ATTACHMENT C

RESPONDENT'S ARGUMENT

From: christine heaney
To: CalPERS Board of Administration
Subject: [**External**] - Fwd: Written Appeal of Reinstatement from Industrial Disability Retirement
Date: Thursday, December 26, 2024 4:55:48 PM

CAUTION: This email originated from outside the CalPERS organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Sent from my iPhone

Begin forwarded message:

From: christine heaney <[redacted]>
Date: December 24, 2024 at 12:30:23 PM PST
To: "board@calpers.ca.gove" <board@calpers.ca.gove>
Subject: Written Appeal of Reinstatement from Industrial Disability Retirement

Board Services Unit Coordinator California Public Employees Systems

Please see my written appeal attached and appeal sent in mail December 24th 2024. Thank you for your time.

Christine Heaney
[redacted]
<Scan 7.jpeg>

From: [redacted]
To: CalPERS Board of Administration
Subject: [**External**] - Written appeal of reinstatement from industrial disability retirement
Date: Thursday, December 26, 2024 9:00:00 PM

CAUTION: This email originated from outside the CalPERS organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Board Services Unit Coordinator California Public Employees Systems

Please see my written appeal attached and appeal sent in mail December 24th 2024 Thank you for your time

Christine Heaney
(559)936-0357

Date: December 20, 2024

Ref. No. 2023-0983

Board Service Unit Coordinator
California Public Employees'' Retirement System
Post Office Box 942701
Sacramento Ca 94229-2701
Email: Board@CalPERS.ca.gov
Facsimile: (916)795-3972

Subject: Respondent's Argument In the Matter of the Appeal of Reinstatement from Industrial Disability Retirement of CHRISTINE V. HEANEY, Respondent, and SUBSTANCE ABUSE TREATMENT FACILITY, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondent.
Hearing Date: January 13, 2024; Hearing Location: Written Response

Dear Presiding Judge:

In pursuant of the findings of the Proposed Decision of the Administrative Law Judge I am appealing the decision to return to SATF State Prison as a Safety Licensed Vocational Nurse. As both Work Compensation (State Fund) Dr. William Foxely and Hand Surgeon (Regional Hand Center) Dr. Randi Galli have put in place work restrictions that would not qualify for return to a Safety Licensed Vocation Nurse at SATF State Prison. Due to the current physical requirements of the position/occupational title per CalPERS I would not be able to safely perform my job duties as a Safety Licensed Vocational Nurse. The current job restrictions have not changed since I was Medically retired as a Safety Licensed Vocational Nurse in April 2019. Please see documentation of work restrictions and IME (independent medical examination) from Hand Surgeon Dr. Randi Galli dated December 18th, 2024.

Christine Heaney
[redacted]

RANDI A. GALLI, M.D., F.A.C.S., INC.

Diplomate American Board of Surgery
Diplomate American Board of Plastic Surgery
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Qualified Medical Examiner

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720 West Main Street, Suite A
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2139 E. Beechwood Avenue
Fresno, California 93720

105 West El Portal Drive, Suite A
Merced, California 95348

December 12, 2024

DATE OF VISIT:	12/18/24
PATIENT'S NAME:	HEANEY, CHRISTINE
MEDICAL RECORD NO:	[redacted]
OAH NO:	2024060492
AGENCY CASE NO:	2023-0983
DATE OF INJURY:	11/02/17

INDEPENDENT MEDICAL EXAMINATION

This is a Independent medical examination taking place at 2139 E Beechwood Ave, Fresno, California 95348.

The past medical history, past surgical history, the review of systems, the social history, medications, and allergy history were performed by my assistant Felicia Felix, MA. I then reviewed the data collected by her with the patient. The evaluation of the patient, including the taking of the history and the performing of the physical examination were performed by me. I performed the review of records. I produced this report and performed the intermediate and final report editing.

JOB DESCRIPTION:

Date hired: 03/01/2011
Job title: LVN
Hours worked per day: 8
Hours worked per week: 40
Currently working?: No
Last day of regular duty: 11/2/2017
Description of job duties: The patients job duties consist of responding to all medical emergencies and provide direct patient care to all inmates and staff. She is required to administer medication to inmates, restock medical supplies, provide medical care as needed.
Average weight lifting: 5
Max weight lifting (lbs): 100
Freq. of weight lifting: Daily

HISTORY OF PRESENT ILLNESS:

