The social security number and dates of birth have been redacted from this opinion.

**STATE OF MICHIGAN**
**DEPARTMENT OF LABOR AND ECONOMIC GROWTH**
**WORKER'S COMPENSATION AGENCY**

**SUNITHA ATLURI,**
**SS# xxx,**
**Plaintiff,**

**v**

**Northville Regional Psychiatric Hospital,**
**Self Insured,**
**Defendant.**
_____/

**APPEARANCES**

PLAINTIFF

Donald L. Petrulis (P18845)

DEFENDANTS

Kenneth E. Jones (P32029)

**TRIAL DATE**

The case was scheduled on July 12, 2005, July 20, 2005, August 4, 2005, August 24, 2005 and closed December 1, 2005.

**CLAIM**

Plaintiff, by Application for Mediation or Hearing – Form A, filed, alleged an April 29, 2002, date of injury as follows:

> Traumatic brain injury, TMJ, neck, post concussion syndrome, closed head residuals and post traumatic stress disorder after being assaulted by a patient. Plaintiff seeks attendant care benefits and all other benefits.

At trial, plaintiff withdrew the claim for attendant care and added a claim for a compensable

depression. Defendant did not object.

An Application for Mediation or Hearing – Form B was filed by Thomas C. Spoor. That Application was dismissed for lack of prosecution.

Additionally, an Application for Mediation or Hearing – Form B was filed by St. John Macomb Hospital. It seeks $89,599.76 for medical treatment provided to plaintiff. Plaintiff's attorney is representing the Hospital in this Application.

## STIPULATIONS

The parties stipulated that, on April 29, 2002, plaintiff and defendant were subject to the Worker's Disability Compensation Act, that defendant was self insured and that defendant employed plaintiff.

Defendant left to proofs the issue of whether a personal injury arose out of and in the course of plaintiff's employment on April 29, 2002. Defendant left to proofs the issue of whether plaintiff's disability, if any, was due to her alleged injury.

Defendant received timely notice of the claimed personal injury. Defendant admitted that plaintiff made timely claim for compensation benefits with regard to the claimed injury.

Plaintiff was engaged in dual employment on April 29, 2002, but the parties stipulated that the threshold amount was not reached by the second employment; therefore, the dual employment provision was not added. The issue of benefits that are subject to coordination was left to proofs.

Plaintiff's cash average weekly wage on April 29, 2002 was $2,725.53. The issue of fringe benefits was reserved. Plaintiff's IRS filing status on April 29, 2002, and the issue of dependents were left to proofs.

## WITNESSES TESTIFYING AT TRIAL

PLAINTIFF

Sunitha Atluri

DEFENDANT

None

## WITNESSES TESTIFYING BY DEPOSITION

PLAINTIFF

Anthony Petrilli, M.D.
Eric Backos, M.D.
Chakrapani Ranganathan
Bradley Sewick

DEFENDANT

Richard Jackson
Raymond Mercier
W. John Baker
Lucius Tripp
Joseph Femminineo

**EXHIBITS**

PLAINTIFF

1 – Transcript of the deposition testimony of Anthony Petrilli, M.D., taken on March 16, 2004.
2 – Transcript of the deposition testimony of Eric Backos, M.D., taken on April 23, 2004.
3 – Transcript of the deposition testimony of Chakrapani Ranganathan, M.D., taken on April 25, 2005.
4 – Transcript of the deposition testimony of Bradley Sewick, Ph.D., taken on May 25, 2005.

DEFENDANT

A – Transcript of the deposition testimony of Richard Jackson, M.D., taken on June 22, 2005.
B – Transcript of the deposition testimony of Raymond Mercier, M.D., taken on June 13, 2005.
C – Transcript of the deposition testimony of W. John Baker, Ph.D., taken on July 7, 2005.
D – Transcript of the deposition testimony of Lucius Tripp, M.D., taken on June 24, 2005.
E – Transcript of the deposition testimony of Joseph Femminineo, M.D., taken on June 6, 2005.
F – Undated Michigan Driver's License Application
G – Benefit Payment History
H – Payment History
I – Notices of Dispute
J – Independent Medical Examination Report of Dr. Rainey

K – Continuing education documents
L – Letter from Rae Ramsdell dated September 20, 2005.
M – Emergency room records from Botsford Hospital dated April 29, 2002.

