July 14, 2017

The Law Offices of
Kagan, Breyer and Sotomayor
Huntington Beach, California 92648

Attention: Donna Kagan

The Law Offices of
Thomas, Gorsuch and Alito
Irvine, California 92614

Attention: Clarence Thomas

RE:	John Doe
EMP:	ABCXYZ Corp.
D/I:	CT November 12, 2009 - November 12, 2010
CLM#:	123456789
WCAB#:	123456789
PANEL#:	123456789

INITIAL PSYCHIATRIC AGREED PANEL QUALIFIED MEDICAL EVALUATION

Dear Interested Parties:

At your request, Mr. John Doe was examined at my Manhattan Beach office (1600 Rosecrans Avenue, Media Center, 4th Floor, Manhattan Beach, California 90266) on **July 1, 2017**.

Authorization for this evaluation was provided in the March 9, 2017, Cover Letter signed by both parties.

The Applicant Cover Letter states,

> "Thank you for your participation in the medical-legal evaluation of the above-named applicant in your capacity as a Panel Qualified Medical Evaluator in psychiatry. Please be advised that the physical injury has been accepted but the psychiatric injury is still in question."

The Defense Cover Letter states,

> "Thank you for serving as the QME in the above referenced matter. By way of brief background the applicant worked as a product mixer for ABCXYZ Corporation. He began working in approximately 2000 and ended work in November 2010. Throughout his employment, he worked with various chemicals and developed bronchiolitis obliterans."
>
> "Please evaluate the applicant in your capacity as a psychiatric QME and address all issues including but not limited to any impairment you find industrially related, apportionment to nonindustrial causes, address industrial causation, and the need for any future medical care on an industrial basis."

Face to Face interview was 3 hours. Review and summary of personnel, medical records and ancillary information required 6 hours. Psychological testing required 3 hours for administration and analysis.

This report was very complex in scope beyond an ordinary medical examination. Issues of causation, motivation, psychiatric theory, character strength and weakness, potential denial and malingering were explored in order to fully understand the claimant's current situation and how it may or may not relate to the workplace environment.

In addition to the usual comprehensive clinical interview, all available records were reviewed and considered in the preparation of this report.

The claimant was advised of the right to ask this evaluator about any matter concerning the evaluation process and that the claimant may, with good cause, discontinue the evaluation. The claimant was also informed of the nonconfidential nature of this examination and agreed to proceed.

The clinical history, psychological testing, and examination were performed by myself. The evaluation was conducted in English, without the assistance of an interpreter.

The evaluation was completed in accordance with the standards set by the Industrial Medical Council for ML-104. Medical legal psychiatric evaluations, by their very nature, are unusually complex in comparison to other types of medical evaluations. My personal standard for each report is necessarily unusually detailed. Even though these reports are single spaced, they tend to be lengthy. Each evaluation encompasses a review of a patient's life history including past employment history, marital history, developmental history, drug and alcohol history, personality, social support systems, intellectual and personal strengths and weaknesses as well as

aspects of an AOE/COE investigation and pertinent Workers' Compensation issues such as work restrictions, vocational rehabilitation, apportionment etc.

The diagnosis and conclusions are not based solely on subjective and objective findings, but also upon the patient's past life history and other complex factors. It is not comparable to a simple or even a relatively complex orthopedic examination. It is not possible to see a large number of psychiatric medical legal cases in a day or a week. These reports are time-intensive, individualized, and require a great deal of experience, thought and expertise in forensic psychiatry. These reports are far more detailed than most claimant psychiatric reports, which are based upon the claimant's testimony exclusively and generally do not include review of collateral sources that I have access to. This report is both more time intensive and thorough than an applicant psychiatric report. Hence, this report should be compensated at the ML-104 level.

This is a comprehensive evaluation of industrial and nonindustrial stressors in the claimant's life, in compliance with current guidelines for psychiatric reports. This process might uncover unpleasant aspects of the claimant's past or present history, or a stigmatizing psychiatric diagnosis that should not be utilized by the employer in consideration of any future personnel decision. The claimant's volitional manifest behavior and his performance in the workplace alone should be the sole basis for any and all future decisions regarding the employment status of this individual.

Medical information that the employer obtains regarding an injured worker may only be disclosed and used for purposes of providing Workers' Compensation benefits, or defending against a Workers' Compensation claim. (See Civ Code 56.10(c)(8)(A) and (B), and 556.20(c)(2) and (3).

IDENTIFICATION OF CLAIMANT AND CLAIM

Mr. John Doe is a 40-year-old, married, Hawaiian male who is currently not working. The claimant presently resides at 12345 Main St, Manhattan Beach, California 90266.

The claimant is reporting the development of psychological symptoms secondary to his employment experience with ABCXYZ Corporation. This is a physical – mental compensable consequence claim as he liked his job and reported no source of stress save the effects of his pulmonary injuries.

The Cover Letter indicates this is an accepted claim for bronchiolitis obliterans secondary to exposure to diacetyl at work.

HISTORY OF INJURY (According to Claimant)

Mr. Doe began working as a Compounder for ABCXYZ Corporation located in Hermosa Beach, California in 2000.

The claimant states he enjoyed his job, the people he worked with, and the steady income.

As a nonunion employee, he worked 40 hours per week and earned $25 per hour.

He described "good" working relationships with co-workers, supervisors, and management.

According to the claimant, he received "above average" performance appraisals of his work. He acknowledged receiving verbal warnings for safety issues but denied ever receiving a written warning.

In connection with this claim, Mr. Doe stopped working on November 12, 2010, secondary to breathing problems. He was placed on disability at that time and continues to receive compensation benefits to date.

He subsequently filed his Workers' Compensation claim in 2011, citing a Date of Injury of November 12, 2010, due to "physical problems – breathing."

In describing his physical-mental stress claim, Mr. Doe states he gradually developed respiratory problems and eventually developed bronchiolitis obliterans secondary to exposure to diacetyl at work.

He indicates in 2005 it was learned that a former employee had been diagnosed with respiratory problems after his departure from the insured. Cal/OSHA became involved, and all of the employees for the insured underwent spirometry testing. His results came back low, and he underwent repeat testing. Apparently he was evaluated at the Pulmonary Injuries R Us located in Colorado in 2005.

By 2007, Mr. Doe indicates he was experiencing breathing problems and suffering pneumonias. Records indicate he was hospitalized at General Hospital in Torrance in 2007 for shortness of breath and diagnosed with pneumonia. He missed a couple of weeks from work.

The claimant states his respiratory issues continued to worsen, and during the last two to three years he was employed, he underwent numerous lung tests.

According to the claimant's deposition testimony, he was apparently re-evaluated at Pulmonary Injuries R Us in 2010. In November 2010, the claimant was taken off work due to respiratory insufficiency and never returned. He states by the end of his

employment, safety equipment had improved but he was still having breathing problems.

Mr. Doe indicates he became angry and depressed in 2010 that Pulmonary Injuries R Us had misdiagnosed him. He states his breathing continued to worsen after he left work.

He indicates he would have continued working for the insured if not for his respiratory difficulties.

Mr. Doe was initially evaluated by Dr. Seuss at UCLA in 2010 for his respiratory difficulties. Due to worsening of his condition, Dr. Seuss recommended the claimant not return to work in any capacity in January of 2011.

The claimant subsequently began treating with Dr. Glitter in July of 2012 for his pulmonary issues. At that time, the claimant reported to be experiencing stress at home related to his respiratory difficulties, and a psychological evaluation was recommended.

In August of 2012, the claimant was psychologically evaluated by Dr. Sigmund Freud, Ph.D. He was prescribed Paxil 20 mg by Carl Jung, M.D.; however, he states he only took this medication for one month because, "It didn't make any difference." He indicates he was seen in follow-up on three occasions.

The claimant was evaluated by Internal Medicine - Pulmonary Disease Panel QME, Dr. Dre, in 2015 for his breathing difficulties. Dr. Dre recommended a lung transplant surgery, which can only be performed if the claimant loses significant weight.

Mr. Doe remain off work to date. He is not seeking other employment at this time.

CURRENT FUNCTIONING

The claimant continues to experience breathing difficulties and is now using oxygen through a cannula. He states he is oxygen dependent except when at rest. He states, "Some days are worse than others. It depends on the weather."

In describing his current psychiatric symptoms, Mr. Doe reports anxiety and worry about his future as well as depression, anger, and frustration regarding his condition. He reports increased irritability and some social isolation. He experiences some difficulty sleeping and much difficulty engaging in sexual relations secondary to shortness of breath. He reports a weight gain of 70 pounds since 2010.

A typical day for the claimant begins by arising at noon or earlier if his children are in

school. In the mornings, he transports his children to school and performs household chores. In the afternoon, he takes a nap, picks up his children, and assists his children with homework. In the evenings, he watches television or movies. He indicates he goes to bed early due to panic feelings.

On weekends, he attends church and goes to the park with his children. He denies hobbies.

The claimant states he is able to manage his personal responsibilities. He feels emotionally capable of working at this time but not physically. He is not seeking other employment.

