3-28-2017

Jobe v. Dirne Clinic/Heritage Health Respondent's Brief Dckt. 44604

BEFORE THE SUPREME COURT OF THE STATE OF IDAHO

RICHARD JOBE, Claimant/Appellant, vs. DIRNE CLINIC/HERITAGE HEALTH, Employer, and STATE INSURANCE FUND, Surety, Defendants/Respondents.	SUPREME COURT NO. 44604 I.C. Case No. 2014-014091

RESPONDENTS' BRIEF

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APPEAL FROM
THE IDAHO INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

CHAIRMAN R.D. MAYNARD PRESIDING

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I.

STATEMENT OF THE CASE

NATURE OF THE CASE:

This is a worker's compensation case relating to an alleged occupational disease with first symptoms occurring on or about June 17, 2013. Dr. Jobe's Worker's Compensation Complaint was filed on May 29, 2014.

COURSE OF PROCEEDINGS:

The Industrial Commission assigned this matter to Referee Brian Harper who conducted a hearing in Coeur d'Alene on March 4, 2016, on the issues of:

1. Whether Claimant suffers from a compensable occupational disease, including whether the provisions of Idaho Code §72-448 serve as a bar to the claim.

2. Whether and to what extent Claimant is entitled to the following benefits:

    a. Medical care;

    b. Temporary disability benefits, partial or total (TPD/TTD);

    c. Permanent Partial Impairment (PPI);

    d. Permanent Partial Disability in excess of Impairment, including Total Permanent Disability pursuant to the Odd-lot Doctrine; and

    e. Attorney Fees.

3. Whether Claimant is totally and permanently disabled; and

4. Whether the *Neel* Doctrine applies to Claimant's past medical bills.

R, p. 68.

On September 23, 2016, the Commission adopted Findings of Facts, Conclusions of Law and Recommendation, and entered an Order that stated:

1. Claimant has failed to prove his MRSA infection constitutes a compensable occupational disease caused by his employment with Employer.

2. Claimant has failed to prove his entitlement to attorney fees.

3. All remaining issues are rendered moot by the Claimant's failure to prove causation.

4. Pursuant to Idaho Code §72-718, this decision is final and conclusive as to all matters adjudicated.

R, pp. 89-90.

STATEMENT OF FACTS:

The Commission made the following findings of fact:

1. At the time of hearing, Claimant was an 80 year old married man living in Spokane Valley, Washington. Claimant is a licensed physician; he graduated from medical school in 1961, completed a residency in internal medicine, then a fellowship in hematology and oncology in 1965.

2. Claimant went to work for Employer on October 8, 2012 as an internist and primary care physician. He saw patients five days a week for Employer. His last day of work was June 19, 2013. Prior, Claimant had worked at various hospitals and clinics.

3. Claimant presented to Patrick Mullen, M.D., on June 17, 2013, complaining of sudden onset right thumb pain. Eventually, the infection was determined to be caused by methicillin-resistant staphylococcus aureus, or MRSA. When asked as to a possible source of the infection, Claimant told Dr. Mullen the only thing that came to mind was the fact that his cat had scratched him on his right hand a few weeks previous.[3]

4. The infection spread throughout Claimant's body. This widely-disseminated MRSA infection had by the time of hearing resulted in numerous surgeries, including multiple hand, wrist, and forearm surgeries to clean out infection, surgeries to Claimant's back and left shoulder, and removal of Claimant's previously-installed artificial hip joint. Claimant was placed on IV antibiotics for suppressive therapy of his incurable MRSA infection, and will remain so for life.

5. Since June 2013, Claimant has suffered two strokes, arguably related to his MRSA infection. The strokes have left him unable to effectively communicate. He has trouble in his movements and needs assistance for things such as sitting, putting on his socks and shoes, and walking (he uses a cane and walks with a shuffling gait). Claimant was unable to attend the hearing in this matter due to his health condition, including his second stroke. He was never deposed in this matter, perhaps due to his inability to precisely communicate, or testify under oath.

6. Claimant hired John McNulty, M.D., to assess Claimant's impairment. Dr. McNulty assigned Claimant an impairment rating of 67% of the whole person due to Claimant's hip, shoulder, thoracic spine, wrist, and forearm condition, as well as his loss of ability to express speech.

7. Claimant's preexisting conditions relevant to this discussion include pseudogout involving Claimant's right knee, which requires periodic draining of fluid from the knee joint. Claimant had his knee drained a few weeks before experiencing MRSA infection symptoms. Claimant also has a condition known as hemochromatosis, which causes an accumulation of iron in the blood. Treatment includes ongoing phlebotomy (blood draining) approximately quarterly. Claimant was also diagnosed with diabetes during his treatment for MRSA infection, but was not prescribed insulin injections.

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[3] Claimant's wife testified at hearing that Claimant had not been scratched by his cat, and in fact rarely if ever interacted with the cat since he was allergic to it. Claimant's son testified that it was he, and not his father, who was allergic to the cat.