## OPINION

Plaintiff, date of birth xxx, was an extremely credible witness. She testified that she was born in India and was married in 1988. She has two children: a daughter, Mokshasree (date of birth xxx) and a son, Harish (date of birth xxx). Her tax filing status for the year of her injury was "married filed joint." Her husband's earnings that year were $70,000.00 to $80,000.00 per year.

Plaintiff testified that she was raised by her grandmother because her mother worked. Plaintiff graduated from Andhra University with a degree M.B.B.S. (bachelor of medicine and bachelor of surgery) in 1990. She did her internship there as a requirement to graduate. She came to the United States in 1992. She became a citizen while she was working for the defendant.

When plaintiff came to the United States, she applied for her residency at Sinai Grace. She performed 3 years of a residency in psychiatry and 2 years of a fellowship. She began working at Southwest Community Health Clinic, a juvenile detention center, and several public clinics.

Plaintiff testified that she became licensed to practice medicine in the State of Michigan in 1993. She received her permanent license in 1994. She is also board eligible in Psychiatry. She passes the written part prior to 2002 (prior to the alleged incident). She is unable to take her oral boards at this time. Plaintiff broke down in tears remembering why she could not complete her boards. She last attempted to take them in 2004.

Plaintiff testified that she was hired by defendant in June of 1999, although it was apparent that she had difficulty remembering. On cross examination, plaintiff admitted that June 12, 2000, could have been the appropriate date. She testified that she was already working as an adult and child psychiatrist part time at two locations (totaling basically full time work – greater than 40 hours per week). Plaintiff provided outpatient type care. Plaintiff testified that she had no problems when she hired at Northville. She testified that she enjoys psychiatry (both child and adult psychiatry). She had no prior history of psychiatric problems and has no family history of them. She took a pre-employment physical and was hired as a staff psychiatrist to manage patient care without restrictions.

Plaintiff testified that she worked from 8:00 a.m. to 4:30 p.m., Monday through Friday. She saw 33 patients on average in her unit each day. The number of reviews (such as medication and treatment reviews) varied day to day. She worked in the forensic unit. These were patients who had been found by a court to be not guilty by reason of insanity or not fit to stand trial as well as generally psychotic patients.

A medication review required her to interview the patient, review the medical records and

adjust the medication accordingly. Plaintiff prescribed the medication as part of her job duties.

Plaintiff also worked at Community Care Services. She began working there in the year 2000. She dealt with children at that location. Plaintiff testified that she was working there on her alleged date of injury. Plaintiff denied having a preference for children and testified that she enjoyed all ages of patients. I accept that credible testimony.

Approximately six months prior to her last day of work, plaintiff became the only physician on the floor at Northville Regional Psychiatric Hospital. She did not feel that it doubled her workload since the other physician who was there had many other duties so his loss did not affect her greatly.

Plaintiff denied having problems with a nurse who came to the unit. Plaintiff testified that this unnamed nurse had no experience with the forensic setting and was not supervised. She testified that she did not have any altercation with her. Plaintiff testified that the nurse sent a patient out of the unit without an order and then asked plaintiff to sign an order and timing it prior to the incident. Plaintiff refused to do so. I find that this incident is irrelevant.

On April 29, 2002, plaintiff went for her morning report and discussed the patients on the floor. During the report, a patient was brought in by the staff who indicated that the patient needed consultation from the treatment team (nursing staff, occupational therapist, social worker, psychiatrist, and psychologist).

The team members asked questions, and the patient answered without apparent agitation. When they were done talking to him, plaintiff was writing in the chart, and the next thing plaintiff can remember is someone hitting her from the back. The patient was striking her on both sides of the head. Plaintiff broke down crying during her testimony.

She remembered sinking down onto the table. She could not recall if her glasses were knocked off (I find this irrelevant as well). Plaintiff testified that she was in a daze. She thought bricks were falling from the ceiling although defense counsel stipulated that no bricks actually fell from the ceiling. I accept plaintiff's credible and unrebutted testimony that she was savagely attached by a patient while performing the duties of her job.

Plaintiff was taken to the clinic Concentra Clinic by Dr. Bandla. Plaintiff testified that she was told by the Concentra physicians to go to the emergency room, and she was taken to the emergency room at Botsford Hospital by Dr. Bandla.

At Botsford, imaging studies were taken (CT scan, x-rays of neck). Plaintiff testified that she was vomiting and was dizzy. She told the physicians she was struck in the parietal area (the side of the head above and behind the ear). She was discharged the same day, and her colleague brought her home. Plaintiff testified that she was still in a daze and not able to associate what had happened and what was happening. She did not complain of neck pain. They checked her jaw, and she could open and close it without problems. Plaintiff's testimony is supported by the Botsford Hospital records admitted as Defendant's Exhibit M.

