a flu shot on October 1, 2013. (*Id.* at 9). Claimant asked Ms. Duin about information related to the flu vaccination she had received. Claimant asked about the Lot Number, the vaccine, and the manufacturer. Ms. Duin provided that information to Claimant.

Ms. Duin asked Claimant to fill out an Event form. Deposition Exhibit 7 is an email from Ms. Duin requesting Claimant fill out the form. Ms. Duin attached the form to the email. Claimant filled out the form for Ms. Duin. The form has been marked Duin Deposition Number 8, and it is the same as Exhibit 5 from the hearing. (*Id.* at 12).

Ms. Duin was asked the following questions and gave the following answers at Duin deposition, page 12:

> Q. And did she describe what her injury or her claim was for?
>
> A. After receiving a flu shot, she had expressed a weakness in arms, legs, difficulty walking, loss of balance, pins and needles, numbness

in hands and feet, burning in feet, tremors, trouble with memory and concentration, headaches.

Q. And is this the first information coupled with the phone call she made to you on January 10th of reporting to you an accident or injury?

A. Yes.

Ms. Duin reported the information to Employer's Workers' Compensation insurer. (*Id.* at 13).

Ms. Duin's office ran a check on the specific flu vaccine provided to Claimant to see if it had been recalled. Duin Deposition Exhibit 9 is a copy of the report that was generated on her search. (*Id.* at 13). Ms. Duin testified the flu vaccine was not included on that list of recalls. She testified there was no information that indicated from her search that showed that the specific flu vaccine provided to Claimant had been recalled for any reason. (*Id.* at 14).

Ms. Duin identified Duin Deposition Exhibit 10, which is a list of individuals by number showing persons in the hospital that were provided the same flu vaccine as Claimant. More than 3,000 employees received the same vaccine as Claimant. None of those employees reported any kind of complaints or adverse reactions to the flu vaccine to Ms. Duin or her office other than Claimant. (*Id.* at 15).

Ms. Duin identified Duin Deposition Exhibit 11, which are Employee health records of documentation of vaccinations, TB, flu shots, and lab draws. Exhibit 11 reflects the history of flu vaccinations that Claimant received. (*Id.* at 15-16). Claimant received flu vaccinations in 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013. (*Id.* at 16). Claimant never reported to Ms. Duin any adverse reaction to any of the vaccinations she received other than the last one. Claimant never requested not to take the flu vaccine to Ms. Duin's office to her knowledge. The flu vaccination first became mandatory at Employer in 2012. (*Id.* at 16).

When the vaccine is given to individuals at Employer, it is not a live virus. (*Id.* at 17).

Ms. Duin testified that during her time the flu vaccination was provided to individuals from the hospital, she was not aware of any other claims of adverse reaction to the vaccination beyond redness or something associated with the shot. (*Id.* at 17).

Ms. Duin found out that Claimant had filed for FMLA after Claimant made a claim of injury to her. (*Id.* at 17-18). FMLA benefits are not run by Ms. Duin. They are

taken care of by Theresa Jones, a leave management coordinator. Ms. Jones never came to Ms. Duin about any indication from Claimant that she had received a vaccination and that she had an adverse reaction and was making a claim. (*Id.* at 19).

Ms. Duin is aware Claimant had FMLA leave that was submitted in October 2013, as noted in Exhibit B. (*Id.* at 21).

Ms. Duin did not make a check of the CDC of adverse reactions to vaccines for this particular lot. (*Id.* at 21).

Ms. Duin is aware that the VAERS program is the Vaccine Adverse Event Reporting System. She is aware it is part of a system for compensation of people because they have had an adverse reaction to a vaccination. (*Id.* at 22). She understood that people can have reactions to vaccinations. (*Id.* at 23). She never spoke with Ms. Jones about this situation.

The AVERS reporting is a self-reporting type system. (*Id.* at 25).

I find Sara Duin's testimony to be credible.

Medical Treatment Records Prior to October 1, 2013

Exhibit X contains records of Family Medicine Associates of St. Joseph, Dr. Lill. A record dated October 13, 1982 notes Claimant came in for a re-check on weight loss, fatigue, and irritability. Claimant complained that she "just feels anxious all the time." She was assessed with fatigue, irritability, anxiety, and suspicious nevus. She was put on Vistaril for the anxiety.

Dr. Lill's record dated February 15, 1994 notes Claimant came that day to discuss her anxiety. Claimant reported the Vistaril made her too drowsy. The record states in part: "She also relates now that she is feeling like she is quite depressed on top of that and she is getting worsening of these panic attacks when she doesn't take the Vistaril. But she feels like the Vistaril she can't work with." Claimant was assessed with panic attacks with intermittent depression. BuSpar was prescribed.

A May 20, 1994 note of Dr. Lill states Claimant came in that day and related that the BuSpar was not helping. She was having more anxiety and mood swings. Dr. Lill assessed mood swings, intermittent anxiety attacks, and depression. The record notes in part: "The patient needs to be seen with counseling at this time and I refer her to Family Guidance. I will switch her from BuSpar to Zoloft 100mg daily."

A June 29, 1994 record of Dr. Lill notes Claimant came in that day "complaining about neck feeling like it is swelling, feeling like it is giving her problems breathing, makes her feel almost panicked, generalized aches and pains, fever and chilling." Dr. Lill assessed pharyngitis with generalized myalgia. Dr. Lill put Claimant on Keflex and Anaprox.

Exhibit T contains records of Dr. Wendell Bronson, D.O. Dr. Bronson evaluated Claimant on August 1, 1995 for evaluation of low back pain. Dr. Bronson's note states in part: "To add drama she says that if she's on her feet more than about 15 minutes she starts to feel sleepy, then her back starts hurting, then her ears start ringing, and then she starts to see back and she will pass out unless she sits down and sometimes puts her head between her legs and then she does fine." The note also states in part: "On modified AIMs inventory she scores 9.57 for anxiety and 8.25 from depression, extremely high scores. Fatigue is a major problem. Her stomach bothers her. She is very dissatisfied with the current level of health."

Dr. Bronson's Impressions on August 1, 1995 were:

1. Myofascial back pain.
2. History of anxiety disorder and depression.
3. Probably some issues of personality.
4. Planning to have a baby.
5. Family history of Fibromyalgia and depression.

Exhibit U contains records of Dr. Irene Bettinger, M.D. relating to treatment of Claimant in 2009. Dr. Bettinger's June 2, 2009 Physicians Response Note states in part: "I reviewed my 2000 hospital notes. I suspect she can come off Warfarin/Coumadin. BUT I also think she needs to have repeat cerebral angiography to see what the arteries in the neck and brain look like at this time."

Dr. Bettinger wrote a letter dated December 12, 2009 to Dr. Rebecca Baskins stating in part that she had seen Claimant in a neurological consultation on February 12, 2009. Claimant had been seen by Dr. Bettinger about nine years before for an acute stroke following several months of TIAs. The question Dr. Bettinger was asked to address was whether Claimant might consider discontinuing her Warfarin. Dr. Bettinger's letter notes in part: "PMH is also pertinent for depression or perhaps some bipolar problems. She has been on Paxil 40mg for years. Just two months ago, she was starting on Divalproex 750 mg daily."

Exhibit T includes Dr. Bronson's Office/Clinic Note-Physician dated March 31, 2011. The chief complaint was that Claimant she has sensitive finger tips. The record states in part:

> She says I saw her 15 or more years ago and diagnosed her with Fibromyalgia. She has had some things going on. What brings her back to me now is sensitivity in her fingertips. She says when they get to burning, then it makes her grind her teeth and her teeth hurt. She also has some trouble in her low back that goes into her hips. She says eight or nine years ago she had a spell of finger sensitivity and then she put some rubber tips on her fingertips and they felt better.

Dr. Bronson noted on March 31, 2011 that it had bothered Claimant for the last four to five months and that it gets worse as the day it goes on. Claimant described pain that feels like she has been beaten by a baseball bat but has not really affected the fingertip sensation. Dr. Bronson noted current medications included Lyrica.[2] Active problems included depression and anxiety.

Dr. Bronson's March 31, 2011 note states in part:

> **Impression**
> 1. Paresthesias of the fingers.
> 2. 20 year history of myofascial back pain.
> 3. Fibromyalgia (729.1)
>
> **Complicating factors**
> 1. Apparently issues of anxiety and depression. She takes Paxil 40 mg a day.
> 2. Peripheral edema that could be related to sedentary lifestyle and her weight.
> 3. She relates a history of "three major strokes" at age 29 with extensive evaluation, mostly in KC.
> 4. In my 1995 evaluation I commented on some personality issues and obviously symptom reporting styles today.
> 5. I did not see signs of an inflammatory rheumatic syndrome in 1995 and don't see it now.

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[2] The Prescribers' Digital Reference (PDR) describes Lyrica as follows: "Anticonvulsant that is chemically and structurally similar to gabapentin. Approved for neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia, or spinal cord injury; also approved for the treatment of fibromyalgia and as adjunct treatment of partial seizures. Controlled substance; close monitoring for emerging or worsening suicidal thoughts/behavior or depression is recommended." (*http://www.pdr.net/drug-summary/Lyrica-pregabalin-467.8329.)*

Claimant reported to Dr. Bronson that she had a sleep study. He noted that sounded "real appropriate."

Exhibit V contains records of Dr. Rebecca Baskins. Dr. Baskins's July 31, 2011 note states Claimant reported she does not feel well. The Progress Note History of Present Illness states in part, "Everything hurts by her report. Hurts so bad she cannot get out of bed at times. All muscles and joints is her perception. Has been going on for years duration, but worse recently." The Progress Note records: "Fatigue. Poor sleep. Known OSA which is severe. Some depression symptoms. Has a history of carotid stenosis, and is due for labs to check her cholesterol. Will do CK with myalgias, but sounds more like fibromyalgia. Timing does not correlate with statin use. Prior history of stroke."

Active Problems were noted to include anxiety (Symptom), bipolar disorder, depression, drowsiness, fatigue, fibromyalgia, and myalgia and myositis. The results of the physical exam were noted to be normal except "Mood and affect: flat affect. Abnormal."

Dr. Baskins' assessment on July 31, 2011 was Myalgia and Myositis, bipolar disorder, dyslipidemia, carotid artery stenosis, occlusion of distal right internal carotid artery, hematology – ESR elevated, fibromyalgia, vitamin D deficiency, vitamin B-12 deficiency, fatigue and drowsiness. Lyrica was prescribed for fibromyalgia.

Exhibit S is an Office/Clinic Note-Physician of Dr. Ronald Kempton dated June 25, 2012. Claimant's Chief Complaint states: "Patient hands get sensitive where she can't touch anything. Patient has also been swelling. Patient mid to lower back hurts when she puts heat on those places. Her hands are better. Patient also has a sore throat, started three days ago." Problems and Past Medical History are noted to include depression with anxiety, history of cerebral vascular accident, low back pain, and upper back pain. Family History includes fibromyalgia medical history, mother. Current medications include Ativan (lorazepam), Lyrica, and Paxil. Dr. Kempton's Impression was sore throat, palpitations, neuropathy, congenital, sensory, low back pain, edema, and shortness of air.

Dr. Kempton's June 25, 2012 record notes Claimant has had increased swelling recently and increased myalgias, arthralgias. The record notes she has had a history of the same and a normal ANA, sedimentation rheumatoid factor. Her current medications include Lyrica and Paxil. Dr. Kempton's Impression was sore throat, palpitations, neuropathy, genital, sensory, low back pain, edema and shortness of air, but he was going to treat for strep, check labs, and get an X-ray and EKG, and follow-up after they get results.

Medical Treatment Records after October 1, 2013

The Office/Clinic Note – Physician of Dr. Ronald S. Kempton, M.D. dated 10/2/2013, Claimant's Exhibit D, states in part

Chief Complaint
Patient is having back pain that feels like pins needles and numbness.

History of Present Illness
This is a 42-year-old white female who comes in with some very diffuse nonspecific symptoms. He [*sic*] is having headaches, some visual changes in the form of blurred vision. She is also having diffuse myalgias and arthralgias, but she also notes that her biggest problem is here [*sic*] fatigue and her weakness, especially in lower extremities. She has a lot of weakness to the point that she has trouble during her job. She says her symptoms are moderate in severity, about 6/10 in severity scale and she is having neck pain at 6/10, nonradiating and moderate in severity, worse with activity, better with rest. She notes that her mother reports that she had the same set of symptoms that started when she was in her early 40s, about the same age, although they have both been told they have fibromyalgia. It seems to be more progress in nature.

Pain Assessment
Cognitive Status: Independent, decision consistent/reasonable.
Intensity: 6
Location: Neck
Scale Type: 0-10 Pain scale
Radiation Location: Upper back, Lower back.

Review of Systems
She denies any chest pain, palpitations, nausea, vomiting or diaphoresis.

. . . . . .

Vital signs are stable. Afebrile, HEENT: Cranial nerves 2-12 are intact. Neck is supple and there is some decreased range of motion secondary to pain. Heart regular rate and rhythm. Lungs clear. Abdomen benign. Extremities have no clubbing, cyanosis, edema, but she does have some questionable weakness in both of her lower extremities.

Impression
1. Leg weakness, bilateral (720.89}
2. Myalgia (729.1)
3. Fatigue (780.79)
4. Arthralgia (719.40)
5. Metabolic Syndrome x (277.77)

. . . . . .

My biggest concern is that she may have polymyalgia rheumatic, but she has been told in the past that she has some sort of autoimmune disorder. She has had history of metabolic syndrome and is very concerned. So at this point, we will draw lab to check for all of the above. Her Accu-Chek today was normal in 20s an hour after she ate, but she had a low glycemic meal. In the meantime, after we get the lab work drawn, for symptomatic control, we will give her a Medrol Dosepak and Decadron. Depo-Medrol 160 IM now. I plan on seeing her back after we get the results back. Other considerations are we may want to have her see an ophthalmologist and her rheumatologist. However, this certainly could be a neurological problem and we may want to consider getting neurology involved, but first we will get the work up and see how she is doing and see if she will respond to initial treatment.

Exhibit D includes Dr. Kempton's October 11, 2013 Office/Clinic Note. Claimant was there for follow-up. The record notes she was having diffuse myalgias and arthralgias. The record notes her ANA was elevated and her insulin level was very high. She reported pain of 7 in the neck, upper back, mid back, and lower back.

Dr. Kempton's October 11, 2013 Office Clinic Note-Physician states in part:

Impression
1. Metabolic Syndrome X (277.7)
2. Positive ANA (795.79)

Plan
At this point she has an autoimmune disorder. We will send her to rheumatology as per her request and for the metabolic syndrome we will put her on the whole foods diet. Cut out the processed food. Lots of vegetables, meats that are not breaded, preferable grass fed. Report

problems and adjust therapy as necessary and follow up otherwise as needed. We spent greater than 50% of the time discussing diet, nutrition, exercise, and activity. The patient agrees to be compliant. She will report problems.

Risks, benefits of medications and/or treatment options explained. Alternatives and expected outcome discussed. Patient and/or family verbalized understanding. Patient instructed to follow up sooner than directed if new symptoms develop or current symptoms worsen. Otherwise follow up prn.

Dr. Thornton's Office/Clinic Note – Physician dated October 17, 2013, Claimant's Exhibit E, states in part:

History of Present Illness
Debbie is a pleasant 42-year-old female, who presents to my clinic for establish care. She was previously under the care of Dr. Scott Kempton. Dr. Kempton had recently made a presumptive diagnosis of lupus and suggested the patient go on a Paleo diet for treatment. Patient was unsatisfied with that result and so she presented to me a second opinion and for establish care. Patient's symptom complex is quite perturbing. I cannot really pinpoint any one focal diagnosis for the patient.

Essentially the patient states that she feels like she cannot walk; this has been happening over the last 4 days or so. She states that her brain feels cloudy and she is confused. She has weakness in her arms and legs. She is very tired, cloudy, has a headache, has a neck ache, has a back ache, bilaterally arm pain, pins and needles type of sensation in her arms and legs and occasional dizziness. She has had some hand and foot paraesthesias as well. These actually date back quite some time, she has evaluated by Dr. Wendell Bronson for her hand paraesthesias. It is sort of undifferentiated and unidentified at that time.

More recently, patient states that she had had a vision problems [*sic*]. She works as a telemetry technician monitor and states that she has a hard time seeing the tele strips lately. She has also had problems, occasionally forming words that start with S. Also has new onset of right knee pain and this walking abnormality is also new, again 4-5 days. She attributes it to just being profoundly weak. Patient is very anxious and she is worried that something ominous is occurring.

. . . . . .

Neurological: Cranial nerves 2-12 specifically assessed and are within normal limits. No dysdiadochokinesia. Finger to nose testing normal. Strength is 5/5 in upper and lower extremities. Patient does have hyperreflexia noted on the left, when compared with right. Reflexes seem more brisk in the lower extremities, when compared with upper extremities. Gait is considered to be abnormal. Patient has a very methodical, purposeful, wide based gait; appears to squat when she walks. She moves very slowly from one end of the room to the other, definitely atypical for a 42-year-old female. At a couple of different points, I thought she would fall over; she reached out to grab the exam table or the counter top to steady herself.

Data Reviewed
I reviewed her past primary care documentation; went back all the way to the year 2000 and reviewed Dr. Bronson's consultation for her paraesthesias. I reviewed all of the lab work that Dr. Kempton had ordered.

Impression and Plan
1. Weakness (780.79) I am really, actually at a loss for what is going on here. It sure does not sound like lupus. If it is lupus, then it is neural systemic lupus in that, the central nervous system is involved. Laboratory work is not exactly remarkable for lupus; she has ANA (antinuclear antibody positivity). However, it is pretty nonspecific. Her ESR (erythrocyte sedimentation rate) is within normal limits. CRP (C-reactive protein) is within normal limits. Anti DNA and anti-Smith antibodies are within normal limits. I am going to rule out a myopathic process by getting CPK (creatine phosphokinase) and aldolase. I lean more toward a neural process versus autoimmune. We will get an MRI of the brain with and without contrast, looking for multiple sclerosis lesions or encephalopathy. We will also get an MRI of the lumbar spine, because the patient has pain, weakness and abnormal reflexes. I do not know whether this is a neuromuscular disorder or not. She has an upcoming appointment with rheumatology. I advised that she keep that. We will refer her to Dr. David Ewing as well. We will get the records from St. Lukes in regard to Dr. Bettinger and see what she has done in the past. I want to get to the bottom of these strokes and the past too; were they really strokes or something else?