Ms. Heaney is a 41-year-old, right-hand dominant female, who was previously employed a s licensed vocational nurse for the California Substance Abuse Treatment Facility in Corcoran, California. She was actively employed as a licensed vocational nurse at that facility from June 2011 until her date of injury of November 2, 2017. I provided care for her through the California workers' compensation system. I first performed an evaluation on her behalf on February 14, 2018. I documented that on November 2, 2017, she responded to an alarm. An inmate's throat had been cut. She applied pressure to the inmate's cut throat to prevent the inmate from bleeding to death. As she was getting up off the ground, she put her right hand into a fist. She was going to push up off the ground with her hand in that formation. Unfortunately, her right

wrist rolled forward such that the right wrist hyperflexed suddenly. She had immediate pain in the dorsal central aspect of her right wrist. Because of the circumstances at that moment, she ignored the pain. Over the next several days, the pain worsened. Over a period of several weeks, she was no longer able to tolerate the symptoms. Her primary treating physician had obtained a non-contrast MRI of her right wrist, which took place on December 18, 2017. That study did not identify an injury to the scapholunate ligament.

At the time of my evaluation on February 14, 2018, I noted both a mechanism of injury and subjective complaints with physical findings consistent with an injury of the scapholunate ligament as documented by diagnosis #1 on page 6 of that report.

She underwent an MR arthrogram and completion arthrogram study of the right wrist on March 22, 2018. The study was read by Robert Lee, M.D., Board certified radiologist specializing in musculoskeletal injuries of this nature. The study stated that "intact volar and membranous scapholunate ligament fibers are identified. There is trace intermediate signal along the dorsal fibers, somewhat obscured by an adjacent loculated 4 x 7 x 12 AP x transverse x longitudinal dimension ganglion cyst. This tracks along the dorsal fibers in coronal image #4 and axial image #11, a non-enhancing collection. A small perforation is considered." In the study, Dr. Lee documented that linear contrast was noted at the scaphocapitate articulation, meaning that dye extravasated from the radiocarpal joint to the midcarpal joint.

On July 17, 2018, I also performed an open and arthroscopic assisted repair of the tear of the triangular fibrocartilage complex that was confirmed in the MR arthrogram and confirmed arthroscopically.

During the July 17, 2018 arthroscopic examination of the right wrist on noted the dorsal and proximal components of the scapholunate ligament appeared intact. As part of that surgery, I excised the ganglion from the dorsal aspect of the scapholunate ligament. I noted that "a large portion of the dorsal distal aspect of the scapholunate interosseous ligament appeared to have mucinous material embedded into the ligament." I left the mucinous material that was embedded into the ligament in order to avoid trauma of any ligament component.

During the course of her follow-up, the Covid pandemic developed, which shut down much of the medical system. She was seen again by me on August 4, 2021. I confirmed that she would not be able to perform lifting, carrying or forceful manipulation requiring 51-100+ pounds of force with the injured wrist. Her grip strength on examination on August 4, 2021, ranged between 50 and 53 pounds.

She had a positive scaphoid shift test, also known as a Watson's test or Watson's maneuver. I also documented passive right wrist extension produced immediate pain at the dorsoradial-central aspect of the right wrist, which was an area that was not being touched as part of that maneuver. Those findings were consistent with a loss of normal integrity of the scapholunate ligament. I discussed the reconstruction of the scapholunate ligament. I discussed the difference in force that could be withstood by a normal intact scapholunate ligament as opposed to a reconstructed scapholunate ligament utilizing the SwiveLock technique. We also reviewed a video regarding the technique.

https://www.arthrex.com/resources/AN1-00132-en-US/all-dorsal-scapholunate-reconstruction-with-internalbrace-ligament-augmentation-repair?referringteam=hand_and_wrist

She underwent a reconstruction of the scapholunate ligament utilizing the Arthrex SwiveLock technique, which also utilized the right palmaris longus tendon, which I harvested through a separate incision on the volar aspect of her right wrist and forearm. She did well following that surgrery.

Prior to my evaluation of her on December 16, 2024, I last saw her for an evaluation on June 29, 2022. Grip strength on the uninjured left nondominant measured 58, 58, 55 pounds, while the right injured dominant measured 30, 28, 25 pounds. I placed her at a 10-pound weight restriction. I also informed her that she should "avoid forceful repetitive use of the right wrist, although mild force on a nonrepetitive basis and mild repetition are acceptable." I stated, "She is not able to perform CPR in a standard fashion with the wrist extended with pressure on the palmar aspect of the hand." I also stated in the section on "Future Medical care," that, "The patient is not in need of any surgery in the immediate near future. In fact, she may not need any other surgeries in the future. She is at risk for possible need for other surgery in the future specific to the

right wrist if she were to suddenly torque her right wrist or fall. She may require additional surgery to the right wrist such as a limited intercarpal fusion or one of the other salvage procedures. There is no immediate need for any salvage procedure in the foreseeable future."

She is able to fulfill the work requirements as an LVN in the Fresno Unified School District. It did not require unpredictable very forceful use of her right wrist which would exert substantial pressure across the scapholunate ligament.