Plaintiff testified that she did not go to work the following morning. In fact, she was unable to get out of bed because of dizziness. She "called in sick" and was told to go back to Concentra. She does not recall what they did at the clinic. She remembered, however, that she went to Concentra approximately four to five times. They did x-rays. She was given a physician's name by the Concentra people, but went to a different physician.

Plaintiff testified that she treated with Dr. David Steinberger, her family physician. He referred plaintiff to a neurologist, Dr. Kushner. She saw Dr. Kushner three or four times.

Dr. Kushner referred plaintiff to an emergency room psychiatrist. She did not go because they were all her colleagues and did not want to be seen by them. Dr. Kushner called Dr. Sheiner and plaintiff did not see him because he was an attending physician at plaintiff's facility.

Plaintiff testified that a colleague told her about Anthony Petrelli, M.D., and plaintiff went to see him in July of 2002. A transcript of the deposition testimony of Dr. Petrelli was admitted as Plaintiff's Exhibit 1. All objections contained within that deposition are overruled – many of which are merely irrelevant and argumentative.

Cutting through the numerous records admitted as part of Dr. Petrelli's deposition (three volumes which I have reviewed but do not find necessary to summarize in detail because they are supported by Dr. Petrelli's credible testimony), it is clear that he diagnosed plaintiff with: post-traumatic stress disorder, cognitive difficulties, confusion, panic disorder, anxiety, mild traumatic brain injury, and major depression (Petrelli, 1-15).

On July 16, 2002, plaintiff was admitted to St. John Macomb Hospital partial day program through Dr. Petrelli. She told Dr. Petrelli that she remembered a big blow to her head on the left side. She recalled being struck twice and described being dazed (which is consistent with her testimony). Clearly, she remembered in detail the incident and the events that followed.

Plaintiff complained of decreased short term memory, constant headaches (present all the time), sensitivity to light (any light gave her headaches), decreased concentration (inability to focus), word finding difficulties (she knows a word but cannot get it out of her mouth), depression, anxiety, and crying spells. Plaintiff did "not want to live anymore." Every day was a struggle. She had memory difficulty, dizziness, and she was withdrawn. She had difficulty sleeping – she was having nightmares about the incident.

After the evaluation, Dr. Petrelli prescribed different medications (plaintiff cannot remember them all and noted that they have changed throughout treatment). She takes Zoloft and has since she began seeing Dr. Petrelli, Clonipin, Lamiceal, Vitaplex Vitamin E, fish oil, regular Tylenol as needed, Imitrex both in pills and injections if needed, Motrin. There was much ado made about plaintiff's medication. I find that the medication prescribed to her has been reasonable and necessary. The fact that the physicians are struggling to find that appropriate doses and combinations of drugs is part of the art and science of treating her.

Plaintiff has been treating with Dr. Petrelli ever since that date. He provides psychiatric evaluation, prescriptions for medication, testing (such as EEGs and SPECT scans). Plaintiff goes

to the daycare program from Monday through Friday 8:30 a.m. through 4:30 p.m.

Dr. Petrelli testified that, as part of the day program, he has worked with plaintiff in trying to return her to a functional level. In fact, on good days, he has tried to have her work with interviewing patients; however, she has been unable to handle even that situation (Petrelli, 15).

Plaintiff testified that she is unable to drive to the program, and she testified that an outfit known as Total Transportation drives plaintiff to and from the program by prescription. Her husband worked and she had no other means to get to the program. Plaintiff did not believe that her transportation bill had been paid.

In August of 2002, plaintiff was referred to a neuropsychologist, Dr. Vredevoogd. Plaintiff told him that she used to get up at 5:00 a.m. and take her children to school. Plaintiff also told Dr. Vredevoogd that she had no energy.

Plaintiff testified that, at first, Zoloft was prescribed at 25 mg. Dr. Petrelli increased the Zoloft beyond 200 mg but plaintiff got hypomanic. She had a decreased need for sleep and was moody and sarcastic. She could "not keep to herself." Plaintiff was at that limit for a short time. When she returned to 200 mg of Zoloft, plaintiff felt and acted "more like herself." This testimony was confirmed by Dr. Petrelli.