> 2. Confusion (298.9) Again, unknown etiology; is this some sort of encephalitis versus multiple sclerosis versus psychosomatic versus normal variant.
> 3. Depression (311) Conversion disorder is certainly in the differential, that is going to be tough to tease out.
> 4. IBS (Irritable Bowel Syndrome) (564.1) Again would lean more toward conversion type disorder.
> 5. Abnormal Gait. (781.2)
>
> . . . . . .
>
> Return to clinic tomorrow, as I want to make sure this neuromuscular weakness is not progressing. An interesting consideration I have, is that the patient did receive the flu vaccine about a week ago, Guillian-Barre is in the differential diagnosis. However, this is not a classic ascending type of weakness; it sort of happened globally, or maybe even started in hands. All of the AIDPs (acute inflammatory demyelinating polyneuropathy) and Guillian-Barre variance are in the differential. She has got no sign of respiratory compromise, then again it would definitely be atypical in presentation. She was advised to present to the emergency room if her weakness progressed or if it involved her respiration in any fashion.

Exhibit F contains records of Dr. David Ewing and Heartland Neurology. Dr. Ewing's October 23, 2013 note states Claimant's chief complaint was weakness, unsteady gait, and confusion. Dr. Ewing noted Claimant "was apparently diagnosed many years ago with having multiple strokes." The record states in part:

> She is describing significant difficulty with her gait and her balance, and feeling like her arms are very weak. She said that this really seemed to start several weeks ago. She got a flu shot, she said that ever since then she has had a lot of problems with getting around. She says her walking has deteriorated dramatically. She feels like it is about as bad now as it was when she had her strokes. She says she was dragging a leg when she had the strokes, and she feels like she is still dragging her leg. However, she does not feel like it is quite as bad as it was when she had the strokes many years ago.

Dr. Ewing's October 23, 2013 record notes Claimant said her vision was blurring a little bit and she complained about a lot of memory loss that has been worse since she had the flu shot. The record states:

> She says she just cannot remember things that she should know. She is not able to give me specifics. I pointed out to her that she was able to provide extensive history related to her past stroke like activity. She said that those are things she has remembered for a long time, she felt like she should know all that. She said that new things seem to be a big problem for her, she forgets things she is supposed to complete and does not get it done.

Dr. Ewing noted that Claimant's gait "is clearly functional. There is nothing neurologic or pathologic about it. She walks with a very wide based extremely unsteady gait. She exhibits astasia-abasia when she is asked to walk heel to toe and to perform tandem gait. She did not fall, even though she was staggering around the room."

Dr. Ewing's October 23, 2013 Impression states:

> 1. Generalized Weakness (780.79), undetermined etiology. It is possible this is related to the flu shot, but I would expect her with inflammatory neuropathy to have lost reflexes, and her [*sic*] are quite brisk.
> 2. Gait Instability (781.2). Again, this is a very unusual gait. It is quite functional. I suspect fear is playing a larger role in it than anything else. I do not see anything that suggests a central cause.
> 3. Memory Loss (780.903), possibly anxiety. However, the patient is obviously fearful of the possibility of having strokes, so I really think we need to evaluate that and see if there has been any change. She has not had an echocardiogram so I do not know if there is globular dysfunction, although the heart cath makes it sound like she probably had some sort of valve or clot problem.

Dr. Ewing's Plan was MRI of the brain, MRI of the cervical spine, Echocardiogram, and follow up in 3 weeks.

Exhibit E includes Dr. Byron Thornton's October 25, 2013 Office/Clinic Note. Dr. Thornton saw Claimant that day for weakness, gait abnormality, and to review MRI from October 21, 2013. Claimant reported pain intensity of 5 in lower back, hips, ankles, and hands. Medications included Paxil. Dr. Thornton's October 25, 2013 note states in part:

> **Impression and Plan**
> 1. Gait Instability (781.2) As yet, undetermined etiology. MRI looked good, no cause identified. Send her to physical therapy for strengthening.

2. Weakness (780.79) Thankfully, it is localized to just lower extremities and her upper extremities. There is no respiratory compromise. Still yet undetermined etiology. Continue to follow up with Dr. David Ewing. Work with physical therapy. Patient is going to need to be off of work for a significant period of time. She is actually going to make the determination whether she can return to work at all. We will see how physical therapy progresses and how the testing turns out.

Dr. Bronson's October 29, 2013 Office/Clinic note contained in Exhibit G states in part:

Debbie is a 42-year-old lady I have not seen for two and a half years. She has a history of fibromyalgia. Certainly, earlier this month she had a spell where she felt a lot worse. She was having more trouble walking. She was terribly fatigued. She wants to go to sleep all of the time. She switched physicians from Dr. Kempton to Dr. Byron Thornton recently. As far as an evaluation, she was found to have a positive ANA and a titer of 1:12890 in a homogeneous pattern with a negative profile, negative rheumatoid factor, normal CBC, unremarkable set rate of 21, unremarkable chemistry profile, normal hemoglobin A1c, normal aldolase. The question would be if her trouble walking and fatigue are related to this ANA or is there any sign of a connective tissue disease.

As part of the evaluation of this abnormal gait, she has had MRIs of the neck and the lumbar spine and the brain. She does have old strokes there. When she gets up, she walks down the hall. She certainly would have an unusual gait and it might be a gait that could be bothered by a sore knee, possibly, but not necessarily consistently. She said her knee is not really sore, it is just that she feels tired and weak.

Impression

1. Fibromyalgia (729.1) long history
2. Gait instability (781.2), nonspecific and 50% better?
3. Bouts of fatigue that has been worse in October 2013.
4. Positive ANA but no other signs of connective tissue disease that I can identify.
5. Sleep apnea. She uses a CPAP. She has had it for the past 4 years.
6. She works as a heart monitor tech for Heartland.

> 7. She is also going to be getting, or in the process of getting a neurological evaluation
>
> **Plan**
> **Orders this visit:**
> Follow Up 1 Month-Request
>
> I do not see any signs or an active connective tissue disease, or an inflammatory arthritis. She is getting better. My initial thought was to, since she is getting better, to reacquaint myself with her care, see how it is doing in a month to see if we can sort this out over a little time. To have a gait of that nature, you may actually have to have good balance to pull that off? I think we are going to see what happens over the little bit of time as we sort this out.

Dr. Ewing's November 1, 2013 note (Exhibit F) states Claimant returned after having "repeated MRI of her brain, cervical spine, and the echocardiogram with bubble study. All of those studies were negative. The MRI does show her old stroke with no other significant changes." The note states in part: "I do not think that the MR itself does not create any problems, does not show anything that would cause spasticity in both legs." He noted she continued to have significant problems with fatigue, weakness, and just not functioning very well. The note states he told Claimant that he cannot find neurologic cause for most of this. He noted she does have a history of fibromyalgia and has been worked up for positive ANA. The note states that Dr. Bronson did not think ANA had anything to do with her other ongoing problems.

Dr. Ewing's November 1, 2013 note states in part:

> She feels like the weakness is related to the flu shot. I told her again I cannot see any evidence on the exam that suggests that she is having weakness. She is not functioning as well as she would like to, but she is also not having that much in the way of problems. Her memory loss also bothers her. I told her I suspect this is in large due to fibromyalgia. She has sleep apnea, which could affect her memory as well. I do not see any other changes on her exam to suggest a source for this. I think at this point the best thing to do is going to be to keep it simple. We will get the MRI for thoracic spine and start her on some Baclofen to see if that helps the spasm. I do not know that if it will help the weakness, but it is worth a try.

Dr. Ewing's November 1, 2013 record further states in part: "Gait, Walking does not appear to be nearly as unsteady as it did last time. She walks with a wide based,

almost 'monster like' gait, lifting each leg up, swinging it from the hip and stomping it down. She is not falling. A gait is very odd and is not something that would appear to be normally neurologic."

Dr. Ewing's November 1, 2013 Impression states: "1. Generalized Weakness (780.79) Possibly fibromyalgia. I cannot find any other changes that seem to be causing this. I am not sure if it is fibromyalgia or not, but I cannot find a consistent neurology cause. 2. Gait Instability (781.2) It remains quite functional with no evidence of neurologic cause. We will get a MRI of her thoracic spine to be sure that I am not missing something there, but otherwise I cannot explain her gait. 3. Memory loss. Possibly related to anxiety. 4. Muscle Spasm (728.85). 5. Myelopathy (336.9)."

Dr. Ewing's November 26, 2013 Office/Clinic Note states in part:

Chief Complaint
1. Leg weakness.
2. Progressive gait instability.

History of Present Illness
Debbie returns today after completing an MRI of her thoracic spine which is normal. I told her this certainly raises questions. She apparently had all of this start after she had a flu shot earlier this year. She got it the first of October, by the middle of October she was unable to walk. She walks with a very wide based, very unsteady gait. She says that her mother has a very similar problem and walks somewhat the same way but does not have as bad a problem as she does. Her mother also has not had as much numbness and tingling. However, they do tend to walk alike. She said her mother has been disabled for years. Debbie is afraid she is going to lose her job.

She definitely has problems with her walking. She also has a lot of tremulousness in her hands. The way she moves her hands is quite odd. I certainly do not know what is causing it. When I ask her to do finger nose finger, I am not able to find anything else, and overall the history is pretty unusual.

I talked with her about different things that we can try to do. I think she probably is going to need a spinal tap. However, I am not able at this time to tell her what is going on.

. . . . . .

Impression

1. Weakness (780.79)
2. Gait Instability (781.2), progressive with hyperreflexia, weakness, and tremor. I am not sure exactly what the source of this is. It seems to have come on at least in the patient's mind since she had a flu shot earlier this year. The gait is very unusual and does not appear to be neurologic but the patient also reports that her mother does the same thing. Facioscapulohumeral dystrophy or something like that could be playing a role here but I would expect to see more muscle weakness, less tremor, and less in the legs. She is hyperreflexic but she does not have any evidence of ALS (amyotrophic lateral sclerosis). There is no evidence of neuropathy. There is no visible evidence of encephalopathy on any of the imaging.
3. Tremors (781.0)
4. Anxiety (300.00)

Plan

1. We will pursue a spinal tap.
2. Check a copper level.
3. Follow-up with me after the spinal tap.

Dr. Ewing's December 13, 2013 Office/Clinic note states Claimant returned after having undergone lumbar puncture three weeks ago. The record notes, "All of the testing from that was normal. She also had a copper elevation done, which was likewise normal." Claimant asked about Guillain-Barre. Dr. Ewing told her it unequivocally is not Guillain-Barre.

Exhibit J contains records of the University of Kansas Hospital. These include Progress Notes of Dr. Vernita Hairston, M.D. dated December 27, 2013. Dr. Hairston evaluated Claimant for difficulty walking since a flu shot on October 1, 2013. The History of Present Illness states in part:

> Debbie Shanks is a left-handed 42 y.o. Caucasian female who presents for an evaluation of difficulty walking since a flu shot. She had a flu shot October 1, 2013. October 2, 2013 she felt weak in her arms and legs with mild aching. She was so weak that she left work as a heart monitor watcher at the hospital. She saw her doctor that day. She had blood work that day which showed ANA 1:1280. Two weeks later she had difficulty walking. Her arms and legs became tremulous with effort. No tremors when she was not exerting herself. She also developed headaches at the back of her head which have persisted and are now daily. On October 3, 2013 she noticed pins and needles in her

> hands and feet which have not gone away. She also had some dizziness.
>
> All of these symptoms have persisted since the second day of her flu shot.
>
> She is also complaining of forgetting her words, fatigue, poor concentration with aching sensation of hips. She has a history of fibromyalgia for years. Her legs are stiff when she first awakens in the morning. Then when she is walking they become like jello. Two months of physical therapy did not help. Her hands will shake with exertion.

Dr. Hairston's December 27, 2013 Progress Note summarizes her review of records from Heartland. She noted an ANA profile from October 2, 2013 was completely normal. An MRI of the brain on October 28, 2013 showed leukomalacia related to her previous ischemic event. An MRI of the thoracic spine on November 13, 2013 was normal. An MRI of the cervical spine without contrast on 10/28/2013 revealed diffuse cervical spine narrowing.

Dr. Hairston's December 27, 2013 Progress Note states in part:

> Her [*sic*] has a past medical history of Arthritis; Other dysphagia; Generalized headaches; Movement disorder, Memory loss; Altered mental status; Vision decreased; Abnormal involuntary movements; Stroke; Sleep disorder, Disorganized thinking; Subacute dyskinesia due to drugs(333.85); Strabismus (12/29/2013); Abnormal gait (12/29/2013); and Attention and concentration deficit (12/29/2013).

The results of Dr. Hairston's general physical exam and neurological examination are reported.

Dr. Hairston's Assessment and Plan states:

> Her examination is notable for mild left sided weakness and Nystagmus with intermittent exotropia of the right eye. Her mild left-sided weakness with hyperreflexia is probably due to her strokes at the age of 29 and ocular finds are due to her strabismus. There is clearly a functional overlay to her gait. Her gait as not at all like that of her mother. Her mother may have some type of hereditary spastic paraparesis. But this patient's tone was actually normal and her

symptoms were dissimilar to her mother in that with exertion she lost strength.

I did discuss this with other neurological colleagues at KU. We are unaware of a flu shot causing the symptoms that she has.

She has had an extensive workup. I would, however, like to review the MRI that was already performed.

Exhibit J includes Dr. Hairston's January 2, 2014 Progress Note. Claimant returned that day with copies of her actual films. Claimant stated she had intermittent muscle spasms of her left [*sic*]. Dr. Hairston noted Claimant's leg "would suddenly jump and make her hip feel painful."

Dr. Hairston's January 2, 2014 note describes the results of MRI's and X-rays from Heartland in 2013.

Dr. Hairston's January 2, 2014 note states in part:

Assessment and Plan:B

1. Gait abnormality
2. Chronic fatigue syndrome
3. Daytime hypersomnolence
4. OSA (obstructive sleep apnea)
5. Elevated antinuclear antibody (ANA) level
6. Attention and concentration deficit
7. Nystagmus, dissociated
8. Strabismus
9. Stroke, thrombotic

I did discuss her case with another colleague in neurology. No one is aware of a flu shot that would cause such a gait. It was explained to the patient that her exam was not like her mother's exam who may have an hereditary disorder causing spastic paraparesis. Her mother first walked with stiff legs that were extended that improved with ambulation. The patient keeps her knees bent and her tone is normal.

Her left sided weakness is a residual from her prior strokes and has been stable for awhile according to the patient. Her abnormal eye movements can be explained by her strabismus. She was not even aware of this. Her eye movements were videotaped on the patients

[*sic*] phone so that she could see what I was seeing. I then showed her the findings. This, however, is an incidental finding.

I cannot find a neurological basis for her gait. I suspect a functional overlay to her exam. It was explained to her that her anxiety could play a role in her findings. If she desires, she can go to Mayo Clinic. I recommended that she find an activity that she enjoys but she stated that she could not work because her arms become tremulous with exertion. Vocational rehab may be helpful.

Could perform neuropsychological testing if her memory issues continue.
Follow up with Dr. Ewing pm.
Recommend physical and occupational therapy.
Will cancel the rheumatology referral.
Orders Placed This Encounter

- SLEEP STUDY, NOCTURNAL NEURO
- ANTI-NUCLEAR ANTIBODY (ANA) today

Exhibit E includes Physical Capacity Questionnaire of Dr. Thornton dated January 3, 2013 [*sic*]. It notes he last saw Claimant on January 3, 2014. It states that she was not able to perform work on a regular and continuing basis (8 hour workday, 40 hour work week) without an unusual number and length of rest periods relating to his/her medical condition. The following objective and clinical findings supporting his opinions are noted to be: "blurry vision, memory impairment, fatigue, ataxia, unknown [*illegible word]* etiology, currently undergoing medical workup." Dr. Thornton's diagnosis is "ataxia."

Exhibit E also includes a Mental Capacity Questionnaire of Dr. Thornton dated January 3, 2013 [*sic*]. It diagnoses ataxia and states, "No" to the question, "Is your patient mentally able to perform simple, repetitive tasks?" The record also answers, "No" to the question, "2. Given your knowledge of the claimant's medical conditions, do you believe that he/she retains the capacity to perform <u>any work</u> for 8 hours per day, 40 hours per week for 50 weeks per year?"

Employer Exhibit 4 is an email dated January 10, 2014 from Sara Duin to Claimant referencing an attachment regarding the information they discussed and requesting she complete and enclose the event report and return it to the Employee Health Office. Exhibit 4 includes Claimant's hand-written Employee Event Report dated January 13, 2014 that states in part in response to paragraph 4, "What Happened":

> 10/1/13 I received flu shot. 10/2/13 had to leave work to see my Dr because of extreme weakness in arm & legs. By 10/13/13 I was having difficulty walking, loss of balance, pins & needles & numbness in hands & feet, burning in feet, tremors, trouble with memory & concentration, headaches. My Dr has called the CDC to report this.

Exhibit K contains records of Social Welfare Board and Dr. Robert Stuber pertaining to Claimant. A record of Megan Eppens, FNP, dated March 13, 2014 notes Claimant was there to establish care. The History of Present Illness in the note of Megan Eppens, FNP, dated March 13, 2014 states in part:

> Debbie A. Shanks is a 42 year old female.
> Pt here to establish care. She is a very complicated hx and is currently under the care of several specialist [*sic*]. States she got a flu shot on 10/1/2014 [*sic*] immediately began feeling like her arms are [*sic*] legs were heavy. States that after about 2 weeks she began having difficulty walking. Felt like she could not straighten her knees without them giving out. Some numbness/tingling in hands and feet as well.
>
> . . . . . .
>
> States that since her sx started in October, she is about the same. Some of the weakness in her arms has improved, however she is having more joint pain than she was previously.
> • Feeling tired or poorly.
> • LMP not documented: Hysterectomy.
> • Arthraigias
> • Limb weakness • Tingling of the hands • Of the feet • Numbness of the hands • Of the feet

Megan Ebbens assessed arthralgia, limb weakness, and chronic major depression. The record notes in part under "Plan":

> Very interesting case. All diagnostic testing so far has been normal, with the exception of a +ANA. However DsDNA was negative. Unfortunately, pt states she was given steroid shot and prednisone taper in October and cause [*sic*] her to become suicidal. Specialist consulted thus far believe this is some sort of conversion d/o. She does hx of fibromyalgia, chronic fatigue, chronic depression. Will continue on her Paxil, Baclofen, Ibuprofen 800 mg TID. Adding Tramadol to this as well. Also sending for EMG of UE. F/u with Dr.

