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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION TWO

SURAYA RASHID,

Petitioner,

v.

BOARD OF RETIREMENT OF THE
ALAMEDA COUNTY EMPLOYEES'
RETIREMENT ASSOCIATION et al.,

Respondents.

A134140

(Alameda County
Super. Ct. No. RG 11560860)

Petitioner/appellant Suraya Rashid applied for service-connected disability retirement from her job as a medical clerk at the Alameda County Medical Center (ACMC). The Board of Retirement of the Alameda County Employees' Retirement Association (Board) denied her application, but granted her nonservice-connected disability retirement, finding that she was permanently disabled based on a psychiatric disorder but that the incapacity was not work related. The trial court denied Rashid's petition for writ of mandate seeking to reverse the denial of service-connected disability retirement. We conclude the trial court's decision was supported by substantial evidence, and we affirm.

BACKGROUND

The February 2002 Incident

On May 30, 2000, Rashid began working at ACMC as a medical clerk, a job that entailed providing clerical support to medical personnel who were admitting and

discharging psychiatric patients, as well as performing clerical tasks such as transcription, making photocopies, transmitting faxes, and maintaining office supplies.

On February 10, 2002, Rashid was at work at the John George Psychiatric Pavilion when she was intentionally tripped by a patient. She sought emergency medical treatment and was diagnosed with ankle and wrist sprains, and contusions. She filed a claim for workers' compensation that day, identifying her injuries as "R wrist & R knee & ankle pain and swelling." A few days later, she followed up with a doctor at Kaiser who diagnosed her as suffering from "Left shoulder strain, right wrist strain, right ankle strain, right knee contusion."

Rashid was off work for the following six months. On August 12, 2002, she returned to work on a modified-duty basis with restrictions. She continued to perform her modified clerical work for ACMC full time for five years, until June 2007 when, as will be seen, she left active employment.

Medical Treatment From the Date of the Incident Through 2004

Despite having suffered seemingly minor injuries, Rashid complained of ongoing pain in the two years following the incident. She sought extensive medical treatment during that time frame from a cadre of medical professionals. She was referred to numerous specialists, but they were largely unable to offer medical explanations for her subjective symptoms.

Rashid was initially treated by orthopedist Vatche Cabayan, M.D. Dr. Cabayan's treatment plan consisted of diagnostic testing, pain management, and physical therapy.

Podiatrist Richard Lavigna, D.P.M. treated Rashid for bilateral ankle pain and injury to her left great toe from August 2002 to May 2004. The treatment included minor surgery (a partial ostectomy, similar to a "bunionectomy") on the toe in January 2003. Following the surgery, Rashid was again off work from January 9, 2003 until March 18, 2003. Upon returning to work, she was given restrictions of sitting 15 minutes every hour, avoiding repetitive, forceful grasping or pinching, and heavy lifting.

Rashid's complaints of toe pain inexplicably continued postsurgery, so she was referred to orthopedic foot specialist Glenn Pfeffer, M.D. Dr. Pfeffer noted normal

objective findings and was unable to explain Rashid's ongoing foot and ankle pain. As of September 15, 2003, Dr. Pfeffer considered Rashid's foot and ankle problems permanent and stationary, and concluded that she could "work without restrictions regarding her feet and ankles."

On February 23, 2004, Dr. Lavigna reported that Rashid continued to complain of pain in her feet and ankles, and he recommended she continue physical therapy. Rashid declined on the grounds that it was too far and too much of a hassle. In May, she was still complaining about foot and ankle pain, describing it as worse than before. Dr. Lavigna noted that Rashid had full range of motion and no swelling. According to the doctor, her "subjective complaints do not match my objective findings." He recommended cortisone injections, continued physical therapy, and orthotics.

Physiatrist Michael Hebrard, M.D. began treating Rashid for ongoing wrist complaints in November 2002. He performed an EMG and nerve conduction study of both upper extremities and reported the study to be normal. He diagnosed Rashid as suffering from a "bilateral upper extremity repetitive stress injury" and "bilateral carpal tunnel syndrome." Dr. Hebrard made multiple referrals: to orthopedic hand and wrist surgeon Kendrick Lee, M.D., for evaluation and treatment of Rashid's wrist pain; to Dennis Lee, who provided a course of acupuncture; and to psychiatrist Robert Avenson, M.D., who diagnosed Rashid with depression and anxiety. She attended 12 or 13 therapy sessions with Dr. Avenson but then terminated treatment because she felt it was not helping.

In January 2004, Dr. Hebrard prepared a narrative report stating that his objective clinical examination findings were essentially normal, including motion, strength, alignment, absence of atrophy, as well as neurological, such as motor, reflex, and sensation. He pronounced Rashid permanent and stationary with regard to the wrist conditions stemming from the February 10, 2002 incident, and recommended work preclusions from repetitive typing/keyboarding or gripping, plus future medical care of a conservative nature.

Dr. Lee treated Rashid for her wrist complaints from January 2003 to July 2004, giving her the options of continuing with hand therapy and anti-inflammatory medications or undergoing exploratory arthroscopy of the wrists. Rashid opted to continue the conservative treatment. Dr. Lee eventually became skeptical of Rashid's complaints, referring to "evolving" symptoms and "migratory pain" in his reports. In a report dated February 2, 2004, he noted, "Etiology of migratory pains and numbness remain [*sic*] unclear," stating that he had "no recommendations for further treatment, given absence of clear findings." Dr. Lee determined that her condition became permanent and stationary on January 14, 2004, and he ordered that she return to work with restrictions such as no repetitive typing or gripping.

Dr. Lee referred Rashid to neurologist Bowen Wong, M.D. Following an examination, Dr. Wong documented full range of motion in Rashid's neck and otherwise normal findings with respect to her upper extremities. Noting that previous nerves studies were normal, Dr. Wong expressed skepticism regarding Rashid's complaints, referring to "intermittent neurological symptoms" in his report.