Chakrapani Ranganathan, M.D., who is board certified in neurology, first examined plaintiff on August 27, 2002 (Ranganathan, 5, 6). A transcript of the deposition testimony of Dr. Ranganathan was admitted as Plaintiff's Exhibit 3. All objections contained within the transcript are overruled.

At that examination, plaintiff complained of headaches, a "foggy mind," twitching on the left side, dizziness, depression, sensitivity to light, and vomiting (Ranganathan, 7). This is consistent with plaintiff's testimony at trial. Again, her history regarding the injury was consistent with her testimony at trial.

Lucius Tripp, M.D., "trained in neurosurgery and board certified in occupational medicine," examined plaintiff at the request of defendant on September 9, 2002 (Tripp, 4-5). A transcript of the deposition testimony of Dr. Tripp was admitted as Defendant's Exhibit D. All objections contained therein are overruled. As an aside, while I do agree with plaintiff's counsel's statement on page 45 of the deposition that The Evaluation Group should not play "hide the weenie," I also find that The Evaluation Group was not guilty of that particular concealment.

Based on his clinical examination, Dr. Tripp found that, while plaintiff may have been assaulted at work, her presentation was not consistent with a continuing disability and that it was wrought with exaggerations (Tripp, 17-19).

Plaintiff first saw Eric Backos, M.D., who is board certified in physical medicine and rehabilitation at the request of Dr. Petrelli on November 22, 2002 (Backos, 4, 9). A transcript of

the deposition testimony of Dr. Backos was admitted as Plaintiff's Exhibit 2. All objections contained within that deposition are overruled. Based on his initial clinical examination, Dr. Backos diagnosed: (1) traumatic brain injury; (2) cervical and thoracic spasm; (3) left patellar tendinitis; and (4) temporo-mandibular joint dysfunction (TMJ).

Plaintiff testified that Dr. Backos examined her, prescribed medication, and gave her shots for neck and shoulders. He asked that plaintiff return in six weeks; however, plaintiff did not return for 10 months.

Plaintiff testified that she saw Richard Jackson, M.D., on January 13, 2003. She told him that she worked on the forensic unit at Northville. She did not recall telling him that she worked mostly with criminals. I find that testimony very credible and find that, in essence, plaintiff admitted that her work with patients at Northville dealt with the cross between psychiatry and the law.

Dr. Jackson, who is board certified in psychiatry, confirmed that he examined plaintiff at the request of defendant on January 13, 2003 (Jackson, 5, 12). A transcript of the deposition testimony of Dr. Jackson was admitted as Defendant's Exhibit A. All objections contained therein are overruled.

Based on his clinical examination, Dr. Jackson felt that plaintiff was vague, evasive, exaggerated, and not consistent with a closed head injury (Jackson, 35-37). However, based on her depressive symptoms, he felt that she was unable to return to work (Jackson, 37). He felt that, given plaintiff's limited progress in Dr. Petrelli's program, that she should seek alternative treatment (Jackson, 37). He also recommended a change in plaintiff's medication (Jackson, 43).

Dr. Jackson testified that some of plaintiff's cognitive difficulties could be related to her depression but that she exaggerated and did not appear to have any evidence of difficulties related to a traumatic brain injury (Jackson, 50). I find Dr. Jackson's testimony not credible particularly in light of the credible testimony of plaintiff's treating physicians and plaintiff, herself.

By May 7, 2003, Dr. Ranganathan noted that plaintiff's neck symptoms were less but that plaintiff was still having positional vertigo, fatigue and depression (Ranganathan, 12). On August 26, 2003, Dr. Ranganathan wrote the American Board of Psychiatry and Neurology asking that plaintiff be excused from taking her boards since she was not mentally capable of taking them at that time (Ranganathan, 13-14).

Plaintiff returned to Dr. Backos on September 19, 2003 (Backos, 14). At that time, plaintiff still exhibited severe cervical and trapezius muscle spasm (Backos, 15). Dr. Backos performed six trigger point injections.

Based on plaintiff's history and clinical examinations, Dr. Backos testified that plaintiff's condition was directly related to the work assault and that plaintiff was disabled from returning to her previous employment (Backos, 23).

On November 15, 2003, Dr. Ranganathan noted that plaintiff was getting better. She was able to read longer books and comprehend better although she still had memory problems, vertigo, and sleep disturbances (Ranganathan, 14).