8. Claimant had several surgeries prior to 2012, including bilateral shoulder replacement surgery (one medical record notes the date as 2003; Claimant's CV also notes a shoulder surgery in 2010), ankle surgery in 2009, lumbar fusion surgery in about 1992, a left hip replacement in 1990, and bilateral second metacarpophalangeal joint replacement surgery, no date given.

MRSA BACKGROUND

12. Staphylococcus aureus (*S. aureus*) is the most commonly isolated human bacterial pathogen; at least one-third of the population carries the bacteria in their noses or on their bodies. Typically, the "colonized" bacteria ("colonized" refers to a colony of bacteria living on a person, but producing no symptoms) cause no harm. However, sometimes these colonized bacteria can enter the person's bloodstream, causing bacteremia or sepsis, such as in Claimant's case. When this happens, it is known as "disseminated," as it spreads to various parts of the body, removed from its original colony site, and often results in infection. The bacteria can also cause various skin and soft tissue (SSTI) infections, creating abscesses, boils and cellulitis. Various antibiotics can successfully treat regular "staph" bacteria.

13. As noted above, MRSA stands for methicillin-resistant staphylococcus aureus. In other words, MRSA is a form of staphylococcus bacteria which has developed a resistance to certain antibiotics, such as methicillin, an antibiotic in the penicillin family often used to treat staph infections. There are strains of drug-resistant staphylococcus bacteria, such as afflicts Claimant, which are also resistant to other antibiotics in addition to methicillin. For the purpose of this case, all antibiotic-resistant staphylococcus bacteria will be called "MRSA."

14. In 1961, strains of *S. aureus* were identified in the United Kingdom which were resistant to methicillin. With time, the resistant bacteria (MRSA) spread throughout Europe, although it was confined mainly to hospital settings. In 1968, MRSA found its way to the United States, first noted in a Boston hospital. By 2000, nearly 126,000 cases of MRSA were diagnosed annually.[4]

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[4] The information on MRSA in this and subsequent paragraphs is synthesized from the voluminous reference materials supplied by Claimant as part of his exhibits, and the deposition testimony of medical experts retained in this matter.

15. Until the mid-1990s, MRSA in this country was rarely seen in otherwise healthy individuals outside of a health care setting. Since then, there has been an explosion of "community-associated" MRSA (CA-MRSA) infections, where individuals not at risk due to factors such as hemodialysis, surgery, residence in a long-term care facility, indwelling catheter or percutaneous device use, or hospitalization in the previous year, nevertheless are diagnosed with MRSA. All other MRSA infections are known as "hospital-associated" MRSA (HA-MRSA). [5]

16. Currently, CA-MRSA risk factors include children under age two, athletes, people who frequent or work at gyms, persons living with a MRSA SSTI infection patient, ER patients, residents in urban underserved communities, indigenous populations, cystic fibrosis patients, military personnel, persons in jail or prison, men who have sex with men, HIV patients, injection drug users, veterinarians, pet owners, livestock handlers, pig farmers, diabetics, and persons over 65 years of age.

17. Individuals can carry colonized MRSA for years without the bacteria producing infection. Skin is an effective barrier for preventing MRSA from causing infection. Often a break in one's skin provides the opening for the bacteria to enter the bloodstream, disseminate, and cause infections. The bacteria are also capable of airborne transmission.

18. It is undisputed that health care workers as a whole have a higher incidence of colonized MRSA than the general public. In addition, health care workers have a greater risk of contracting symptomatic MRSA (either SSTI infections or disseminated through the blood stream) than the public at large. Of course, patients at health care facilities are at greater risk of MRSA infection due to risk factors including weakened immune systems, open wounds, incisions associated with surgery or invasive procedures, intravenous catheters, and/or other breaks in the skin surface, coupled with greater opportunity for infection from the higher incidence of MRSA bacteria (and MRSA colonized staff) often present at such facilities.

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[5] Originally, there were molecular differences between MRSA found at hospitals (HA) and MRSA infecting the community outside the health care setting (CA), but those differences have become blurred as MRSA strains continue to evolve, CA-type MRSA patients treat their infections medically, and HA MRSA left the health care setting and made its way into the community. In the present case, Claimant's MRSA strain was not identified, so it is not known if it was of a type commonly associated with health care facilities or molecularly similar to CA strains. Even if this information was known it would not be determinative of the causation issue, since there is no strain which is *never* found in health care settings. Furthermore, if it was a HA strain, Claimant was both a physician and a patient, so such information would not assist in determining if he incurred his MRSA as a physician or as a patient.

Expert Testimony

Dr. Souvenir

19. Claimant's primary treating infectious disease physician, David Souvenir, M.D., checked the "agree" box when presented with an "agree or disagree" proposition which stated that Claimant's MRSA colonization was due to MRSA exposure while he was working as a physician. Subsequently, Dr. Souvenir was deposed.