At this examination, I had an opportunity to review the 13-page report dated August 18, 2023, exhibit 12. Please refer to my comments and discussion at the end of this report.

CHIEF COMPLAINTS:

1. The patient complains of numbness and tingling to the right index and long fingers.
The degree of numbness in each finger is as follows:
Right Index Finger: constantly
Right Long Finger: constantly
The patient states that they have worn a splint on the right wrist for 3 years during the nighttime.
The patient drops things.
Associated Symptoms: weakness.

2. The patient complains of right central dorsal wrist pain.
Severity: at rest 5/10 and with use 8/10.
Frequency: throughout the day and constant.
Quality: aching, sharp, piercing and throbbing.
Duration: constant.
Associated Symptoms: weakness.
Made Worse By: forceful pushing, pulling and manipulation, repetitive motion and repetitive use.
Improved By: Motrin.

3. The patient complains of right lateral elbow.
Severity: with use 3/10.
Frequency: intermittent.
Quality: aching, sharp, piercing and throbbing.
Duration: 10 seconds.
Associated Symptoms: weakness.
Made Worse By: repetitive motion and repetitive use.
Improved By: rest.

PAST MEDICAL HISTORY:

Disease	Onset Date	Comments
reflux disease		

PAST SURGICAL HISTORY:

Management	Date	Comments
Reconstruction of the scapholunate ligament with denervation of the PIN	11/18/2021	
Arthroscopic examination right wrist with open repair TFCC and dorsal ganglion excision	07/17/2018	
Appendectomy	09/2017	

Cholecystectomy	03/2017
C-Section	04/14/2015
Endometriosis	12/2013

MEDICATIONS:

Ibuprofen 800mg
Prilosec OTC

ALLERGIES:

Ingredient	Reaction (Severity)	Medication Name	Comment
PERTUSSIS IMMUNE GLOBULIN			respiratory

FAMILY HISTORY:

Patient reports there is no relevant family history.

SOCIAL HISTORY:

Tobacco use reviewed.

Preferred language is English.

Tobacco use status: Current non-smoker.

Smoking status: Never smoker.

Alcohol

There is a history of alcohol use.
consumed socially.

Review of Systems

System	Neg/Pos	Details
Constitutional	Negative	Fatigue, Fever and Night sweats.
Eyes	Negative	Vision loss.
Respiratory	Negative	Cough and Dyspnea.
Cardio	Negative	Chest pain, Cyanosis and Irregular heartbeat/palpitations.
GI	Negative	Constipation, Diarrhea, Nausea and Vomiting.
GU	Negative	Dysuria and Hematuria.
Endocrine	Negative	Cold intolerance and Heat intolerance.
Neuro	Negative	Difficulty walking, Dizziness and Headache.
Integumentary	Negative	Rash.
MS	Negative	Except as noted in HPI and Chief complaint.
Hema/Lymph	Negative	Easy bleeding and Easy bruising.
Allergic/Immuno	Negative	Environmental allergies and Food allergies.

PHYSICAL EXAM:

Time	BP mm/Hg	Pulse /min	Resp /min	Temp F	Ht ft	Ht in	Ht cm	Wt lb	Wt kg	BMI kg/m2	BSA m2	O2 Sat%
1:15 PM	133/81	86			5.0	7.00	170.18	206.00	93.440	32.26		

The following constitutes a comprehensive physical examination based on 1995 CMS Documentation Guidelines.

CONSTITUTIONAL: Patient has a normal appearance with respect to development, nutrition, attention to grooming.

EYES: Pupils equally reactive to ambient light. Extra-ocular eye movements are normal. There does not appear to be any abnormal discoloration of the sclerae.

HENT: The patient is of normal cephalic appearance. There are no congenital variants. Facial features are symmetrical. Ear canals are patent without drainage. Nasal vestibules are patent without drainage or epistaxis. The oropharynx is moist and clear of lesions. The tongue is midline. There are no visible masses noted in the area of the neck.

CARDIOVASCULAR: Pulses are full bilaterally, regular rate and rhythm. Normal capillary refill in all digits. No cyanosis noted.

RESPIRATORY: Breathing non-labored without audible wheezes. There is no tachypnea and no dyspnea.

INTEGUMENTARY (SKIN, HAIR, NAILS): Gross inspection of skin demonstrates no evidence of abnormality. There are no ulcerative or significant hyperkeratotic lesions. There is no visible rash. Hair growth demonstrates normal patterns. Nails are also normal. Skin is warm and dry without evidence of hyperhidrosis.

PSYCHIATRIC: Alert, oriented to person, place and time. The patient is in no acute distress, and answers all questions with normal affect and mood.

HEMATOLOGIC / LYMPHATIC SYSTEM: There are no palpable lymph nodes in the upper extremities, antecubital fossae and axillae.