John Rainey, M.D., Ph.D., examined plaintiff on January 6, 2004. His report was admitted as Defendant's Exhibit J. He diagnosed: (1) major depressive disorder; (2) post-traumatic stress disorder; (3) panic disorder. He disabled plaintiff and related it directly to the assault that occurred at work. He indicated that the case was "complex." He did not feel that treatment for a traumatic brain injury was appropriate.

In May of 2004, Dr. Ranganathan wrote that plaintiff was getting worse. He felt that she was "cognitively affected" by her traumatic brain injury, and he felt that she had a significant reactive depression to the work injury.

Based on his numerous contacts with plaintiff, Dr. Ranganathan felt that plaintiff continued to be disabled from returning to work as a psychiatrist although he was hopeful that she may one day be able to return. He related plaintiff's condition directly to the work trauma (Ranganathan, 29-30). He felt that plaintiff's major problem was the traumatic brain injury (Ranganathan, 32).

Plaintiff testified that the day care program essentially is the same since she first went there. On an average day, she signs in and finds what treatment room she should be in. She undergoes group therapy which includes group support, self esteem training, life skills training, and medication side effects discussion. There are eight to 10 patients in each group. Dr. Petrelli runs the sessions. Each session is 45 minutes in length. After the group session, there is a 10 to 15 minute break then another group session begins. Plaintiff undergoes 4 or 5 group sessions per day.

Plaintiff also talks with Dr. Petrelli. She talks to him about "all of the things she is going through" and how hard it is for her. She talks to him about what she needs to do to return to work.

Plaintiff testified that going to the program gives her a place to go and discuss her problems. She gets to see others going through the same problems. It helps her learn coping mechanisms and return to a functioning level. This testimony was extremely credible.

Plaintiff testified that she can now drive. She was evaluated by the driver training and has been driving for approximately one year. She drives her children to school. She cannot drive to the daycare program because she can only drive up to 40 – 45 miles per hour. Speed makes her sick to her stomach. She stops on the side of the road and composes herself. She cannot drive in the dark or when it is raining. She does not drive on the freeway.

Plaintiff testified that, since 2002, her complaints have changed. She attributes her life to the program. She is now in a routine and she is able to drive her children short distances. It enables her to push herself and gives her self worth. She pushes herself to do things.

Plaintiff testified that her headaches are better – they are not constant. She gets them only when she pushes herself too hard. They are also less intense. She only requires the Tylenol and Imitrex but does not have to take the shots.

Plaintiff testified that her sensitivity to light is better although she wears lenses that reduce the light. She still prefers to sit in the dark but being able to sit in this courtroom is an improvement.

Plaintiff testified that her depression is being managed and controlled with medication and support. She can get along, but still has difficulty at independent medical examinations when she is forced to remember the incident. She still has frequent nightmares about the incident.

She believes that Dr. Petrelli's program has made her much better. She thinks it is the "best program that anybody can have." I find her testimony very credible. Dr. Petrelli addressed the contents of his program on both direct and cross examination. I find his testimony persuasive and, in combination with plaintiff's credible testimony, I find that it is an excellent program for both the clinical and palliative treatment of plaintiff's condition.

Plaintiff admitted that she went to India in June, 2004, after consulting with Dr. Petrelli. She was there for two and a half months. Her temple arranged this trip. Plaintiff did nothing as far as making arrangements. She got to the airport with her husband. Her children went with her on the trip (they were ages 14 and 7). Plaintiff watched her children from security, through customs, and to the plane. She testified that they also had people that they knew who were on the same flight. She changed planes and repeated the process.

Her brother and brother-in-law met her at the airport. She stayed with family there. Her family took care of her. Plaintiff testified that she went to the Himalayas on a group bus tour. She made none of the arrangements. While in India she took more pain and sleep medications than were prescribed. Dr. Ranganathan did not feel that it was inconsistent with her clinical condition that plaintiff was able to travel to India and the Himalayan mountains (Ranganathan, 57-58). I accept that testimony.

Plaintiff testified that seeing her family was very "pleasant." She told Dr. Ranganathan that she enjoyed the trip. She did not have any worsening of the positional vertigo. She feels that the trip was very beneficial. Dr. Petrelli had prescribed the medication to care for her the entire time in India. After plaintiff returned she again returned to the day care program. There was a short delay due to jet lag. She said returning was like "hitting an iron wall." She had to try to do things on her own again. She thought she could manage but could not, and she returned to the program on October 7, 2004.