Orthopedist Bryan Barber, M.D., examined Rashid in August 2004 in connection with her workers' compensation claim. Her continued complaints included pain in both ankles and wrists. Dr. Barber noted normal range of motion and strength and the absence of swelling and instability. He made normal neurological findings, including motor, sensory, and reflexes. With regards to Rashid's right wrist, Dr. Barber recommended a prophylactic preclusion from very heavy lifting and forceful pushing, as well as occasional splinting. He concluded there was no disability with regard to Rashid's left wrist, ankles, or left toe. He recommended anti-inflammatories if a flare up occurred but did not recommend any work restrictions, future treatment, or follow up diagnostic studies.

June 2007: Rashid Left Active Employment and Filed For Workers' Compensation Benefits

Rashid did not produce any medical records for the latter part of 2004, all of 2005 and 2006, and early 2007, during which time she was working full-time on modified duty

at ACMC. The first record following that long break in medical records was a May 2007 workers' compensation progress report by Sultan Hamid, M.D., Ph.D., a physician at the "As Soon As Possible" clinic.¹ He advised that Rashid continued to complain about ongoing wrist pain, which he diagnosed as carpal tunnel syndrome/unspecified synovitis tenosynovitis, closed dislocation of wrist, and wrist sprain. He recommended a referral to a hand specialist and approved modified duty with no repetitive typing or keyboarding. The following month, however, Dr. Hamid advised that Rashid should be off work.

On June 1, 2007, Rashid left active employment.² She filed a second claim for workers' compensation benefits six days later. On the claim form, Rashid identified her date of injury as "CT to June 1, 2007" and the affected body parts as "CT to bilateral upper extremities, CT to bilateral ankles, left foot."³

In August 2007, Rashid completed a "Psychological Symptom Questionnaire" administered by Dr. Hamid. She checked off 27 of the 30 possible categories of symptoms, reporting, for example, depression, anxiety, feelings of helplessness, nervousness, loss of interest in life, thoughts of suicide, confused thoughts, poor concentration, crying spells, poor self-esteem, withdrawal, feelings of discrimination, physical pain, self-doubt due to physical injury, frustration, and loss of interest in usual activities. The only "no" responses were to questions about verbal abuse at work, harassment by her supervisor or co-workers, and thoughts of homicide.

On August 27, 2007, Dr. Hamid completed a "Doctor's First Report of Occupational Injury or Illness" related to Rashid's workers' compensation claim. He described the accident causing Rashid's work-related injuries as "while performing work

¹ The only indication that Rashid received any medical treatment during that time period was a single reference in a July 31, 2008 report by Dr. Hamid that he began treating Rashid "in August 2005." The report did not identify Rashid's complaints nor did it detail any treatments in 2005 and 2006.

² She did not formally resign until December 30, 2007.

³ Rashid's claim was denied on July 10, 2008 based on the opinion of orthopedist Michael Charles, M.D., discussed *ante*, that Rashid had not sustained a more recent injury and that her problems related to the February 10, 2002 incident.

duties repetitively began to develop pain in neck, arms, hands, knees, and feet.” According to Dr. Hamid, Rashid’s subjective complaints included constant bilateral wrist, ankle, knee, and neck pain, and low back pain. His examination of Rashid revealed loss of motion in the cervical and lumbar spine. He diagnosed cervicobrachial syndrome, cervical sprain strain, wrist sprain strain, and depression. He identified the date of injury as June 1, 2007.

Also in August 2007, chiropractor Richard Skala, D.C., conducted a qualified medical evaluation for purposes of Rashid’s workers’ compensation claim. Following his examination, Skala diagnosed Rashid as suffering from chronic subacute bilateral wrist, shoulder, cervical, and lumbar sprain/strain, depression, anxiety, and sleep deficit, further noting that she exhibited “psychosocial yellow flags.”⁴ Skala concluded that extensive diagnostic testing “of the cervical spine, lumbar spine, both shoulders, both knees and both wrists, as well as a psychosocial” evaluation were medically necessary in order to diagnose the cause of Rashid’s ongoing complaints. In his opinion, Rashid was not permanent and stationary because she had not been provided with all treatment options reasonably required to cure her injuries.

A follow-up report by Skala two months later detailed the results from additional MRI and nerve conditions studies. Based on these results, Skala added another host of diagnoses: preexisting cervical spondylosis, bilateral radial neuropathy, left shoulder supraspinatus tear, possible left shoulder impingement syndrome, left shoulder bursitis, right shoulder tendinosis/bursitis, bilateral elbow effusion, bilateral wrist effusion, cervical intervertebral disk syndrome, and lumbar intervertebral disk (multilevel) disk syndrome with radiculopathy.

In March 2008, physical medicine and rehabilitation specialist Calvin Pon, M.D., examined Rashid with regard to her workers’ compensation claim. He noted that Rashid complained of chronic pain in her neck, wrists, lower back, knees, ankles, and feet. He

⁴ Skala’s diagnosis was based exclusively on his evaluation of Rashid and her subjective complaints, since his report represented that he did not review any of her medical records.

found normal alignment as well as full active and normal range of motion of the elbows and wrists, fine motion of the fingers, an absence of atrophy in the upper extremities, and normal motion in the hips, ankles, and right knee. Dr. Pon concluded that Rashid's symptoms were probably due to degenerative joint changes and disease, and it was his opinion that she could perform the duties of a medical clerk with restrictions.

The Social Security Administration referred Rashid to psychiatrist Jasdeep Aulakh, M.D., who conducted a psychiatric evaluation on March 15, 2008. He diagnosed Rashid as suffering from major depressive disorder, first episode. He stated that from a psychiatric point of view, she had a history of depressive cognitions, that her problems were treatable, and that the prognosis seemed good. In Dr. Aulakh's opinion, Rashid might be able to function well in a physically less demanding job and might be able to resume her usual activities steadily with time.