> Stuber for further consultation. Also requesting handicap sticker for car, this was given.
> Presciption(s) Given.

A note of Dr. Robert Stuber dated April 25, 2014 in Exhibit K states in part that Claimant "has had a mysterious illness beginning Oct 1 when she had a flu shot and within 24 hrs had weakness of her legs and arms. They felt heavy. Withing [*sic*] 2 weeks had numbness and tingling and difficulty with memory. Had felt foggy. For the past 2 mos she has had joint pains and stiffness which are worse in the morning, but the weakness is worse later in the day."

On April 25, 2014, Dr. Stuber assessed weakness and arthralgia. His April 25, 2014 note further states:

> I think everyone is in agreement that something is wrong here. An ana profiles neg except for a +ANA of 1:1280. Intellectually she seems quite bright and alert and intelligent. Is trying to get away from the fact that this all started with a flu shot leading one to the conclusion that some sort of degenerative neurologic disease is going on, something akin to Guillin-Barre, and yet not Guillin-Barre. The muscle stiffness and the joint pain certainly incriminate a collagen disease that may have been ongoing for some time since she has had FMA[3] for 20 yrs. Will get CPK, aldolase, anca, myesthenia antibodies, esr, ra, ana. See me 2 weeks.

Dr. Stuber's May 9, 2014 note states in part: "Claimant now has difficulty getting out of a chair, must walk with a walker. She has developed multiple joint pains. Has had FMA for years." Dr. Stuber assessed chronic major depression, limb weakness, arthralgia, and fibromyalgia. He prescribed Lyrica and Cymbalta.

Dr. Stuber's May 9, 2014 note also states in part:

> Hard to say what is going on here. Prior to October 1, she was a monitor tech at Heartland. Certainly with a combination in neurologic and skeletal muscle symptoms, one must consider a collagen disease. Also can't sleep at night, body hurts all over. Legs feel weird. After struggling with a Dx here, FMA with muscle aches, headaches, depression fatigue best hits but the severe stiffness does not. Will need patient assistance on Meds. See back in June.

---

[3] "FMA" is an abbreviation for Fibromyalgia. (*https://www.allacronyms.com/_medical/FMA/fibromyalgia.*)

Dr. Stuber's June 25, 2014 Note states Claimant walked with a waddling gait. He noted individual muscle testing is normal. Dr. Stuber assessed limb weakness and fibromyalgia. Medications prescribed included Lyrica and Cymbalta. The note states in part that Claimant has to take naps during the day and that a note excusing her from jury duty should read that she has an undiagnosed debilitating neurologic disease and is not capable of jury duty.

Dr. Ewing saw Claimant on July 17, 2014. His Office/Clinic Note of that date in Exhibit F states in part:

> Dr. Stuber apparently told the patient he thought she had progressive MS (multiple sclerosis). I told her I disagreed with that diagnosis. My reasoning is one, her spinal fluid is completely normal, two, her symptoms are not those of progressive MS, three, MS does not come on the way she has described, nor does it progress the way she has described and four, all of her MRIs are negative. In short, there is nothing to suggest that she has MS. She also said that she was told she might have muscular dystrophy. Once again, I would disagree with that. Muscular dystrophy does not start abruptly, it is a very gradual deterioration. You do not go from walking normally to not walking in a 24-hour period. While she may have weakness in and around her shoulders and her hips, it is not evident on exam that she has any weakness at all in her shoulders.
>
> . . . . . .
>
> She seems to be quite clear mentally, and she did not seem offended at the thought that this could be psychological. I asked her if she had some fear of the immunization. She said that she would never get another flu shot. I told her this is not a reaction that has ever been described with a flu shot. I looked up the CDC reports of what happens with a flu shot and there is no one that has ever had this before that I can find in any of the literature. I told her this is not a consequence of it. It is not Guillan-Barre. The weakness that she has is as much proximal as distal. It did not have slow ascending weakness. She has maintained her reflexes. That lets out all of the inflammatory polyradicular neuropathies. She has no blood work to suggest a myopathy or a myositis. Her EMG does not suggest a myopathy, a myositis or a neuropathy. It does not leave anything that really suggests a source.

Dr. Stuber's November 12, 2014 note assesses limb weakness, fibromyalgia and chronic major depression. Lyrica and Cymbalta were prescribed. The note states in part: "The patient definitely has fibrtomyalgia [*sic*]. She also appears to have a neurologic disorder causing her hip flexor weakness. Whether or not this is the result of a flu shot is argumentative but the temporal sequence certainly would lead one to believe that the flu shot may have had something to do with the neurologic problem."

Dr. Stuber's January 30, 2015 note reports Claimant had right arm swelling, pain to right shoulder and thumb and tingling of right hand and also on left side but right side worse. Dr. Stuber assessed arthralgia, fibromyalgia and fatigue. His note states in part: "The patient continues to be a diagnostic mystery. I think she has FMA for sure but neurologically it is hard to say what is going on. The palmar erythema is striking. A collagen disease is very possible but her ANA is neg." Lyrica was increased.

Dr. Stuber's March 11, 2015 note records multiple tender lumps and tender points all over. He assessed limb weakness, fibromyalgia, and chronic major depression. The note states in part: "The patient appears to be disabled from fibromyalgia. She walks in here today with the aid of a walker, and when I got her from the exam room, she had a great deal of difficulty in getting out of her chair. She hass [*sic*] all the tenderpoints associated with fibromyalgia. this [*sic*] is what I am going to treat her for.. It also sounds like her mother has this as well. Increasing the Lyrica to 75 mg tid. See again in two months." Dr. Stuber also prescribed Cymbalta.

Evaluation of Lewis Tom Bein, Psychologist

Exhibit I is a Psychological Evaluation Report of Lewis Tom Bein dated June 10, 2014. The report notes Tom Bein is a psychologist licensed in Missouri. He interviewed Claimant. She reported a problem walking, tremors on her hands, feeling constantly exhausted, weakness in her legs requiring her to use assistance when walking, an arm feeling "strange", and having some problems with memory. She reported those difficulties occurred after she received a flu shot on October 2014 [*sic*]. She reported, "It seems like I can't think, I can't focus on anything, have to reread things, way worse than after the stroke" than she had when she was 29-years-old. She reported experiencing suicidal thoughts about two weeks before his interview. She was taking Paxil that she had started in her early twenties. She also was taking Cymbalta that she started about two months before. She reported having last worked in December, 2013 and quit following her flu shot.

Tom Bein's report sets forth the following Diagnostic Impression:

Axis I: 296.90 Mood disorder, not otherwise specified.
799.9 Diagnosis deferred, rule out somatoform disorder,

social anxiety disorder and/or cognitive disorder.
Axis II: V71.09 No diagnosis.
Axis III: Deferred.
Axis IV: Unemployment.
Axis V: Current GAF 52.

Social Security Evaluation

Exhibit L includes a Medical Interrogatory Physical Impairment(s) – Adults form of Dr. Oliver Gerald Orth dated December 20, 2015 regarding Claimant. Dr. Orth checked "No" to the question: "7. Do any of the claimant's impairments established by the medical evidence, combined or separately, meet or equal any impairment described in the Listing of Impairments?" Page 6 of 13 of Claimant's Exhibit L states in part:

> Physicians 14F & 7F extensive discussion with patient regarding her complaints & findings.
>
> Patient has no neurological findings to suggest organic disease process. Does not meet listing under 11.00 or 1.00. Claimant has not received psychiatric evaluation or treatment as noted in 14F. Case complicated by physicians subscribing to disease process as underlying cause. 9F & 12F
>
> Claimant may meet listing under 12.00 Mental Disorders. 12.07

Exhibit L includes Social Security Administration Office of Disability Adjudication Review Medical Source Statement of Ability To Do Work-Related Activities (Physical), pages 7 through 12 dated December 20, 2015. Dr. Orth provided restrictions for Claimant including frequently lifting up to ten pounds, occasionally lifting 11 to 20 pounds, never lifting over 21 pounds, 30 minutes standing and walking at one time without interruption and one hour sitting at one time without interruption, total one hour standing and walking in an 8-hour work day and seven hours sitting. Dr. Orth also checked restrictions regarding use of hands and use of feet in postural activities and environmental limitations.

Exhibit L includes a Curricular Vitae of Dr. Oliver Gerald Orth. The CV notes Dr. Orth retired from active clinical practice in 1999. His clinical practice was in neurological surgery, Columbia, Missouri, from 1969 to 1999.

Additional Exhibits

Exhibit M is a three-page document entitled "VAERS Event Details" relating to VAERS ID: 520031-1. Event Information describes a vaccination in Kentucky on January 7, 2014. The reporting was done on January 20, 2014 and is related to a Novartis vaccine, Lot number 13433P. The Adverse Event Description states: "Patient stated she 'felt weird' when she woke up at 0500. At 2:00 PM she became weak. It was hard for her to walk. Stated bilateral arms and legs were weak. Reported to her PCP. Flu test (-) sent home. 1/14/14 Back to her PCP. Now only feels weak on (L) side, sent to hosp. for stroke work up." Lab Data entry states: "Flu test = negative. I hospital over night. Ruled out stroke. Dx: neuropathy. PCP informed patient to never take the flu shot again." Page 3 of Exhibit M states in part: "Caveats: NOTE: Submission of a VAERS report does not constitute admission that healthcare personnel or the vaccine caused or contributed to the event."

Evaluation of Dr. P. Brent Koprivica

Exhibit N is a report of Dr. P. Brent Koprivica dated January 18, 2016 addressed to Claimant's attorney that documents Dr. Koprivica's independent medical evaluation of Claimant on January 18, 2016. The report notes Dr. Koprivica is board certified by the American Board of Preventive Medicine and Occupational Medicine.

Dr. Koprivica's report notes that Dr. Koprivica reviewed medical records from Mosaic regarding treatment of Dr. David Ewing, records of Dr. Richard [*sic*] Stuber, records from KU regarding neurology treatment with Dr. Hairston, spinal tab data dated December 3, 2013, additional records of Dr. Ewing, records of Heartland Arthritis and Osteoporosis Center Dr. Bronson, a copy of MRI scan dated October 20, 2013, records of Dr. Thornton, records of Dr. Kempton, lab data dated October 2013, VAERS detail reporting response to a vaccination on January 7, 2014, records of Dr. Bettinger, and records of Dr. Baskins.

Dr. Koprivica's report sets out Claimant's educational and vocational history. The report describes the history of Claimant's present history/illness. Dr. Koprivica's report states in part that Claimant "has poor memory and seems to focus a number of her subjective symptoms to the reaction to the flu vaccine that arose out of her employment on October 1, 2013. However, a number of these complaints were documented in contemporaneous records, even though she has no recall of the symptoms predating the October 1, 2013 date."

Dr. Koprivica's report states that he believes there is a psychological/psychiatric contributor to the disability presentation that both predated October 1, 2013 and that

which he asserts is attributable to the October 1, 2013 injury. Dr. Koprivica's report summarizes the treatment records in evidence.

Dr. Koprivica's report dated January 18, 2016, states in part:

> Current Complaints
>
> Subjectively, Ms. Shanks complains of fatigue to a point that she cannot stay awake during the day. She has sleep interruption and insomnia at night. She has muscle spasms "everywhere". She has pain that shoots down both buttocks and hip areas. She has developed knots in her arms since the flu vaccine. She has pins and needles in her hands and feet. She has numbness in her hands and feet. She has new weakness in her legs and arms. Her difficulty walking has progressed to her legs and arms. Her difficulty walking has progressed to the point that she is now using a walker. She feels like her eyesight has gotten worse. She has also developed new tremor.

Dr. Koprivica performed an examination of Claimant. He noted her height is 5' 9" and her weight is 285. He noted she has a flat affect.

Dr. Koprivica's report states in part:

> Clinically, as noted in the contemporaneous records, it is my opinion that there is some functional overlay in the presentation. Some of the observations suggesting psychological overlay include a non-bell-type distribution on grip strength testing on the right. She is relying on a walker at this point. She did have some titubation of her head. There is intermittent tremor. She has non-physiologic ratchet types of response on resistance testing of the proximal upper extremity muscle groups. There are also regional light touch pain findings in the lumbar region.
>
> Her sensory complaints are intermittent with intact examination today regarding the upper and lower extremities.
>
> Clinically, it is my opinion that there is psychological overlay in Ms. Shanks' presentation, but I do believe she is genuine in regard to her presentation.
>
> . . . . . .

Proprioception is performed in a bizarre fashion. When trying to test Proprioception of the lower extremities, Ms. Shanks hyperextended her back and started to raise her arms overhead. This is a somewhat bizarre response.

I would note that I did not test lumbar motion because of the subjective weakness with which she presents.

. . . . . .

Ms. Shanks presents using a wheeled-walker. The bizarre wide-based gait is not apparent when using the walker.

Dr. Koprivica's January 18, 2016 report states in part:

1. Ms. Shanks' work-related vaccination on October 1, 2013, and the adverse reaction to that vaccination is felt to represent the direct, proximate and prevailing factor in Ms. Shanks' development of physical symptoms. Unfortunately, flowing from this adverse reaction to the vaccination is the development of what I believe is a likely conversion disorder.

In terms of the adverse reaction, in support of the objective nature of this reaction from a physical perspective, is the additional report by a separate individual of reaction to the same lot of vaccine with the vaccination for that individual on January 7, 2014.

2. Regarding this October 1, 2013, injury, I would be in agreement with the recommendation for the performance of a formal neuropsychological evaluation.

The mental health expert performing the neuropsychological testing can help validate the presentation and also validate that the disability presentation and also validate that the disability presentation is on a psychological/psychiatric basis.

3. In looking at Ms. Shanks' presentation based on her conversion disorder, I would note that at this point, Ms. Shanks' is using a walker.

> At this point, I believe that this, in fact, is a conversion disorder and the deficits noted are psychologically based. In terms of Ms. Shanks' experience of disability, it makes it no less real.
> .....
>
> 7. I would note that in making the conclusions I have already expressed, the validation of Ms. Shanks' presentation from a behavioral standpoint will be important.
> .....
>
> 9. Ms. Shanks was temporarily totally disabled from October 1, 2013, until last seen by Dr. Ewing on July 17, 2014.
>
> This period of temporary total disability is felt to be medically reasonable and a direct necessity of the adverse reaction to the vaccination on October 1, 2013, and the subsequent attempts at diagnosing her disability as well as provision of care and treatment subsequent to that date up through July 17, 2014.
>
> I would consider the October 1, 2013 work injury to be the prevailing factor in the necessity for this period of temporary total disability.

Evaluation of Dr. Daniel Claiborn, PhD.

The deposition of Dr. Daniel Claiborn, PhD., taken on January 12, 2017 was admitted as Exhibit O. Dr. Claiborn is a psychologist licensed in Missouri and Kansas. He has been licensed for 37 years. (Claiborn deposition, page 4). He started his private practice in Iowa in 1976. (*Id.* at 7). The bulk of his work over the past 25-years has been with police departments and private departments where he has done fitness for duty evaluations. (*Id.* at 8).

Dr. Claiborn has taught clinical psychology at the doctoral level at Iowa State University, University of Missouri/Columbia, and the University of Missouri at Kansas City. (*Id.* at 9). He has also been an instructor at several local police academies teaching police officers. He has done individual psychological assessments for disability determination for the Iowa Disability Determination Services. (*Id.* at 10). He is currently ethics chair for the Kansas Psychological Association. He has been president for the Practice Division of the Kansas Psychological Association. (*Id.* at 11).

Dr. Claiborn saw Claimant on April 14, 2016 at the request of Claimant's attorney. He reviewed medical records and administered tests to Claimant on April 14, 2016, including the Minnesota Multi-Basic Personality Inventory-2, and the Million Clinical

Multi-Axio Inventory – III. (*Id.* at 12). The highest score achieved on the Million test was on major depression, and the second highest was on Somatoform Syndrome.

Dr. Claiborn testified Somatoform Syndrome "is a psychological pattern or disorder that is characterized by physical symptoms that the person's displaying and also by an excessive amount of concern about the physical symptoms." Claimant's score was a 77, which is a significant symptom, possibly worthy of treatment, but was not in a serious, severe range. (*Id.* at 13-14).

Claimant's score on major depression was in the severe range, a score of 92 on the Million Scale. (*Id.* at 14). Claimant had very high scores consistent with people who have severe pain disorder on the MMPI. Under the DSM-IV, it is a pain disorder. (*Id.* at 15).

The two diagnoses Dr. Claiborn gave in his supplemental report were somatic symptom disorder and major depressive disorder. The somatic disorder is not under the pain disorder. (*Id.* at 18).

Dr. Claiborn was not making a mental health diagnoses when he referred to severe pain disorder on page 4 in his first report. He stated the way she answered the test questions and the overall testing pattern was "very consistent with people who are experiencing intense physical pain." (*Id.* at 21).

Dr. Claiborn interviewed Claimant. He asked background questions and focused mainly on her mental health treatment history, her experience with the flu vaccination and the subsequent experiences she had from that, and on her current complaints and current condition. (*Id.* at 21-22). He saw that Claimant had a history of anxiety and depression since her teenage years. She related she began taking anti-depression medication in her early 20's and had been diagnosed with fibromyalgia around the age of 21. She had three strokes in 2000, had a neurological evaluation in 2001, and was currently taking anti-depressant medication at the time of his evaluation. (*Id.* at 22-23).

It appeared to Dr. Claiborn that as of the time immediately preceding the vaccination she received in October of 2013, whatever anxiety or depression Claimant may have had, she was able to function satisfactorily in an occupational setting. (*Id.* at 23). Dr. Claiborn noted Claimant had been working for Employer for over nine years.

Dr. Claiborn testified at Claiborn deposition, pages 23-24:

> She [Claimant] described herself before the vaccination as having the best job she'd ever had, loving it, feeling very important in her role at that company, and trusted. She said she was very happy,

good at her job, she was training new nurses. That she felt always included and called upon to do certain tasks, so she felt competent, and she was the only one in her department that she was certified to do some of these tasks.

Outside of the workplace, she had a new relationship ongoing with a boyfriend and she was enjoying that relationship as well as the job and her freedom. Her home was almost paid for. And so she summarized her status at the point by saying, 'My life was awesome at that time.'