His plans for the immediate future are to "try to survive for my kids. My breathing problems come and go."

PRE-EXISTENT AND NONINDUSTRIAL STRESSORS

The claimant was questioned regarding extraoccupational stressors which have occurred over the last year, such as marital difficulties, a recent death or serious illness in family members, drug or alcohol problems, financial difficulties, etc.

He denied extraoccupational stressors within the past year.

Prior to the filing of his claim, Mr. Doe reports to have received treatment for gout and was taking medication for this condition. A review of records indicates the claimant received extensive treatment for gout at UCLA from 2001 through 2015, including hospitalizations and surgery to the left knee. Records indicate the claimant also suffered from other medical conditions including kidney problems, obstructive sleep apnea, arthritis, gastroesophageal problems, possible hypertension, borderline diabetes, and morbid obesity. It is noted a lung transplant surgery has been recommended for Mr. Doe; however, he needs to lose significant weight in order to undergo the surgery. The claimant reports he has gained 70 pounds since 2010 and has not had success with weight loss programs.

There is a dispute regarding causation as the claimant did have a history of smoking in his youth. Records indicate the claimant has a 16-year history of smoking one package of cigarettes per day from 1995 until 2011. However, a review of records from Pulmonology Panel QME, Dr. Dre, indicates that the claimant's smoking history is not significant in the development of his respiratory issues.

The claimant acknowledges an arrest in 1996 for a misdemeanor. He indicates he was the sleeping passenger in a friend's car when his friend crashed the car. He reports he was charged for moving the car following the accident after a person died.

It is noted a review of records indicates the claimant's arrest in 1996 led to three years probation. Records also indicate the claimant reported a month or two of incarceration in L.A. County Jail.

A history of previous psychological treatment is denied.

SOCIAL AND OCCUPATIONAL HISTORY

Mr. John Doe was born in Honolulu, Hawaii. He reports he came to the mainland United States in 1994. His parents divorced when he was young. His mother never remarried. His father remarried when he was in the third grade.

The claimant has no siblings.

His father was employed as a mechanic previous to his death at the age of 53 due to lung cancer. The claimant reports his death occurred in 1996; however, records indicate the claimant reported his death occurred in 2005. He described his father as "a good man" and states he had a "real good" relationship with him.

His 85-year-old mother works as a housekeeper and lives with the claimant. She is depicted by the claimant as "helpful and supportive." He states he has always had a "good" relationship with his mother.

The claimant denies a history of physical, sexual, or emotional abuse. He feels he had a "happy" childhood.

He denies that either parent was ever disabled.

In 1994, the claimant graduated from high school in Hawaii. He discontinued his education to begin working. The claimant is not presently attending school but is considering returning in the future.

The claimant married in 2000, and he describes this relationship as "supportive. We are best friends." His wife is employed on a full-time basis as an auditor for Loyola Marymount. This union has resulted in two sons, ages 8 and 5, and a 4-year-old daughter. He currently resides with his three children, his wife, and his mother in a home he owns. He reports his 8-year-old son suffers from asthma and allergies.

The following occupational history was provided.

From 1994 until 1995, the claimant worked as a truck driver/groundsman for Acme Railroad located in Cudahy, California. He indicates he lost this employment when due to a layoff.

From 1995 until 1996, the claimant worked as a loader for Acme 2 Company located in San Pedro, California. He resigned from this position.

He next worked various construction jobs off and on jobs from 1996 until 2000.

From 2000 to 2001, he secured employment as a ramp agent for LAX. Also in 2000, he secured his employment with the insured. He indicates he left his employment at LAX because having two jobs was too much. He continued to work for the insured until 2010, when he stopped working due to physical injury.

The claimant denied any previously unmentioned work-related injuries and/or Worker's Compensation claims.

There is no history of military service.

The claimant acknowledges an arrest in 1996 for a misdemeanor. He indicates he was the sleeping passenger in a friend's car when his friend crashed the car. He reports he was charged for moving the car following the accident after a person died. It is noted a review of records indicates the claimant's arrest in 1996 led to three years probation. Records also indicate the claimant reported a month or two of incarceration in Orange County Jail.

The claimant denies ever being injured in an automobile accident.

He reports to have filed a personal injury lawsuit related to liability for his toxic exposure.

The claimant quit smoking in 2011. Records indicate the claimant began smoking in 1995 and smoked one package of cigarettes per day through November 2011, when he quit. He describes his consumption of alcoholic beverages as "rare" at one to two drinks per month. Caffeine consumption is reported as two colas per week.

The claimant reports exposure to mixing flavor compounds in connection with his employment for the insured. He denied exposure to dust, fumes, or solvents.

PSYCHIATRIC HISTORY

There is no history of psychiatric or psychological treatment prior to the filing of this claim.

No prior history of eating disorder, manic episodes, psychosis, or depression is reported.

He denies a past history of problems related to alcohol and/or drug abuse. Records indicate the claimant reported from 1991 until approximately 1997 he consumed one bottle of hard liquor on each weekend day.

The claimant has never been psychiatrically hospitalized.

He denied a family history of mental illness.

MEDICAL HISTORY

The claimant is self-described as 5' 11" in height and weighs 280 pounds. He reports a weight gain of 70 pounds since 2010 from his usual stated weight of 210. He indicates he is currently dieting. He wears glasses/contacts. He feels he was in good general health until his work-related injuries.

Family medical history is positive for cancer, diabetes, heart trouble, hypertension, and stroke.

Physical symptoms reported by the claimant include hives/rash, frequent infection, headaches, eye problems, double vision, itching eyes/nose, sneezing/runny nose, nosebleeds, chronic sinus trouble, ear problems, dizziness, episodes of unconsciousness, healing slowly after cuts, and abnormal clotting.

Respiratory symptoms include chronic frequent cough, asthma/wheezing, difficulty breathing, spitting up blood, and lung problems.

Musculoskeletal symptoms include upper back pain, neck stiffness, shoulder pain, arm pain, wrist pain, lower back pain, leg pain, ankle pain, difficulty walking, and weakness of muscles and joints. He reports he has had gout chronically since 2000.

Cardiovascular symptoms include chest pain, shortness of breath, heart trouble, heart murmur, hypertension, swelling of the hands/feet/ankles, and awakening at night with a smothering feeling.

Gastrointestinal symptoms are denied.

The claimant has no known allergies to medication.

Surgical history is positive for left knee surgery on August 1, 2012, secondary to gout. He indicates the name of his regular physician is Dr. Who for the past 5+ years. .

He is currently prescribed allopurinal 300 mg b.i.d., Indocin 50 mg p.r.n., and Advair 500 mg two puffs q.d. He is not taking any psychotropic medications.

MENTAL STATUS EXAMINATION

The claimant is an bald, bearded, obese, Hawaiian male who presented for today's interview casually dressed and neatly groomed. Behavior revealed no evidence of psychomotor agitation but some slowing and he was generally apathetic. There was no evidence of abnormal tics, tremors, or mannerisms. Speech was normal. The claimant drove to the appointment. He was using an oxygen kit and cannula to assist with respiratory failure.

Affect was depressed. Mood was sad, worried about pulmonary status.

Thought content revealed no evidence of delusions, hallucinations, or illusions. There was no evidence of suicidal or homicidal ideation. Thought processes were normal. The claimant was primarily concerned about his health and the possibility of a lung transplant.

The claimant was alert and oriented to time, place, and person. Short-term and long-term memory were fair to good. Concentration was intact. Intelligence was below average to average. Insight and judgment were fair.

Clinical Symptom Interview

Mr. Doe continues to experience difficulty breathing and is oxygen dependent except when at rest. He reports anxiety and worry about his future, depression, anger, frustration, difficulty sleeping, social isolation, a weight gain of 70 pounds, and difficulty engaging in sexual relations secondary to shortness of breath. He has not returned to any type of employment and is not seeking work. He feels emotionally capable of working at this time but not physically.

His current daily activities include caring for his children, performing household chores, assisting with homework, napping, and watching television. On weekends, he attends church and goes to the park with his children.

In order to determine whether the applicant has exaggerated, embellished or possibly underreported presenting complaints, the following analyses were performed:

Subjectively, the claimant is endorsing a severe level of both anxiety and depression, as indicated on the BAI and BDI-II below.

EPWORTH SLEEPINESS SCALE

This questionnaire, called the Epworth Sleepiness Scale, was developed by Dr.

Murray Johns of Melbourne, Australia to measure daytime sleepiness.

A score of less than 10 suggests the patient is getting adequate amount of sleep. A score of greater than 10 suggests there is sleep disorder.

The claimant scored 17.