NEUROLOGICAL: There is no evidence of a resting tremor or an intention tremor. The patient demonstrates normal deep tendon reflex to both upper extremities.

MUSCULOSKELETAL:

GAIT: The patient ambulates with normal gait without assistive device.

POSTURE: Patient demonstrates normal posture without any protective posturing.

EXTREMITY EXAMINATION: I performed a right scaphoid shift test, noting that the distal pole of the scaphoid is stable. I did note that the greater the pressure placed at the distal pole the scaphoid, pain began to develop.

A more accurate assessment of the integrity scapholunate ligament was performed as I extended the right wrist and then axially loaded the right wrist. With mild force she had no pain. The wrist appeared quite stable. As I continue to generate more force, equaling the realm of 30-40 pounds of force, she began to have intolerable pain. That pain was at the dorsal central aspect of the wrist where one would expect pain with a tear of the scapholunate ligament.

Assessment of muscle strength using the Jamar dynamometer on position 2 with rapid exchange technique shows the following values:

Grip/Pinch Strengths	Right	Left
Jamar (Position 2) Elbow Flexed (lbs)	50 / 45 / 40	85 / 80 / 75

Range of Motion - Wrist	Right	Left
Extension/Flexion 60/60	40/45	70/65
Radial/Ulnar Dev. 20/30	25/20	30/25

Provocative Tests (Wrist)	Right	Left
Scaphoid Shift Test	positive	negative

Distance to Palmar Contact	Right	Left
Index	0	0
Long	0	0
Ring	0	0
Small	0	0

ASSESSMENT:

1. Tear of the radial aspect of the right triangular fibrocartilage complex at the sigmoid notch, confirmed on the MR arthrogram and completion arthrogram study on March 22, 2018, and confirmed arthroscopically on July 17, 2018, undergoing an arthroscopic/open repair of the triangular fibrocartilage complex, stable, ICD-10 M24.131.
2. Chronic right scapholunate ligament tear confirmed by history and physical examination and by the MR arthrogram study on 03/20/18, ultimately requiring a reconstruction of the right scapholunate ligament on 11/18/21, stable, ICD-10 M24.231.
3. History of right wrist ganglion, surgically excised on 07/17/18, ICD-10 M67.431.
4. Stiffness, right wrist, ICD-10 M25.631.
5. Right median neuropathy localized to the carpal tunnel confirmed by history and physical examination, presently with a normal 5 mm two-point discrimination, ICD-10 G56.01.

DISCUSSION:

As documented in Techniques in Hand and Upper Extremity Surgery, 1999; 3(3): 151-153, entitled, "Certificate of Added Qualifications in Hand Surgery: History, Status and Future," there is documentation of the process that took place, wherein the American Board of Orthopedic Surgery, American Board of Surgery, and American Board of Plastic Surgery, put forth a joint application for the Certificate of Qualification for Surgery of the Hand, which was subsequently approved by the American Board of Medical Specialties. On page 151, the article states, "Under the guidelines of ABMS, a "grandfather" period of five years was established, during which time, applicants actively engaged in the practice of hand surgery, who otherwise met the requirements (peer review, case volume and balance) but who had not completed a one-year fellowship in surgery of the hand, would be eligible to take the CAQSH, providing they fulfilled all of the other requirements for the examination. This grandfather period ended July 1, 1994. Thereafter, candidates from any of the three boards must have satisfactorily completed a one-year fellowship in surgery of the hand."

The American Board of Orthopaedic Surgery states ,"The Subspecialty Certificate in Orthopaedic Surgery of the Hand, established in 1989, is for Board-Certified orthopaedic surgeons who have demonstrated qualifications in hand surgery beyond those expected of other orthopaedic surgeons by virtue of additional training and a practice characterized by volume and diversity of cases in hand surgery or have made significant contributions to this field. The examination is

developed and administered by the Joint Committee on Surgery of the Hand of the American Boards of Orthopaedic Surgery and Plastic Surgery. Applicants must have completed a one year ACGME accredited fellowship in surgery of the hand to qualify. In addition, a one year case list must be submitted which meets the required number of cases in 5 of 9 categories.

I am not aware that Dr. Williams sat for the examination based upon expertise in hand and wrist surgery. Undoubtedly, he has much greater expertise than I possess in areas of the ankle, knee, hip, or the spine.

Ms. Healney underwent an IME performed by Don Williams, M.D. on August 18, 2023, as part of a CalPERS evaluation. On page four, Dr. Williams documented grip strength on the right injured dominant at 30, 30, 30, with the left demonstrating value of 60, 60, 60 pounds.