She testified that, when she returned from India, she saw Dr. Petrelli and the daycare program on October 7, 2004. She was taking numerous medications. Wellbutrin is for depression. Concerta is a stimulant. Zoloft is a anti-depressant. Sonata is a sleeping medication. Depacote is for seizure activity but used in her case as a mood stabilizer. Ritalin is for concentration and focus.

Raymond Mercier, M.D., who is board certified in psychiatry, examined plaintiff at the request of defendant on January 14, 2005 (Mercier, 4, 12). A transcript of the deposition testimony of Dr. Mercier was admitted as Defendant's Exhibit B. All objections contained therein are overruled.

Based on his clinical examination, Dr. Mercier felt that plaintiff was "certainly in a chronic state of depression" which he diagnosed as major depression (Mercier, 28, 30). He did not identify any evidence, however, of a traumatic brain injury (Mercier, 29). He felt that, given plaintiff's lack of progress in her current treatment, she should be treated by another doctor other than Dr. Petrelli (Mercier, 29).

Joseph Femminineo, M.D., who is board certified in physical medicine and rehabilitation, examined plaintiff at the request of defendant on February 7, 2005, (Femminineo, 4, 7). A transcript of the deposition testimony of Dr. Femminineo was admitted as Defendant's Exhibit E. All objections contained therein are overruled.

Based on his clinical examination, Dr. Femminineo felt that plaintiff did not suffer from any physical residuals from her assault. He identified a bulging C5-C6 disc based on a review of an MRI report; however, he did not feel that there was any traumatic basis for that condition (Femminineo, 17).

Bradley Sewick, Ph.D., who is board certified in neuropsychology, examined plaintiff at the request of Dr. Petrelli on February 8 and 11, 2005 (Sewick, 5-6). A transcript of the deposition testimony of Dr. Sewick was admitted as Plaintiff's Exhibit 4. All objections contained within that deposition are overruled including the lengthy objection from pages 74 through 76.

Based on numerous studies, Dr. Sewick found that plaintiff was "clearly in distress" (Sewick, 9). He found her to be fatigued, depressed, and impaired in "important areas of cognitive functioning and important areas of emotional and behavioral functioning" (Sewick, 9-16). He felt that plaintiff suffered from a post concussion syndrome, a mood disorder with somatoform features, and a pain disorder secondary to her injury on April 28, 2002 (Sewick 56-57).

Dr. Sewick felt that the treatment rendered by Dr. Petrelli was reasonable, necessary, and related to her condition (Sewick, 20-21). He felt that plaintiff was credible and did not exhibit any evidence of malingering (Sewick, 23-30). Dr. Sewick felt that plaintiff's condition was directly related to the trauma she sustained at work and that she was disabled from returning to her employment. In fact, he felt that her prognosis was poor (Sewick, 34).

W. John Baker, Ph.D., who is a licensed neuropsychologist, examined plaintiff at the request of defendant on February 23, 2005 (Baker, 4, 21). A transcript of the deposition testimony of Dr. Baker was admitted as Defendant's Exhibit C. All objections contained therein are overruled.

Based on his clinical examination, Dr. Baker felt that plaintiff had a normal neurological status. He felt that plaintiff was an emotionally brittle and hypersensitive person who is having a great deal of difficulty dealing with the assault. Basically, he felt that she might be faking given her knowledge of the diagnostic criteria (Baker, 45). Since I find plaintiff credible and since every other physician found at least a major depressive disorder, I specifically find Dr. Baker's testimony not credible. I reject his opinion and find that he is nothing more than a "hired gun" for defendant and that his opinion in this case is worthless.

Plaintiff testified that she receives $644.00 per week in wage loss benefits. They are not paying for her medication. Plaintiff's husband's insurance pays for some of it. Plaintiff received her full pay based on statute which includes assault pay for approximately 2 years.

Plaintiff received an insurance card from "Progressive Medical" through the State, but she testified that all her prescriptions were not being covered. She testified that she used the insurance card while it was available. She admitted that she last used it last January.

Plaintiff testified that she also sees Dr. Davidson, a TMJ specialist at the referral of Dr. Petrelli. He helped her with jaw pain due to bruxing. He helped her "get through" that. She does not believe that he has been paid.

Plaintiff testified that Bal Gupta, M.D., is a psychiatrist who saw plaintiff one time on referral from Dr. Petrelli. She does not believe that he has been paid. Plaintiff cannot remember when she was seen by him.