PSYCHOLOGICAL TESTING

Methods of Evaluation

1. Beck Depression Inventory (BDI-II)

2. Beck Anxiety Inventory (BAI)

3. Structured Inventory of Malingered Symptomatology (SIMS)

4. Rey Word Finding Test

5. Rey Dot Counting Test

6. Short Form McGill Pain Questionnaire and Pain Diagram

7. Trailmaking Test Parts A & B

8. Rey 15 Item Malingering Test (with recognition)

9. Personality Assessment Inventory (PAI)

TEST RESULTS

Beck Depression Inventory - II

The Beck Depression Inventory (BDI-II) is a subjective test to measure depression developed by Aaron Beck at the University of Pennsylvania. This is one of the most frequently used self-report inventories, both in general practice and also in Workers' Compensation evaluations.

The scale is composed of 21 items. Initially, it was designed to be part of an interview format or administered by an examiner. The 21 items on this scale are actually broken down into four statements. Thus, there are 84 actual statements on this scale. The examinee checks one statement for each of the 21 groups that is most descriptive of him or her. The statements are scored from 0 to 3. The higher scores

indicate a greater degree of depression. The score range is from 0 to 63 (e.g., if a person endorsed the 3-point statement for each of the 21 items, they would get a score of 63).

Clinical significance in medical legal settings, such as Workers' Compensation, is that the subjective degree of depression should correlate with clinical observations. In other words, if an individual is endorsing a high degree of subjective depression, that level of depression should be observed on examination. There often tends to be a high degree of false positives in medical-legal settings, as there is a tendency for subjective symptoms to dissimulate from objective symptoms.

On the Beck Depression Inventory, scoring is based upon what the subject states. There is no correction for test taking attitude, nor any method of detecting exaggeration or inconsistent reporting, such as is available on the MMPI-2. In medical-legal settings, the test will accurately reflect the absence of depression if the results are low, unless the subject is in obvious denial. On the other hand, if the results are high, this could either be consistent with actual depression, or clinical dissimulation.

The claimant scored a total of forty-four (44), indicating a severe level of subjective depression.

Beck Anxiety Inventory

This test was also developed by Aaron Beck, M.D. It is a self-report inventory used to assess the degree of an examinee's anxiety, and what symptoms reflect the nature of the anxiety.

The claimant scored a total of forty-four (44), indicating a severe level of subjective anxiety.

Structured Inventory of Malingered Symptomatology (SIMS)

The Structured Inventory of Malingered Symptomatology (SIMS) is a multi-axial, self-administered measure developed to serve as a screening tool for the detection of feigned or exaggerated psychiatric disturbance and cognitive dysfunction among adults ages 18 years and older across a variety of clinical and forensic settings. The SIMS consists of 75 items that yield a summary score reflective of a general feigning presentation (Total score), as well as five nonoverlapping scales that reflect theoretical and statistical considerations of the more commonly feigned or exaggerated disorders: (a) Psychosis, (b) Neurologic Impairment, (c) Amnestic Disorders, (d) Low Intelligence, and (e) Affective Disorders. The SIMS is intended to serve multiple functions as (a) an initial screening tool for individuals who may not

otherwise be referred for specific evaluation of potential feigning within a forensic or medico-legal context or setting.

Scale Raw Scores:

Neurologic Impairment (NI)	= 7	Low Intelligence (LI)	= 2
Affective Disorders (AF)	= 11	Amnestic Disorder (AM)	= 8
Psychosis (P)	= 5	Total	= 33

Clinical Cutoff Scores:

Neurologic Impairment (NI)	>2	Low Intelligence (LI)	>2
Affective Disorders (AF)	>5	Amnestic Disorder (AM)	>2
Psychosis (P)	>1	Total	>14

This result provides some global evidence of exaggeration of mental deficits as shown by a score of 33.

Rey Word Finding Test

The Rey Word Finding Test is a clinical test for embellishment of memory deficits and symptom exaggeration, developed by Andre Rey. The principle of this test is that individuals can memorize items easier with assistance of cueing than by rote reproduction. In other words, it is far easier to remember a list of items off a larger list, or a multiple choice format, than it is to remember them without any cueing.

In this test, an individual is shown fifteen nouns, such as "elbow, wing, cat, shoe, etc." The subject is then instructed to memorize as many of these words as possible and then reproduce, without any type of aid, as many of these items as possible.

Then, the subject is shown a longer list of words that includes the items on the original list. He or she is then asked to reproduce as many as possible of the words that were on the original list.

The basic principle of this test is that an individual should always be able to correctly identify more items from the original list off the choice selection than by rote.

The claimant was able to recall 3 items without error by rote and 5 items without error with cueing.

These results suggest no evidence of malingered recall.

Rey Dot Counting Test

The Rey Dot Counting Test is a way to measure feigned deficits by comparing memory responses in random arrangements to that in organized groups. The examinee is asked to remember the number of dots arranged in domino-like patterns vs. scattered patterns. Obviously, it is much easier to give a rapid and correct response to 24 dots arranged in "boxcar" sets of 6 than if these are dispersed.

A malingering claimant may take longer to count dots in organized patterns. This is inconsistent with memory deficits even in genuinely affected individuals, who will have an easier time with counting organized rather than unorganized dots.

Total Errors	+	Mean UG Time 5.3	+	Mean G Time 2.5	=	E-Score 10

There is no evidence of malingered recall as the grouped dot times were significantly lower than the scatter patterns.

Short Form McGill Pain Questionnaire and Pain Diagram

A short form of the McGill Pain Questionnaire (SF-MPQ) has been developed. The main component of the SF-MPQ consists of 15 descriptors (11 sensory; 4 affective) which are rated on an intensity scale as 0 = none, 1 = mild, 2 = moderate or 3 = severe. Three pain scores are derived from the sum of the intensity rank values of the words chosen for sensory, affective and total descriptors.

Sensory = 24 Affective = 4 Total Descriptors = 9

The perception of pain is described both in physical and emotional terms affecting the cervical spine, shoulder, chest, thoracic spine, elbows, hands, lumbar spine, knees, ankles and feet.

Trailmaking Test Parts A & B

The Trailmaking Test Parts A & B was administered as a brief neuropsychological screen. This two-part test is well-normed for both the normal age appropriate population and the brain impaired population.

The Trailmaking Test Part A consists of the simple task of connecting numbers that are randomly presented in a standardized form. The examinee is required to sequentially connect numbers 1-25 in order.

The Trailmaking Test Part B entails the more complex task of alternating between numbers and letters in sequential order. This part consists of 13 numbers and 12 letters, which are randomly presented in a standardized form. The applicant is

required to sequentially connect the first number with the first letter, the second number with the second letter and so forth, (i.e., 1-A, 2-B, 3-C, etc.).

The applicant completed both parts of this test with no errors.

Part A - 28 Seconds Part B - 80 Seconds

These are normal response times for simple and more complicated visual motor tasks.

Rey 15 Item Malingering Test (with recognition)

The Rey 15 Item Malingering Test was administered. This test consists of a series of five rows of numbers, upper and lower case letters, Roman numerals, and geometric shapes, which is shown to the subject for approximately ten seconds. The examinee is then asked to reproduce the list from memory. While this test on the surface appears to be difficult, in actuality it is quite easy, as the items are clustered into groups of three, with five rows in all. The principle here is that all but the most severely brain damaged individuals can recall most of the items. This test is specific for malingered recall but not sensitive so thus the false negative rate was high even though incorrectly identified false positives were low.

A valuable improvement to this simple test was the addition of a recognition trail based on a 2002 article published in the Journal of Clinical and Experimental Neuropsychology (Vol. 24, No. 5, pp. 561-573) by Boone, Salazar, et. al. The use of a combined recall and recognition score (i.e., free recall +‡ [recognition-false answers] < 20) substantially increased sensitivity (71%) while maintaining high specificity (92%) for deliberate exaggeration of deficits.

The applicant was able to duplicate 14 items of the Rey Malingering test without error in free recall and 15 with cueing with no errors for a score of 29 which is negative for malingered recall.

PAI - Personality Assessment Inventory

The objective inventory of adult personality assesses psychopathological syndromes and provides information relevant for clinical diagnosis, treatment planning, and screening for psychopathology. The 344 PAI items constitute 22 nonoverlapping scales covering the constructs most relevant to a broad-based assessment of mental disorders: four validity scales, 11 clinical scales, five treatment scales, and two interpersonal scales. Reliability and validity are based on data from a U.S. Census-matched normative sample of 1,000 community-dwelling adults, a sample of 1,265 patients from 69 clinical sites, an a college sample of 1,051 students. Because the PAI was normed on adults in a variety of clinical and community settings, profiles can be

compared with both normal and clinical populations. Reliability studies indicate that the PAI has a high degree of internal consistency across samples. Validity studies demonstrate convergent and discriminant validity with more than 50 other measures of psychopathology.

The following narrative is derived from the PARiConnect scoring method for online administration of PAI with additional relevant comments from this evaluator.

Validity of Test Results:

> The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. For this protocol, the number of uncompleted items is within acceptable limits.
>
> Also evaluated is the extent to which the respondent attended appropriately and responded consistently to the content of test items. The respondent's score on the INF scale exceeds the cutoff for profile validity, suggesting problems attending to or interpreting item content in responding to the PAI items. There are several potential reasons for this failure to attend, including reading difficulties, careless or random responding, marked confusion or idiosyncratic item interpretation, or failure to follow the test instructions. Exploring responses to the INF items with the client can help clarify the nature of the difficulties. Regardless of the cause, however, the test results can only be assumed to be invalid—therefore, no clinical interpretation is provided.