Now, I also felt that she was not suffering a mental health condition, because as I looked at the medical records it didn't seem as though I could find any ongoing treatment referred to of a mental health injury in those records as of 2012 or '13. The medical records I have I think range up to about 2011 in terms of mental health treatment, and that was Dr. Bronson, and he had seen her over like a 10- or 15-year period from I think 1995 to 2011, and had seen her for anxiety and depression.

So, anyway, I concluded for those two reasons that at the time of the vaccination she likely did not have a mental health condition, although she has a history of mental health conditions and also a family history of mental health conditions.

Dr. Claiborn understood from his review of medical records that Claimant had an adverse reaction to a vaccination in October of 2013. (*Id.* at 24).

Dr. Claiborn was asked the following questions and gave the following answers at pages 27-30:

Q. Thereafter did she develop some sequelae from that instance that causes her to have some component of psychological distress that is present at the time that you saw her?

A. That is my opinion.

Q. Can you describe that for the Court with some detail?

A. Yes. It seemed to me from my review of the records, and also from what she said, that she developed various pain conditions and

sleep problems after the vaccination that were supported or substantiated by the physicians.

And my view of her is that these physical sequelae that she did experience also then caused her to be depressed, to have her life activities restricted not to be able to work. So the pain and the sleep problems, my theory is that these caused her to be depressed. And here's a person who's likely vulnerable to be depressed, because she's been depressed before.

And so, once she's depressed, my theory is that she began to experience maybe either an exacerbation of the physical symptoms that she already was experiencing, or some other symptoms that couldn't be explained by medical testing, weakness in her legs and hips, that are a result of the depression. That's the way I looked at the sequence of events.

Q. In your opinion, Doctor, what was the prevailing factor for the development of the sequela?

MR. HOFFMEISTER: I just have an objection at this point to lack of foundation and outside this physician's expertise.

Q. (By Mr. Smith) Go ahead and answer.

A. I thought that the prevailing factor and the kind of the initiating event was her physical reactions to the vaccination. I felt that that's what set these processes in motion.

Q. Is it your opinion that the pain and discomfort that she felt following the adverse reaction to the vaccination caused her to have a pain syndrome or somatoform syndrome?

A. Yes. I would call it a somatoform disorder, or whatever I alluded to in my supplemental report; meaning, not so much in questioning the medical validity of the symptoms themselves, but rather her excessive attention to the symptoms, the amount of distress she had about time, the way she looked at the way they affected her lifestyle. That is now the way that the DSM really looks at the somatoform category.

We used to look at it as though it was physical symptoms that had no medical explanation, but now the way DSM-V looks at it is not so

> much whether or not the physical symptoms have a definable medical underpinning, but rather whether the person is distress and excessively upset about the symptoms, whether they're interpreting the symptoms in a way that lead them to feel more restricted than they otherwise could. So the focus now is more on the person's interpretation of the symptoms that they have, whether or not there's medical underpinning for those symptoms.
>
> Q. In a layman's sense, would it be appropriate to consider the physical injury having precipitated a psychological reaction?
>
> A. Yes. That's my view of this.

Dr. Claiborn testified Exhibit 2 is his initial report, and Exhibit 3 is his further report. (*Id.* at 30). He also reviewed Exhibit 4, a report of psychologist Tom Bein for the Social Security Administration in June 2014. (*Id.* at 31).

Dr. Claiborn testified he came up with two diagnoses in his supplemental report that he felt covered Claimant the most accurately, and they were major depressive disorder and somatic symptom disorder. (*Id.* at 32). It is Dr. Claiborn's opinion that the vaccination is the prevailing factor for the somatoform condition and the diagnosis for the development of the major depression. (*Id.* at 33-34).

Dr. Claiborn had reviewed a report of Dr. Orth. He noted that Dr. Orth had found no neurological findings. (*Id.* at 37).

Dr. Claiborn felt the somatoform disorder better explained Claimant's situation than a simple pain disorder or a conversion disorder. (*Id.* at 40). He testified that whether considered a somatoform condition or the conversion disorder referenced by Dr. Koprivica, the initiation would be some physical stimuli such as the adverse reaction to the vaccination in this instance. (*Id.* at 40).

Dr. Claiborn was asked the following questions and gave the following answers at Claiborn deposition, pages 41-43:

> Q. In that instance, to interrupt you, just so I get it, are you saying that the patient just has an elevated reaction to the condition whether the condition is severe or otherwise?
>
> A. That's correct.

Q. And so the reaction itself is not driven by the severity of the physical injury as much as it is by the way it is perceived psychologically.

A. Well, I think in Ms. Shanks' case it's really both. She has some physical issues that appear to have been substantiated medically, and some of her pain conditions seem to be consistent with medical findings, and yet some of her weaknesses aren't consistent, so far, with the medical findings. And she's concerned about both the ones that are substantiated and the ones that aren't.

Q. And that's why you've picked the somatoform as opposed to conversion reaction; is that - -

A. Exactly.

Q. - - a fair understanding?

A. Yes.

Q. Okay. Do you think that Ms. Shanks requires treatment at this time?

A. Yes.

Q. What do you propose the treatment that she have?

A. Well, she's taking antidepressant medication, I don't know exactly which one and the dosage, so that would need to be reviewed. But my major concern is that she's not receiving - - or at the time I evaluated her she wasn't receiving psychotherapy. And the research on depression indicates that by far the most effective approach and the most lasting approach for people is to have the medication treatment and the psychological treatment in combination.

So I believe that what should be added to this picture would be the psychological component of cognitive behavioral therapy, specifically targeted with her particular kind of depression which resolves around her perceived limitations and the pain that she's undergoing.

There's good research on psychological treatment even of pain itself, and I don't think she's had that either. Ways people can both

use relaxation techniques and meditation techniques, but also some cognitive strategies to actually reduce the experience of the pain itself; and, if she had that, and the pain itself reduced in its intensity and she felt more freedom and less restrictions, then I think she would be less depressed, and if she were less depressed I think she would experience less pain, and it would be a - - you can get a process going that would get some momentum going in a healthy direction.

I just don't think antidepressants by themselves are sufficient in this case or in most cases. And I think that's evident by the fact that she scored extremely depressed on the testing while on antidepressants. So I took that into consideration, too, that she's already taking antidepressants. Although, many people are underdosed. So that's another thing that could be reviewed. It's possible she's not taking anywhere near enough medication.

Dr. Claiborn did not recall whether Claimant was seeing a psychiatrist. (*Id.* at 44).

Dr. Claiborn was asked the following questions and gave the following answers at Claiborn deposition, pages 44-46:

Q. At this time would Ms. Shanks be employable, in your opinion, based on what you found?

A. No.

Q. What is your basis for reaching that conclusion?

A. Well, just the severity of the symptoms she's reporting and the limited abilities she's reporting that she has to function day to day, and the sleep issues that she's having. I'm not saying she couldn't do some kind of work for an hour or two here or there, but I don't think she can work at full time at present in this condition.

Q. She'd be very limited in terms of her stamina for a position?

A. That's what I would say. And concentration and ability to be accurate and successful. I wouldn't worry about her willingness to do it, but I would worry about her success.

Q. Is part of that due to the fact that she has these concerns about her health condition that would interfere with her concentration on a job?

A. Yes.

Q. Do you anticipate that perhaps with successful treatment that you've recommended that she might regain ability to be employed?

A. It's - - I think it's definitely possible. I don't know whether I could put a percentage or a - -

Q. I'm not asking you to do that. Just whether or not you anticipate maybe she might get better.

A. I would say yes because she has recently been better and enjoyed it. So I don't see secondary gain here, that because of these conditions she's in some psychological way better off. She is miserable, and just recently was happy and functioning better, as we talked about earlier. So I would say if she felt hope and saw improvement that she would be motivated to continue with it and regain employability.

Q. And was it your understanding that she had not been gainfully employed since the vaccination?

A. That's what I understood, yes.

Q. Would it be your opinion that her lack of ability to be employed since October of '13 to the time that you evaluated her was a result or the vaccination and its adverse sequela?

MR. HOFFMEISTER: Objection. I think it lacks foundation. The doctor didn't see her in that period of time you're discussing.

A. Yes.

Q. (By Mr. Smith) In your opinion, Doctor, would the vaccination of October 2013 be the prevailing factor for her inability at the current time to be employed?

A. Yes.

Looking at the MPI results, Claimant has an elevated Hs scale at the 99.9 percentile range. (*Id.* at 47).

Dr. Claiborn thought the hypochondriasis elevation was directly related to the vaccination issue. (*Id.* at 48). Claimant also had a very extreme condition, 99.9 percentile level on the elevated D scale that measures symptoms of depression. (*Id.* at 48-49).

Dr. Claiborn testified that Claimant's pattern on the MMPI is very consistent with people suffering severe pain. Claimant also had an extremely high elevated Hy, hysteria scale in the 99th percentile. (*Id.* at 50). He felt the three high scales on the MMPI were a result of or reflected the reaction to the vaccination sequela. (*Id.* at 51). He did not expect the patient with that degree of elevation of the three scales concurrently as he saw with Claimant to be employable. He noted it would be an unusual person with that degree of distress to be able to concentrate and focus on a job. (*Id.* at 51). And would also have a very low energy level on the Ma scale of the MMPI which was at about the 15th or 20th percentile of the population that would make it very difficult if she had a demanding job at all that required attention and multi-tasking. (*Id.* at 52). He also testified the low score on the energy usually indicates the person has been depressed for some time. (*Id.* at 53).

Some of the MMPI findings also indicated Claimant had symptoms of fatigue and some degree of social anxiety discomfort being around other persons, those conditions would make it difficult for Claimant to be employed in the open labor market. (*Id.* at 54).

Dr. Claiborn testified these opinions he expressed had been offered to a reasonable degree of psychological probability. (*Id.* at 54).

Dr. Claiborn testified on cross-examination that in his review of the records, Claimant had been diagnosed with depression and anxiety before the vaccination in 2013, and there was a notation she had a suicidal ideation at one point. For one would get to the point of suicidal thoughts, they would typically be considered major depressive. (*Id.* at 57). Dr. Claiborn testified that if Claimant were provided some therapy in conjunction with medication she had been taking, that might be effective in reducing or eliminating potentially her depression. (*Id.* at 59). He thought it might be more difficult to improve her depression unless the pain disorder and difficulty sleeping were addressed or successfully treated. (*Id.* at 59).

Dr. Claiborn believed Claimant did not have a conversion disorder but rather had a somatoform disorder. He noted Dr. Koprivica called it a conversion disorder. Dr. Claiborn called it something different, but he noted the idea was the same. (*Id.* at 63). Dr. Claiborn testified that he was calling it depression, but Dr Koprivica was providing "more of a psycho-dynamic explanation of converting stress and the physical symptoms, which I thought was old fashioned." (*Id.* at 64).

Dr. Claiborn testified that he has not indicated that Claimant is permanently and totally disabled. (*Id.* at 70). He believed through treatment that she possibly would be able to return to work. (*Id.* at 71). He did not think that Claimant presently could work even half-time or full-time at this point. He testified Claimant is not at maximum medical improvement as of the date of the deposition in terms of the psychological part. (*Id.* at 72).

Claimant has a family history with mental health issues, but Dr. Claiborn did not see anything to do with somatic symptoms like Claimant talked about herself. (*Id.* at 75)

One of the MMPI scales for Claimant, the FBS scale, was very high, which is often true of malingerers and would be an indicator of malingering. (*Id.* at 81). Dr. Claiborn testified at Claiborn deposition, page 82:

> People with severe pain conditions have very high scores on the MMPI that in any other kind of person would look like exaggeration, but for people with pain oftentimes it's a true representation of how they feel. So I think with a person like her you could say there is some symptom exaggeration going on, not in a conscious way, but she is feeling these symptoms pretty extremely.

Dr. Claiborn was asked the following question and gave the following answer on redirect at page 86:

> Q. Would it be your opinion still that Ms. Shanks did not have major depression in effect, in at least the couple of years prior to this vaccination, because of her successful employment course?
>
> A. Yes, that, plus her own description, plus the lack of medical records to that effect. If she had depressive symptoms and they were treated, then that may be why there weren't medical records or why she was able to function well at the workplace.

Dr. Claiborn did not feel Claimant's family history would have any bearing upon the issues concerning Claimant's disability. (*Id.* at 86). Dr. Claiborn did not feel that Claimant was consciously exaggerating her symptoms for secondary gain. (*Id.* at 88). He testified that from a psychological standpoint, Claimant believed she was genuinely ill, and that she was sincere in her description of her maladies. (*Id.* at 88-89).

Dr. Claiborn testified that Claimant's somataform was caused by the sequela of the vaccination as opposed to being triggered by it. (*Id.* at 89). He also testified that the

major depressive disorder was a result of or caused by the sequela of the vaccination. (*Id.* at 89).

Dr. Claiborn was asked the following questions and gave the following answers at Claiborn deposition, pages 90-92:

> Q. Doctor, with regard to this last line of questioning, so are you indicating that a strong basis for your opinion today, that this somatoform disorder and depression are a result of the flu vaccination, is due to the fact that they occur after the flu vaccination? That the timing of them would indicate to you that they were from that?
>
> A. Well, maybe. I guess I'm looking at the sequence like there's the vaccination, which by itself I don't think directly caused anything, but if it caused the tumbling of pain disorders and all the distress that came from that, and the restrictions of her life activities that resulted as a result that, and she couldn't go back to work, then I think those things are what caused the depression, and then the depression causes the somatic symptom disorder. So, yes, I guess that this is a chronology, but it isn't that the vaccination itself - - she's had vaccinations before that didn't trigger this cascade of events. I don't know whether I've even answered your question.
>
> Q. The vaccination itself didn't trigger these things, it's the events after that.
>
> A. Yes.
>
> Q. Is the timing part of what you're basing your diagnosis on; that is, the fact that they have occurred now after rather that before?
>
> A. Yes.
>
> Q. And you also referenced the fact that there weren't any records just prior to this incident that would show it was still ongoing the depression?
>
> A. Yes.
>
> MR. HOFFMEISTER: That's all I have.
>
> FURTHER EXAMINATION

BY MR. SMITH:

Q. Was it the adverse sequelae of the vaccination, where she felt physically bad within a day or so of the vaccination, that set this cascade in place?

A. I believe so, yes.

Dr. Claiborn's April 16, 2016 report states in part:

Ms. Shanks' current psychological testing results are consistent with a severe pain disorder. Ms. Shank's testing indicates extreme anxiety and depression, deep concern about her health conditions, social withdrawal, low motivation, and loss of energy. Similar to individuals with conversion disorder, her testing indicates extreme concern with a variety of physical symptoms; different from conversion disorder individuals with regard to psychological testing patterns, Ms. Shanks' results indicate much more significant major depression.

. . . . . .

Responses to Evaluation Questions.

1. It appears to me that the vaccination and Ms. Shanks' immediately resulting physical symptoms have been the prevailing factors in producing Ms. Shanks' current depression, which depression then may be exacerbating her physical symptoms and/or resulting in anger which Ms. Shanks is expressing (without awareness) through allowing herself to feel more debilitated than her actual physical condition would warrant.

Dr. Claiborn's June 15, 2016 report states in part:

Supplementary Observations and Comments.

In my initial report, I found Ms. Shanks to be suffering from chronic pain, sleep disturbance, and major depression. I posited that Ms. Shanks' pain and deep issues (and the life limitations ensuing from them) were likely the causes of her major depression, while her leg weakness and gait issues were likely psychological results of her depression, hopelessness, and frustration (affecting the way she reacts

to her physical conditions). I would like to add that I see her current Global Assessment of Functioning rating as 45. Her depression has not adequately been treated, so I consider her to be temporarily totally disabled regarding her work capacity.

Because of controversy and confusion about diagnosing Somatoform Disorders in the DSM-IV(1994), DSM-5(2013) has clarified some diagnostic assumptions , category labels, and definitions. The primary diagnostic category in this symptom class is now called Somatic Symptom Disorder, and it is a diagnosis 'made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. (P. 309)

The focus is now not so much on the physical symptoms themselves (and whether they have demonstrable physical causes), but on the way the person presents and interprets their symptoms.

'(DSM-IV) overemphasized the centrality of medically unexplained symptoms...It is not appropriate to give an individual a mental disorder diagnosis solely because a medical cause cannot be demonstrated...Furthermore...individuals regarded these diagnoses as pejorative and demeaning, implying that their physical symptoms were not 'real'. (P. 309)

Conclusions:

With these new considerations in mind, I believe Ms. Shanks can be diagnosed as:

Somatic Symptom Disorder (DSM-5 300.892)

Major Depressive Disorder (DSM-5 296.22)

I believe the prevailing factor in producing these two mental health conditions was the flu vaccine incident. While her Depressive Disorder likely stems from her pain conditions, sleep disorder, and consequent life limitations, her leg weakness and gait issues likely are Somatic Symptoms stemming from her unique way of perceiving and emotionally reacting to her "injury" (abnormal thoughts, feelings, and behaviors in response to her symptoms.)

Treatment recommendations for both these disorders focus on a combination of Cognitive Behavioral Therapy by a Ph.D. psychologist and appropriate antidepressant medication through a psychiatrist.

Exhibit P is a Resume of Dr. Daniel C. Claiborn, Ph.D. Dr. Claiborn has experience working with numerous organizations including St. Joseph State Hospital, Veterans Administration, Medical Center, Leavenworth, Shawnee Mission Medical Center, Woodson State Hospital, St. Joseph, Johnson County Domestic Court Services, and others. He has worked with numerous sheriff and police departments. Presently he is an instructor for Topeka Police Department Academy and has been an instructor and professor for University of Missouri, Kansas City and Iowa State University. Eight papers and publications are described in the Resume, and are noted to have been published between 1970 and 1985. The most recent publication noted is titled, "Assessment in the Treatment of Couples and Families." The Resume identifies numerous professional presentations. The CV notes he has twice been president, Kansas Association of Professional Psychologists.

Evaluation by Dr. Harold Barkman

The deposition of Dr. Harold Barkman, Jr. taken on February 28, 2017 was admitted as Employer's Exhibit 1.