On May 29, 2008, orthopedist Michael Charles examined Rashid for the purpose of an agreed medical evaluation in connection with her workers' compensation claim. He reviewed x-rays and MRI studies, and noted that Rashid's cervical spine and lumbar studies were interpreted as normal, with the exception of a 3mm disc bulge central and eccentric, right L4-L5 nerve root foramen, and mild degenerative osteophytosis. The X-rays of Rashid's right wrist and both hands were unremarkable. He also reviewed a nerve conduction study of the upper extremities and interpreted it as within the normal limits.

In his report, Dr. Charles described Rashid's subjective complaints: "The patient states her most painful areas today are her back and neck, radiating sharp stabbing pains. There is a constant presence of pain and its intensity will vary, increased with prolonged sitting, repetitive bending, prolonged walking, twisting and turning. [¶] Second area of concern are her wrists, dull deep pain with occasional radiating pain and numbness. [¶] Her feet are also affected, bilateral dull deep constant pain with radiation of pain and numbness, with lifting, prolonged walking, twisting. Next are the ankles, knife-like burning pain, radiating pain, continuous arm pain bilateral fingers, elbows, shoulders, knees, pain varying from dull deep to sharp stabbing intense pain." He diagnosed her

with chronic low back syndrome, possible right lumbar radiculopathy from L4-5, left medial meniscus re-tear, chronic sprain of the anterior cruciate ligament, right ankle sprain, “overuse syndrome” in her upper extremities, and mild, bilateral plantar fasciitis in her feet.

Dr. Charles concluded that since Rashid did not report any major trauma after the 2002 incident, her complaints likely reflected “a progression of injuries sustained in 2002 as opposed to any more recent or new injuries.”

On June 17, 2008, clinical psychologist James House, Ph.D., conducted a comprehensive psychological evaluation of Rashid with regard to her workers’ compensation claim. According to Dr. House, Rashid presented with complaints of “tension, worry, anxiety, agitation, depression, weight loss, preoccupation and worry about the future, irritability, mood swings, and ongoing physical pain secondary to her work-place injury.” Rashid also reported that “she has had dizzy spells, numbness and weakness in parts of her body, and has a stiff neck. She states that she has dropped things out of her hands and she loses her balance easily. She indicates that she has had changes in the way she walks, her memory, and her sexual response. She states that she sometimes slurs her words and has recently started to say something and then forgot what it was.” She had also experienced ringing in her ears, felt at times as if something was crawling on her skin, and had experienced hot or cold feelings on her body. Dr. House explained that he did not believe Rashid was exaggerating her symptoms, but rather that she “elaborates her symptoms out of a genuine need to convince [him] that her pain is serious and that she needs help with her clinical depression and anxiety. She is therefore not viewed as a malingerer—defined as having conscious awareness of feigning illness—but rather as one who is expressing functional disability. This belief may have developed out of a plea for help or to enlist others as an advocate in her care.”

Dr. House diagnosed Rashid as suffering from a major depressive disorder, single episode; mood disorder due to a general medical condition; sleep disorder due to a general medical condition; and insomnia. In Dr. House’s opinion, her condition reflected “a somatic manifestation of her emotional state,” and she had “psychosocial or other than

medical barriers to recovery.” He concluded that Rashid’s condition had developed “as a consequence of the orthopedic injury she sustained while employed by Alameda County Medical Center on June 1, 2007” and that her condition “appear[ed] to have been caused by the limitations associated with her various physical problems as a result of her work-related injury.” She was, in Dr. House’s opinion, “temporarily totally psychologically disabled,” a disability he attributed 100 percent to “the described incident.”

Looking forward, Dr. House recommended a psychiatric consultation to determine if Rashid would benefit from treatment with psychotropic medications, participation in individual or group psychotherapy or stress and pain management therapy, relaxation training, assessment at a sleep clinic, training in body mechanics and goal-oriented work conditioning, and participation in physical and recreational activities.

Rashid’s Application for Service-Connected Disability Retirement

On August 4, 2008, approximately 14 months after she stopped working, Rashid filed for service-connected disability retirement with the Alameda County Employees’ Retirement System (ACERA).⁵ In her application, she identified her disabling injuries as (1) physical injuries from her toe to her neck (left toe; both ankles, knees, elbows, and wrists; neck; and back), and (2) depression. She claimed her physical and psychiatric injuries were caused by the February 10, 2002 incident and that they were permanently incapacitating.

At ACERA’s request, Dr. Hamid submitted a treating physician’s narrative. In it, he advised that Rashid’s current diagnoses were as follows: carpal tunnel syndrome; cervicobrachial syndrome; neck, wrist, ankle, and lumbosacral sprain and strain; unspecified tenosynovitis synovitis; closed dislocation of wrist; and herniated disks at each level between L3 and S1. He also indicated that she suffered from the psychological disorders diagnosed by Dr. House.

⁵ ACERA is a public pension system organized under the County Employees Retirement Law of 1937 (Gov. Code, § 31450 et seq.) which administers retirement, disability, and death benefits for employees or former employees of Alameda County. Management of the retirement system is vested with the Board. (*Id.*, § 31520.)

Dr. Hamid stated that Rashid was in need of further evaluation by an orthopedic surgeon, neurologist, or pain specialist, and was likely a candidate for carpal tunnel release and injection therapy. He noted that she had been on modified duty from August 2002 until June 2007, but was unable to continue due to the repetitive nature of the work and lack of adequate accommodation. He represented that she was unable to perform such basic tasks as lifting charts, sitting for long periods of time, typing, getting up and down from sitting positions, and gripping things like door knobs, without aggravation of pain. Despite ACMC's accommodations, Rashid's condition had nevertheless worsened. Dr. Hamid opined that Rashid's employment had "substantially" contributed to her injuries, referring to the February 2002 incident as the "inciting event" of Rashid's chronic pain.