20. After detailing his treatment history with Claimant, Dr. Souvenir testified about MRSA causation. He noted that health care workers, as a general class, can have an increased incidence of MRSA colonization. However, Dr. Souvenir testified that it is difficult to assess where people acquire the bacteria. Physicians can become colonized with MRSA at work, but Dr. Souvenir stated that he did not know where or when Claimant acquired his MRSA. In spite of not knowing the when and where, Dr. Souvenir felt it was more likely than not that Claimant acquired MRSA "in the course and scope of his duties as a physician." Depo of Souvenir, p. 24, ll. 15 – 20.

Dr. Hull

21. Claimant also relies on the opinions of Harry Hull, M.D., of Reno, Nevada, to support causation. Since 2006, Dr. Hull has primarily consulted parties in litigation. He does not actively practice medicine currently. Dr. Hull is, or was, a board-certified pediatrician, and has extensive experience in infectious disease epidemiology, serving at various times as state epidemiologist for New Mexico and Minnesota.

22. Dr. Hull was hired by Claimant to review this case and opine on causation. After reviewing various medical records, Dr. Hull prepared a report dated February 4, 2016, addressed to Claimant's attorney. Therein, Dr. Hull opined that Claimant more likely than not acquired the MRSA bacteria which led to his infection from one of his patients he examined at work in the months preceding the infection onset.

23. Dr. Hull was deposed. Much of his testimony revolved around studies exploring hospital-caused MRSA infections. Dr. Hull noted that while between 1% and 1.5% of the general public carries colonized MRSA, approximately 4% to 5% of health care workers are carriers of the bacteria. The doctor pointed out that MRSA bacteria is found in virtually every hospital in the country, although the rate of MRSA colonization among hospital staff varies widely, from zero at the low end to nearly 60% at the other extreme.

24. According to Dr. Hull, patients frequently become infected while treating at health care facilities, and the facility's staff are often implicated as the source of the MRSA. The general conclusion from the studies Dr. Hull reviewed is that the most important risk factor for community members carrying MRSA is exposure to the medical system; therefore medical facilities need to do a better job of controlling MRSA within its confines, in order to limit its spread to the community.

25. Dr. Hull also noted that MRSA carriers are at risk of developing MRSA infections for years after being colonized with the bacteria.

26. Dr. Hull succinctly summarized his thought process and opinion thusly;

I believe because [Claimant] was a physician, because he was a physician caring for MRSA patients he was at increased risk of becoming colonized. And because [Claimant] was at increased risk of becoming colonized, he would be at increased risk of developing ... [MRSA] infections....

Depo. of Dr. Hull, p. 21, ll. 7 – 13.

Dr. Riedo

27. Defendants sought an independent evaluation and examination of Claimant from Francis Riedo, M.D., a Kirkland, Washington board-certified internist and infectious disease physician.

28. On June 24, 2015, Dr. Riedo examined Claimant. Thereafter, the doctor opined in a report of that date that Claimant had widely disseminated, incurable MRSA infections which would require suppressive antibiotics for the remainder of Claimant's life. Dr. Riedo did not believe it is possible to establish that Claimant's MRSA colonization or infection was acquired in the course of his work with Employer.[6] As stated in his report;

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[6] At the time the report was authored, Dr. Riedo believed Claimant had stopped working for Employer in October 2012, when in fact that is when Claimant began such employment. At his deposition, Dr. Riedo amended his statement, but again got Claimant's last date of employment wrong. Dr. Riedo testified as to his then-current understanding that Claimant's last day of work was in March 2013. In reality, Claimant worked for Employer until June 19, 2013 – two days after he was initially seen for his MRSA infection. Dr. Riedo's opinion was not based on Claimant's last work day, so his inaccuracy in this regard is not fatal to his opinion.

[Claimant] feels that he acquired MRSA colonization while working for [Employer], but unfortunately it is impossible to determine exactly when and where the colonization would have occurred.

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The duration of carriage can be as short as days or as long as years, and only under the most unusual circumstances can the acquisition be attributed to a single event.

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MRSA colonization can persist for years, as well as be lost and reacquired. In addition, careful hand hygiene and infection control should limit the acquisition of MRSA as well as carriage of any other bacteria while practicing medicine. In sum, I do not believe it is possible, on a more probable than not basis, to attribute [Claimant's] acquisition of MRSA colonization or MRSA infection to his employment at [Employer].

DE Ex. 4, p. 239.

29. Dr. Riedo was deposed. Much of his testimony concerned various studies which attempted to quantify the increased risk of carriage among health care workers compared to the general population. Many of Dr. Riedo's observations concerning the difficulties of attempting to make "one-size-fits-all" conclusions from these studies were illuminating. However, this case does not turn on whether health care workers are four times more likely, five times more likely, or just barely more likely to carry MRSA than the general public. (However, Dr. Riedo's criticism of the argument that health care workers are nearly twenty times more likely to carry MRSA when compared to the public is accurate. For the sake of this decision, it has already been assumed that health care workers are approximately four to five times more likely to carry colonized MRSA than the general population.)