Dr. Barkman is a physician at the University of Kansas Medical Center. (Barkman deposition, page 4). He identified Barkman Deposition No. 1, his Curriculum Vitae. Dr. Barkman's Curriculum Vitae notes licensures in Oklahoma, Iowa, and Kansas. It notes he is a Diplomate, National Board of Medical Examiners; Diplomate, American Board of Internal Medicine; Diplomate, American Board of Internal Medicine, Sub-specialty, Pulmonary Diseases; Diplomate, American Board of Internal Medicine, Sub-specialty, Critical Care, and "B" Reader Certification, National Institute for Occupational Safety and Health. Dr. Barkman's Curriculum Vitae notes that he is presently Medical Director, Occupational Health, University of Kansas Hospital.

Dr. Barkman's Curriculum Vitae is twelve pages in length, and identifies professional appointments, memberships, awards, invited presentations (numerous), numerous committees and editorial boards, including review for American Review of Respiratory Disease, Chest and archives of Internal Medicine, numerous publications, M.I.H. research activities, and other research activities.

Dr. Barkman evaluated Claimant at the request of Employer. (*Id.* at 6). He met with her on October 1, 2016. (*Id.* at 6). Dr. Barkman identified Barkman Deposition, Exhibit No. 2, his letter to Employer's attorney after reviewing records and his initial

evaluation. Exhibit 2 includes his original notes from when he saw Claimant on October 21. (*Id.* at 7).

Dr. Barkman reviewed records, including a list of Claimant's vaccinations, saw Claimant, did a history, and performed a physical examination. Claimant entered the room using a walker. (*Id.* at 9).

Dr. Barkman was asked the following questions and gave the following answers at Barkman deposition, pages 9-10:

> Q. All right. Doctor, ultimately you were asked by Mr. Hoffmeister two questions; is that correct?
>
> A. Correct.
>
> Q. What was the first of those questions?
>
> A. May I read it right out of –
>
> Q. I think that would be the simplest thing to do.
>
> A. 'Diagnosis of the claimant's medical condition and whether or not she suffered any long term or short term physical effects or injuries from taking the flu vaccine in October of 2013.'
>
> Q. After you review of the records and the physical examination of Ms. Shanks did you come up with an answer to that question?
>
> A. Yes.
>
> Q. What was your answer to his question?
>
> A. Well, my answer here is, 'She has multiple comorbidities that some are preexisting, but at the current time she has allergic rhinitis, mood disorder, history of cardiovascular accident, hyperlipidemia, low back pain, metabolic syndrome, leg weakness, fatigue, obstructive sleep apnea and arthritis.'
>
> Q. Doctor, were any of those conditions related to her receiving a flu vaccine in October of 2013?
>
> A. I don't believe so.

Dr. Barkman was asked the following questions and gave the following answers at Barkman deposition, pages 11-14:

> Q. Turning specifically to Ms. Shanks, was there any medical science that you're aware of that supported whether the flu vaccine could have caused the symptomology that she was complaining of?
>
> Mr. Smith: At what point in time, Counsel?
>
> By Mr. Bandre:
>
> Q. In October of 2013.
>
> A. No.
>
> Q. Is there any medical science to support that the flu vaccine caused her symptomology after October of 2013?
>
> A. I don't believe so.
>
> Q. Doctor, in your review of the records were there other diagnosis or has there been a diagnosis regarding whether the flu vaccine caused any of these symptoms by any of the other physicians you looked at in your review of the records?
>
> A. Well, the records are quite extensive and she's seen a number of different specialists, as well as some psychologists, as well as I believe one occupational medicine physician that evaluated her and rated her, and so there are several diagnosis across the board. Some again have my opinion that there is not a link to the vaccination and others, I think Dr. Koprivica talked about a conversion reaction associated with the injection.
>
> Q. Okay. Do you have an opinion whether Ms. Shanks suffered any short or long term illness from the effect of the October 1st, 2013 shot?
>
> A. Yes.
>
> Q. What is that opinion?
>
> A. I don't believe she suffered any temporary or long term effect.

Q. Doctor, there was a second question that you were posed. Do you recall what the second question was?

A. 'Please advise whether under the criteria set forth above, the claimant's work for Heartland Regional Medical Center was the prevailing factor in causing her alleged medical condition as opposed to all others. Please be advised that prevailing factor is defined as primary factor in relation to any other factor, such as age, preexisting medical condition, non work-related, exposures, etc.'

Q. Did you come to an answer to that question?

A. Yes.

Q. What was your answer to that question that was posed?

A. Her receiving the flu vaccine was not a prevailing factor in any of her medical conditions. The prevailing factor was more related to her preexisting medical conditions.

Q. You don't have any specialty in psychology or psychiatry or anything like that, correct?

A. Correct.

Q. Is it safe to say that your evaluations were limited strictly to the physical side of things with Ms. Shanks?

A. I'm not quite sure how to answer that. I mean, I did review her records, her medical records beyond just the psychological or psyche records that are in there, and so pose the question again.

Q. It was probably a poorly formed question as many of mine might be. Doctor, you're not offering a psychiatric or psychological diagnosis of Ms. Shanks; is that true?

A. Correct.

Q. Okay. Were the opinions you've given today given within a reasonable degree of medical certainty?

A. Yes.

Dr. Barkman testified his conclusion as to whether Claimant had short term or transient reaction to the flu vaccination was based solely upon records he reviewed, and not from any examination that he particularly had made. (*Id.* at 15-16).

Dr. Barkman identified Barkman Deposition Exhibit 3, a record received from Employer's attorney containing a list of vaccinations Claimant had received at Employer. (*Id.* at 17). He identified Barkman Deposition Exhibit 4, the color version of the listing of Claimant's complaints, or history she provided to Dr. Barkman on a separate sheet. (*Id.* at 20). Dr. Barkman identified Barkman Deposition No. 5, the letter referral he received from Employer's attorney, Mr. Hoffmeister. (*Id.* at 20).

Dr. Barkman did not know who the manufacturer of the vaccination was. (*Id.* at 21). He did not look at the VAERS, the vaccination alert response form, for the particular influenza vaccination to Ms. Shanks in October 2013. He looked at what is online for flu vaccinations for 2013. He stated there was not anything out there of the major providers that showed anything that matched Claimant's symptoms. (*Id.* at 22). Dr. Barkman was unaware that there had been some adverse reactions reported prior to October 1, 2013 for this particular lot by the particular manufacturer of the vaccine. (*Id.* at 23).

Dr. Barkman stated there is some sort of product insert that goes with the vaccine generally, and one of the things on the package insert says is that a person receiving the injection may suffer some transient symptoms. He testified the symptoms in the insert are generally localized injection site temporary pain. Dr. Barkman testified, ". . . some people feel they get the flu from it, but there's no science to support that either." (*Id.* at 24).

The package insert talks about patients may report having muscle pain, especially localized. It could also be myalgias, body wide, and headaches. A small percentage of the population who receive the flu vaccination will report body-wide myalgias, body aches and kind of feeling icky all over. (*Id.* at 25).

Dr. Barkman noted that on the day after Claimant received the flu vaccine in October, 2013, she felt weak and sought medical attention. Her main complaint, according to the record, was back pain, feeling pins and needles, and numbness. He noted the flu vaccine was not mentioned, and the physician moved onto doing other things, work-up and treatment. (*Id.* at 26). She had back pain before. (*Id.* at 31).

Dr. Barkman found no evidence of any connection that anyone has made between taking the flu vaccination and the altered gait of Claimant. (*Id.* at 37).

Dr. Barkman did not look at the VAERS data base. (*Id.* at 38). The VAERS reports are from a patient that received the vaccination going to a medical provider who then reports to the CDC or to a pharmacy, who reports to the CDC. (*Id.* at 39).

Dr. Barkman's January 20, 2017 report states in part:

> In reference to your specific questions in your letter of August 2016, I will address those individually:
> 1. Diagnosis of claimant's medical condition whether or not she suffered any long-term or short-term physical illness or injuries from taking the flu vaccine on October 2013. She has multiple comorbidites [*sic*] that some are preexisting, but at the current time she has allergic rhinitis, mood disorder, history of cardiovascular accident, hyperlipidemia, low back pain, metabolic syndrome, leg weakness, fatigue, obstructive sleep apnea and arthritis. None of these conditions were related to her receiving the flu vaccine in October 2013. The vaccine had kill virus. She had no signs of symptoms around the injection site and no prior significant issues associated with the flu vaccine. The following day her symptoms were more consistent with a systemic process that led to multiple evaluations and testing over several months. There is no medical science to support the flu vaccine of 2013 could result in such a constellation of symptoms. Therefore she did not suffer any short or long-term illness from the October 2013 flu shot.
> 2. Please advise whether on the criteria set forth above the claimant's work in Heartland Medical Center was a prevailing cause of her alleged medical conditions opposed to all others. Please advise the prevailing factors defied by the primary factor in relation to any other factor as such of age, preexisting conditions or non-work related exposures, etc. Her receiving the flu vaccine was not a prevailing factor in any of her medical conditions. The prevailing factor is more related to her preexisting medical conditions.
>
> Based on the information I have at this time, my opinion is to a reasonable degree of medical certainty.

Evaluation of Dr. William Logan

The deposition of Dr. William Logan taken on February 14, 2017 was admitted as Employee Exhibit 2. Dr. Logan is a physician that specializes in psychiatry. (Logan deposition, page 4). Dr. Logan is licensed in Texas, Missouri, Kansas, and Nebraska. He is board certified in Psychiatry by the American Board of Psychiatry and Neurology. He

also has board certification in Forensics Psychiatry by the American Board of Forensic Psychiatry. (*Id.* at 5). Dr. Logan's Curriculum Vitae, Logan deposition 1, describes numerous post-residency conferences and courses, professional contributions, hospital affiliations, consultations, education activity (courses taught), presentations, and publications. He has provided psychiatric expert testimony on a variety of issues related to mental health in both state and federal courts on an average of 25 to 30 times a year since 1981. Dr. Logan's Curriculum Vitae is 19 pages in length.

Dr. Logan, at the request of Employer's attorney, met Claimant on September 13, 2016.

Dr. Logan identified Logan Deposition Exhibit 2, his January 20, 2017 letter based on his examination of Claimant's psychological tests and his review of the records with some of the opinions provided at the end. Dr. Logan met with Claimant for two hours. In addition, Claimant took the personality assessment inventory. He reviewed medical records listed on page 1 of his report. He also reviewed employment records from Employer. He noted there was a discrepancy in that Claimant is recorded to have taken flu shots in the past, but she did not believe that she did. (*Id.* at 9).

Dr. Logan reviewed medical records regarding Claimant's prior psychological condition or issues. He noted she had a prior history of attention deficit disorder, social anxiety disorder, and depression. (*Id.* at 10). He also noted there was a history of affective disorders in Claimant's family. He thought there was one case of dementia and someone else who had schizophrenia. He noted at one point someone thought Claimant had bipolar disorder. Page 2 of his report shows a number of pre-existing physical conditions prior to October 1, 2013 and new physical complaints after October 1, 2013. (*Id.* at 10).

Dr. Logan reviewed the results of the personality assessment inventory. He noted Claimant produced what was interpreted as a valid response to the questions that were asked. (*Id.* at 11). It showed she was depressed, had a lot of pain complaints, had a lot of concern over physical functioning, and had poor motivation for treatment. Dr. Logan did not think she had ever had any type of psycho therapy other than medication treatment. (*Id.* at 11-12).

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, page 12:

Q. Did you take a family history from Ms. Shanks?

A. I did.

Q. Was there anything significant that stuck out to you from Ms. Shanks' prior family history?

A. She's had a lot of relationship difficulties over the years and has hooked up with some people who had either drug abuse problems or were physically abusive. She's had a couple of children. Had some concerns particularly about her son who I think has a methamphetamine problem.

Q. Were these things stressful for Ms. Shanks?

A. Yes, as a general rule, although she really denied much stress from the prior separations. I think the most recent one was maybe about four years ago when she was with another man for about two years and the relationship didn't work out.

Claimant described sleep difficulty or initial sleep difficulty and some early morning waking. Dr. Logan believed she was on Cymbalta, primarily as an antidepressant. He believed she had obstructive sleep apnea. (*Id.* at 13). Dr. Logan thought Claimant weighed 320 pounds, but that had gone up. (*Id.* at 14).

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, page 14:

Q. When she appeared before you for your two-hour meeting how did she appear?

A. She was well groomed, neat, presentable, convivial, no difficulty answering questions.

Q. Did she have any indication of a psychosis as you met with her?

A. No. She was rational, and her speech was normal rate and flow, she didn't skip around, or say anything bizarre, or respond to any extraneous phenomenon like hallucinations.

Q. What were her predominant complaints when she met with you?

A. She felt depressed, she felt hopeless, she felt like she was physically impaired and not able to do very much, and really had very little hope for future improvement.

Dr. Logan's diagnosis under the Diagnostic and Statistical manual of Physical Disorders 5th Edition (DSM-V) was major depression disorder, likely recurrent, moderate intensity, and somatic symptom disorder. (*Id.* at 16).

Dr. Logan was asked to explain in layman's terms what a somatic symptom disorder is. He testified at Logan deposition, page 16:

> A. Where somebody is preoccupied about the seriousness of their medical condition, has a lot of anxiety about health issues and a persistent effort to obtain treatment. But really an inclusive medical reason for many of her symptoms really hasn't been identified, at least not neurologically. Despite a couple of extensive evaluations no clear cut cause or etiology has been found.
>
> Q. For the physical symptoms?
>
> A. Right. . . .

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, pages 17-20:

> Q. My fault there. Doctor, could you tell us what a Conversion Disorder is?
>
> A. Basically a Conversion disorder is where somebody develops physical symptoms of some kind for which there is not clear cut medical etiology. In other words, any kind of testing that would reveal the reason for the symptoms is absent. The symptoms themselves may not follow any clear pattern that would indicate an illness. Illnesses have a certain set of symptoms that exist together and follow a typical course and in these cases usually the onset is rather sudden. I guess one of the old time examples was perhaps hysterical blindness where for non-medical reasons somebody would suddenly be unable to see or they may have what they call pseudoseizures, seizure-like episodes for which there's no actual epileptiform focus on the brain. Usually there are various neurological symptoms. Ataxia is one that's often mentioned, which is a symptom that she had. But there's no particular recognition, other than an emotional one, for why these symptoms exist.
>
> Q. Is there a similarity between a Conversion Disorder and a Somatic Symptom Disorder?

A. Yes. They're in the same chapter, you know, the primary difference between them, in the Somatic Symptom disorder there is a lot more anxiety about the physical symptoms, a lot more depression, a lot more seeking medical treatment than you might have in a Conversion Disorder. Of course, the other part of the differential is physical symptoms are not all uncommon in depressive illnesses either, so the two often coexist.

Q. Did you have an opinion as to whether Ms. Shanks' psychological injuries were related to the October, 2013 flu vaccine?

A. I couldn't confirm that they were.

Q. Did you feel that the prevailing factor for her psychological injuries was the taking of the October, 2013 flu vaccine?

A. I didn't think I could say that with a reasonable degree of medical certainty.

Q. By saying that are you saying the opposite, that they're not related?

A. Maybe not that strong, but I certainly didn't see any evidence that I could hang my hat on. It's kind of one of these cases where you're hung either way. If you took either opinion, you know, you'd be subject I think to vigorous dispute because really there is no clear etiological factor, except temporally maybe in terms of time, for attributing this to the flu shot. And early on she didn't exclusively attribute this to the flu shot. She thought there might be some autoimmune reaction, another potential hypothesis early on was mercury poisoning. These things didn't pan out either. But clearly as the several months had passed she had identified it was the flu shot. But primarily it's a self identification. It hasn't really been confirmed as an etiological agent in this case.

Q. And that's from your review of the medical records and talking with her; is that correct?

A. Yes.

Q. Doctor, were the opinions you've given given within a reasonable degree of medical certainty?

A. Yes.

Dr. Logan did not diagnose Bipolar. (*Id.* at 24).

Dr. Logan's practice is about half forensics psychology. Dr. Logan does not do inpatient work. (*Id.* at 26).

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, pages 28-30:

Q. Would it be fair reading to say that Dr. Claiborn was more focused on the depression at this point because it seemed to be more predominant?

A. I don't think that would be necessarily a misreading. I think he, everybody's agreed that her depression is predominant and also the physical problems are significant.

Q. When we say physical problems we're talking about the somatization, correct?

A. Right.

Q. And part of that would go to whether or not the patient had a Conversion Disorder?

A. It could but, you know, people with Conversion Disorder truly believe that they're physically impaired even if physiologically they're not. The belief is sincere.

Q. Isn't that the case here with Ms. Shanks that she feels physically, she feels genuinely that she is physically impairment?

A. Yes.

Q. And even though the neurologist has said there's no neurological basis for a particular gait impairment?

A. That's right.

Q. So wouldn't that follow the classic pattern of a Conversion Disorder?

A. Yeah, there's some overlap between these two conditions, but I tended to favor a little bit more the Somatic Symptom Disorder for reasons I described on direct in the sense that, you know, there's not really, the somatization is something that's really prominent. There are some things like the Ataxia, I guess, that might fall within the Conversion Disorder spectrum, but overall her concern is about physical symptoms. And the fact that she has her concern about physical symptoms doesn't mean that there are not real physical symptoms also that exist. She very easily could also have fibromyalgia. It's just that it's very difficult –

Q. No one's diagnosed that as being a problem that she has currently, have they?

A. There's certainly been multiple diagnosis of that in the past.

Q. I understand, but no one since October 1, 2013, has diagnosed her condition as being fibromyalgia?

A. Well, I'm not sure. The main thing that's been diagnosed since that time probably has been depression. There certainly has been a huge medical workup that really hasn't revealed any outstanding cause.

Dr. Logan was asked about Dr. Kempton 's diagnosis of bilateral leg weakness on October 2nd. (*Id.* at 37). He was asked if that was possibly consistent with someone who is having an adverse reaction to the flu vaccination. Dr. Logan answered that it is "more likely as we don't know why she is having symptoms at this particular time. (*Id.* at 38).

Dr. Logan was asked about Dr, Thornton's October 17 record stating Claimant was displaying abnormal at Ataxia. Dr. Logan agreed she had an abnormal gait. (Page 39) Dr. Logan disagreed with Dr. Thornton's differential diagnosis of conversion disorder. (*Id.* at 39).

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, pages 41-42:

Q. And then he [Dr. Ewing] makes a diagnosis, it says, 'The gait instability, this is a very unusual gait. It is quite functional. I expect fear is playing a larger role. I do not see anything to suggest a central cause.' Would the statement by Dr. Ewing indicate that he thinks that she's got a Conversion Disorder at that point?