Critical Item Endorsement:

> A total of 27 PAI items reflecting serious pathology have very low endorsement rates in normal samples. These items have been termed critical items. Endorsement of these critical items is not in itself diagnostic, but review of the content of these items with the respondent may help to clarify the presenting clinical picture. Significant items with item scores of 1, 2, or 3 are listed below.
>
> Delusions and Hallucinations
>
> > 90. SCZ-P Sometimes it seems that my thoughts are broadcast so that others can hear them. (ST, 1)
> >
> > 130. SCZ-P Others can read my thoughts. (MT, 2)
> >
> > 170. SCZ-P I've heard voices that no one else could hear. (ST, 1)

309. PAR-P I'm the target of a conspiracy. (ST, 1)

Potential for Self-Harm

100. SUI I've made plans about how to kill myself. (ST, 1)

183. BOR-S When I'm upset, I typically do something to hurt myself. (ST, 1)

206. DEP-A I have no interest in life. (MT, 2)

340. SUI I'm considering suicide. (MT, 2)

(COMMENT: He denied he was suicidal, violent, or used drugs despite the responses. It was clear from the INF that he was not paying attention).

Potential for Aggression

21. AGG-P People are afraid of my temper. (ST, 1)

61. AGG-P Sometimes my temper explodes and I completely lose control. (ST, 1)

181. AGG-P I've threatened to hurt people. (ST, 1)

Substance Abuse, Current and Historical

55. ALC I have trouble controlling my use of alcohol. (ST, 1)

222. DRG My drug use is out of control. (ST, 1)

334. ALC My drinking has never gotten me into trouble. (False) (F, 3)

Traumatic Stressors

34. ARD-T I keep reliving something horrible that happened to me. (ST, 1)

114. ARD-T I've been troubled by memories of a bad experience for a long time. (ST, 1)

274. ARD-T Since I had a very bad experience, I am no longer interested

in some things that I used to enjoy. (ST, 1)

Potential Malingering

49. NIM I have visions in which I see myself forced to commit crimes. (MT, 2)

129. NIM I think I have three or four completely different personalities inside of me. (ST, 1)

249. NIM Sometimes my vision is only in black and white. (ST, 1)

Unreliability

71. ANT-E I'll take advantage of others if they leave themselves open to it. (MT, 2)

311. ANT-E When I make a promise, I really don't need to keep it. (MT, 2)

True Response Set

75. DEP-P I have no trouble falling asleep. (False) (MT, 1)

142. DRG I never use illegal drugs. (False) (ST, 2)

Idiosyncratic Context

80. INF Sometimes I get ads in the mail that I don't really want. (False) (ST, 2)

280. INF Most people look forward to a trip to the dentist. (ST, 1)

REVIEW AND SUMMARY OF MEDICAL RECORDS

(Undated), ABCXYZ Respiratory Program.

December 16, 2005, Personal Respirator Protection Program Training and Information, Signed By Claimant.

August 7, 2007, Letter, Patrick Imburgia, ABCXYZ.

November 10, 2011, Workers' Compensation Claim Form.

"11/12/09-11/12/10."

"Continuous exposure to toxic chemicals lungs, psyche."

November 10, 2011, Application for Adjudication of Claim.

January 25, 2012, Deposition of Claimant, Volume I.

(COMMENT: This deposition covers pages 1 - 74.)

Page 38:

Q: Now, in addition to the diagnosis of gout, how you been diagnosed with a problem with your kidneys?
A: Yes.

Q: What problem, as far as you understand it, are you having with your kidneys?
A: It was – when I went in. It was just like – they said, like, it got infected.

Page 43:

Q: Would you say you were friends with Mr. Jones?
A: Yes.

Q: And in or about 2005, was he diagnosed with the disease?
A: I don't know.

Q: Well, did you ever talk to Mr. Jones about whether he was having any symptoms that were causing him problems?
A: No. I never talk to him since when he got hurt.

Page 44:

Q: Well, after Mr. Jones stopped working there, did Cal/OSHA come in?
A: Yes.

Page 50, 51, and 52:

Q: After he left, you've already told us that the folks from Pulmonary R Us came in to give spirometry tests… After your spirometry test was given and you were told that you had a low test, did you talk to your co-employees about that?

A: No.

Q: Okay. Now, after the spirometry tests were given, did anything change at Mission in terms of how you performed your job?
A: Yes…

Q: When did you first start wearing a respirator?
A: I think it was 2005… Because of all the chemicals we work with.

Q: And did anybody tell you why it was you were wearing a respirator in 2005?
A: Because of all the chemicals we worked with....

Q: Did they tell you that if you didn't wear a respirator it would cause injury to your lungs?
A: (Witness nods.)

Q: Is that a "yes?"
A: Yes.

Q: Okay. And did they tell you that the reason you had a low spirometry rating was because of your exposure to those chemicals?
A: Yes.

Q: Who told you that?
A: The doctor.

Q: Dr. Rose?
A: Uh-huh.

Q: Is that a "yes?"
A: Yes.

Page 60 and 61:

Mr. Sprang: Let me show you a document. I'm going to show you a document dated August 7, 2007…

Q: First, you notice in the lower right-hand corner, underneath the words John Doe, is that your signature?
A: Uh-huh.

Q: Is that a "yes?"

A: Yes....

Q: Do you recall being told why it was that in August 2007 you could no longer use a respirator?
A: I was told that, you know, just my breathing – my breathing was – my chest test was low, so they wanted me to hop on a different respirator.

Page 62 and 63:

Q: Isn't it true, Mr. Doe, that in August 2007 you were told that you could no longer use a respirator at ABCXYZ?
A: Yes.

Q: And because of that, you could no longer perform the jobs that required the use of a respirator?
A: Yes…

Page 71:

Q: And it was at that point that ABCXYZ sent you back to Pulmonary R Us for that second opinion?
A: Yes.

Q: And that second opinion was that you couldn't work at the company at all; correct?
A: Yes.

Q: Okay. And it was because of that that you ultimately lost your job; correct?
A: Yes.

February 28, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

"Beginning in about 2003, he started to develop some respiratory symptoms.... in 2007, he was hospitalized at General Hospital in Torrance for shortness of breath and hew as told that he had pneumonia."

Final Diagnosis:

"1. History of bronchiolitis obliterans caused by exposure to contaminants at work.
2. Obstructive airways disease.
3. Severe obesity.

4. Gastroesophageal reflux disorder.
5. Suspected sleep apnea disorder.
6. History of gout.

Discussion:

> "Mr. Doe should also be enrolled in the regimented weight loss program. He is massively obese (he weighs more than 320 pounds for his 70.5 inch frame) and his marked excessive weight is not only having an adverse effect upon his respiratory tract but also playing a role in any coexisting reflux problems and sleep apnea disorder. As such, he should be entered into a carefully monitored program to help reduce his weight into a more normal range."

March 6, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

March 9, 2012, Supplemental Medical-Legal Report, Gary Glitter, M.D.

Review of the Case:

> "Because of his various respiratory problems, Mr. Doe has undergone extensive medical evaluations at various health facilities. In 2005, he underwent extensive evaluation at the Pulmonary R Us Medical and Research Center for increasing shortness of breath and cough productive of phlegm. He was noted to have an obstructive sleep apnea disorder, was not using CPAP, and had declined surgery. It was noted that he was continuing to work with various chemicals at work including aldehydes, acetoin, and acetic acid. In 2006, he underwent repeat evaluation at the Pulmonary R Us Medical and Research Center and it was noted that his lung function test had worsened since his previous evaluation there in December 2005."

Comments and Conclusions:

> "Diacetyl is a ketone that is commonly employed in the flavoring industry. In recent years, various medical studies have shown industrial exposure to flavoring agents such as diacetyl is associated with the development of bronchiolitis obliterans, a severe respiratory illness which produces scarring and obstruction of the airways. Although this type of exposure has been most commonly reported in the microwave popcorn production industry, it also has occurred in other situations. In addition to bronchiolitis obliterans, exposure to diacetyl has been associated with the development of a fixed airflow obstruction and other

respiratory disorders."

March 15, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

"He has a number of other medical problems which include obesity, a sleep apnea disorder, H. Pylori infection of his gut, and a probable vasculitis."

"Chest: Expiratory Wheezing."

Lung Function Testing:

"Conclusion:

1. Findings are consistent with an obstructive ventilatory defect."

March 29, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

April 19, 2011, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

April 5, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

April 26, 2012, Deposition of Claimant, Volume II.

(COMMENT: This deposition is 51 pages in length. It covers pages 75 - 125.)

Page 79:

Q: After you were terminated, which I understood occurred in November 2010, did you continue to seek medical treatment?
A: Yes.

Q: From where?
A: UCLA.

Q: And this was with Dr. Seuss?
A: Yes.