30. Dr. Riedo also expounded on his opinion on causation. He testified on causation by noting;

> I'm not disputing that being a healthcare worker is a risk for being a MRSA carrier. I'm just saying that I don't think, on a more-probable-than-not basis, you can say it was [Claimant's] healthcare-working risk that led to his MRSA because he had multiple other variables that could contribute just as likely.

> And you can't do it based on time, because working in a clinic is not the same as having a surgical procedure. It's not the same as being a patient.
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> ***
>
> So, I mean there's – there's independent variables that I think really make it impossible to ascribe [Claimant's] acquisition of MRSA from his occupational risk as a healthcare worker.

Depo. of Dr. Riedo, p. 27, ll. 15-25, p.28, ll. 3-6.

31. The "independent variables" mentioned by Dr. Riedo are also the "risk factors" which applied to Claimant, and which, as argued by Dr. Riedo, complicated the analysis of why and how Claimant contracted disseminated MRSA.

Risk Factors

32. As noted previously, there are a number of factors which statistically increase one's chances of acquiring symptomatic MRSA. The categories which statistically increase the chance of acquiring an active MRSA infection and which apply to Claimant include;

- Health care worker;
- Health care patient;
- Age over 65;
- Pet owner;
- Diabetic;
- Multiple surgical procedures;
- Arthritis and artificial joints; and
- Liver abnormality.

33. The physicians disagree on some of these factors as being legitimate considerations in this case. Dr. Hull discounted the "pet owner" category, instead suggesting only

veterinarians and pig farmers would fit into this class. Further, he noted Claimant's cat was not sick, so it is unlikely it could be the MRSA culprit, even if it had scratched Claimant's right hand. Regarding Claimant's past surgeries and artificial joints, Dr. Hull and Dr. Souvenir found those to be too remote in time for serious consideration. Reduced immune system function due to liver abnormality was not discussed as a potential factor until Dr. Riedo's deposition. Claimant had only recently been diagnosed as diabetic, and was not taking insulin, so that factor was minimal. As Dr. Hull noted, both diabetics and people over age 65 are typically exposed to the health care system more than healthy younger people, and that fact might account for their increased MRSA risk.

34. Dr. Riedo felt individuals over age 65 were inherently at risk due to decreased immune systems and more abnormal bone and joint tissue. He also cited to the fact that animals can be MRSA carriers without symptoms, and can transmit the bacteria to humans without themselves having to be infected.

35. The only categories of increased risk in this case on which there was no disagreement was health care worker and health care patient.

Causation Analysis and Conclusion

36. Arguments in favor of causation include;

- MRSA is found at most hospitals and health care facilities.
- Sixty percent of health care facilities have at least some MRSA-colonized staff. The worst facilities have 50% or more of work staff carrying colonized MRSA.
- Claimant worked daily at a health care facility; therefore he had a high potential for exposure in his work environment.
- Claimant regularly treated MRSA-infected patients.
- Claimant's MRSA infection likely originated in his right hand, making MRSA infection from an old surgery or artificial joint unlikely.

37. Arguments against causation include;

- Claimant is a member of several high-risk for MRSA infection categories;

- MRSA can be found in and on numerous locations outside of health care facilities;

- Individuals often carry colonized MRSA for years before an infection. One study found the median duration of MRSA carriage was 3.5 years, and some carried the bacteria for greater than 4 years.

- Claimant worked for Employer for less than one year when he was infected with MRSA.

- Claimant was a regular patient at health care facilities and had regular phlebotomy appointments, as well as other periodic invasive procedures in the relevant time frame prior to his MRSA infection.

- Claimant can control his environment at work to minimize his exposure to MRSA but cannot control the environment when he is a patient at other health care facilities.

- Infection risk for patients of invasive procedures is greater than the infection risk of health care workers.

38. When all of the evidence is considered, on a more probable than not basis the Referee finds that Claimant's MRSA infection originated at or near Claimant's right hand, wrist, or arm. His right thumb joint was the first area of infection diagnosed and treated. He had lymphangitic streaking in the vicinity of his right forearm, indicating drainage of staphylococcal toxins through the lymphatic system in the region of the infection.

39. Claimant told his treating physician he had received a scratch from his cat. Claimant's medical assistant, Deborah Gutierrez, testified that Claimant had a scratch on his right hand, which she noticed not long before Claimant's MRSA infection. Notwithstanding Claimant's wife's testimony to the contrary, the evidence supports the fact that Claimant suffered a scratch on his right hand from his cat within the weeks preceding his MRSA infection.

40. It is possible, but not inevitable, that the MRSA bacteria could have entered Claimant's bloodstream through his right hand scratch. It is also possible Claimant could have had the bacteria introduced by his phlebotomist when he went for his quarterly blood withdrawal procedure. However, there is nothing in the record documenting which arm (assuming the blood was drawn from his arm) was used in the procedure. As such, it

would be speculation to assume such a scenario. On the record presented, there is only one likely source of infiltration of the MRSA bacteria – Claimant's right hand cat scratch.