On page eight of the report by Dr. Williams, he reviewed a June 12, 2019, report by Charles Xeller, M.D., who performed an independent medical examination. It states that, "Dr. Xeller reviewed surveillance reports. Diagnosis, right wrist hyperflexion injury. In response to questions felt, "Yes, the member has an actual and present right wrist impairment that arises to the level of substantial incapacity to perform usual job duties. It is permanent."

On page 11, Dr. Williams was asked, "Does the retiree have an actual and present orthopedic right wrist impairment that arises to the level of substantial incapacity to perform their usual job duties?" He responded, "No, I do not feel she has substantial incapacities as a result of her injury."

COMMENT: To make such a statement, would imply that a reconstruction of a scapholunate ligament returns a person to normal strength and ligament integrity within the wrist. That is incorrect.

When asked, Considering the retiree's subjective complaints and the objective findings or lack thereof on the exam, what findings lead you to the conclusion the retiree is or is not substantially incapacitated? Please explain fully." He responded, "She has improved with the second surgery with less pain, and she has improved her motion with therapy and everyday activities since her previous QME status. She has been released from care by Dr. Galli, her hand surgeon, who felt she is not in need of any additional surgery in the immediate future. She will probably not need any other wrist surgeries. Dr. Galli indicates there is a slight possible risk that she will reinjure the wrist if she suddenly torques the right wrist. But this is only a slight possibility. She was given prophylactic restrictions by Dr. Galli and Dr. Pompan. However, prophylactic restrictions to avoid the remote possibility of reinjury are distinctly different than substantial incapacity. A CalPERS disability requires substantial incapacity. Her x-rays and MRIs have shown that the right wrist intercarpal spacing has been maintained, normal spacing. The MRI shows the intercarpal ligaments are intact. The intercarpal ligaments had some partial tears, which were surgically corrected. The ganglion has been corrected. She has had therapy and has improved. Although she has a slight loss of extension of 40 degrees, volar flexion 45 degrees. She does have functional range of motion and improved grip strength."

COMMENT: **This statement is in part correct, and in part incorrect. CalPERS disability does require substantial incapacity, which is different than a prophylactic restriction. I'll discuss all of that at the end of my report. She did not have an intact scapholunate ligament. Dye had extravasated from the radiocarpal joint injection of the MR arthrogram to the midcarpal joint at the scaphocapitate articulation indicating a full-thickness tear of the scapholunate ligament. The patient had physical findings consistent with an injury of the scapholunate ligament, which prompted the need for the scapholunate reconstruction.**

When asked, "If you find the retiree to be substantially incapacitated, is the incapacity permanent or temporary. If temporary, how long will the incapacity last? Please explain in detail." He stated, "I do not find her substantially incapacitated."

In question four, Dr. Williams was asked, "Please list the specific job duties and/or physical requirements of position the retiree is unable to perform for each substantially incapacitated body part/condition. In order to answer this question, we

have enclosed for your review the retiree's duty statement/job description and physical requirements of their former position." Dr. Williams responded, "The examinee job duties were reviewed. She has expressed concern about being able to perform CPR with extension of her wrist because of fear that she will have pain. However, cardiopulmonary resuscitation compression can be performed with her hand in a fist with the wrist straight. So, I feel she is able to do a CPR. I feel that she is able to do lifting and her right wrist is no longer restricted in her lifting abilities. She was given some prophylactic lifting restrictions, but prophylactic lifting restrictions do not constitute a substantial incapacity to perform the usual job duties. The prophylactic restrictions are because her fear of reinjury, but it has been several years since her injury, and the wrist sprain with partial tears has healed."

COMMENT: **While a very minimal partial tear can heal, her tear had not healed over a period of multiple years. She had a full-thickness tear, not a partial thickness tear. Dr. Williams has expressed his personal feelings about the tear. She did not have a wrist sprain. That term would be used by a non-specialist to describe a minor injury to the wrist. That would not require treatment by a specialist in hand and upper extremity surgery. There is no scientific evidence that her wrist ligament injury would magically heal sometime thereafter. That is a personal opinion and not based on scientific evidence in the peer reviewed medical literature. A torn ligament cannot magically stretch itself from one bone to the opposing bone from which it was torn, and secure itself to the bone.**

COMMENT: **While she can perform CPR with her wrist in a neutral position, at 0 degrees of extension and flexion, that is not the technique that is required by the American Heart Association to become licensed in basic life support (BLS). Dr. Williams and I documented that she has limited ability to extend the injured wrist. Her employment by the State of California requires her to be able to perform "basic cardio-pulmonary resuscitation." A person who appears to be punching on the sternum of the "Resusci Anne" is not passed when attempting to obtain that certification. In order to meet that requirement by her school, she passed the online component for BLS and then in person performed the resuscitation on a baby utilizing her thumbs. The resuscitation of a baby/infant allows you to use your thumbs or your fingers. It does not require the same force as CPR on an adult. There is a reason why the American Heart Association does not have a medical person perform CPR with the knuckles of the hand while in the form of a first. While there is no doubt it can be done, there are several reasons why this is not ideal while compressing the chest of an adult male two inches in depth, 100-120 times a minute for 3-5 minutes, or much longer. I have personally performed CPR in an ER for up to 40 minutes in the past before a sustainable heart rhythm was obtained when I was the sole MD at the hospital. I could not have done that with a wrist ligament injury.**