On February 13, 2009, Dr. Hamid prepared a "Primary Treating Physician's Permanent and Stationary Report." He related that he began treating Rashid in August 2005 for "complaints consistent with her 2002 injury." However, "In late 2006 through early 2007, Ms. Rashid began to have complaints that were not consistent with her 2002 injury. Her complaints were consistent with a cervical radiculopathy and included the addition of neck, increased upper extremity pain, mid back, and low back pain," symptoms that worsened to the point where she was unable to work. Dr. Hamid further noted that in addition to her physical complaints, Rashid had been suffering from "depression and sleep difficulties due to persistent pain."

After describing the findings of his physical examination of Rashid, Dr. Hamid identified her diagnoses as unverified cervical radiculopathy, chronic cervical and lumbosacral strain, right carpal tunnel syndrome, bilateral wrist and ankle strain/strain, lumbar neuritis, left medial meniscus tear, and depression. Of these, only the carpal tunnel syndrome and wrist and ankle strains were noted to be due to the 2002 incident. He considered Rashid to have reached maximum medical improvement and recommended that she be restricted to sedentary work not requiring frequent upper or lower extremity movement, repetitive lifting, pushing and pulling, as well as lifting more than 20 pounds, plus frequent breaks from prolonged sitting and weight bearing.

Dr. Hamid concluded with the following: “Absent any records or testimony to the contrary, it is my opinion that the patient’s injury is industrial. The mechanism of the injury is consistent with the subjective complaints and the objective findings. Ms. Rashid denies any injury within or outside of the workplace, aside from what is outlined within this report. For this reason, it would appear to this examiner that her current condition is related to her employment. This is based on the patient’s history, the records that were available, and my examination.”

ACERA Board Medical Advisor Robert Wagner, M.D.

ACERA referred Rashid’s disability application to retirement board medical advisor Robert Wagner, M.D. for review. After reviewing Rashid’s disability packet, Dr. Wagner advised ACERA that “[t]here is doubt on the issues of both permanent disability and causation.” He thus referred Rashid to neurologist Howard Belfer, M.D. for an independent neurological examination and to psychiatrist Erick Hung, M.D. for an independent psychiatric examination.

Dr. Belfer examined Rashid in June 2009. He made normal objective clinical findings with regard to her neck and upper extremities, including full range of motion, lack of radicular symptoms, normal muscle bulk and tone, as well as normal motor, sensory, and reflex testing. With voluntary strength testing, he observed collapsing, nonorganic type weakness in every muscle group tested in all four extremities. Additional nonorganic symptoms included complaints of low back pain on shoulder shrug testing, and pain on light tapping of tendons and muscles in the forearms, the dorsum of the feet, the sides of the forelegs, and diffusely over the spine, to the point where Rashid complained that an ounce or two of pressure in tapping on the lumbar spine was “killing” her.

In Dr. Belfer’s postexamination report, he provided the following insight into Rashid’s condition:

“Ms. Rashid presents a very challenging case, in which a simple fall onto the outstretched arms led to symptoms of neck pain, back pain, ankle pain and wrist pain, and then later on to symptoms of numbness, tightness in the forearms and leg pain, all of

which, by her subjective report, have only worsened since she has become less active and off work. The extensive nature and persistent duration of these symptoms, given the minor nature of this illness, is highly unusual in and of itself, and clearly out of proportion from what would be expected of residual symptoms from an injury of this nature, particularly given the enormous number of borderline abnormal, or normal, studies, particularly the negative MRI scans of the wrist, the normal August 2008 bilateral EMG and nerve conduction study of the lower extremities, negative MRI scan of the cervical spine and minimal disc bulge of the lumbar spine at L4-5.

“Additionally, multiple consultants have found that they cannot determine the source of her continuing ankle pain, and at least one as far back as July 2003, Dr. Pfeffer, found that there was no restriction from her regular work with regard to her foot and ankle symptoms. It is important to note that some of the symptoms she complained of today, such as numbness in the hands, the constancy of the pain in her wrists and ankles, and the tightness in her forearms, as well as the pain to palpation, were not noticed by previous examiners, suggesting a significant element of symptom magnification or exaggeration. Furthermore, she demonstrated multiple pain behaviors and non-organic signs on examination, including persistent holding of her back, complaining of swelling in the ankles when there was none visible, extremely slow movements, despite normal range of motion in her spine, and complaints of low back pain with shoulder shrug, which is a decidedly non-organic finding.”

In response to questions posed in a physician’s questionnaire, Dr. Belfer advised that Rashid’s chronic pain complaints “are unsupported by any physical examination findings today and by the benign or unremarkable radiologic and electrophysiological studies performed in 2008.” He continued that “there is absolutely no objective evidence by my physical examination, by several other previous physician physical examinations, by the 2008 cervical and lumbar spine MRI scans, and EMG and nerve conduction studies of the bilateral lower extremities. Her collapsing give-way weakness present in every muscle group of all four limbs is not explainable on the basis of any known organic injury to her central or peripheral nervous system, and this collapsing weakness, together

with the subjective complaints of pain when lightly tapping on the forearms and severe ‘killing me’ pain when lightly tapping over the lumbar spine, are entirely dependent upon and influenced by the volition of the patient. In light of the absence of objective findings, as noted above, the presence of these highly described subjective complaints is quite remarkable and suggestive of a very high degree of symptom exaggeration and magnification.”

Dr. Belfer advised that, having reviewed the job description for Rashid’s position, he found no movement or activity precluded by any findings from his physical examination. He recommended, however, a 20-pound lifting limitation due to the “mild right L4-5 disc bulge” visible on her lumbar spine MRI, a restriction he suggested could have “resulted in a significant degree” from the 2002 incident.