Plaintiff testified that Dr. Petrelli also referred plaintiff to Dr. Spoor, the eye doctor. He checks her vision and checks for dry eyes. Plaintiff testified that she did not have that problem prior to the assault.

Plaintiff testified that she wants to go back to work and complete her boards; however, she does not feel that she can at this time despite the improvement with treatment. She cannot perform the duties of her job. She cannot evaluate patients and perform medication reviews. She is very concerned for her own safety and is worried that a patient will assault her. She cannot suppress her discomfort or focus on the patients. She cannot focus on the appropriate factors to evaluate patients. Plaintiff does not feel that she can return to any job in the medical field at this time. She lacks concentration and focus.

This testimony is completely credible and supported by Dr. Petrelli who testified that plaintiff is unable to return to work due to her symptoms (Petrelli, 49.) He also testified that "without a doubt in my professional opinion psychiatrically or neuropsychiatrically [plaintiff's] symptoms are related to the work events" (Petrelli, 48). I accept that absolutely credible testimony.

Plaintiff does not ask her husband to give her back rubs for her neck or shoulder problems. Plaintiff admitted that her husband's burden has increased, but further testified that he is the one that takes her to her appointments. Prior to the incident, both shared duties. Plaintiff told Dr. Jackson that she and her husband argued at times over driving the kids to school. They

argued over groceries. She admitted that they argued over getting the children to bed. This clearly reveals a normal family life and further establishes plaintiff's credibility. I find that these family issues are insignificant in the range of stressors.

Plaintiff also admitted that her husband was critical about her remaining off work and called her lazy. This was true even when plaintiff was initially admitted to the day care program in 2002. Although plaintiff testified that her husband was present when she gave that history to Dr. Petrelli. Plaintiff testified that her husband continues to be unsupportive "sometimes." Plaintiff testified that her husband drove her to trial but left her to stay home with the children. Plaintiff's husband is clearly unsympathetic.

Plaintiff testified that she has good days and bad days and she cannot find any pattern in it. She believes that it is hard for her husband to understand what is happening to her and to justify her inability to work. Plaintiff believes that his lack of support may not make her condition worse but that she wishes he would understand her condition better. She testified that he does not seem to understand her condition. I accept that testimony.

Plaintiff testified that the specialists (treatment staff) understand her problem and provide her with support that she does not get from her husband.

Plaintiff is not currently on all the medications she was on in October of 2004. She takes Zoloft, Klonopin, and Lamictal. She testified that she sometimes takes Ritalin. She also takes vitamins, fish oil, Imitrex, and Tylenol.

Plaintiff admitted that she has been diagnosed with major depression. She denied any previous depressive symptoms prior to the injury. She admitted that she saw Dr. Gupta on July 30, 2002. He recorded previous problems but plaintiff did not recall that. She provides strong evidence of family mental illness – plaintiff denied that. She cannot explain why that is in Dr. Gupta's report. She admitted that a strong family history can be important. I accept plaintiff's testimony.

She admitted seeing Dr. Vredevoogd through Dr. Petrelli. Plaintiff testified that she never saw Dr. Vredevoogd's report. Dr. Vredevoogd highly recommended the initial treatment be focused on the depression and anxiety given her significant symptoms.

Plaintiff testified that the whole picture was being treated in the daycare program. She admitted that depression can be treated outside a daycare program. Plaintiff continues in the daycare program five days per week. There was a period of time when she only went three days per week. Plaintiff testified that her going to the daycare program is unrelated to her husband's support.

Plaintiff recently renewed her medical license. She completed 155 hours of continuing education. She kept documentation of the education. Plaintiff testified that some of those classes required her to fill out questionnaires regarding the seminar or class. Plaintiff testified that she obtained the most of the required amount of classes prior to the injury. She testified that merely attending the class qualified her for the continuing medical education credits.

Defendant's Exhibits K and L describe plaintiff's continuing medical education. I find that, based on plaintiff's credible testimony, they do not rebut her claims of an inability to perform the duties of her job and that they do not rebut her testimony that merely appearing at the courses gave her credit.

Plaintiff testified that she went to Chicago for the boards and obtained 30 CME credits. Plaintiff testified that Dr. Petrelli tried to get her to take her oral boards. He offered to be with her while she did the oral evaluation. Plaintiff testified that his presence made her less anxious and more secure; however, plaintiff still had difficulty performing the evaluation and she became extremely anxious. Plaintiff testified that she is still eligible for the oral boards for another year

Plaintiff does drive. She is able to drive her children to the Temple and after school classes. She re-passed the test and drove on the freeway despite the fact that she testified that she cannot drive on the freeway. I find that her ability to drive or the fact that she certified that she could drive safely to drive does not rebut her claims that she cannot perform the duties of a medical doctor. An undated application was admitted as Defendant's Exhibit F. Plaintiff basically identified that document and admitted that she signed it in May of 2005.