Page 83:

Q: Let's talk about those three in more detail. Let's talk about the shortness of breath. How often do you experience that?
A: Every time.

Q: Is this something that occurs daily or weekly; how would you describe it?

A: Daily, every day.

Page 84:

Q: Well, for example, other things which you use to be able to do that you can't do now because you're suffering from this shortness of breath?
A: Yes.

Q: For example?
A: Like, sometimes I can't live my little one up for a while. You know, it's just – put him to sleep.

Page 87:

Q: Do you take regular walks?
A: Yes.

Page 93 and 94:

Q: Let's go on to the question of psychological emotional symptoms.

Your attorneys are claiming, as part of the application they filed on your behalf, that you suffered emotional or psychological injuries as a result of your work at ABCXYZ. I have to inquire about that.

Can you tell me what types of emotional or psychological injuries you're claiming?
A: Sometimes I feel depressed.

Q: Okay.
A: Sometimes I'll be angry at everything…

Q: So you indicated that you're feeling depressed and you're feeling angry; when did you first notice the symptoms?
A: What?

Q: Well, you indicated that you're suffering from feelings of being depressed and you're suffering from feelings of being angry.

Did you have any of those symptoms while you were still working for

ABCXYZ, or did they only start after you stop working?
A: Stopped working.

Q: Can you tell me how long after you stop working that you first begin to feel the symptoms of depression and anger?
A: Like a month.

Page 95:

Q: So it was a shortness of breath and the coughing and the chest tightness that brought on the depression?
A: Yeah.

Page 96:

A: I can't do any work around the house. I can't – whatever I did like two years or three years ago, I still sit there in the house. I can't do anything.

Page 99:

Q: Do you find that you talk less to your wife and children than you used to?
A: Yes.

Q: What do you think the reason for that is?
A: Depressed.

Page 101:

Q: I'm going to have to ask you to be very specific here. Are you engaging in less sexual activity with your wife than you used to?
A: Yes.

Q: With what frequency did you and your wife engage in sexual activity before you began suffering these problems?
A: Like three years now.

Q: You had the problem for three years?
A: Yes.

Page 103:

Q: Let me ask the question differently. Assuming you are suffering from

the shortness of breath or the physical problems, would you like to have sex with your wife is often as you did before?
A: Yes.

Page 105:

Q: Are you claiming to have any problems with your sleeve as a result of your injuries?
A: Yes.

Page 109:

Q: At present, apparently you are going to bed at three or four in the morning. My question is, how long does it take you to get to sleep after you go to bed?
A: 30, 45 minutes.

Page 116:

Q: Has your relationship change at all with your children?
A: No.

Page 119:

Q: Do you think that a CPAP machine is helping you?
A: Yes.

Page 120:

Q: I'll re-ask the question. That was a little casual. Are you receiving money from the Workers' Compensation carrier?
A: Yes.

Q: How much are you getting?
A: $1240.

Q: Every two weeks?
A: Yes.

May 9, 2012, Qualified Medical Examiner's Rheumatology Consultation, Trapper John, M.D.

May 11, 2012, Qualified Medical Examiner's Rheumatology Consultation, Trapper

John, M.D.

May 11, 2012, Radiology Report, Trapper John, M.D.

June 27, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

July 17, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

August 27, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

September 10, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

September 21, 2012, Qualified Medical Examiner's Rheumatology Consultants Re-evaluation Report, Trapper John, M. B.

> "I ordered an appropriate laboratory profile looking at the state of his metabolic rheumatic disease and any complications derived there from. Because of a high risk of coronary artery disease in a patient with chronic gouty arthritis, another electrocardiogram was ordered, looking for evidence of any ischemic change. Simple radiographs were taken of the patient's hands and thoracic spine."
>
> Interim Past Medical History:
>
> > "His past medical history during the past 16 months revealed that he had surgery on his left knee performed on August 2, 2012, and that he is still limping from that procedure."
>
> Physical Examination:
>
> > "Physical examination showed him to be morbidly obese with a body mass index of 48. His blood pressure was 170/100."
>
> Diagnoses:
>
> > "1. A state of morbid obesity with probable sleep apnea associated with poor sleep, marked fatigue, and the sleep-and-arousal disorder.
> > 2. Chronic tophaceous gouty arthritis, now presenting with severe poly-articular gout with uncontrolled hyperuricemia and probable gouty nephropathy with normal renal function.
> > 3. Severe degenerative, hypertrophic new-bone formation around the left-much-more-then-the right ankle.

4. Complaint of thoracic area pain, with past report of chronic low back pain.
5. A pictorial display of a universal state of musculoskeletal pain and neuroparesthesia involving almost the entire body.
6. History of obstructive pulmonary disease."

October 2, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

October 5, 2012, Supplemental Review of Records, Gary Glitter, M.D.

November 1, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

December 11, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

"331 pounds."

Management Plan:

> "Mr. Doe needs to be placed in a carefully monitored weight-reducing program..... this has been necessitated by work because he is massively obese.... also needs to be entered in an exercise program with pool/aquatic therapy....he should be provided with access to a gym.... patient needs a portable, lightweight O2 device."

December 20, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

January 16, 2013, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

Weight: "331+ pounds."

February 18, 2013, Initial Comprehensive Psychological Evaluation with Associated Psychodiagnostic Testing, Sigmund Freud, Ph.D.

History of the Incident As Reported by the Patient:

> "The applicant reports that he had surgery on his left knee two weeks prior to our initial contact on August 15, 2012."

Associated Emotional Symptoms:

> "The applicant discloses that he is been diagnosed with sleep apnea and he uses a CPAP machine. He reports a significant decrease in his

energy level. He estimates it to be 40%.

The applicant begrudgingly discloses he has had passive suicidal thoughts but would not act on them due to the love he has for his children and his family overall. He reports visual illusions (shadows) when he is awake watching television."

Drug Abuse – Alcohol – Tobacco:

"The applicant smokes a pack of cigarettes a day. He started in 1994 but quit last year."

Pertinent Medical-Psychiatric History:

"In 2001, he was diagnosed with gout at UCLA."

Mental Status Examination:

"The applicant is not psychotic though he has reported visual illusions (shadows)."

Associated Psychodiagnostic Test Findings:

"Beck Depression Inventory-II. He obtained a score of 45/63 (severe range.)"

"Beck Anxiety Inventory. He obtained a score of 45/63 (severe range.)"

"Both the MMPI-II and MCMI-III are in the process of being administered and scored."

Discussion:

"On this occasion, Mr. John Doe is temporarily partially disabled from a psychological point of view."

(COMMENT: Why? He left work because of physical injuries.)

Initial Diagnoses:

"Axis I: Major Depressive Disorder, Single Episode, Moderate.
Axis II: No Diagnosis.
Axis III: Headaches (three times a week, severe); weight gain of 30

to 40 pounds; chest pain (occasional); gastrointestinal symptoms (pain, gas, constipation); gastroesophageal reflux disease (GERD); left knee pain post-surgery (mild to moderate).

Axis IV: Current level of stressors: Moderate.

Axis V; Global Assessment of Functioning Past Year: Moderate symptoms (57)."

March 4, 2013, Supplemental Review of Records, Gary Glitter, M.D.

March 7, 2013, Pulmonary Medical Consultation Report, Gary Glitter, M.D.

May 2, 2013, Pulmonary Consultation Report and Request for Authorization, Gary Glitter, M.D.

"339 pounds (weight gain of 15 pounds since last visit one month ago.)"

"He is currently unable to use his portable oxygen system because of several physical reasons and it need to be changed to a lightweight system which he can attach to his belt."

June 4, 2013, Pulmonary Consultation Report and Request for Authorization, Gary Glitter, M.D.

"Weight is down to 327 pounds on Lindora weight loss program."

Final Diagnoses:

"1. Severe bronchiolitis.
2. Sleep apnea disorder.
3. Massive obesity.
4. Hypoxemic respiratory insufficiency.
5. Gastroesophageal reflux disorder.
6. Gout.
7. Elevated blood glucose.
8. Elevated blood lipids."

September 9, 2013, Supplemental Review of Records, Gary Glitter, M.D.

October 8, 2013, Pulmonary Consultation Report and Request for Authorization, Gary Glitter, M.D.

November 5, 2013, Pulmonary Consultation Report and Request for Authorization,

Gary Glitter, M.D.

> "As emphasized in the past, Mr. Doe has severe, permanently disabling, incapacitating, and debilitating lung disease which is a specific restful of exposure to diacetyl at work. He has several concomitant medical conditions which have made treatment of his lung problems more challenging... massively obese....marked exercise intolerance due to his incapacitating work-related lung disease.....problematic because of his gout...."
>
> "... totally and permanently disabled."

December 5, 2013, Consultation Report and Request for Authorization, Gary Glitter, M.D.

> "He told me he was hospitalized last week because of severe joint problems involving his knees and lower extremities. He remained at UCLA for one week's time during which he was placed on steroid therapy."
>
> "He also has several digestive tract problems and should continue on dietary management and omeprazole."