Dr. Hung also examined Rashid in June 2009. He noted that Rashid presented as depressed and slightly withdrawn, and was preoccupied with her complaints of pain. He referred her to psychologist Eric Morganthaler, Ph.D. who, after testing, prepared a psychological testing report opining that Rashid showed signs of possible symptom exaggeration such that her subjective complaints required clinical validation. Dr. Morganthaler also noted that her personality was characterized by an admixture of histrionic and dependent dynamics that could predispose her to repression, emotional lability, somatic expression of emotional distress, attention seeking behavior, helpless dependency, interpersonal hypersensitivity, and impressionistic reasoning. He offered for diagnostic consideration the following conditions: depressive, anxiety, somatoform disorders within the context of symptom exaggeration, signs of histrionic and dependent personality dynamics, and possible personality disorder.

On July 17, 2009, after receipt of Dr. Morganthaler’s report, Dr. Hung prepared his independent psychiatric examination report. He began with a history and recitation of complaints consistent with those in prior reports by other examiners. Dr. Hung then reported that according to Rashid, she “first felt depressed in the context of ongoing pain in her wrist, ankles, legs, neck, and back. After the initial injury, she hoped that the pain would improve and that she would resume her normal work duties. When the pain did

not resolve, she became frustrated.” She later became more depressed due to her inability to maintain her modified duties. Due to her ongoing pain, she essentially reduced her activities to a point of isolation with very low motivation, dependency on her family, and shame and frustration that others have to carry out her household responsibilities.

Based on the psychological assessment conducted of Rashid and Dr. Morgenthaler’s findings, Dr. Hung stated “that Ms. Rashid meets the diagnostic criteria for a *Somatoform Disorder Not Otherwise Specified*,” defined as “physical complaints that persist for six months or longer. . . . These symptoms cannot be fully explained by any known general medical condition or the direct effects of a substance, or the physical complaints or resultant impairment are grossly in excess of what would be expected from the history, physical examination, or laboratory findings. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. These symptoms are not intentionally produced or feigned (e.g. as in malingering).

Dr. Hung elaborated: “While underlying medical causes should be evaluated on an ongoing basis for reported physical symptoms, sufficient evidence has been reviewed to suggest that Ms. Rashid is an individual whose subjective physical complaints are in excess of what would be expected with her objective findings. Numerous examinations and studies since 2002 including physical examinations by specialists, radiographic studies, and nerve conduction studies have yielded normal results or found only subtle findings incongruent with her subjective experience. The evidence suggests that Ms. Rashid experienced minor physical injuries on 10 February 2002. Since this injury, the physical and psychiatric symptoms have taken on a life of its own. As suggested in the psychological testing, Ms. Rashid likely is prone to the somatic expression of emotional distress with physical complaints utilized to elicit attention and support. . . . There is no evidence to suggest that she is consciously producing physical symptoms for secondary gain (i.e. malingering); but rather she is an individual who has tendencies to unconsciously produce physical symptoms in order to elicit help and attention from others.”

Dr. Hung further reported that Rashid met the diagnostic criteria for a “*Depressive Disorder Not Otherwise Specified*,” an episode that began in February 2002. In his opinion, Rashid’s depression was in the “moderate severity range. This depression is atypical than a major depressive disorder because the symptoms appear to have started solely in the context of this injury. . . . The precipitant to this episode appears to be the work-related injury on 10 February 2002. Ongoing stressors affecting this episode include ongoing pain, changes in physical functional status since 2002, changes in employment status since 2002, role transition from taking care of others to depending on others for help, and financial difficulties related to lack of employment.”

Ultimately, however, Dr. Hung concluded that Rashid’s county employment “*did not contribute* to her current incapacity” because she was “prone to the somatic expression of emotional distress with physical complaints utilized to elicit attention and support. While her current psychiatric disorders are temporarily totally incapacitating, there is no service-connection for these psychiatric disorders. Employment has played a passive role in the development of the incapacity (i.e. the employment has merely been a ‘stage’ for the natural progression of a non-industrial injury).”

On September 25, 2009, having received the reports of Drs. Belfer and Hung, Dr. Wagner reported his recommendations to ACERA. He advised that, in his opinion, Rashid was permanently disabled by her psychological conditions but not on the basis of any physical injuries nor on the basis of her employment. Noting that many other physicians found her symptoms could not be corroborated by objective findings, Dr. Wagner concluded they were largely or entirely caused by a nonindustrial psychiatric disorder.

The Hearing Officer’s Recommendation

In light of Dr. Wagner’s recommendation that the Board deny her application for service-connected disability retirement, Rashid requested an evidentiary hearing. The hearing was held on April 21, 2010 before hearing officer Christopher Harnett.

In a determination dated July 21, 2010, Harnett issued a recommendation consistent with that of Dr. Wagner, that is, denying Rashid’s application for service-

connected disability retirement but granting her application for nonservice-connected disability retirement based on her psychiatric condition. He determined that Rashid suffered work-related injuries to her right wrist, right knee, and ankles bilaterally in 2002 but that those injuries did “*not* substantially incapacitate her from performance of the modified-duty Medical Clerk assignment provided by the Employer, and did not incapacitate her at the time she stopped working on June 1, 2007.” He further determined that those injuries did not include her neck or low back, that she had not met her burden of proving that her neck and low back injuries were caused by her employment, or that any neck and back injuries “substantially and permanently incapacitated her from her modified medical clerk duties.” Harnett did find, however, that Rashid met her burden of proving that she was permanently incapacitated on psychiatric grounds, separate and distinct from the alleged orthopedic grounds. She had not established, however, that her employment substantially contributed to her disabling psychiatric condition.