On page 2 of the Physician's Re-evaluation of Current Disability, Section 3, entitled Retiree Incapacity, the following questions are posed:

1. Is the retiree current substantially incapacitated from preforming the usual duties of the position from which he or she retired on disability? Answer: **YES**

2. If yes, how long is the incapacity expected to continue? Answer: **Permanent (with no improvement anticipated)**

3. If yes, please describe the specific job duties/physical requirements that the retiree is unable to perform due to his or her incapacity: **She does not have the physical capacity to perform effective CPR as instructed and certified by the American Heart Association. She can do CPR effectively on infants and very young children. She does not have the physical strength to apply 100-125 pounds**

of force to compress the human male chest 1.5-2 inches using both hands with the wrists extended to administer proper CPR. She does not have enough integrity of the scapholunate ligament of the right wrist to allow her to lift 51-100+ pounds up to three hours each work shift.

4. Did you review the job duty statement and physical requirements to make your medical opinion?
Yes

I hereby certify that the above information is true, complete, and correct to the best of my knowledge.

CalPERS has my permission to release a photocopy of the report to the retiree upon written request.

RANDI A. GALLI, M.D., F.A.C.S.
License #A43628
Diplomate, American Board of Surgery
Diplomate, American Board of Plastic Surgery
Certificate of Added Qualification for Surgery of the Hand

Below you will find supporting data for my statements above:

In the article entitled, "Chest Compression Force of Trained and Untrained CPR Rescuers" published in Cardiovasc Eng. 2007 June; 7(2):47-50, authors Geddes, Boland, Taleyarkhan, and Vitter stated, "The objective of this study was the major of the force exerted by 83 trained CPR rescuers and 104 untrained adult layperson's (college students and staff). A bathroom scale was used to measure the force exerted by the subjects with their hands on the bathroom scale in the CPR position. The weight range for both groups was the same. Of the trained rescuers, 60% pressed with more than 125 pounds, whereas only 37% of the layperson's pressed with more than 125 pounds. **In view of the American Heart Association guidelines (2000) to depress the chest 1.5 to 2 inches, which requires 100-125 pounds, it would appear that most layperson's do not exert enough force for effective CPR**."

Comment: **Ms Heaney is not capable of exerting 100-125 pounds of force with the wrists extended as an axial load across the wrist as required to perform normal adult CPR.**

Very detailed information regarding the kinematics of what occurs with an isolated injury to the scapholunate ligament is discussed in the Journal of Hand Surgery 2012;37A:2175-2196, "Scapholunate Instability: Current Concepts in Diagnosis and Management, authored by Alison Kitay, M.D., and Scott Wolfe, M.D. page 2179 the authors stated "Patients with subacute injuries (1-6-week) often present with a history of painful popping or clicking with activities, decreased grip strength, and well localized tenderness about the scaphoid and dorsal scapholunate interval. Watson et al. described a provocative maneuver known as a scaphoid shift test that can detect subtle degrees of scaphoid instability. The examiners thumb applies pressure to the scaphoid tubercle as the patient's wrist is brought from a position of ulnar deviation and slight extension to radial deviation and slight flexion. The scaphoid will normally flex and pronate during this maneuver, but in the scaphoid instability of the maneuver will be painful, and some pressure will force the proximal scaphoid from the scaphoid fossa onto the dorsal articular lip of the

radius. Relief of thumb pressure allows a scaphoid proximal pole to spontaneously reduce, often with an audible or palpable "clunk." Patients with an appropriate history and positive scaphoid shift test should be considered as having a suspected scapholunate interosseous ligament disruption and should be evaluated further with appropriate imaging or arthroscopy. Even though the arthroscopic examination performed by me demonstrated the visible component of the dorsal scapholunate ligament to be intact, that should not imply to anyone that all of the ligament tissue in the 3 mm thick ligament spanning from the scaphoid proximal pole to the dorsal aspect of the lunate maintained its normal integrity. **Enough integrity was lost to allow dye to extravasate from the radiocarpal joint injection through the ligament into the midcarpal joint at the articulation between the scaphoid and the capitate.**

Ms. Heaney has both prophylactic restrictions and restriction based on her inability to function with normal wrist range of motion and normal strength. Without normal integrity of the scapholunate ligament she does not have normal strength of the wrist. In my physical examination when she was first evaluated by me, I documented her inability to tolerate forceful wrist extension and axial loading of the wrist. As discussed in the journal article described above, the scapholunate ligament is most several stressed when there is an axial load to the palmar aspect of the hand with the wrist in extension, such as when one is doing a push up or in her case, CPR.