Plaintiff makes sure that her children finish their homework. To the extent that she tries her best to help them with their home work, I find that such help with grade school (even high school) homework hardly constitutes and ability to function as a doctor of medicine. Plaintiff testified that her driving restrictions are self imposed.

Plaintiff testified that her husband helps with the day-to-day family needs. He keeps track of her medications. He also attends visits with Dr. Petrelli.

Plaintiff was required to sustain his/her burden of proof by a preponderance of the evidence. MCL 418.851; MSA 17.237(851); *Aquilina v General Motors Corp*, 403 Mich 206; 267 NW2d 923 (1978). In order to establish a work-related disability, plaintiff must demonstrate that he/she has a limitation of his maximum wage earning capacity in work suitable to his/her qualifications and training. MCL 418.301(4); MSA 17.237(301)(4); *Sington v Chrysler Corp.*, 467 Mich 144, 154; 648 NW2d 624 (2002). Plaintiff succeeded.

I find that plaintiff was extremely credible. Therefore, I accept her testimony in its entirety. I find that the incident alleged by plaintiff occurred as she testified on April 29, 2002. I further find that the testimony of Dr. Petrelli is absolutely credible, and I adopt it completely. I find that plaintiff suffers from: "post-traumatic stress disorder, cognitive difficulties, confusion, panic disorder, anxiety, mild traumatic brain injury, and major depression" as identified by Drs. Petrelli, Backos, Ranganathan, and Sewick. I find that these conditions are directly related to plaintiff's work related injury.

With regard to the major depression, I find that the work injury is the ONLY relevant stressor in plaintiff's life. Plaintiff credibly testified that she had no previous history of psychiatric illness or treatment. I further find that, to the extent that she has difficulties stemming from her husband's reaction to her problem, it is merely a minor stressor in the totality of the circumstances. I find that the significant trauma she sustained at the hands of the violent

patient is far more important than any difficulties with her husband who, by her own testimony, is becoming more supportive of her.

I further accept plaintiff's testimony that her treatment for jaw pain and eye symptoms is related to her work injury since she did not suffer from these conditions prior to the assault. In fact, I find that all the treatment rendered to plaintiff here-to-date is reasonable, necessary, and related to her work related injury. This includes the out-patient day care program prescribed by Dr. Petrelli. While defendant's examining physicians do not agree, I find that Dr. Petrelli's extremely credible testimony outweighs their opinions. Further, I find plaintiff's testimony that the program helps her to better cope with her situation to be extremely compelling.

However, given plaintiff's testimony that her driving restrictions are self imposed and given that there was no testimony that plaintiff required any specific or special transportation needs, I find that plaintiff is merely entitled to mileage based on the State tables for her travel to and from her physician's appointments. To the extent that plaintiff received a ride from Total Transportation due to her fear of driving, I find that the ride itself is necessary and related but that any bill beyond the actual allowable reimbursement per mile is unreasonable.

I also find that, as a result of the significant trauma plaintiff sustained at work and due to plaintiff's continued symptoms, plaintiff is disabled within the meaning of the Act. Clearly, plaintiff's highest paying job was as a psychiatrist. I find that she is completely disabled at this time from performing the duties for which she is qualified and trained. I find that plaintiff's cognitive and emotional difficulties prevent her from performing this job despite her ability to help her children with their homework. The fact that plaintiff can barely function in a daily setting does not change my opinion that she cannot operate at the high level required to practice medicine in the State of Michigan.

Finally, plaintiff made a motion for attorney's fees on the unpaid medical. Given that reasonable physicians disagreed on the method of treatment, I find that the dispute was reasonable despite the fact that I ultimately ruled in plaintiff's favor. Therefore, I am not awarding an attorney fee on the unpaid medical (although, to the extent that plaintiff's attorney has made arrangements with the medical providers, those arrangements are not subject to this order).

## ORDER

See the attached order that is a part of this decision.

**WORKERS' COMPENSATION BOARD OF MAGISTRATES**

**JOHN J. RABAUT, Magistrate (196)**

Signed this 3rd day of April, 2006 at Detroit, Michigan.