41. Finding that the MRSA was introduced into Claimant's system through this scratch does not answer the question regarding the source of the bacteria. It could have come from the cat's nails. It could have been present as colonized MRSA, present at the site of the scratch for days, weeks, or years before the scratch. It could have been MRSA colonized and living anywhere on Claimant (for example, in his nose) and transferred by him to the wound site by Claimant touching the wound with contaminated hands (for example, after rubbing his nose). It could be that the MRSA was introduced directly from a patient, or Claimant's work environment, after the scratch took place but while the skin was still compromised.

42. If the MRSA which infected Claimant was introduced into the scratch by a patient of Employer, or Claimant's work environment, then clearly Claimant has proven causation. However, there is no direct evidence that such is the case.

43. If the MRSA came from the cat's nails, Claimant has argued the most likely source of the bacteria initially was Claimant, who transferred the MRSA he picked up at work to the cat, who then transferred it back with the scratch. Claimant cites to an instance of that very scenario in one of the articles he produced as an exhibit in this case. If that hypothesis is correct (and it would be speculation to assume it is), it still does not answer the question of when the cat was colonized in relation to when Claimant began working for Employer. Of course, the cat could also have acquired MRSA from a source independent from Claimant.

44. The final possibility is that Claimant was an active MRSA carrier at the time he was scratched, and the infection resulted from colonized MRSA entering his bloodstream at that time. This seems closest to the argument advanced by Claimant. However, Claimant assumes under his argument that the MRSA which colonized him came from his work with Employer. That proposition bears further scrutiny.

45. All the experts in this matter agree one can be colonized with MRSA for years prior to an infection. All the experts further agree that being in the health care industry is a risk factor for becoming a carrier for MRSA. Therefore, Claimant, as a physician in the health care industry, was at a greater risk than the general population for carrying MRSA. Because Claimant could come into contact with MRSA at any point in his medical career, which he has pursued since 1961, and once colonized, the bacteria could remain with Claimant for years prior to finding its way into his bloodstream, it is not axiomatic that Claimant's MRSA was acquired out of and in the course of his employment with

Employer. Even if it was certain, and it is not, that Claimant acquired MRSA from his work as a physician, that would not necessarily mean he acquired MRSA while working for Employer. Claimant could have been colonized with MRSA prior to October 2012, when he first went to work for Employer.

46. All of Claimant's expert testimony in this case has centered on the increased risk of colonization due to Claimant's occupation as a physician. No expert has credibly explained why Claimant could not have been colonized with MRSA while working as a physician prior to employment with Employer. While there is an increased risk of becoming colonized due to his profession, that risk existed prior to Claimant's most-recent employment. Claimant's employment for years prior to his MRSA infection included work as a hospitalist at various locations, work in a clinic, and at a hospice. All those assignments carry risk of MRSA colonization.

47. Claimant must prove causation. The weight of the evidence has shown that Claimant is at increased risk for MRSA colonization due to his profession, and that his infection began while working for Employer. However, those facts do not, by themselves, establish that Claimant's infection came about as a result of his employment with Employer. A temporal connection is insufficient to prove causation.

48. There is no evidence to suggest that Claimant was colonized with MRSA within eight months of his infection, to the exclusion of his former employment. (For example, there is no evidence that Claimant was checked for MRSA at the time he was employed by Employer, and found to be MRSA free.) Each of Claimant's past employments since 2009[7] carried the risk of colonization.

49. When all of the potential ways Claimant could have been infected and/or colonized with MRSA are considered, including;

- Claimant's employment with Employer;
- Claimant's previous employments at various hospitals and clinics;

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[7] 2009 is used because of the fact MRSA bacteria can remain colonized for years, and four years was suggested by one study. Claimant's work and patient status subjected him to increased risk of MRSA for years prior to 2009, but that year was used as the cut off as being a reasonable outer limit of time for carriage of the bacteria.

- Claimant's regular contact with the health care industry as a patient (undergoing invasive procedures);
- Introduction of the bacteria from any number of extra-employment activities;
- Cat scratch;
- 2010 shoulder surgery;
- 2009 ankle surgery; and perhaps
- Bilateral second metacarpophalangeal joint replacement surgery, depending on when that surgery took place;
- it can not be said that Claimant has produced evidence which establishes that it is more probable than not that he was colonized and infected with MRSA while working for Employer from October 2012 through June 2013. While certainly not all of the above-listed events are equally likely to have been the culprit for Claimant's MRSA infection, only one event – Claimant's employment with Employer – would allow Claimant to obtain compensation under Idaho's worker's compensation statutes.