A. Not necessarily a Conversion Disorder, but he does not believe there's a physiological cause for her gait disturbance. Functional is a very general word to say that he believes the problem is psychiatric in some way or in her head.

Q. At that point in time what other factors are in play other than the fact that there was a prior flu vaccination?

A. Well, she is temporally trying to make a causal connection between the flu vaccine and her Ataxia, but if it, in fact, had been due to the flu vaccine there should have been some, it should have been physiologically based. And the fact that it wasn't physiologically based means basically that emotionally she's attributing this to the flu vaccination, but it's unsubstantiated that the flu vaccination had anything to do with it.

Q. Other than in her mind that she –

A. Other than in her mind.

Q. Okay.

A. And early on even her mind was not set on the flu vaccination. She also thought it might be heavy metal poisoning such as mercury poisoning. So she was considering other etiologies for it even early on.

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, page 43:

Q. Okay. So at least in her mind she has it that the flu shot is the source of her difficulties, correct?

A. Right. I think she believes that.

Q. You think that's a genuine belief?

A. Yeah, I think it's a genuine belief. It doesn't mean it's a correct belief.

Q. Understood. Understood. I think we're all in agreement she probably doesn't have genuine Ataxia, but has what is perceived to be Ataxia?

A. Right. That was the neurologist's conclusion at least.

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, page 48:

Q. Then looking at the, I know you've brought your copy of the DSM-V with you, so I'd have you look at 44.4.

A. I'm sorry, give me the page reference you're asking about.

Q. Just a moment. Looks like it's 318.

A. Okay. Yeah, the section on Conversion Disorder.

Q. And specifically it directs the symptom type as F44.4 with abnormal movement such as tremor, dystonic movement, myoclonus, and gait disorder, correct?

A. Right. That's one particular manifestation of a Conversion Disorder, can be.

Dr. Logan agreed Claimant had criteria B, "Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions" because the neurologists all said "We don't think it is neurological. We think it's something else--." (*Id.* at 50-51).

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, pages 51-52:

Q. So she meets A and B. Now to C. 'The symptom or deficit is not better explained by another medical or mental disorder.' Is there any other medical disorder aside from psychological ones that would better explain this condition?

A. Unknown.

Q. Okay. Is there a mental disorder that would better explain this condition?

A. Yes. I think the depression and combined with the Somatic Symptom disorder that I diagnosed would better explain it.

Q. We've already indicated that you do not expect depression to cause a sudden gait alteration, correct?

A. No. Generally that's not one of the things, but then again even in a Conversion Disorder most of them don't manifest themselves as a gait disturbance.

Q. Then moving to D, 'The symptoms or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.' In this instance her inability to walk she felt was an impediment or an impairment to her, correct?

A. Right. The criteria in D, however, is a gateway criteria for all the conditions in this entire book. They all, if somebody has symptoms but it doesn't cause them any particular distress you don't diagnose it or treat it. So it kind of goes without saying for every particular diagnosis in this book you'll find that same criteria.

Q. Would you agree generally she met all four criteria?

A. No. As I said, I think this is a moot point, but I thought she fit better into another closely related condition in this same chapter that I diagnosed, but these things are not like the difference between an apple and a watermelon. It's more like the difference in the variety of an apple.

Dr. Logan was asked the following questions and gave the following answers at Logan deposition, page 63:

Q. Okay. Do you recommend that she have psychotherapy?

A. I think it would help. It couldn't hurt.

Q. Okay. Do you think she needs a different set of psychotropic drugs?

A. Possibly since she hasn't been terribly responsive to what she's been receiving, but I would hasten to say that there may be no magic bullets out there that are going to remove her symptoms.

Q. But it's worth taking?

A. It's worth investigating.

Dr. Logan testified Claimant is very low functioning and is occupationally impaired. (*Id.* at 67).

Dr. Logan agreed Claimant was previously diagnosed with fibromyalgia and was treating for fibromyalgia prior to October 1, 2013. (*Id.* at 69). He stated fibromyalgia is not something you cure. There are exacerbations and remissions. Claimant had been prescribed Lyrica and that is commonly used for symptoms of fibromyalgia. Dr. Logan testified all of the neurologists were unanimous and ran multiple tests and they could not find any etiological cause for the Ataxia. (*Id.* at 70).

Dr. Logan's January 20, 2017 report states in part:

Opinions on Refocused Questions

1A. Ms Shanks diaposes fit, best in the following categories in DSM-5.

Major Depressive Disorder, likely recurrent, moderate (F33.2).

Somatic Symptoms Disorder with predominant pain, persistent moderate to severe, including persistent thought of a serious illness, high anxiety about health issues and persistent effort to obtain treatment in terms if treatment effort Ms. Shanks has not pursue psychotherapy as recommended by Dr. Claiborn. There are some features of a Conversion Disorder in terms of the incompatibility between symptom and recognized neurological or medical conditions and significant impairment in the areas of social and occupational findings. No specific psychological stressor is identified (F45.1)

1B. I am not able to attribute Ms. Shank's [*sic*] psychological injuries to the October 2013 flu vaccine. Ms. Shanks has a number of physical

> conditions with a variable course including anxiety, depression, number of physical impairments and a history of fibromyalgia that could influence many of her physical complaints, life stressors as well as obstructive sleep apnea. Somatic preoccupation is not unusual in a depressive illness.
>
> **2.** I am unable to conclude with a reasonable medical certainty that Ms. Shanks [*sic*] work at Heartland Regional Medical Center is the prevailing factor in causing her psychological conditions opposed to all other factors.
>
> The above opinions are offered with a reasonable medical certainty.

Exhibit B contains Family and Medical Leave Act records of Employer pertaining to Claimant. Page 1 is dated October 12, 2013 and notes that on October 10, 2013, Claimant informed Employer that she needed leave beginning on October 9, 2013 for her own serious health condition. Page 1 also states that the notice is to inform Claimant that she is eligible for FMLA leave. Exhibit B includes pages from Dr. Byron Thornton dated October 25, 2013. Dr. Thornton's portion of the form states that Claimant is unable to perform any of her job functions due to her condition.

Exhibit C is a record of Kati Dentin, Human Resources Assistant of Employer, dated January 28, 2014 and addressed to "Whom It May Concern." Exhibit C states that Claimant "was employed at Heartland Health from 8/17/2004 through 12/16/2013. She was off work on an approved medical leave due to her serious health condition from 10/9/2013 to the effective date of separation on 12/16/2013."

Rulings of Law

Based on the substantial and competent evidence, the stipulations of the parties, and the application of the Workers' Compensation Law, I make the following Rulings of Law:

Section 287.800, RSMo[4] provides in part that administrative law judges shall construe the provisions of this chapter strictly and shall weigh the evidence impartially

[4] All statutory references are to RSMo 2006 unless otherwise indicated. In a workers' compensation case, the statute in effect at the time of the injury is generally the applicable version. *Chouteau v. Netco Construction*, 132 S.W.3d 328, 336 (Mo.App. 2004); *Tillman v. Cam's Trucking Inc.*, 20 S.W.3d 579, 585-86 (Mo.App. 2000). *See also Lawson v. Ford Motor Co.*, 217 S.W.3d 345 (Mo.App. 2007).

without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts.

Section 287.808, RSMo provides:

> The burden of establishing any affirmative defense is on the employer. The burden of proving an entitlement to compensation under this chapter is on the employee or dependent. In asserting any claim or defense based on a factual proposition, the party asserting such claim or defense must establish that such proposition is more likely to be true than not true.

Section 287.020.2, RSMo provides:

> The word 'accident' as used in this chapter shall mean an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift. An injury is not compensable because work was a triggering or precipitating factor.

Section 287.020.3, RSMo provides in part:

> 3. (1) In this chapter the term 'injury' is hereby defined to be an injury which has arisen out of and in the course of employment. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.
> (2) An injury shall be deemed to arise out of and in the course of the employment only if:
> (a) It is reasonably apparent, upon consideration of all the circumstances, that the accident is the prevailing factor in causing the injury; and
> (b) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal nonemployment life.
> (3) An injury resulting directly or indirectly from idiopathic causes is not compensable.

> (5) The terms 'injury' and 'personal injuries' shall mean violence to the physical structure of the body. . . .

Section 287.020.10, RSMo provides:

> In applying the provisions of this chapter, it is the intent of the legislature to reject and abrogate earlier case law interpretations on the meaning of or definition of 'accident', 'occupational disease', 'arising out of', and 'in the course of the employment' to include, but not be limited to, holdings in: Bennett v. Columbia Health Care and Rehabilitation, 80 S.W.3d 524 (Mo.App. W.D. 2002); Kasl v. Bristol Care, Inc., 984 S.W.2d 852 (Mo.banc 1999); and Drewes v. TWA, 984 S.W.2d 512 (Mo.banc 1999) and all cases citing, interpreting, applying, or following those cases.

The workers' compensation claimant bears the burden of proof to show that her injury was compensable in workers' compensation. *Johme v. St. John's Mercy Healthcare*, --- S.W.3d ----, 2012 WL 1931223 (Mo.) *(citing Sanderson v. Producers Comm'n Ass'n,* 360 Mo. 571, 229 S.W.2d 563, 566 (Mo. 1950).

"In a workers' compensation case, the claimant carries the burden of proving all essential elements of the claim." *Fischer v. Archdiocese of St. Louis*, 793 S.W.2d 195, 198 (Mo.App. 1990), *overruled in part on other grounds by Hampton v. Big Boy Steel Erection* , 121 S.W.3d 220, 230 (Mo.banc 2003)[5]. The employee must establish a causal connection between the accident and the claimed injuries. *Thorsen v. Sachs Elec. Co.,* 52 S.W.3d 616, 618 (Mo.App.2001); *Williams v. DePaul Ctr,* 996 S.W.2d 619, 625 (Mo.App. 1999); *Decker v. Square D Co.*, 974 S.W.2d 667, 670 (Mo.App. 1998); *Fischer*, 793 S.W.2d at 198.

The testimony of Claimant or other lay witnesses as to facts within the realm of lay understanding can constitute substantial evidence of the nature, cause, and extent of disability when taken in connection with or where supported by some medical evidence. *Pruteanu v. Electro Core, Inc.*, 847 S.W.2d 203, 206 (Mo.App. 1993), 29; *Reiner v. Treasurer of State of Mo.*, 837 S.W.2d 363, 367 (Mo.App 1992); *Fischer*, 793 S.W.2d at 199. The trier of facts may also disbelieve the testimony of a witness even if no contradictory or impeaching testimony appears. *Hutchinson, 721 S.W.2d* at 161-2; *Barrett v. Bentzinger Brothers, Inc.*, 595 S.W.2d 441, 443 (Mo.App. 1980). The

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[5]Several cases are cited herein that were among many overruled by *Hampton* on an unrelated issue (*Id.* at 224-32). Such cases do not otherwise conflict with *Hampton* and are cited for legal principles unaffected thereby; thus *Hampton*'s effect thereon will not be further noted.

testimony of the employee may be believed or disbelieved even if uncontradicted. *Weeks v. Maple Lawn Nursing Home*, 848 S.W.2d 515, 516 (Mo.App. 1993).

The Court in *Silman v. William Montgomery & Assocs.*, 891 S.W.2d 173 (Mo. App. 1995) stated at 175-76:

> The testimony of a claimant or other lay witness can constitute substantial evidence of the nature, cause, and extent of disability when the facts fall within the realm of lay understanding. However, an injury may be of such a nature that expert opinion is essential to show that it was caused by the accident to which it is ascribed. Where the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific technique for diagnosis, and particularly where there is a serious question of pre-existing disability and its extent, the proof of causation is not within the realm of lay understanding nor--in the absence of expert opinion--is the finding of causation within the competency of the administrative tribunal. (citations omitted)

Where there are conflicting medical opinions, the fact finder may reject all or part of one party's expert testimony which it does not consider credible and accept as true the contrary testimony given by the other litigant's expert. *Kelley v. Banta & Stude Constr. Co. Inc.*, 1 S.W.3d 43, 48 (Mo.App. 1999); *Webber v. Chrysler Corp.*, 826 S.W.2d 51, 54 (Mo.App. 1992)), *overruled on other grounds by Hampton v. Big Boy Steel Erection,* 121 S.W.3d 220, 229 (Mo. banc 2003); *Hutchinson v. Tri-State Motor Transit Co.*, 721 S.W.2d 158, 162 (Mo.App. 1986). The Commission's decision will generally be upheld if it is consistent with either of two conflicting medical opinions. *Smith v. Donco Const.*, 182 S.W.3d 693, 701 (Mo.App. 2006). The acceptance or rejection of medical evidence is for the Commission. *Smith,* 182 S.W.3d at 701; *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 263 (Mo.App. 2004).

The Court in *Angus v. Second Injury Fund*, 328 S.W.3d 294 (Mo.App. 2010) states at 300:

> [W]e defer to the Commission on issues involving the credibility of witnesses and the weight to be given testimony, and we acknowledge that the Commission may decide a case 'upon its disbelief of uncontradicted and unimpeached testimony.' *Alexander v. D.L. Sitton Motor Lines,* 851 S.W.2d 525, 527 (Mo. banc 1993) (quoting *Ricks v. H.K. Porter, Inc.*, 439 S.W.2d 164, 167 (Mo.1969)). However, '[t]he commission may not substitute an administrative law judge's personal opinion on the question of medical causation of [an injury] for the

> uncontradicted testimony of a qualified medical expert.' *Wright v. Sports Associated, Inc.,* 887 S.W.2d 596, 600 (Mo. banc 1994). '[T]he question of causation is one for medical testimony, without which a finding for claimant would be based upon mere conjecture and speculation and not on substantial evidence.' *Elliott v. Kansas City, Mo., Sch. Dist.,* 71 S.W.3d 652, 658 (Mo.App. W.D.2002). When 'expert medical testimony is presented,' 'an ALJ's personal views of [the evidence] cannot provide a sufficient basis to decide the causation question, at least where the ALJ fails to account for the relevant medical testimony.' *Van Winkle,* 258 S.W.3d at 898.

The Commission may not arbitrarily disregard and ignore competent, substantial, and undisputed evidence of witnesses who are not shown by the record to have been impeached and the Commission may not base its findings upon conjecture or its own mere personal opinion unsupported by sufficient and competent evidence. *Cardwell v. Treasurer of State of Missouri,* 249 S.W.3d 902, 907 (Mo.App. 2008), citing *Copeland v. Thurman Stout, Inc.,* 204 S.W.3d 737, 743 (Mo.App. 2006).

8 CSR 50–2.010(14) states in part, "Prior to hearing, the parties shall stipulate uncontested facts and present evidence only on contested issues." Such stipulations "are controlling and conclusive, and the courts are bound to enforce them." *Hutson v. Treasurer of Missouri as Custodian of Second Injury Fund,* 2012 WL 1319428 (Mo.App. 2012) (c*iting Boyer v. Nat'l Express Co.,* 29 S.W.3d 700, 705 (Mo.App. 2001)).

The Court in *Knipp vs. Nordyne, Inc.*, 969 S.W.2d 236 (Mo.App 1998), states at 239:

> Mrs. Knipp is correct that expert medical testimony is not necessary to establish the cause of an injury if causation is a matter within the understanding of lay persons. *Quilty v. Frank's Food Mart*, 890 S.W.2d 360, 364 (Mo.App.1994). If medical causation is not within common knowledge or experience, however, then:
>
> > an injury may be of such a nature that expert opinion is essential to show that it was caused by the accident to which it is ascribed. When the condition presented is a sophisticated injury that requires surgical intervention or other highly scientific technique for diagnosis, and particularly where there is a serious question of pre-existing disability and its extent, the proof of causation is not within the realm of lay understanding nor—in the

> absence of expert opinion—is the finding of causation within the competency of the administrative tribunal.
>
> *Silman v. William Montgomery & Assoc.*, 891 S.W.2d 173, 175–76 (Mo.App.1995) (citations omitted). *See also Brundige v. Boehringer Ingelheim*, 812 S.W.2d 200, 202 (Mo.App.1991).

"A conclusory but unsupported statement that work was a significant factor in causing the claimant's mental condition simply is not enough to carry the claimant's burden of proof. [We] need further explanation as to the relationship between the work-related injury and the mental condition. The record lacks any explanation as to how work was a substantial factor in causing the claimant's somatoform disorder." *Royal v. Advantica Restaurant Group, Inc.*, 194 S.W.3d 371, 378 (Mo.App. 2006).

"[E]xpert testimony was required to establish causation, inasmuch as 'the causation of a mental condition is not as apparent as that of many physical conditions and ... proof of it would almost always be dependent on expert testimony.' *Tibbs v. Rowe Furniture Corp.*, 691 S.W.2d 410, 413 (Mo.App. S.D.1985), *superseded by statute on other grounds as stated in Kasl,* 984 S.W.2d at 855, and *overruled on other grounds by Hampton,* 121 S.W.3d at 231. *Royal,* 194 S.W.3d at 378.

"Furthermore, the record amply supports the Commission's conclusion that Dr. Khalid, who was Royal's sole expert witness as to the causation of her somatoform disorder, failed to provide any legitimate, persuasive explanation as to how work was a substantial factor in causing Royal's somatoform disorder, making only a conclusory and unsupported statement that was insufficient to carry Royal's burden of proof." *Id.*

> While it is true that the claimant had no difficulty walking before the October 15th injury and did have problems walking within two *378 weeks of the work-related accident, this close relationship in time between the injury and the complained-of condition does not in and of itself establish causation.... [We are] unconvinced that the work-related accident and physical injury to the claimant's left knee and leg or the resulting deep-vein thrombosis was a significant cause of [her] psychological disorder. *Royal* at 377-78.

1. Did Claimant sustain an injury by accident on or about October 1, 2013 arising out of and in the course of her employment for Employer?

I find Claimant failed to prove she sustained an injury by accident on or about October 1, 2013 arising out of in the course of employment for Employer. I find and conclude Claimant failed to prove that she sustained an accident that was the prevailing

factor in causing both the medical condition and disability. I find and conclude Claimant failed to prove that she sustained an accident that was the prevailing factor in causing an injury. These conclusions are supported by the following:

I find causation of Claimant's alleged injury is not within common knowledge or experience and that expert testimony is required to establish causation of Claimant's alleged injury. *Knipp,* 969 S.W.2d at 239; *Royal,* 194 S.W.3d at 378.