According to Harnett, the “essential thrust” of Rashid’s claim was that “she suffered ‘serious’ on-the-job orthopedic injuries as a result of an ‘assault,’ from which she did not recover, that the injuries produced lasting symptoms, including pain and numbness to multiple parts of the body, and that despite substantial accommodations made by the Employers, the orthopedic symptoms not only failed to disappear, but became progressively worse over the next several years, as a result of which she could no longer continue on her job, and meanwhile began suffering a multitude of psychiatric symptoms. [Rashid] contends nothing in her personal life aside from employment explains these symptoms, and that with regard to expert opinions pointing to an underlying propensity or tendency toward a particular condition such as somatoform disorder, the Employer takes her as it finds her, and is responsible for any aggravation.”

Hearing officer Harnett rejected Rashid’s argument, noting first that Rashid’s characterization of the incident as an “assault” was an exaggeration. Further, he noted, Rashid’s extensive medical records confirmed that active treatment of her injuries ceased in early 2004, and there were no records for the remainder of 2004, all of 2005 and 2006, and the beginning of 2007 that substantiated Rashid’s claims of ongoing pain, numbness,

or other symptoms during that time period. And the records showed that many of the medical professionals were skeptical of Rashid's subjective complaints of pain and numbness, which extensive diagnostic testing failed to confirm. As such, Harnett concluded that "Under the circumstances, the evidence as a whole indicates that physical injuries from the February 10, 2002 incident, as well as any residuals of the same were minor in nature, had essentially resolved long before [Rashid] stopped working, and could not explain ongoing complaints, or depressive symptoms." This conclusion was further supported by the medical records, which showed that the neck and back pain or radicular symptoms—which Harnett considered a significant component of Rashid's depressive and other psychiatric symptoms—did not manifest until 2007, well after the injuries from the 2002 incident had resolved. In reaching his conclusion, Harnett found the opinions of Drs. Hung and Wagner to be better reasoned and supported than those of Drs. House and Hamid (who relied on Rashid's representation that the neck and back symptoms were industrial) and chiropractor Skala (who was not a medical doctor).

The Board's Decision

On November 30, 2010, the Board accepted hearing officer Harnett's findings and recommendations denying Rashid service-connected disability but granting non-service connected disability.⁶ Rashid was so notified by letter dated December 7, 2010.

Petition for Writ of Administrative Mandamus

On February 10, 2011, Rashid filed a petition for writ of administrative mandamus, followed by an amended petition on March 1, 2011.⁷ She asserted two causes of action, the first for a peremptory writ of mandate setting aside the Board's decision, the second for a declaration that Rashid was " 'permanently incapacitated from the performance of duty' as the 'result of an injury or disease arising out of and in the

⁶ On November 29, 2010, Rashid served objections to the hearing officer's report and recommendations. Because they were untimely, however, the Board did not consider them.

⁷ The amended petition added ACMC as a real party in interest.

course of the member's employment and such employment contributes substantially to such incapacity’ ”

On September 1, 2011, Rashid filed a notice of motion and motion for peremptory writ of mandate in which she argued that the Board's findings were not supported by the medical evidence. She also sought an award of attorney fees pursuant to Government Code section 800.

ACERA and ACMC filed separate oppositions on October 3, 2011, and Rashid filed a reply.

On October 25, 2011, the matter came on for hearing before the Honorable Frank Roesch. Following argument, Judge Roesch took it under submission and, the next day, entered an order denying Rashid's petition. His order reasoned as follows:

“Petitioner Rashid applied for benefits on August 4, 2008, and ACERA's medical advisor Dr. Wagner determined that Ms. Rashid's psychological conditions were not service related. [Citation.] Ms. Rashid requests [*sic*] a full evidentiary hearing and the matter was heard before Christopher Harnett. Mr. Harnett issued his 38 page Report of Findings and Recommendations on July 21, 2010, and recommended that Rashid's application for a service-related disability retirement be denied but that a non-service connected disability retirement be granted based on psychiatric conditions but not the orthopedic conditions. [Citation.] The ACERA Board considered and adopted the recommendation.

“Petitioner Rashid filed this petition asserting that the Board improperly denied her application for service related disability retirement. The Court reviews the Board's decision under C.C.P. 1094.5. The retirement benefits at issue are a vested and fundamental right, so the Court exercises its independent judgment in reviewing whether the Board's decision was supported by the weight of the evidence. *Strumsky v. San Diego County Employees Retirement Assn.* (1974) 11 Cal.3d 28, 44; *Singh v. Board of Retirement* (1996) 41 Cal.App.4th 1180, 1185. The record of the administrative proceedings has been filed with the Court.

“Petitioner Rashid asserts that the Board erred in denying her request because her disability was service related within the meaning of Gov. Code 31720(a). Section 31720(a) states, ‘Any member permanently incapacitated for the performance of duty shall be retired for disability regardless of age if, and only if: (a) His incapacity is a result of injury or disease arising out of and in the course of his employment and such employment contributes substantially to such incapacity.’ *Bowen v. Board of Retirement* (1986) 42 Cal.3d 572, 578, holds that ‘while the causal connection between the [job] stress and the disability may be a small part of the causal factors, it must nevertheless be real and measurable. There must be substantial evidence of some connection between the disability and the job.’

“The Court has reviewed the administrative record and finds that the Board’s decision is supported by the weight of the evidence. The central issue is whether the work related orthopedic injury to Ms. Rashid’s right wrist, right knee, and both ankles in 2002 had a ‘real and measurable’ causal connection to the psychiatric injury that caused her current state of psychiatric disability. Petitioner Rashid has the burden of proving that causal connection.

“The Court concludes that the ACERA Board’s decision is supported by the weight of the evidence. In reviewing the record, the Court gives greater weight to Ms. Rashid’s contemporaneous medical history, which suggests that she recovered from her 2002 injury by 2004 and was able to work until 2007, than to the retrospective evaluations that conclude that her 2002 injury caused a psychiatric depression which is presently ongoing and disabling [*sic*].”