50. The opinion of Dr. Riedo, that it is simply not possible to state from a medical and scientific base, that Claimant's MRSA infection resulted from his work with Employer, carries more weight than the opinions of Drs. Souvenir and Hull. The latter's opinions were based generally on Claimant's occupation, and did not address why Claimant's colonization could not have occurred prior to his most recent employment. Nor did they take into account Claimant's more recent surgeries; instead they merely discounted his more remote surgeries, such as his hip replacement surgery in 1990.

51. When the totality of the evidence, including expert witness testimony and related exhibits are considered, Claimant has failed to prove his MRSA infection was caused by his employment with Employer.

R, pp. 70-86.

II.

RESTATED ISSUE PRESENTED ON APPEAL

1. Whether the Commission's conclusion that Claimant has failed to prove his MRSA constitutes a compensable occupational disease is supported by substantial and competent evidence.

III.

STANDARD OF REVIEW

The Court may set aside an order or award by the Commission if: (1) the Commission's findings of fact are not based on any substantial competent evidence; (2) the Commission has acted without jurisdiction or in excess of its powers; (3) the findings of fact, order or award were procured by fraud; or (4) the findings of fact do not as a matter of law support the order or award. I.C. §72-732; *Ewins v. Allied Sec.*, 138 Idaho 343, 345-46, 63 P.3d 469, 471-472 (2003). The Court exercises free review over the Commission's legal conclusions but does not disturb factual findings that are supported by substantial and competent evidence. *Ewins*, 138 Idaho at 346, 63 P.3d at 472.

When hearing an appeal from a decision of the Idaho Industrial Commission, this Court must view the facts and all inferences therefore most favorably to the party who prevailed before the Commission. *Garcia v. J.R. Simplot Co.*, 115 Idaho 966, 969, 772 P.2d 173 (1989). When this Court reviews the Commission's factual findings, we must affirm if those findings are

supported by substantial and competent evidence. *Mapusaqa v. Red Lion Riverside Inn*, 113 Idaho 842, 748 P.2d 1372 (1987).

In addition, it is within the Commission's province to decide what weight should be given to the facts presented and conclusions drawn from those facts. The Commission's conclusions on the weight and credibility of the evidence should not be disturbed on appeal unless they are clearly erroneous. *Zapata v. J.R. Simplot Co.*, 132 Idaho 513, 515, 975 P.2d 1178, 1180 (1999).

Substantial evidence is more than a scintilla of proof, but less than a preponderance. It is relevant evidence that a reasonable mind might accept to support a conclusion. *Id.*

IV.

ARGUMENT

A. The Commission's conclusion that Claimant has failed to prove his MRSA infection constitutes a compensable occupational disease is supported by substantial competent evidence.

An occupational disease is one that is due to the nature of an employment in which the hazards of such disease actually exist, are characteristic of, and peculiar to the trade, occupation, process or employment. *See* Idaho Code § 72-102(22)(a). The terms "contracted" and "incurred," when referring to an occupational disease, are deemed to be the equivalent of "arising out of and in the course of employment". *See* Idaho Code § 72-102(22)(b). Under Idaho Code § 72-439, an employer cannot be held liable for an occupational disease unless such disease is actually "incurred" in that employment.

Claimant has the burden of proving, by a preponderance of the evidence, all facts essential to recovery to his claims. *Duncan v. Navajo Trucking,* 134 Idaho 202, 203, 998 P.2d 1115, 1116 (2000). Claimant, in pursuing an occupational disease claim, has the burden of proving, to a reasonable degree of medical probability, a causal connection between the condition for which compensation is claimed and occupational exposure to the substance or conditions which caused the alleged condition. *Watson v. Joslin Millwork, Inc.*, 149 Idaho 850, 855, 243 P.3d 666, 671 (2010). "Probable" is defined as "having more evidence for than against." *Fisher v. Bunker Hill Company*, 96 Idaho 341, 344, 528 P.2d 903, 906 (1974). In determining causation, it is the role of the Commission to determine credibility of witnesses, and to resolve conflicting interpretations of, and assign relative weight to, testimony. *See Rivas v. K.C. Logging*, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000).

The threshold issue properly considered by the Commission is whether Claimant has proven he contracted his disseminated MRSA infection arising out of and in the course of his employment as a physician with Employer.

The medical evidence primarily consisted of testimony and reports from three physicians: David Souvenir, M.D., Harry Hull, M.D., and Francis X. Riedo, M.D.

Dr. Souvenir was Claimant's primary infectious disease physician. Dr. Souvenir testified that it was difficult to assess where people acquire the MRSA bacteria. He did not know when or where Jobe acquired MRSA. Nevertheless, Dr. Souvenir felt it was more likely than not that Jobe

acquired MRSA "in the course and scope of his duties as a physician." Depo. of Souvenir, p. 24, ll. 15-20.