Claimant's treating doctors failed to diagnose a physical injury caused by Claimant's October 1, 2013 flu shot. The flu shot was not mentioned in Dr. Kempton's October 2, 2013 records. Dr. Kempton did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. He did not diagnose an injury caused by the flu shot.

Dr. Thornton treated Claimant in October 2013. He was not sure what caused her problems. Dr. Thornton noted on October 25, 2013, "I am really actually at a loss for what is going on here." His Impression Plan notes, "As yet, undetermined ideology." Dr. Thornton did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. He did not diagnose an injury caused by the flu shot.

Dr. Ewing treated Claimant after the October 1, 2013 flu shot. He found no physical injury resulting from the flu shot. Claimant received extensive testing after the flu shot, and the testing results were normal. Dr. Ewing's November 1, 2013 note states he could not find a neurologic cause from most of Claimant's symptoms. He noted she had a history of fibromyalgia. He noted that she was not functioning as well as she would like to and her memory loss bothered her. He told Claimant he suspected that was in large due to fibromyalgia. His Impression was, "Possibly fibromyalgia. I cannot find any other changes that seem to be causing this. I am not sure if it is fibromyalgia or not, but I cannot find a consistent neurology cause."

Dr. Bronson noted on November 1, 2013 that Claimant has a history of fibromyalgia and that "certainly, earlier this month she had a spell where she felt a lot worse." He noted her trouble walking and fatigue and stated a question would be if those were related to a positive ANA, or if there is any sign of a connective tissue disease. His Impression was fibromyalgia, long history. Dr. Bronson did not see any signs of or an active connective tissue disease or inflammatory arthritis. Dr. Bronson's November 1, 2013 note does not mention the flu shot. Dr. Bronson did not relate Claimant's symptoms and complaints to the flu shot. He did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. He did not diagnose an injury caused by the flu shot.

Dr. Ewing noted on November 26, 2013 that he was not sure exactly what the source of Claimant's hyperreflexia, weakness and tremor were. He noted there was no evidence of neuropathy and no visible evidence of encephalopathy on any of the imaging. Dr. Ewing noted on December 13, 2013 that all of the testing from Claimant's lumbar puncture had been normal. Dr. Ewing did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. He did not diagnose an injury caused by the flu shot.

Dr. Hairston noted on December 27, 2013 that there was clearly a functional overlay to Claimant's gait. Her record notes, "I did discuss this with other neurological colleagues at KU. We are unaware of a flu shot causing the symptoms that she has." Dr. Hairston noted normal tests. She concluded the etiology of Claimant's condition was unknown.

On January 2, 2014, Dr. Hairston diagnosed gait abnormality, chronic fatigue syndrome, daytime hypersomnolence, obstructive sleep apnea, elevated ANA level, and attention concentration deficit. Her record notes "I did discuss her case with other colleagues in neurology. No one is aware of a flu shot that would cause such a gait." Dr. Hairston noted that Claimant's left sided weakness is a residual from her prior strokes and her abnormal eye movements can be explained by her strabismus. Dr. Hairston noted, "I cannot find a neurologic basis for her gait. I suspect a functional overlay to her exam. It was explained to her that her exam anxiety could play a role in her findings." Dr. Hairston did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. She did not diagnose an injury caused by the flu shot.

Claimant reported to Tom Bein on June 10, 2014 that she had a problem walking, tremors in her hands, feeling constantly exhausted, weakness in her legs and walking, and her arms feeling strange and having some problems with memory. While Claimant reported difficulties after receiving a flu shot, Tom Bein did not express any opinion that Claimant's flu shot on October 3, 2013 caused her complaints or condition. He did not diagnose an injury caused by the flu shot.

Dr. Ewing saw Claimant on July 17, 2014. His record notes, "I told her this is not a reaction that has ever been described with a flu shot. I looked up the CDC reports of what happens with a flu shot and there is no one that has ever had this before that I can find in any of the literature. I told her this is not a consequence of it."

Dr. Stuber treated Claimant in 2014 and 2015. Dr. Stuber assessed limb weakness, fibromyalgia, and chronic major depression. He prescribed Lyrica and Cymbalta. His January 30, 2015 record states in part: "The patient continues to be a diagnostic mystery. I think she has FMA for sure but neurologically it is hard to say what is going on. The palmar erythema is striking. A collagen disease is very possible but her ANA is neg.

Dr. Stuber noted on March 11, 2015 that Claimant appeared to be disabled from fibromyalgia. He noted she walked there that day with the aid of a walker and had a great deal of difficulty in getting out of her chair. He noted she had all of the tender points associated with fibromyalgia, and that was what he was going to treat her for. He increased Claimant's Lyrica, a medication prescribed to treat fibromyalgia. Dr. Stuber did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. He did not diagnose an injury caused by the flu shot.

Dr. Barkman, a highly qualified doctor from KU, reviewed records and examined Claimant. He testified Claimant " has multiple comorbidities that some are preexisting, but at the current time she has allergic rhinitis, mood disorder, history of cardiovascular accident, hyperlipidemia, low back pain, metabolic syndrome, leg weakness, fatigue, obstructive sleep apnea and arthritis." He did not believe any of those conditions were related to Claimant receiving a flu vaccine in October 2013.

Dr. Barkman was not aware of any medical science that supported whether the flu vaccine could have caused the symptomatology that Claimant was complaining of in October 2013. He did not believe there was any medical science to support that the flu vaccine caused Claimant's symptomatology after October 2013. He does not believe that Claimant suffered any temporary or long-term effect from the October 1, 2013 flu shot. He testified that Claimant's receiving the flu shot was not a prevailing factor in any of her medical conditions. He testified "the prevailing factor was more related to her pre-existing medical conditions." Dr. Barkman did not conclude Claimant's October 1, 2013 flu shot caused her symptoms and complaints. He did not diagnose an injury caused by the flu shot.

Dr. Barkman looked at what was online for flu vaccinations for 2013. He testified there was nothing he found of the major providers that showed anything that matched Claimant's symptoms. He was unaware of any adverse reactions reported prior to October 1, 2013 for that particular lot by that particular manufacturer.

Dr. Barkman stated one of the things on the package insert that goes with the vaccine says that a person receiving the injection may suffer some transient symptoms. He testified the symptoms in the insert are generally localized injection site temporary pain. Dr. Barkman testified, ". . . some people feel they get the flu from it, but there's no science to support that either." He found no evidence of any connection that anyone had made between Claimant taking the flu vaccination and her altered gait.

I find and conclude that Dr. Barkman's opinions are credible and persuasive.

Dr. Logan, a highly qualified psychiatrist, did not think with a reasonable medical certainty that Claimant's psychological injuries were related to the October 2013 flu vaccine. He noted that it had not been confirmed as an etiological agent in this case.

Dr. Logan testified, "Oh well, she is temporally trying to make a causal connection between the flu vaccine and her Ataxia, but if it, in fact, had been due to the flu vaccine there should have been some, it should have been physiologically based. And the fact that it wasn't physiologically based means that emotionally she is attributing this to the flu vaccination, but it is unsubstantiated that the flu vaccination had anything to do with it."

Dr. Logan stated in his report:

> **1B.** I am not able to attribute Ms. Shank's [*sic*] psychological injuries to the October 2013 flu vaccine. Ms. Shanks has a number of physical conditions with a variable course including anxiety, depression, number of physical impairments and a history of fibromyalgia that could influence many of her physical complaints, life stressors as well as obstructive sleep apnea. Somatic preoccupation is not unusual in a depressive illness.
>
> **2.** I am unable to conclude with a reasonable medical certainty that Ms. Shanks [*sic*] work at Heartland Regional Medical Center is the prevailing factor in causing her psychological conditions opposed to all other factors.
>
> The above opinions are offered with a reasonable medical certainty.

I find and conclude these opinions of Dr. Logan are credible and persuasive.

Dr. Koprivica concludes in part:

> Ms. Shanks' work-related vaccination on October 1, 2013, and the adverse reaction to that vaccination is felt to represent the direct, proximate and prevailing factor in Ms. Shanks' development of physical symptoms. Unfortunately, flowing from this adverse reaction to the vaccination is the development of what I believe is a likely conversion disorder.
>
> In terms of the adverse reaction, in support of the objective nature of this reaction from a physical perspective, is the additional report by a

separate individual of reaction to the same lot of vaccine with the vaccination for that individual on January 7, 2014.

I find these conclusions of Dr. Koprivica are not credible or persuasive. They lack foundation. As in *Royal v. Advantica Restaurant Group, Inc.*, 194 S.W.3d 371, 378 (Mo.App. 2006), they fail to provide any legitimate, persuasive explanation as to how work was the prevailing factor in causing Claimant's conversion disorder. They make only conclusory and unsupported statements. They overlook the fact that there was never any convincing diagnosis that the flu shot caused any physical injury. They ignore that more than 3,000 individuals at Employer were given the same flu vaccine and none were reported to have had any reaction to the shot. They ignore the fact that Claimant received a flu shot yearly for eight years before the 2013 shot and she had no reaction to the shots.

Dr. Koprivica's conclusions are also not persuasive because they do not consider Claimant's pre-existing psychological conditions and fibromyalgia and the fact that she continued to receive medication for her psychological condition as of the time of the October 1, 2013 flu shot. Claimant had been diagnosed with fibromyalgia years before the flu shot and had been treated with Lyrica for fibromyalgia before she received the 2013 flu shot.

Dr. Koprivica did not provide any legitimate persuasive explanation as to why the shot was the prevailing factor in causing Claimant's injury. Dr. Koprivica is not a psychologist or a psychiatrist. His reliance on a single hearsay VAERS reported reaction to a vaccine is not convincing and lacks foundation. The VAERS report does not prove the vaccine caused the reaction described in the VAERS report.

The close relationship in time between the vaccination and the complaint of condition does not in of itself establish causation. *Royal* at 377-78.

Dr. Claiborn concluded in his supplemental report that Claimant had somatic symptom disorder and major depressive disorder. Dr. Claiborn testified that he understood from his review of the medical records that Claimant had an adverse reaction to the vaccination in October 2013. He testified, "I thought that the prevailing factor and the kind of initiating event was her physical reactions to the vaccination. I felt that that is what set these processes in motion." He felt that following the adverse reaction to the vaccination caused her to have a pain syndrome, or rather caused her to have a somatic symptom disorder and depression.

I find Dr. Claiborn's opinions and conclusions that Claimant's somataform was caused by the sequela of the vaccination as opposed to being triggered by it, that it would be appropriate to consider the physical injury having precipitated a psychological reaction, and that the major depressive disorder was a result of or caused by the sequela

of the vaccination are not credible or persuasive. They presume that Claimant had a physical reaction to the vaccination which I find is not credible.

Dr. Claiborn acknowledged that he did not think the vaccination by itself directly caused anything, but if it caused the tumbling of pain disorders and all of the stress that came from that and restrictions, he thought those things were what caused the depression, and the depression caused the somatic symptom disorder. He testified the vaccination itself did not trigger those things, it is the events after that.

I find these conclusions of Dr. Claiborn are not credible or persuasive. They lack foundation. As in *Royal,* 194 S.W.3d at 378, they fail to provide any legitimate, persuasive explanation as to how work was the prevailing factor in causing Claimant's somatoform disorder and depressive disorder. They make only conclusory and unsupported statements. They overlook the fact that there was never any convincing diagnosis that the flu shot caused any physical injury. They rely on Dr. Koprivica's unsupported opinion that Claimant had an adverse reaction to the vaccination that Dr. Koprivica felt represented the direct, proximate and prevailing factor in Claimant's development of physical symptoms, an opinion I have found is not credible or persuasive.

Another important reason supporting my conclusion that Claimant failed to prove she sustained an accident that was the prevailing factor in causing an injury is that Claimant had significant pre-existing conditions before October 1, 2013. She received treatment for strokes, depression, and fibromyalgia before October 1, 2013. She took Lyrica for fibromyalgia and Paxil for depression. She received treatment for feeling anxious before the flu shot.

Dr. Bronson noted Claimant had a history of anxiety disorder and depression. Dr. Bronson noted in July 2011 that Claimant had depression symptoms. He diagnosed fibromyalgia and ordered Lyrica.

Dr. Baskins noted on July 31, 2011 that Claimant reported that she did not feel well, that everything hurt, and it hurt so bad she could not get out of bed at times. Dr. Baskins noted it had been going on for year's duration but had worsened recently. Dr. Baskins assessed myalgia and myositis, bipolar disorder, fibromyalgia, fatigue, and drowsiness. She prescribed Lyrica for fibromyalgia. Claimant was taking Lyrica, Paxil and Ativan on June 25, 2012 according to Dr. Kempton's record.

Claimant was diagnosed with and treated for fibromyalgia before the flu shot. Claimant testified her fibromyalgia worsened after the flu shot, but she did not convincingly establish the flu shot caused her fibromyalgia to worsen.

Claimant's symptoms after October 1, 2013 were similar to symptoms that she had prior to the shot. She had similar complaints and symptoms before she took the October flu shot. She had prior difficulty walking following her strokes. She had pins and needles feelings in 2012 according to Dr. Kempton's records. She testified that she had fingertip sensitivity in 2012. Dr. Bronson had diagnosed active problems in March 2011, including depression and anxiety.

Another factor of importance is that Claimant took the flu shot eight times before the 2013 shot. She did not have any adverse reaction to those shots.

Sarah Duin's credible testimony that none of the other 3,000 employees of Employer besides Claimant reported any complaints or adverse reactions to the flu shot provided in 2013 is also noteworthy. Further, the vaccine was not a live virus when it was given to Claimant.

I find the opinions of Dr. Barkman and Dr. Logan are more persuasive than the opinions of Dr. Koprivica and Dr. Claiborn.

I find the cases Claimant's counsel cites in his Post-Hearing Brief in support of Claimant's claim that she sustained an injury by accident arising out of the course of her employment are distinguishable from the case at hand for the following reasons.

The Court agrees with Claimant's argument that *Lampkin v. Harzfeld's*, 407 SW 2d 894 (Mo. 1966) and *Doyle v. Lakeland Regional Hospital,* Injury Number 05-141082 (December 8, 2011) support the conclusion that an adverse reaction to a flu shot which results in a compensable injury may be a compensable accident under Section 287.020.3, RSMo. However, an employee still needs to establish that she sustained a compensable injury as a result of the flu vaccination.

I find the *Lampkin* and *Doyle* cases are distinguishable from the case at hand because I have concluded that Claimant failed to prove that the October 1, 2013 flu shot was the prevailing factor in causing both the resulting medical condition and disability. In *Lampkin*, the employee made no contention in her brief that her injuries did not result from an accident. In *Doyle,* the Commission found the employee's transverse myelitis was a result of an influenza vaccine she received.

I also find the *Jerry Fisher* case cited by Claimant's counsel, Injury Number 04-052344 is distinguishable from the case at hand. First, the *Jerry Fisher* case involved an accident that occurred prior to the enactment of the 2006 amendments to the Workers' Compensation law.

ALJ Doughty correctly noted in his Award in *Fisher* that because that claim pre-dated the 2005 legislative changes to the law, "All relevant statutory provision must be liberally construed, broadly interpreted in favor of Fisher and in such fashion as 'to extend its benefits to the largest possible class', in accordance with Section 287.800." The law in effect at the time of this case provides in part that "administrative law judges shall construe the provisions of this chapter strictly and shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts."

Judge Doughty also correctly noted the applicable law in effect at the time of the accident in the *Fisher* case under Section 287.020.2 was, "an injury is compensable if it is clearly work-related. An injury is clearly work-related if work was a substantial factor in the cause of the resulting medical condition disability." That standard is a lower standard than the current prevailing factor standard.

In addition, the *Fisher* case did not involve an alleged injury by accident from a flu vaccination. Rather, in the *Fisher* case, Claimant fell backward off a vehicle and struck his back and head against a bucket that was embedded in the ground. He bled from a scalp laceration and required immediate medical attention as a result of the accident.

The day after the accident, Mr. Fisher went to the Emergency Room because he was acting confused, did not recall the events of the day, reported feeling weak and funny, and reported twitching in his arms and legs. He was diagnosed two days after the accident as having concussion syndrome. A few days later, he was diagnosed with cerebral concussion and compression fracture of T-7. There was no dispute in *Fisher* about whether he sustained an accident that resulted in a physical injury.

Also, in the *Fisher* case, Claimant had no pre-existing symptoms or complaints similar to those that arose after the work accident.

Employer cites Section 287.120.8, RSMo that states: "Mental injury resulting from work-related stress does not arise out of in the course of employment, unless it is demonstrated that this stress is work-related and was extraordinary and unusual. The amount of work stress should be measured by objective standards and actual events." That statute is not relevant here. Claimant has not alleged a mental injury resulting from work-related stress.

Based on the substantial and competent evidence and the application of the Workers' Compensation Law, I find and conclude Claimant failed to prove she sustained an injury by accident arising out of in the course of employment for Employer. I find and conclude Claimant failed to prove that she sustained an accident that was the prevailing factor in causing both the medical condition and disability. I find and conclude Claimant

failed to prove that she sustained an accident that was the prevailing factor in causing an injury. I deny Claimant's claim in its entirety.

2. Did Claimant provide notice of her alleged accident as required by law?

While it is not necessary that I make findings regarding the issue of whether Claimant gave notice of her alleged injury to Employer as required by law because I have found that she did not sustain a compensable injury by accident, I nevertheless find that Claimant's claim is not barred for failure to provide notice of her alleged accident to Employer under Section 287.420, RSMo.

Section 287.420, RSMo provides:

> 287.420. No proceedings for compensation for any accident under this chapter shall be maintained unless written notice of the time, place and nature of the injury, and the name and address of the person injured, has been given to the employer no later than thirty days after the accident, unless the employer was not prejudiced by failure to receive the notice. No proceedings for compensation for any occupational disease or repetitive trauma under this chapter shall be maintained unless written notice of the time, place, and nature of the injury, and the name and address of the person injured, has been given to the employer no later than thirty days after the diagnosis of the condition unless the employee can prove the employer was not prejudiced by failure to receive the notice.