January 7, 2014, Consultation Report and Request for Authorization, Gary Glitter, M.D.

January 23, 2014, Consultation Report and Request for Authorization, Gary Glitter, M.D.

March 4, 2014, Consultation Report and Request for Authorization, Gary Glitter, M.D.

March 11, 2014 - March 21, 2014, Surveillance Video.

> **(COMMENT: This video was 2.25 hours in length).**
>
> The claimant is seen repeatedly walking, driving a van, and being a passenger in a van. In one notable instance on the March 20 - 21, 2014 tape, he was carrying a young girl and playing with her, laughing and not displaying any obvious discomfort. He was not observed using an O2 cannula at any time.

June 4, 2014, Consultation Report and Request for Authorization, Gary Glitter, M.D.

September 9, 2014, Consultation Report and Request for Authorization, Gary Glitter, M.D.

Weight: "358 pounds."

"He is probably headed for a lung transplant in the not too distant future.... no surgeon will perform lung transplant unless he gets his weight into more normal range."

October 14, 2014, Consultation Report and Request for Authorization, Gary Glitter, M.D.

March 23, 2015, Lung Transplant Consultation Note, Marcus Welby, M.D.

April 15, 2015, Consultation Report and Request for Authorization, Andre Glitter, M.D.

June 1, 2015, Pulmonary Function Test.

June 1, 2015, Panel QME Medical Legal Evaluation, Andre Dre, M.D., Internal Medicine.

History of Present Illness:

"The patient has always been large. He says his typical adult weight might have been around 275 pounds."

"It is difficult for him to remember what happened when regarding his lung history. He thinks that maybe he started to have symptoms of shortness of breath around 2008."

"The patient has no history of childhood asthma."

"He thinks his lung condition might have been diagnosed around 2010."

"He also has gout since around 2002."

"The patient also has some obstructive sleep apnea."

Review of Medical Records:

"A letter of 10-25-10 by Dr. Seuss at UCLA states that the patient has obliterative bronchiolitis. He no longer is working at the production line. He has been reassigned to work in the warehouse and no longer has exposure to diacetyl. His chronic airflow obstruction is due to diacetyl."

"Deposition of Dr. Christopher Cooper, dated 7-24-14, were reviewed. He has

been retained by the defendant to serve as an expert. He has been retained in other diacetyl cases. He does not believe the applicant has bronchiolitis obliterans. He thinks he has asthma. There may be some COPD from cigarettes."

Diagnoses:

"1. Obliterated bronchiolitis.
2. No asthma by definition of that condition and that the airway obstruction is not completely reversible.
3 Insufficient tobacco history to justify diagnosis of COPD.
4. Morbid obesity.
5. Obstructive sleep apnea.
6. Gout.
7. Possible hypertension.
8. Borderline diabetes."

Discussion:

"I have an advocacy letter from both defense and applicant rather than a joint letter.

The applicant letter states that the defendant has accepted the claim.

The defense letter also says that the claim has been accepted to his 'nervous and respiratory systems'. I am not sure that is meant by his 'nervous' system or that he has any neurological disorders."

"The patient has had a period of temporary total disability from the time he left work until the present and continuing."

"If he is unable to lose weight....then that would be the time at the end of his period of temporary disability.

In that his pulmonary function tests data has stabilized, he would be able to be rated."

"I read the statements that the patient is totally permanently disabled. I would agree. To rate his obstructive airway disease I turned to tables 5-9 and 5-10 on page 104 of the textbook. He would have four asthma points because his post-bronchodilator value is less than 50% of predicted. He would have another two asthma points because of the percent of FEV reversibility.

The patient is on daily high does inhaled corticosteroids, but not systemic steroids, so he would only have three more points for medication. That give him a total of nine asthma point, which puts him at the very high end of Class III at 50% WPI.

In that the patient requires oxygen, he should be put into Class IV. Given his physical limitations, a diffusion capacity rating could also be applied."

"According to table 5-12 he would have a Class II impairment for this diffusion because it is more than 60% of predicted and below the lower limit of normal. With the need for supplemental oxygen he would be at 25%. I think this should be added, not via the Combined Values Chart. He would have a 75% WPI.

Causation and apportionment would be entirely industrial. The patient does not have asthma."

"He does not have cigarette-related COPD. His tobacco history is clinically insignificant. The report in the medical records says it somewhere between 15 and 20 pack years. In pulmonary medicine there is usually a minimal threshold of at least 20 pack years tobacco history to be considered injurious to the lungs."

"In my opinion, causation and apportionment would be entirely industrial. There is no basis for non-industrial apportionment."

"He weighed about 300 pounds when he developed the disease. Now he is 375 pounds. It is probable that sleep apnea has been aggravated, if not caused by this substantial weight gain."

"The gout is probably totally non-industrial, but should be treated in order for him to optimize his physical activity level.

His morbid obesity needs to be treated on an industrial basis as well. He needs to lose weight in order to have the lung transplant."

June 10, 2015, Consultation Report and Request for Authorization, Gary Glitter, M.D.

August 19, 2015, Consultation Report and Request for Authorization, Gary Glitter, M.D.

August 29, 2015, Panel QME Supplemental Report, Andre Dre, M.D.

"The report says the insurance company repeatedly refuses to provide the

necessary certification. The patient is a candidate for lung transplant surgery, but cannot undergo such a procedure until he reduces his weight to a less dangerous level. He may even need a procedure to facilitate weight loss."

Diagnosis:

"1. Obliterative bronchiolitis with severe obstructive airway disease with partial reversibility.
2. Severe obstructive sleep apnea.
3. Gout.
4. Possible hypertension.
5. Borderline diabetes.
6. Morbid obesity."

Discussion:

"This applicant has obliterans bronchiolitis, an extremely serious and often fatal lung disease despite lung transplantation."

"I am at a complete loss as to understand why the carrier would not authorize appropriate treatment.

Although the gout is not industrial, it certainly would impede his ability to participate in the pulmonary rehabilitation program."

"The patient is totally in permanently disabled and apportionment is 100% industrial. It is illogical to think that his minimal tobacco history has anything to do whatsoever with his lung disease."

October 29, 2015, Deposition of Andre Dre, M.D., Volume I.

(COMMENT: This deposition covers pages 1 - 40.)

Page 36:

Q: Do you believe that Mr. Doe is currently in need of a lung transplant?
A: I don't know.

He needs to have access to the lung-transplant program.

Mr. Gonzalez:

He was evaluated – I can't remember by which doctor – but a

recommendations was made for him to lose weight because of his high BMI.

....a formal eight-loss program was denied by defendant. So that has not happened.

January 13, 2016, Consultation Report and Request for Authorization, Gary Glitter, M.D.

Impression:

"1. Bronchiolitis obliterans secondary to diacetyl exposure at work.
2. Hypoxemic respiratory insufficiency.
3. Morbid obesity.
4. Sleep apnea disorder.
5. Gout."

"...totally and permanently disabled."

March 3, 2016, Deposition of Andre Dre, M.D., Volume II.

(COMMENT: This deposition is 29 pages in length. It covers pages 41 - 69.)

Page 62:

Q: Your opinion was that he was totally permanently disabled as of the time that you evaluated him in June of 2015; correct?
A: Yes.

Q: And you've not seen anything further since formulating that opinion that would change your opinion in that regard; correct?
A: Correct.

March 4, 2016, Panel QME Supplemental Report, Andre Dre, M.D.

"As I mentioned above, the pathophysiology and histology of cigarette-related airway damage and obliterative bronchiolitis are not the same. The authors of this article worked for the diacetyl industry. If their findings are to be believed, then the billions of cigarette smokers in the world would develop obliterative bronchiolitis. They do not."

"As mentioned in my deposition, the patient became disabled from being able to work when he was taken off work by a company doctor in November 2010.

When he became disabled is probably later that [sic] when it should have been because of incorrect evaluation at Pulmonary R Us.

When the patient was seen at Pulmonary R Us he was diagnosed with not having food-flavoring lung disease. This is surprising because his chest imaging studies and pulmonary function tests were consistent with obliterative bronchiolitis in 2007.

Part of the history is that supposedly his screening spirometries were first abnormal in January 2005. I could not find a spirometry with a legible date for January 2005, but the spirometry on 4-25-05 was distinctly abnormal with FVC at 75% and FEV1 at 59% of predicted.

So when the patient became disabled may be a legal question. He continued to work, so he was not disabled until he was taken off work when he became disabled."

"Based on predicted, there should have been no age taken into consideration. He lost almost 50% of his lung function, dropping 59% of predicted to 35% of predicted. His lung disease was extremely advanced by 2010."

March 16, 2016, Consultation Report and Request for Authorization, Gary Glitter, M.D.

August 30, 2016, Panel QME Supplemental Report, Andre Dre, M.D.

"This new paperwork states the applicant has included psyche as part of the claim for injury arising from the CT claim as filed.

I am Board Certified in three specialties: internal medicine, pulmonary diseases, and critical care medicine. I am not a psychiatrist. I woul efer issues pertaining to the evaluation of such a claim to a QME in psychiatry.