In the same note, her job as described in the "Physical Requirements of Position/Occupational Title" requires that she "Occasionally lift up to 51-75 pounds, 76-100 pounds, and 100+ pounds up to 3 hours" per day. The grip strength documented many times by me and previously by Dr. Williams does not allow her to generate that kind of force. She would not be able to grasp, lift and manipulate with the right wrist an item weighing "51-100+ pounds" in the course of her work whether it is up to 3 hours/day or less than 1 hour/day.

In Atlas of Hand Clinics, "Scapholunate Ligament Injuries, September 2003, the chapter on Anatomy, biomechanics, and natural history of scapholunate interosseous ligament injuries" was authored by Sunjay Berdia, M.D. (Dept of Surgery, Uniformed Services University of Health Sciences), and Scott Wolfe, M.D. (Weill-Cornell Medical College, Hospital for Special Surgery), (Atlas Hand Clin 8(2003), 191-199) On page 193 the authors stated, "The tensile loading experiments have helped to define some of the material properties of the scapholunate interosseous ligament. Mayfield et al. studied the load-2-failure properties of the carpal ligaments at a constant strain rate (60 mm/min). They found the scapholunate ligament failed at an average of 359 N under tensile strength. They also reported that failure occurred within the substance of the ligament. 56% of the time while the remainder of the tested specimens failed by an avulsion fracture." On page 196 the authors state, "In conclusion, several laboratory and in vivo mechanical studies of the scapholunate interosseous ligament have demonstrated that isolated traumatic disruption of the scapholunate interosseous ligament profoundly alters the loading patterns and kinematics of the carpal bones but does not affect a change in radiographic alignment initially. Loss of this critical stabilizer of the carpus may lead to attenuation of secondary supporting ligaments and set in motion a progressive degenerative sequence. Although the timing of this postural change is variable, it is recognized that there is an inevitable progression towards increasingly abnormal kinematics, altered force transmission and degenerative arthritis."

You will note from the article, "Current Role of Open Reconstruction of the Scapholunate Ligament" authored by Luchetti et al, the types of tears of the scapholunate ligament, and the various forms of treatment are quite complex. (J Wrist Surg, 2013, May 2(2):116-125). You can also see the options for techniques in the reconstruction as published in Journal of hand Surgery Am. 2023;48 (12):1252-1262, "Scapholunate Instability: Diagnosis and Management-Classification and Treament considerations," authored by Lauren Wessel, M.D., and Scott Wolfe, M.D. You can see an excellent description of the technique that I utilized for the reconstruction of the scapholunate injury of Ms. Heaney in the Journal of Clinical Medicine 2021;10:1492, "Comparison of Three Different Internal Brace Augmentation Techniques for Scaphllunte Dissociation: A Cadaveric Biomechanical Study., authored by Park, et al." I utilized the technique described at "IIB." I have utilized many techniques when performing surgery for repair or

reconstruction of the scapholunate ligament over the past 30 years. I have performed more than 1000 ligament reconstructive surgeries of the wrist. the one utilized for Ms. Heaney is still the strongest form of reconstruction that is available, excepting only the 360 degree reconstruction, which I have also performed. Because the latter technique can result in osteolysis by the polyethylene suture tape, I limit the use of the suture tape to the all dorsal approach. (JBJS Case Connect 2023 Dec 4;13(4), ecollection Oct 1, 2023, Alexander Shin, M.D., Mayo Clinic).

At one of the Arthrex wrist reconstructive courses, I had an opportunity to discuss the strength of the scapholunate ligament in vivo and after a reconstruction, with Steven Shin, M.D., one of the authors on the paper cited above describing the three different internal brace augmentation techniques. He explained that the intact, uninjured scapholunate ligament could withstand up to 400 N of force (consistent with other articles in the peer-reviewed medical literature), but the swivel lock technique (the strongest of all the techniques) could only withstand up to 250 N of force. That would make sense, since the normal scapholunate ligament is continuous from the dorsal distal aspect of the articulation between the scapholunate ligament along the dorsum, and then proximal, and then volar aspect of the scaphoid and lunate, covering a much larger surface area. The reconstruction utilizing suture tape and bone anchors only has two bands of suture tape, 2mm wide, crossing the dorsum of the scapholunate articulation. This is easier to understand when reviewing the articles that are attached to this report.

Physician's Re-evaluation of Current Disability

CalPERS

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (916) 795-1280

Note to retiree: Your current treating physician must complete this form.