Dr. Hull does not actively practice medicine but has experience in infectious disease epidemiology. Since 2006 he has primarily consulted parties in litigation. Depo. of Hull, p. 21, l. 21 – p. 22, l. 23. Dr. Hull opined that since Jobe was a physician and had cared for MRSA patients he was at an increased risk of becoming colonized. Since he was at increased risk of becoming colonized, he would be at increased risk for developing MRSA. Depo. of Hull, p. 21, ll. 7-13.

Francis X. Riedo, M.D., Board Certified in Internal Medicine and Infectious Disease, has practiced clinical medicine and infectious disease since 1991. Depo. of Francis Riedo, M.D., p. 11, ll. 2-15. The functions he does include running an internal medicine clinic and as the medical director for infectious control program, employee health, pharmacy therapeutics and the microbiology lab at Evergreen Hospital, Kirkland, Washington. *Id.* He has been Assistant Professor at University of Washington School of Medicine since 1996. *Id.* at p. 12, ll. 3-6; Def. Ex. 6. Dr. Riedo spent time training with the CDC Epidemic Intelligence Service. Depo. of Dr. Riedo at p. 12, ll. 24-25. In Dr. Riedo's practice he has treated approximately 9,000 individuals in patient consultations and triple that number of outpatients with conditions from staph aureus and MRSA infections. *Id.* at p. 13, l. 23 – p. 14, l. 18.

Dr. Riedo evaluated Claimant. *Id.* at 20. That evaluation included extensive records review and physical evaluation. Dr. Riedo noted Claimant had fairly significant MRSA infection with huge complications. *Id.* at p. 20, ll. 23-25. Dr. Riedo testified:

> He was – he had infections, at one point, in his bloodstream, his aortic valve. He had an iliopsoas abscess, septic arthritis of his right wrist, right forearm. He had vertebral osteomyelitis at T6-T7 and at T9-T10. He had an iliacus muscle abscess with extension into the left prosthetic hip, a left shoulder infection. Just a variety of different foci of infection.
>
> I think part of the goal of seeing him and reviewing records was also to try to ascertain whether or not there was a risk factor associated with his occupation as a physician versus other risk factors that Dr. Jobe had that might predispose him to, initially, MRSA colonization and subsequently disseminated disease.

Id. at p. 21, ll. 1-15.

Dr. Riedo noted there are a number of risk factors for colonization of MRSA. Colonization can lead to dissemination. *Id.* at p. 22. ll. 4-6. Dr. Riedo testified that oftentimes people are colonized with MRSA bacteria before they develop invasive disease. *Id.* at 22/12-14. With regard to potential risk factors, Dr. Riedo described them:

> Participation in athletics, children less than two, injection drug users, military personnel, people in correctional facilities, residential homes, shelters, men who have sex with men, pet owners, veterinarians, pig farmers, adults over 65, blacks, if you have a recent illness or pneumonia, any sort of concurrent skin or soft tissue infection, a history of colonization or contact with somebody who could be colonized, healthcare workers, people recently hospitalized or in nursing homes. And I think I added a couple of other groups. Diabetics. And I'm sure I've missed one or two.
>
> But there's a – sort of a long list of individuals who have been identified as – as being at increased risk for MRSA colonization either by virtue of who they are, over 65 or diabetic, or people with chronic skin conditions, or who they're

> associating with, whether it's athletes, prisons, jails, military personnel, living in close quarters with other individuals.

Id. p. 22, l. 21 – p. 23, l. 15.

As to whether Dr. Riedo could develop an opinion as to whether Claimant's MRSA condition was connected to employment, he testified, "there's independent variables that I think really make it impossible to ascribe his acquisition of MRSA from his occupational risk as a healthcare worker." *Id.* at p. 28, ll. 3-6. Claimant had a great number and variety of risk factors that would increase his risk for being a MRSA carrier. Claimant is over 65, he had exposure to animals, he had multiple surgical procedures and injections over the years, and he had exposure not as a health care worker but as a health care recipient. He was going in regularly to the medical system to be phlebotomized because of his hemochromatosis.[1] *Id.* at p. 26, l. 23 – p. 27, l. 5. Claimant summarized, "And then it was just a question of time. You know, if you say that carriage state is a – is a common prerequisite to developing a basic disease, you know, it's a matter of time before there's a breach in the skin and you disseminate." *Id.* at p. 26, ll. 18-22.

Dr. Riedo testified that the duration of carriage of MRSA from studies done is around nine months. He testified:

> So let me back up. He could have been colonized for three weeks before that or four weeks before that, or he could have been colonized for the previous five years. There's no way to know, not unless you're doing swabs. There's no way to know. MRSA carriage is asymptomatic, by definition.

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1 Hemochromatosis is a disorder due to disposition of hemosiderin in the pareischymal cells, causing tissue damage, and dysfunction of the liver, pancreas, heart and pituitary. *Dorland's Illustrated Medical Dictionary* 27th Ed. (1988). It is commonly described as a build-up of iron in the blood.