As such, there would be a need for an additional Panel QME to evaluate the psychiatric claim."

September 27, 2016, Consultation Report and Request for Authorization, Gary Glitter, M.D.

October 14, 2016, Panel QME Supplemental Report, Andre Dre, M.D.

"I am receipt of a letter from each party."

Discussion:

"Both of the letters incorrectly state the patient's tobacco history. The patient did not smoke '20 packs per day' as stated in the letter from the applicant attorney. The patient does not have a '20 pack days' tobacco history as stated in the defense letter.

Starting with the family history question, in my first report of 6-01-15 I reported the patient told me that his father died of lung cancer. He told me that one of his three children has allergies. I am not aware that one of this children has asthma.

As for his tobacco history, the patient erpoerted to me that he smoked one half to one pack a day starting at the age of 18 years and quit in the year 2011. That means he smoked for 17 years somewhere between one half to one pack per day. That means he has somewhere between an 8.5 to 17 pack year tobacco history, which is probably clinically insignificant.

From my training, I was taught as a Fellow at UCLA that a 20 pack year was the threshold of concern."

The patient does not have asthma.

The patient does not have COPD.

The patient has obliterative bronchiolitis due to diacetyl exposure."

November 30, 2016, Consultation Report and Request for Authorization, Gary Glitter, M.D.

March 23, 2017, Deposition of Andre Dre, M.D., Volume III.

(COMMENT: This deposition is 34 pages in length. It covers pages 70 - 103.)

Page 76:

Q: And is it still your opinion today that the applicant is still totally and permanently disabled?
A: Well, I haven't seen him in two years, so I don't know how he is, if he is any better or worse. Based on what I know based on from what I know from him back, the, I would say yes.

September 27, 2011, Employee's Claim for Workers' Compensation Benefits.

"11/1/10."

"Toxic exposure to chemicals. Shortness of breath, coughing, fatigue, psyche."

January 30, 2012, Hospital Records, MSS Pulmonary.

January 30, 2012, Pulmonary Function Report, UCLA Healthcare.

March 12, 2012, Hospital Records, Medical Group MB FAC.

Problem List:

> "Gout flare.... low back pain... COPD.... Obesity....HTN.... obstructive sleep apnea...cellulitis... non-compliant patient... vitamin D deficiency.... joint pain.... tophaceous gout... high risk medication use.... RESOLVED: Rheumatoid arthritis."

May 25, 2012, Hospital Records, Sm ED Legacy Conv.

July 18, 2012, Hospital Records, Medical Group MB FAC.

August 4, 2012, Inpatient Consult Note, Benjamin Spock, M.D.

Chronic Conditions:

> "1. Suspected bronchiolitis obliterans related to powdered flavor exposure at work.
> 2. Gout
> 3. Hypertension.
> 4. History of plantar fascitis.
> 5. History of questionable asthma."

May 11, 2013, Discharge Summary, Gonzo Gates, M.D.

"Gout flare."

May 15, 2013, Hospital Records, Rheumatology SM.

May 22, 2013, Hospital Records, MSS Pulmonology MP2.

May 22, 2013, Pulmonary Function Report.

May 23, 2013, Progress Notes, Joseph Seuss III, M.D.

June 6, 2013, Hospital Records.

June 11, 2013, June 16, 2013, Hospital Records, CPN Manhattan Bch.

July 1, 2013, July 2, 2013, July 3, 2013, Hospital Records, SM 4MN.

July 3, 2013, Visit Summary, signature illegible.

Problem List:

"Cellulitis of foot.
Gout flare
Pyogenic arthritis, lower leg.
Obstructive chronic bronchitis without exacerbation
Other emphysema.
Chronic airway obstruction, not elsewhere classified.
Chronic ulcer of unspecified site.
Chronic kidney disease, stage II (mild).
Rheumatoid arthritis.
Low back pain.
COPD.
Obesity.
HTN.
Obstructive sleep apnea.
Right arm cellulitis.
Cellulitis."

September 4, 2013, Hospital Records, SM ED.

September 5, 2013, September 10, 2013, September 30, 2013, October 2, 2013, October 15, 2013, November 7, 2013, Hospital Records, CPN Manhattan Bch.

November 13, 2013, Hospital Records, Rheumatology SM.

"... history of very poor compliance with appointments and medications."

November 18, 2013, November 19, 2013, November 20, 2013, November 21, 2013, November 22, 2013, November 23, 2013, November 24, 2013, November 25, 2013, November 26, 2013, Hospital Records, SM 4MN.

December 17, 2013, December 18, 2013, Hospital Records, MP2 Pulm Func Lab.

December 18, 2013, Progress Notes, Joseph Seuss, M.D.

"Initially saw John in consultation on February 8, 2010. At that visit, I told him

that there was no easy way to discriminate diacetyl-induced OB from other causes of small airways disease. During subsequent visits with me, his PFTs deteriorated. In light of this, I recommend that he not return to work in any capacity (stated in my dictated letter from 1/31/11)."

December 20, 2013, Hospital Records, Rheumatology SM.

January 14, 2014, January 15, 2014, Hospital Records, SM 4NW.

May 2, 2014, Hospital Records, CPN Manhattan Beach.

May 9, 2014, Hospital Records, MSS Pulmonology MP2.

May 9, 2014, Pulmonary Function Report.

May 14, 2014, Hospital Records, Rheumatology SM.

June 10, 2014, Hospital Records, CPN Manhattan Bch.

August 1, 2014, Hospital Records, MP2 Pulm Func Lab.

August 1, 2014, Pulmonary Function Test.

August 4, 2014, Hospital Records, MSS Pulmonology MP2.

August 4, 2014, Progress Notes, Joseph Seuss III, M.D.

August 14, 2014, Hospital Records, Rheumatology SM.

August 27, 2014, Hospital Records, Path Blood Draw Ctr SM.

November 17, 2014, December 3, 2014, Hospital Records, CPN Manhattan Bch.

December 15, 2014, December 16, 2014, Hospital Records, Rheumatology SM.

December 30, 2014, February 2, 2015, Hospital Records, CPN Manhattan Bch.

January 7, 2015, Hospital Records, Rheumatology SM.

February 2, 2015, Progress Notes, Horton Who, M.D.

"Wants to see Dr. Seuss. Fu now under HMO as his case has been settled."

"Former smoker - 1.0 packs/day for 16 years
Types: Cigarettes
Start Date: 10/03/1995
Quit Date: 11/13/2011."

"Neck pain on left side.... Shortness of breath oxygen dependent... referral fu with his pulmonologist."

February 10, 2015, February 11, 2015, Hospital Records, SM ED.

"...c/o bilateral flank pain and lower mid back pain which is causing him to have SOB. He states he does not have COPD but has obstructive sleep apnea... unable to sit still and wishes to stand because it helps him breath better."

February 10, 2015, Emergency Department Service Report, Jason Bourne, M.D.

"Shortness of breath.... the problem occurs frequently.... has been worsening."

February 10, 2015, ECG.

February 12, 2015, Hospital Records, CPN Manhattan Bch.

February 16, 2015, Hospital Records, SM ED.

February 18, 2015, February 23, 2015, Hospital Records, CPN Manhattan Bch.

February 23, 2015, Progress Notes, Horton Who, M.D.

"Back pain... can't do anything now.... not wearing oxygen machine now."

March 5, 2015, Hospital Records, SM ED.

March 5, 2015, Emergency Department Service Report, Martin Balsam, M.D.

"Back pain... current episode started 2 days ago."

March 6, 2015, Hospital Records, CPN Manhattan Bch.

March 10, 2015, Hospital Records, UCLA.

April 2, 2015, Hospital Records, Rheumatology SM.

RECORDS FROM MANAGED MED HAVE BEEN REVIEWED IN THEIR ENTIRETY.

(Undated), Psych Symptoms Checklist.

July 17, 2012, Pulmonary Medical Consultation Report, Gary Glitter, M.D., Q.M.E.

> "Exposure to diacetyl.... As a result of his severe bronchiolitis, he has permanently disabling fatigue and difficulty breathing with exertion. He also told me that he is very stressed out about the condition and he is having a lot of trouble in his home environment. His wife does not accept the severity of his illness and thinks he is malingering. .... attending a weight reduction program...."
>
> Final Diagnoses:
>
> "1. Severe bronchiolitis obliterans triggered by exposure to diacetyl in the food flavoring industry with severe permanently disabling respiratory disease.
> 2. Obstructive sleep apnea disorder.
> 3. Morbid obesity.
> 4. Gastroesophogeal reflux disorder.
> 5. Exertional hypoxemia.
> 6. Obstructive airways disease.
> 7. Gout.
> 8. Lower back pain.
> 9. Traumatic stress syndrome."
>
> "Mr. Doe clearly expresses a need for psychological treatment. He is having a lot of stress problems in his home environment with his spouse who apparently does not accept the severity of his illness."