Judge was entered on December 22, 2011, and this timely appeal followed.

DISCUSSION

The Law Governing ACERA Disability Retirement and the Standard of Review

Under the County Employees Retirement Law of 1937, an applicant is entitled to disability retirement benefits if he or she establishes that he or she is “permanently incapacitated” physically or mentally from the performance of his or her duties. (Gov.

Code, § 31720.) In order to qualify for *service-connected* disability retirement—which affords the retiree a larger benefit than non-service connected disability retirement—the applicant must establish that his or her “incapacity is a result of injury or disease arising out of and in the course of the member’s employment, and such employment contributes substantially to such incapacity. . . .” (*Id.*, subd. (a).) As recently confirmed in *Valero v. Board of Retirement* (2012) 205 Cal.App.4th 960 (*Valero*), the “contributes substantially” requirement means more than an “infinitesimal” contribution of the applicant’s employment to the disability. (*Id.* at p. 964; *Bowen v. Board of Retirement* (1986) 42 Cal.3d 572, 576; see also *Heaton v. Marin County Employees Retirement Bd.* (1976) 63 Cal.App.3d 421, 430-431.) Instead, it demands that the employment be a “ ‘real and measurable’ ” part of the applicant’s disability. (*Valero, supra*, 205 Cal.App.4th at pp. 963-964; see also *Bowen v. Board of Retirement, supra*, 42 Cal.3d at p. 579; *DePuy v. Board of Retirement* (1978) 87 Cal.App.3d 392, 398-399.)

The *Valero* court likewise summarized the standard of review we are to apply in reviewing the trial court’s decision, as follows: “After a retirement board has reached a decision, the superior court exercises its independent judgment in reviewing the administrative decision of the board. [Citations.] On an appeal from the superior court, an appellate court applies the substantial evidence test. ‘After the trial court has exercised its independent judgment in weighing the evidence, our task is to review the record to determine whether the trial court’s findings are supported by substantial evidence. [Citation.] The trial court’s decision should be sustained if it is supported by credible and competent evidence. [Citation.]’ ” (*Valero, supra*, 205 Cal.App.4th at p. 965.)

Put another way, Rashid “bore the burden to affirmatively show a real and measurable connection between [her] psychiatric disability and [her] employment. The trial court found [s]he did not meet that burden. As appellant, [s]he must show that [her] affirmative evidence was (1) ‘uncontradicted and unimpeached’ and (2) ‘of such a character and weight as to leave no room for a [trial court] determination that it was

insufficient to support a finding’ ” (*Valero, supra*, 205 Cal.App.4th at p. 966.) With these guidelines in mind, we turn to the trial court’s determination.

Substantial Evidence Supports the Trial Court’s Conclusion That Rashid’s Employment Did Not Contribute Substantially To Her Disability

There is no dispute that Rashid was permanently disabled on psychiatric grounds. The hearing officer, the Board, and Judge Roesch so found, and no challenge to that finding is presented on appeal. Nor is there any issue concerning Rashid’s orthopedic injuries at the time of her separation from service, since disability retirement was granted based on her psychiatric state, not her physical state. The sole question, then, is whether Rashid’s employment contributed substantially to, or was a real and measurable part of, her psychiatric disability. (*Valero, supra*, 205 Cal.App.4th at p. 964.) Judge Roesch exercised his independent judgment and agreed with the hearing officer’s finding that it was not. We conclude there was substantial evidence supporting his conclusion.

Dr. Hung’s report alone provides sufficient support for the Judge Roesch’s conclusion. Dr. Hung conducted an exhaustive review of Rashid’s voluminous medical records, completed a clinical examination of Rashid, and reviewed the report by Dr. Morgenthaler. Based on his comprehensive evaluation, he diagnosed Rashid as suffering from somatoform and depressive disorders. In his opinion, the “precipitant” to Rashid’s depressive episode appeared to be the February 2002 tripping incident, in which Rashid suffered minor injuries. But after that, the physical and psychiatric symptoms took on a life of their own because Rashid was “prone to the somatic expression of emotional distress with physical complaints utilized to elicit attention and support.” Significantly, Dr. Hung ultimately concluded that her “County employment *did not contribute* to her current incapacity” because her employment was merely “a ‘stage’ for the natural progression of a non industrial injury.” (See *Atascadero Unified. Sch. Dist. v. Workers’ Comp. Appeals Bd.* (2002) 98 Cal.App.4th 880, 884 [no industrial causation where “ ‘ ‘the evidence established that the employment was a mere passive element that a nonindustrial condition happened to have focused on’ ’ ”].) In light of Dr. Hung’s

conclusion, we reject Rashid’s assertion that the evidence of a substantial connection between her employment and disability was “uncontradicted and unimpeached.”

Rashid challenges this conclusion on multiple grounds. First, despite Dr. Hung’s conclusion that her psychiatric disability was not service related, Rashid contends that his report actually *supports* her position. This is so, she claims, because it “notes a strong connection between her psychiatric injury and her County employment.” Calling it a “strong” connection contravenes the specific findings of Dr. Hung, who expressly categorized the connection as “passive.” A “passive” connection fails to rise to the standard confirmed in *Valero* that the connection must be substantial or real and measurable. (*Valero, supra*, 205 Cal.App.4th at p. 964.)

Rashid also urges that we consider only Dr. Hung’s findings that her depressive episode began after the incident in 2002 and disregard his conclusion that her employment played only a passive role in her disability. She contends his conclusion was based on an error of law, because it was legally irrelevant that she was prone to psychiatric injury. This is so, she reasons, because being “*prone to* the somatic expression of emotional distress” was the same as having a preexisting condition. Her argument is unavailing.