The following information is needed in connection with the retiree's continuing eligibility for disability retirement benefits under the California Public Employees' Retirement Law. Please complete all sections and do not leave any dates blank. Type or print clearly.

Section 1 — Retiree Information

CHRISTINE V. HEANEY — [redacted]

Name of Retiree (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Position/Occupational Title | Birth Date (mm/dd/yyyy)

For Kaiser Patients, Medical Record Number

Section 2 — Physician's Findings

Attach a separate sheet if there is not enough space to enter your diagnosis. Be sure to use a label, or clearly write the retiree's Social Security number or CalPERS ID on each page.

12/18/24

Date of Last Exam (mm/dd/yyyy)

chronic full thickness Tear of right scapholunate ligament

Diagnosis 1

Decreased grip strength, decreased wrist range of motion, and positive scaphoid shift Test

Objective Examination Findings 1

MR arthrogram on 3/22/2018

Diagnostic Test (X-ray, MRI, Laboratory, EKG, etc.) – Dates and Findings

No CPR on adults; No forceful lifting >50#.

Restrictions / Limitations – If so, specify

Full Thickness Tear of the right triangular fibrocartilage complex

Diagnosis 2

Previous pain with forceful supination and pronation.

Objective Examination Findings 2

MR arthrogram on 3/18/22

Diagnostic Test (X-ray, MRI, Laboratory, EKG, etc.) – Dates and Findings

No forceful lifting and manipulation >50#

Restrictions / Limitations – If so, specify

Stiffness right wrist

Diagnosis 3

Decreased right wrist range of motion

Objective Examination Findings 3

Diagnostic Test (X-ray, MRI, Laboratory, EKG, etc.) – Dates and Findings

No CPR on adult males

Restrictions / Limitations – If so, specify

Comments

refer to my report of 12/18/24

0000000130974795

Put retiree's name and Social Security number or CalPERS ID at the top of every page

CHRISTINE V. HEANEY [redacted]

Retiree Name | Social Security Number or CalPERS ID

Section 3

Review the attached duty statement and physical requirements prior to your determination of disability.

Retiree Incapacity

To remain eligible for a disability retirement, the CalPERS retiree must continue to be substantially incapacitated from the performance of the usual duties of his or her position with his or her former employer. This "substantial incapacity" must be due to a medical condition of permanent or extended duration as defined as one that is expected to last at least 12 consecutive months or will result in death as determined by the CalPERS Board, or in the case of a local safety member, by the governing body of the contracting agency employing the member, on the basis of competent medical opinion. Disability is not necessarily an inability to perform fully every function of a given position. Rather, the courts have concluded that the test is whether the member has a substantial inability to perform the usual and customary duties of the position. Prophylactic restrictions are not a basis for a disability retirement (limitations based on "high risk of injury" do not meet the statutory requirements).

1. Is the retiree current substantially incapacitated from performing the usual duties of the position from which he or she retired on disability? ☑ Yes ☐ No

2. If yes, how long is the incapacity expected to continue?
☐ < 1 year ☐ > 1 year ☐ > 2 years ☑ Permanent (with no improvement anticipated)

3. If yes, please describe the specific job duties/physical requirements that the retiree is unable to perform due to his or her incapacity.

She can not perform normal effective CPR on adult model. She can not lift or manipulate 51-100+ pounds up to 3 hrs of her work shift.

4. Did you review the job duty statement and physical requirements to make your medical opinion?
☑ Yes ☐ No

Section 4

Treatment Records

1. Please provide a copy of all the retiree's medical records and referenced diagnostic testing during the past 12 months.

2. I have not provided any medical care for this retiree's ongoing disability during the past 12 months.
Please initial: _____

Section 5

Mail completed report directly to CalPERS. Do not give to the retiree. Original physician signature is required.

Physician's Signature

I hereby certify that the above information is true, complete, and correct to the best of my knowledge.

CalPERS has my permission to release a photocopy of the report to the retiree upon written request.
☑ Yes ☐ No

RANDI A. GALLI, M.D. | (559) 322-6600 | 559-352-4025
Print Physician Name | Phone Number | Fax number

2139 E. Beechwood Ave
Address

Fresno | CA | 93720
City | State | ZIP

Original Signature of Physician | M.D.
Title

Hand Surgery | 12/18/24
Medical Specialty | Date (mm/dd/yyyy)

Mail to: CalPERS Benefit Services Division • P.O. Box 2796, Sacramento, California 95812-2796

0000000130974795

FAX

TO:	Board Services Unit Coordinator CalPERS retirement system	FROM:	Christine Heaney
FAX:	916-795-3972	FAX:	
PHONE:	916-795-0577	PHONE:	[redacted]
SUBJECT:	CPS report	DATE:	12/12/2024

COMMENTS

Total number of pages: 15