August 15, 2012, Initial Psychological Evaluation, Dr. Ruth Westheimer.

> "Pt exposed to chemical Diacetyl. 'We work in it all the time. The state found out about it. I had to see a doctor - 2007. I got a letter (OSHA).' Pt wore a mask - part of the time."
>
> "ETOH - Every weekend, 1 bottle of hard liquor per day, started in 91 until 10 years ago. From then on, only a few beers on special occasions. Pt tried marijuana but wasn't addicted to it."
>
> "Hospitalizations... gout... UCLA - 2001."

"Pt's father passed away from lung cancer 2005."

"Arrests: 1996 - pt refuses to state charge dismissed - other than 'misdemeanor' leading to 3 years probation."

"Incarceration: Served 'a month or two' in LA County."

August 15, 2012, Preliminary Psychological Evaluation, Sigmund Freud, Ph.D.

Preliminary Diagnoses:

"Axis I: Major Depressive Disorder, Single Episode, Moderate.

Axis II: No Diagnosis."

August 15, 2012, Psychotropic Medication Referral, Carl Jung, M.D.

August 15, 2012, August 30, 2012, September 13, 2012, Psychological Testing, Completed by Claimant.

August 30, 2012, Medication Evaluation, Carl Jung, M.D., Family Practice.

August 30, 2012, Prescription, Carl Jung, M.D.

October 19, 2012, Handwritten Notes, Signature Illegible.

"Pt to try 30 mg Paxil."

January 29, 2013, October 2, 2013, Handwritten Notes, Signature Illegible.

February 18, 2013, Initial Comprehensive Psychological Evaluation With Associated Psychodiagnostic Testing, Sigmund Freud, Ph.D.

Initial Diagnosis:

"Axis I Major Depressive Disorder, Single Episode, Moderate."

This concludes Review and Summary of Medical Records.

<u>DIAGNOSIS</u>

In the year 2000, the American Psychiatric Association published the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). The development of DSM-IV-TR has benefitted from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-IV. The manual involves the use of a multiaxial system that facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on assessing a single presenting problem.

DSM-V, published in 2013 is not being used for this report as it has been widely rejected in professional circles and hundreds of psychological and psychiatric organizations, even the National Institute of Mental Health because of poor reliability and validity in field trials and intense methodological criticism from previously editors of DSM-III and IV. In addition, DSM-5 cannot be used as it does not include the GAF which is necessary for rating purposes.

On Axis I (Clinical Disorders, Other Conditions That May Be a Focus of Clinical Attention) several disorders previously coded on Axis II are included. Only Personality Disorders and Developmental Disabilities remain coded on Axis II for DSM-IV. Axis III continues to be used for coding General Medical Conditions, and an appendix listing selected general medical conditions with their ICD-9-CM codes has been introduced for DSM-IV. Axis IV is used for reporting Psychosocial and Environmental Problems. Axis IV provides a rating scale for severity of stressors. Axis V (Global Assessment of Functioning (GAF) Scale) is a graded 100 point scale to rate the highest level of functioning in time period specified (past year).

Axis I:	Depressive Disorder Not Otherwise Specified Due to Declining Health.
Axis II:	No Diagnosis.
Axis III:	Pulmonary Injuries (Bronchiolitis Obliterans), Gastrointestinal Reflux Disorder, Back Pain, Obesity, Gout.
Axis IV:	Health problems, and problems related to interaction with the Workers' Compensation system.
Axis V:	GAF = 55. This score is consistent with moderate psychological symptoms.
	The GAF corresponds to 23% Whole Person Impairment not including Future Earning Capacity adjustments.

Note that symptoms of pain and insomnia (sleep is an activity of daily living) are incorporated in the symptom severity rating of the psychiatric GAF described here rather than in the neurological or orthopedic chapters of the AMA guidelines. The GAF rating does NOT include impairment in functioning due to physical or environmental limitations per the specific instructions of the 2005 PDRS and DSM-IV-TR.

AMA Evaluation of Impairment

1. Ability to perform activities of daily living.

   Level of Impairment: Class 3 - Moderate Impairment.

2. Social Functioning.

   Level of Impairment: Class 2 - Mild Impairment.

3. Concentration, Persistence and Pace.

   Level of Impairment: Class 3 - Moderate Impairment.

4. Adaptation in Work Settings.

   Level of Impairment: Class 3 - Moderate Impairment.

Class 1 - No Impairment

No impairment noted.

Class 2 - Mild Impairment

Impairment levels are compatible with most useful functioning.

Class 3 - Moderate Impairment

Impairment levels are compatible with some but not all useful functioning.

Class 4 - Marked Impairment

Impairment levels significantly impedes useful functioning.

Class 5 - Extreme Impairment

Impairment levels preclude useful functioning.

STATUS

The claimant is Psychiatrically Maximally Medically Improved. Temporary disability is deferred to pulmonology. It is clear that the claimant would have continued working but for the physical disability.

IMPAIRMENT

Residual impairment is due to mood disorder and anxiety about health concerns affecting work pace and concentration.

TREATMENT

Future psychiatric treatment is indicated.

WORK RESTRICTIONS

There are no psychiatric work restrictions. Other work restrictions are to be deferred to pulmonology.

INDUSTRIAL CAUSATION

This claim is regarding a severe pulmonary CT injury developed over the period of employment of 2000 to 2010.

In my opinion, this psychiatric claim is compensable as an emotional consequence of the industrial cumulative pulmonary injury as the predominant cause.

APPORTIONMENT

Per Labor Code 4663 and 4664, by causation 80% of the applicant's current permanent impairment is caused by or results from the industrial pulmonary injury and 20% of the applicant's current permanent impairment is caused by or results from other factors including the pain and chronicity of his preexistent gout.

Although it is difficult to quantify the effects of nonindustrial stress on overall causation of symptoms and functional decline, it is certainly not zero and this is the best estimate I can offer.

VOCATIONAL REHABILITATION

Vocational rehabilitation is not indicated on a psychiatric basis.

COMMENTS AND CONCLUSIONS

The claimant was a Compounder who claimed pulmonary injury, a chronic toxic exposure from diacetyl noticed about 2007. The condition, bronchiolitis obliterans, is basically popcorn workers' lung and is irreversible. He went in for treatment and had extensive studies but he was told it was not work-related initially and he was sent to Colorado for special studies. Later on, OSHA was involved and he had to use additional breathing apparatuses but his breathing worsened to the point where he stopped working due to respiratory failure on November 12, 2010.

His pulmonary history shows that he underwent treatment without much success. He was seen by Dr. Dre, QME pulmonologist, who issued a 75% Whole Person Impairment rating with all permanent impairment apportioned to the industrial injury. There is now talk that he is going to be a candidate for lung transplant but that this could only happen if he loses weight from 280 pounds. He says he gained 70 pounds since 2010. He is not in any kind of weight loss program. He did try Lindora but it failed. I didn't see much motivation for weight loss despite the seriousness of the situation and the apparent need for him to lose weight for a life-saving operation.

The claimant has not returned to any kind of work since 2010. It was around this time that he developed, understandably, a depression. He is still on disability. He has not worked elsewhere. He continues to have chronic pain and some other secondary psychiatric symptoms which include anxiety, worry regarding his future, depression, anger, and frustration regarding his condition. He also reports increased irritability and some social isolation. Some of the chronic pain involves symptoms related to chronic gout, well documented in the above records.

His self-reported subjective symptoms on the Beck tests show severe depression and anxiety but this is mitigated in the assessment by the tests for exaggeration. There was some evidence of exaggeration by the results of the SIMS test. On the PAI he paid little attention and responded randomly. It was clear he made very little effort during testing. This mitigates to some extent his self-reported distress.

Therefore, his residual mental symptoms are overall moderate including assessment of subjective and objective findings.

He has had very little in the way of mental health intervention despite getting depressed once he could not work anymore. He was seen by Dr. Freud in 2012.

He freely admits nonindustrial stress due to chronic pain of preexisting gout and that this is currently stressful. There is no relevant past psychiatric history to apportionment as none of his past issues related to any disability matter. Furthermore, Dr. Dre has indicated that there was no apportionment by causation to smoking.

Regarding any possible impairment rating outside the AMA Guides permitted by recent case law (Almaraz and Guzman, 2009), please note that the GAF rating system for psychiatric claims is already outside the Guides as described in the 2005 PDRS rating system.

Thank you for permitting me to participate in the evaluation of this interesting individual. Should you have any questions or comments regarding this report, please do not hesitate to contact me.

This report was reviewed for completeness and structural content by D. Riojas. Whoscription services were provided by K. Flora. The psychiatric history and evaluation, formulation of medical-legal opinions, and the dictation of this report have been performed by the undersigned.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true.

I certify under penalty of perjury that I have not violated Labor Code Section 139.3 and that the contents of my report are true and correct to the best of my knowledge.

This report was signed in the County of Riverside on the 14th day of July, 2017.

Sincerely,

James O'Brien, M.D.
Diplomate, American Board
of Psychiatry and Neurology

California Qualified
Medical Evaluator