The Court in *Aramark Educational Services, Inc. v. Faulkner*, 408 S.W.3d 271 (Mo.App. 2013) states at 275-76:

> The purpose of Section 287.420 'is to give the employer timely opportunity to investigate the facts surrounding the accident and, if an accident occurred, to provide the employee medical attention in order to minimize the disability.' *Doerr v. Teton Transp., Inc.*, 258 S.W.3d 514, 527 (Mo.App.S.D.2008); *see also Messersmith v. Univ. of Mo.-Columbia/Mt. Vernon Rehab. Ctr.*, 43 S.W.3d 829, 832 (Mo. banc 2001).[FN2]
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> . . . . . .
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> [5] [6] Generally, pursuant to Section 287.808, the employer has the burden of establishing any affirmative defense, which includes statutory notice of injury under Section 288.420. Section 287.808; see also *Snow v. Hicks Bros. Chevrolet Inc.*, 480 S.W.2d 97, 100 (Mo.App.1972). However, once the employer establishes lack of

written notice or lack of timely written notice as required by Section 287.420, the burden shifts back to the claimant. *See Allcorn v. Tap Enter., Inc.,* 277 S.W.3d 823, 831 (Mo.App.S.D.2009) ("The final sentence of Section 287.420 saves a failed attempt at notice"). At that point, the claimant must establish that his or her failure to give notice or timely written notice did not prejudice the employer. *Soos v. Mallinckrodt Chem. Co.,* 19 S.W.3d 683, 686 (Mo.App.E.D.2000).[FN3] A claimant can prove lack of prejudice in one of two ways.

FN3. The "good cause" excuse for failure to provide timely notice was eliminated by the legislature in 2005 by S.B. 130 (2005). *See* S.B. 130 (2005); *Compare* Section 287.420 (2013) with Section 287.420 (2004).

[7] First, if the claimant proffers substantial evidence that the employer had "actual knowledge" of the injury, there is no need for written notice. *Hall v. G.W. Fiberglass, Inc.,* 873 S.W.2d 297, 298 (Mo.App.E.D.1994). This option has been coined as the "prima facie" showing of no prejudice. *Willis v. Jewish Hosp.,* 854 S.W.2d 82, 85 (Mo.App.E.D.1993). Accordingly, if the employer admits or the claimant proffers substantial evidence demonstrating that the employer had "actual knowledge of the accident *at the time *276 it occurred* it has been held that employer could not have been prejudiced by a failure to receive the statutory written notice, and compensation has been allowed." *Klopstein v. Schroll House Moving Co.,* 425 S.W.2d 498, 503 (Mo.App.1968) (emphasis added). Consequently, "if a claimant makes a prima facie showing of no prejudice, the burden [again] shifts to the employer to show prejudice." *Hannick v. Kelly Temp. Serv.,* 855 S.W.2d 497, 499 (Mo.App.E.D.1993).

[8] [9] [10] Second, if the employer does not admit actual knowledge and the claimant does not present substantial evidence of the employer's actual knowledge of the injury, the issue of notice becomes one of fact and the claimant bears the burden of proving lack of prejudice. *Soos,* 19 S.W.3d at 686; *see also Farmer–Cummings v. Future Foam, Inc.,* 44 S.W.3d 830, 836 (Mo.App.W.D.2001) (written notice to the employer of a work-related accident is not a prerequisite for recover where the employer suffers no prejudice). Under this second option, "the Commission must hear evidence on the issue and the [claimant] bears the burden of proof of lack of prejudice." *Pursifull v. Braun Plastering & Drywall,* 233 S.W.3d 219, 223

> (Mo.App.W.D.2007). The claimant must produce competent and substantial evidence that the employer was not prejudiced by the lack of a timely notice in order to shift the burden, again, to the employer. *Klopstein,* 425 S.W.2d at 503–04. If no such competent and substantial evidence is adduced, the employer is presumed to have been prejudiced by the untimely notice of injury. *Soos,* 19 S.W.3d at 686.

See also Soos v. Mallinckrodt Chemical Co., 19 S.W.3d 683, 686 (Mo.App. 2000); *Seyler v. Spirtas Indus.*, 974 S.W.2d 536, 538 (Mo.App. 1998); *Klopstein v. Schroll House Moving Co.,* 425 S.W.2d 498, 504 (Mo.App.1968).

Employee testified she had an ongoing dialogue with her supervisor during October 2013 that she thought the flu shot may have caused symptoms. I find this testimony is not credible. Claimant testified she did not work after October 9, 2013. There is no mention in the medical records of the flu shot until October 17, 2013 when Claimant saw Dr. Thornton. Claimant was not working at that time. Claimant's Family Medical Leave request in October 2013 does not mention the flu shot as causing her complaints. I find Claimant's testimony that Dr. Thornton told her she had an adverse reaction to the flu shot is not credible. There is no such statement in Dr. Thornton's records.

Claimant did report to Employer's Employee Health in January 2014 in her Events Report of January 13, 2014 that after she received the flu shot, she had a weakness in her arms, legs, difficulty walking, loss of balance, pins and needles, numbness in hands and feet, burning in feet, tremors, trouble with memory concentration, and headaches. Employer had notice in January 2014 of Claimant's alleged injury from the October 1, 2013 flu shot.

The Missouri courts have determined that where an employer receives actual notice of an employee's injury, the burden shifts to employer to demonstrate some prejudice resulted from the employee's failure to provide a written notice meeting the above-enumerated statutory requirements. See *Sell v. Ozarks Med. Ctr.*, 333 S.W.3d 498, 510 (Mo. App. 2011). If the employer is not shown to be prejudiced, the claim is not barred by operation of § 287.420. *Id.*

I find and conclude Employer did not demonstrate some prejudice resulted from the employee's failure to provide a written notice meeting the above-enumerated statutory requirements. I find Claimant's claim is not barred by failure to give written notice of her alleged accident within thirty days of October 1, 2013.

3. What is Employer's liability, if any, for additional medical aid to cure and relieve the effects of the alleged work injury?

While it is not necessary that I make findings regarding Claimant's claim for additional medical treatment because I have found that she did not sustain a compensable injury by accident, I nevertheless find that the evidence does support a finding that Claimant is in need of additional treatment.

Section 287.140, RSMo requires that the employer/insurer provide "such medical, surgical, chiropractic, and hospital treatment ... as may reasonably be required ... to cure and relieve [the employee] from the effects of the injury." This has been held to mean that the worker is entitled to treatment that gives comfort or relieves even though restoration to soundness [a cure] is beyond avail. *Greer v. SYSCO Food Servs.*, -- S.W.3d --, 2015 WL 8242710 (Mo banc 2015); *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 266 (Mo.App. 2004). Medical aid is a component of the compensation due an injured worker under Section 287.140.1, RSMo. *Bowers,* 132 S.W.3d at 266; *Mathia v. Contract Freighters, Inc.*, 929 S.W.2d 271, 277 (Mo.App. 1996). The employee must prove beyond speculation and by competent and substantial evidence that his or her work related injury is in need of treatment. *Williams v. A.B. Chance Co.*, 676 S.W.2d 1 (Mo.App. 1984). Conclusive evidence is not required. *Farmer v. Advanced Circuitry Division of Litton*, 257 S.W.3d 192, 197 (Mo. App. 2008); *Bowers*, 132 S.W.3d at 270; *Landers v. Chrysler Corp.*, 963 S.W.2d 275, 283 (Mo.App. 1997).

The Missouri Supreme Court in *Greer,* -- S.W.3d --, 2015 WL 8242710 states:

> Greer need not present "conclusive evidence" that future medical treatment is needed to be entitled to an award of future medical benefits. *Null v. New Haven Care Ctr., Inc.*, 425 S.W.3d 172, 180 (Mo.App.E.D.2014). Instead, Greer needs only to show a reasonable probability that the future treatment is necessary because of his work-related injury. Id. Future medical care should not be denied simply because an employee may have achieved maximum medical improvement. *Pennewell v. Hannibal Reg'l Hosp.*, 390 S.W.3d 919, 926 (Mo.App.E.D.2013).

It is sufficient if Claimant shows by reasonable probability that he or she is in need of additional medical treatment. *Tillotson v. St. Joseph Medical Center*, 347 S.W.3d 511, 524 (Mo.App. 2011); *Farmer*, 257 S.W.3d at 197; *ABB Power T & D Co. v. Kempker*, 236 S.W.3d 43, 53 (Mo. App. 2007); *Bowers*, 132 S.W.3d at 270; *Mathia*, 929 S.W.2d at 277; *Downing v. Willamette Industries, Inc.,* 895 S.W.2d 650, 655 (Mo.App. 1995); *Sifferman v. Sears, Roebuck and Co.*, 906 S.W.2d 823, 828 (Mo.App. 1995). "Probable means founded on reason and experience which inclines the mind to believe but leaves

room to doubt." *Tate v. Southwestern Bell Telephone Co.,* 715 S.W.2d 326, 329 (Mo.App. 1986); *Sifferman* at 828. Section 287.140.1, RSMo does not require that the medical evidence identify particular procedures or treatments to be performed or administered. *Tillotson,* 347 S.W.3d 525*; Forshee v. Landmark Excavating & Equipment,* 165 S.W.3d 533, 538 (Mo. App. 2005); *Talley v. Runny Meade Estates, Ltd.*, 831 S.W.2d 692, 695 (Mo.App. 1992); *Bradshaw v. Brown Shoe Co.*, 660 S.W.2d 390, 394 (Mo.App. 1983).

The type of treatment authorized can be for relief from the effects of the injury even if the condition is not expected to improve. *Farmer*, 257 S.W.3d at 197; *Bowers*, 132 S.W.3d at 266; *Landman v. Ice Cream Specialties, Inc.*, 107 S.W.3d 240, 248 (Mo.banc 2003). Future medical care must flow from the accident, via evidence of a medical causal relationship between the condition and the compensable injury, if the employer is to be held responsible. *Conrad v. Jack Cooper Transp. Co.*, 273 S.W.3d 49, 51-4 (Mo. App. 2008); *Bowers v. Hiland Dairy Co.,* 188 S.W.3d 79, 83 (Mo.App. 2006). Once it is determined that there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. *Id; Tillotson*, 47 S.W.3d 519.

The court in *Tillotson* states at 347 S.W.3d 519:

> The existing case law at the time of the 2005 amendments to The Workers' Compensation Law instructs that in determining whether medical treatment is "reasonably required" to cure or relieve a compensable injury, it is immaterial that the treatment may have been required because of the complication of pre-existing conditions, or that the treatment will benefit both the compensable injury and a pre-existing condition. *Bowers v. Hiland Dairy Co.,* 188 S.W.3d 79, 83 (Mo.App. S.D.2006). Rather, once it is determined that there has been a compensable accident, a claimant need only prove that the need for treatment and medication flow from the work injury. *Id.* The fact that the medication or treatment may also benefit a non-compensable or earlier injury or condition is irrelevant. *Id.*

The court in *Tillotson* states at 347 S.W.3d 524:

To receive an award of future medical benefits, a claimant need not show 'conclusive evidence' of a need for future medical treatment." *Stevens,* 244 S.W.3d at 237 (quoting *ABB Power T & D Co. v. Kempker,* 236 S.W.3d 43, 52 (Mo.App.W.D.2007)). "Instead, a claimant need only show a 'reasonable probability' that, because of her work-related injury, future medical treatment will be necessary. A claimant need not show evidence of the specific nature of the treatment required. *Id.*

The court in *Tillotson* also states at 525:

> In summary, we conclude that once the Commission found that Tillotson suffered a compensable injury, the Commission was required to award her compensation for medical care and treatment reasonably required to cure and relieve her compensable injury, and for the disabilities and future medical care naturally flowing from the reasonably required medical treatment.

Claimant has continuing and ongoing physical and psychological symptoms and complaints.

Dr. Claiborn testified Claimant is not at maximum improvement. He thought some therapy with medication might be effective in reducing or eliminating potentially her depression. Dr. Claiborn recommended a combination of cognitive behavioral therapy by a PhD psychologist and an appropriate anti-depressant medication through a psychiatrist. Dr. Logan though psychotherapy would help Claimant. He thought a different set of psychotropic drugs would possibly help her. I find these opinions are credible.

I find the evidence supports a finding that Claimant is in need of additional treatment. I find the opinions of Dr Claiborn and Dr. Logan are persuasive that Claimant needs medication and psychological counseling.

However, I conclude Claimant has not shown a reasonable probability that additional treatment is necessary because of her alleged work injury. I have found Claimant did not prove she sustained a compensable injury by accident in this case. I have denied Claimant's claim. Claimant's request for an award of medical treatment is denied.

4. What is Employer's liability, if any, for past and future temporary total disability benefits?

While I conclude it is not necessary to make findings regarding Claimant's claim for additional medical treatment since I have found that she did not sustain a compensable injury by accident, I nevertheless find that she is temporarily totally disabled and has been since October 9, 2013, the last day she worked.

The burden of proving entitlement to temporary total disability benefits is on the Employee. *Boyles v. USA Rebar Placement, Inc.*, 26 S.W.3d 418, 426 (Mo.App. 2000); *Cooper v. Medical Center of Independence*, 955 S.W.2d 570, 575 (Mo.App. 1997). Section 287.170.1, RSMo provides that an injured employee is entitled to be paid

compensation during the continuance of temporary total disability up to a maximum of 400 weeks. Total disability is defined in section 287.020.7, RSMo as the "inability to return to any employment and not merely . . . [the] inability to return to the employment in which the employee was engaged at the time of the accident." Compensation is payable until the employee is able to find any reasonable or normal employment or until his medical condition has reached the point where further improvement is not anticipated. *Cooper*, 955 S.W.2d at 575; *Vinson v. Curators of Un. of Missouri*, 822 S.W.2d 504, 508 (Mo.App. 1991); *Phelps v. Jeff Wolk Construction Co.*, 803 S.W.2d 641, 645 (Mo.App. 1991); *Williams v. Pillsbury Co.*, 694 S.W.2d 488, 489 (Mo.App. 1985).

Temporary total disability benefits should be awarded only for the period before the employee can return to work. *Greer v. SYSCO Food Servs.*, -- S.W.3d --, 2015 WL 8242710 (Mo banc 2015); *Boyles*, 26 S.W.3d at 424; *Cooper*, 955 S.W.2d at 575; *Phelps*, 803 S.W.2d at 645; *Williams*, 649 S.W.2d at 489. The ability to perform some work is not the test for temporary total disability, but rather, the test is "whether any employer, in the usual course of business, would reasonably be expected to employ Claimant in his present physical condition." *Boyles,* 26 S.W.3d at 424; *Cooper*, 955 S.W.2d at 575; *Brookman v. Henry Transp.*, 924 S.W.2d 286, 290 (Mo.App. 1996). "This standard is applied to temporary total disability, as well as permanent total disability. Contrary to the findings of the Commission, this does not mean that an employer is forced to either make light duty available to a claimant or pay temporary total disability benefits simply because the claimant remains under active medical care and there is a reasonable expectation that the employee's functional level might improve. An employer is only obligated for said benefits if the employee could not compete on the open market for employment." *Cooper*, 955 S.W.2d at 575.

A nonexclusive list of other factors relevant to a claimant's employability on the open market includes the anticipated length of time until claimant's condition has reached the point of maximum medical progress, the nature of the continuing course of treatment, and whether there is a reasonable expectation that claimant will return to his or her former employment. *Cooper*, 955 S.W.2d at 575-76. A significant factor in judging the reasonableness of the inference that a claimant would not be hired is the anticipated length of time until claimant's condition has reached the point of maximum medical progress. If the period is very short, then it would always be reasonable to infer that a claimant could not compete on the open market. If the period is quite long, then it would never be reasonable to make such an inference. *Boyles*, 26 S.W.3d at 425; *Cooper*, 955 S.W.2d at 575-76.

A "'claimant is capable of forming an opinion as to whether she is able to work, and her testimony alone is sufficient evidence on which to base an award of temporary total disability.' " *Stevens v. Citizens Mem. Healthcare Found.,* 244 S.W.3d 234, 238

(Mo.App.2008) (quoting *Landman v. Ice Cream Specialties, Inc.,* 107 S.W.3d 240, 249 (Mo. banc 2003)); *Pruett v. Federal Mogul Corp.,* 365 S.W.3d 296, 309 (Mo.App. 2012).

The evidence establishes, and I find, that Claimant has not worked since October 9, 2013. She filled out FMLA paperwork on October 10, 2013. Dr. Kempton took her off work. She was on FMLA beginning October 25, 2013. Claimant credibly testified that she did not think that she could work as a monitor. She credibly testified she continued to have a lot of pain, had trouble concentrating, and had weakness and tremors. She did not think she could work as a mortgage processor because of problems with attention to detail.

Dr. Thornton's October 25, 2013 note states Claimant was going to be off work for a significant period of time. Dr. Thornton's January 3, 2014 mental capacity questionnaire answered "No" to the question, "2. Given your knowledge of the Claimant's medical conditions, do you believe that he/she retains the capacity to perform any work for eight hours per day, 40 hours per week for 50 weeks per year?"

Dr. Orth's December 20, 2015 statement sets forth significant restrictions. Dr. Stuber's June 25, 2014 note states that Claimant has to take naps during the day and that a note excusing her from jury duty should read that she has a diagnosed debilitating neurologic disease and is not capable of jury duty.

Dr. Koprivica noted in his January 18, 2016 report that Claimant was temporary totally disabled from October 1, 2013 until last seen by Dr. Ewing on July 17, 2014.

Dr. Claiborn saw Claimant on April 14, 2016. He testified that Claimant would not be employable full-time due to the severity of the symptoms she reported and the limited ability she reported and the sleep issue that she was having. She was limited in her terms of her stamina for position and with concentration and the ability to be accurate and successful. Dr. Claiborn did not think Claimant presently could work either half-time or full-time. I find these opinions are credible and persuasive.

I find Claimant is temporarily totally disabled and has been since October 9, 2013, the last day she worked.

I have found Claimant did not prove she sustained a compensable injury by accident in this case. I have denied Claimant's claim. I deny Claimant's claim for temporary total disability benefits.

Second Injury Fund Claim

Claimant's claim against the Second Injury Fund is also denied based on my finding and conclusion that Claimant failed to prove she sustained a compensable injury by accident arising out of and in the course of her employment.

Attorney Fee

Claimant is not allowed an attorney fee.

This Award is final and is subject to immediate appeal.

I certify that on 9-11-17, I delivered a copy of the foregoing award to the parties to the case. A complete record of the method of delivery and date of service upon each party is retained with the executed award in the Division's case file.

By _____

Made by: Robert B. Miner

Robert B. Miner
Administrative Law Judge
Division of Workers' Compensation