It is true, as Rashid notes, that under California law an employer “takes his employee as he finds him and any acceleration or aggravation of a preexisting disability becomes a service-connected injury of that employment.” (*Gelman v. Board of Retirement* (1978) 85 Cal.App.3d 92, 96 (*Gelman*); *Lundak v. Board of Retirement* (1983) 142 Cal.App.3d 1040, 1043; *Brammer v. Workers’ Comp. Appeals Bd.* (1980) 108 Cal.App.3d 806, 812; *Kuntz v. Kern County Employees’ Retirement Assn.* (1976) 64 Cal.App.3d 414, 421; *Lamb v. Workmen’s Comp. Appeals Bd.* (1974) 11 Cal.3d 274, 282 (*Lamb*)). From this, Rashid leaps to the conclusion that “[b]eing ‘prone to’ or ‘predisposed to’ an injury is no different than having a ‘pre existing’ condition” such that her “being ‘prone to’ or ‘predisposed to’ the psychiatric injury she suffered was not relevant and should not have been considered.” In support, she cites *Gelman, supra*, 85 Cal.App.3d 92, and *Lamb, supra*, 11 Cal.3d 274, but neither case supports her claim.

In *Gelman*, after the applicant became disabled due to psychoneurosis, the county retirement board denied his claim for service-connected disability retirement. The trial court denied his writ petition, but the court of appeal reversed, agreeing with the applicant that “the record conclusively established that his employment as a social worker aggravated his preexisting mental illness, therefore his disability must be held to have arisen out of and in the course of his employment as a matter of law.” (*Gelman, supra*, 85 Cal.App.3d at p. 95.) The evidence in the record showed that the applicant had “a chronic psychoneurosis with physical symptoms . . . that existed as early as age 22 to 23 when he was medically discharged from the Army. The passage of time without psychiatric treatment demonstrated a gradual increase in the severity of his symptoms until he had the severe onset of symptoms in 1971.” (*Id.* at pp. 94-95.)

Similarly, employee Lamb had a history of fatigue, shortness of breath, hypertension, and chest pains. Leading up to the day of his death, he had worked 10 days straight without a day off and had worked overtime on seven of those 10 days. He then suffered an arrhythmia at work and died suddenly. (*Lamb, supra*, 11 Cal.3d at p. 277.) Lamb’s widow filed a claim for workers’ compensation death benefits, a claim initially approved by a referee who accepted the testimony of two doctors that Lamb’s “demise was contributed to by his work, largely as a result of the emotional stress which he experienced on the job.” (*Id.* at p. 278.) The Workmen’s Compensation Appeals Board reversed on the ground that Lamb’s death did not result from injury to his heart arising out of and occurring in the course of his employment. (*Id.* at p. 277.) The Supreme Court again reversed, citing the “uncontradicted and unimpeached evidence to the effect that the responsibilities of decedent’s employment, although perhaps not of the nature that would produce emotional stress in every man or most men who might be subject to them, *did in fact result in considerable emotional stress to John Lamb.*”⁸ (*Id.* at p. 282.)

⁸ Although *Lamb* involved a workers’ compensation claim, not a government retirement pension, “it is now well established that the two systems are likeminded in their aim to benefit the employee.” (*Gelman, supra*, 85 Cal.App.3d at p. 96.)

In both of these, and other similar cases (see *Lundak v. Board of Retirement*, *supra*, 142 Cal.App.3d 1040; *Brammer v. Workers' Comp. Appeals Bd.*, *supra*, 108 Cal.App.3d 806; *Kuntz v. Kern County Employees' Retirement Assn.*, *supra*, 64 Cal.App.3d 414), the applicant suffered from a condition that manifested itself prior to the service-related injury—Gelman the preexisting mental illness, Lamb the preexisting heart condition. The same cannot be said of Rashid, who produced no evidence that she suffered any psychiatric problems prior to the somatoform disorder she experienced during her employment at APMC.

In addition, Rashid's extensive medical records showed that the initial physical injuries she suffered in the 2002 fall were relatively minor. Further, her subjective complaints from 2002 to 2004 were largely unsupported by objective findings, and many medical providers during that time expressed skepticism about her symptoms. There were no medical records documenting any treatment Rashid received from mid-2004 to 2007. Rather, the only indication that Rashid's symptoms continued unabated from the time of her initial injury were her own subjective complaints *after* she stopped working in 2007. Judge Roesch could reasonably have construed this evidence to suggest that Rashid's 2002 injuries had resolved by 2004 and did not contribute to the psychiatric disorders she subsequently developed.⁹

To be sure, Rashid submitted evidence linking her psychiatric disorder to the February 2002 incident. Most notably, Dr. House stated that Rashid's depression was "caused by the limitations associated with her various physical problems as a result of her work-related injury." But Dr. House's conclusion was based on Rashid's subjective complaints and self-reported history conveyed during a clinical interview, as well as the results of psychological tests. He did not conduct the exhaustive review of Rashid's medical history that Dr. Hung did, apparently reviewing only Dr. Hamid's March 31, 2008 primary treating physician's progress report. Nor did he analyze how her

⁹ There is no support for Rashid's assertion that "the trial court failed to adequately review the medical and psychiatric evidence . . ." In fact, the court's order specifically states that it "reviewed the administrative record . . ."

“work-related injury” related to her “various physical problems” or depression. As such, it was not unreasonable to conclude, as did the hearing officer, that Dr. Hung’s report was better supported and reasoned. And the mere existence of conflicting evidence as to whether Rashid’s psychiatric disability was substantially connected to her employment requires that we deny her appeal. (*Valero, supra*, 205 Cal.App.4th at p. 966 [in order to prevail appellant must show that her evidence was “uncontradicted and unimpeached”].)

DISPOSITION

The order denying Rashid’s petition for writ of mandate is affirmed.

Richman, J.

We concur:

Kline, P.J.

Haerle, J.