Id. at p. 31, ll. 15-20. As to the timeframe of MRSA dissemination or infection, Dr. Riedo testified it is variable from a few days to probably a month or so at the onset. *Id.* at p. 32, ll. 12-16. Dr. Riedo described the process of colonization to dissemination specifically:

> Once you penetrate that barrier, once you disseminate that infection, the manifestations really depend on a number of things, where – where it happens. So if you inoculate the skin, you're probably going to have an abscess there within three to seven days. You know, that's the typical evolution from inoculation to a boil. You have to have a critical mass, white cells have to come in, and you develop a pus pocket.
>
> But you can get onto a heart valve, and typically within two weeks, three weeks, there's enough bacteria floating off that valve that will make you systemically ill. If you get into a closed space, for example, a joint, the pain will oftentimes drive you in for medical attention before.

Id. at p. 31, l. 21 – p. 32, l. 11.

Dr. Riedo opined that there were no events that happened and he could find nothing connected with Claimant's employment that disseminated the MRSA. *Id.* at p. 32, l. 17 – p. 33, l. 1. As such Dr. Riedo's conclusion is it is not possible to attribute the acquisition of Claimant's MRSA colonization to his clinical work, as opposed to his exposure to the health care system as a patient, his exposure to animals, or to his age. Def. Ex. 7 at 255. Likewise, it is not possible to attribute Claimant's MRSA infection to his employment at Dirne Health Clinic. Def. Ex. 4 at 239.

Based upon expert testimony, the Commission thoroughly examined the evidence and determined which medical opinion was more persuasive. It concluded based upon the totality of the evidence that Dr. Riedo's opinions were more persuasive and that Claimant had failed to

carry his burden of proof on medical causation. The facts set forth in the record are voluminous. The Commission's reliance on finding Dr. Riedo's testimony and opinions more credible is based upon substantial credible evidence.

B. Appellant's issue framed as whether the Commission erred is a matter of law in requiring Claimant to prove both MRSA colonization and MRSA infection is a misstatement of applicable law.

The Commission properly relied on the standard this Court has adopted. Claimant in pursuing an occupational disease claim, has the burden of proving to a reasonable degree of medical probability a causal connection between the condition for which compensation is claimed and occupational exposure to the substance or conditions which caused the alleged condition. *Watson v. Jocelyn Millwork, Inc.*, 149 Idaho 850, 855, 243 P.3d 666, 661 (2010). The Commission made a detailed analysis of the prevalence, epidemiology and methods of contraction of MRSA. It noted certain populations have a greater risk of exposure to MRSA because without exposure an infection cannot be contracted.

Any determination of causation carries an analysis of a number of possible factors which can lead to a conclusion. The Commission has discretion in choosing to place more credibility upon one expert. *Id.* at 857. Here the Commission properly considered there are numerous risk factors for Jobe regarding exposure to MRSA. Dr. Riedo noted MRSA is ubiquitous. Once there is exposure from any source, for MRSA to become an infection it needs to be disseminated which more often than not is through a cut or wound in the skin. Here Claimant offered no

evidence on how Jobe's MRSA became disseminated or how it was incurred. Claimant's argument is that it must have been incurred at work because people who work in the health care industry are at higher risk of exposure to MRSA. All physicians testified that medical personnel and in particular physicians are aware of infectious disease risks and take recognized precautions based upon their expert knowledge in medical fields.

V

CONCLUSION

The Industrial Commission findings are based upon substantial and competent evidence.

The Appellant asks the Supreme Court to re-weigh the evidence.

The Industrial Commission did not abuse its discretion.

The Industrial Commission orders must be affirmed.

RESPECTFULLY SUBMITTED this 28 day of March, 2017.

H. JAMES MAGNUSON
Attorney for Respondents

AFFIDAVIT OF MAILING

STATE OF IDAHO)
)ss.
County of Kootenai)

H. JAMES MAGNUSON, being first duly sworn on oath, deposes and states as follows:

That I am and at all times hereinafter mentioned was a citizen of the United States and a resident of the State of Idaho, over the age of 21 years, and not a party to this action; that I served the RESPONDENTS' BRIEF in the above-entitled action upon the attorney for the Claimant/Appellant in the above matter as follows:

Stephen J. Nemec
James, Vernon & Weeks, P.A.
1626 Lincoln Way
Coeur d'Alene, ID 83814

by depositing in the United States mail, with postage prepaid, two true copies of said Respondents' Brief on the 28 day of March, 2017, addressed to said attorney as hereinabove set forth.

Further, on said date, the original and seven copies of said Respondents' Brief were sent via prepaid Federal Express, addressed to:

Mr. Stephen W. Kenyon
Clerk of the Supreme Court
451 W. State Street
P. O. Box 83720
Boise, ID 83720-0101

SUBSCRIBED AND SWORN to before me this 28 day of March, 2017.

Stephanie Belden
Notary Public for the State of Idaho
Residing in Coeur d'Alene
Commission Expires 3/8/2022

STEPHANIE BELDEN
NOTARY PUBLIC
STATE OF IDAHO