BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RICHARD JOBE, Claimant, v. DIRNE CLINIC/HERITAGE HEALTH, Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-014091** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** Filed September 23, 2016

INTRODUCTION

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Brian Harper, who conducted a hearing in Coeur D'Alene, Idaho, on March 4, 2016. Claimant was represented by Stephen Nemec, of Coeur D'Alene. James Magnuson, of Coeur D'Alene, represented Dirne Clinic/Heritage Health ("Employer") and Idaho State Insurance Fund ("Surety"), Defendants. Oral and documentary evidence was admitted. Post-hearing depositions were taken and the parties submitted post-hearing briefs[1]. The matter came under advisement on August 11, 2016.

[1] Neither party complied with JRP 11A in spacing and/or margin requirements. However, no objections were raised, and neither party used their full thirty-page allotment in their briefing. The briefs are accepted as written, although all counsel practicing under the JRP should keep in mind the formatting requirements when preparing their briefing.

ISSUES

The issues to be decided are[2]:

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.

CONTENTIONS OF THE PARTIES

Claimant, a physician, asserts he contracted disseminated MRSA out of and in the course of his employment with Employer. The infection spread throughout his body, causing numerous and severe complications, and rendering him totally and permanently disabled. Claimant is entitled to all applicable benefits.

Defendants argue Claimant did not prove causation. Furthermore, he failed to comply with the notice and filing requirements of Idaho Code § 72-448. Defendants owe Claimant no benefits. Alternatively, should Claimant's disease be found compensable, Defendants would only be liable for payment of benefits after the date of manifestation.

[2] While the issue of notice under Idaho Code § 72-701 *et seq.* was listed in the Notice of Hearing, this case does not involve a claim of accident, neither party argued for or against the application of these statutes, and the matter is deemed inapplicable to the facts of this case. Also, the parties stipulated that Claimant is entitled to the maximum benefits available under Title 72 for purposes of AWW calculations if he proves a compensable occupational disease. Finally, the parties listed the issue of whether the occupational exposure actually occurred at the time claimed, but neither party specifically addressed this as a separate issue. Rather, it was subsumed into the parties' arguments on timely notice and filing.

EVIDENCE CONSIDERED

The record in this matter consists of the following:

1. The hearing testimony of Claimant's wife, Idalla Jobe, and his son, Brian Jobe, taken at hearing;

2. Claimant's Exhibits (CE) A through Z and AA, admitted at hearing;

3. Defendants' Exhibits (DE) 1 through 7, admitted at hearing, with the exception of pages 13 through 16 and 69 through 74 of DE 1, which were objected to, and which objection is hereby sustained;

4. The post-hearing deposition transcript of David Souvenir, M.D., taken on March 25, 2016;

5. The post-hearing deposition transcript of Harry Hull, M.D., taken on April 29, 2016;

6. The post-hearing deposition transcript of John McNulty, M.D., taken on May 23, 2016;

7. The post-hearing deposition transcript of Mr. Fred Cutler, taken on May 26, 2016; and

8. The post-hearing deposition transcript of Francis Riedo, M.D., taken on June 3, 2016.

Objections

Defendants' objection to Dr. McNulty's testimony totalling Claimant's various impairments is overruled in that the testimony is simply a mathematical exercise using combining tables available to anyone. Defendants' objections to opinion testimony

of Dr. McNulty on page 15, l. 6 and ll. 13 through 21 are sustained in that they go beyond information provided in discovery, and Dr. McNulty's written report, CE S.

Claimant's objection to the admission of Defendants' proposed Exhibits 4 to Dr. Riedo's deposition – a study of the prevalence of MRSA carriage in healthcare workers in non-outbreak settings –is sustained. The motion to strike Dr. Riedo's testimony concerning the study is overruled. While the document is not admissible due to Defendants' failure to provide it in discovery and/or disclose it in "Rule 10" disclosures, the doctor may discuss the study in his oral testimony, as it was referenced previously in his written report.

Having considered the evidence and briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

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 pre-existing 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

[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.

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.

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.

DISCUSSION AND FURTHER FINDINGS

Causation

9. 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 for 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.

10. 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 P3d 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. Loggin*g, 134 Idaho 603, 608, 7 P.3d 212, 217 (2000).

11. The threshold issue 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. To analyze this question it is important to briefly consider some MRSA background.

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]

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,

[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.

[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.

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.

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;

> [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.
>
> ***
>
> 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.
>
> ***
>
> 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

[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.

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.
>
> ***
>
> 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 can not 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;
- 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

[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.

- 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.

Remaining Issues

52. The noticed issues of Claimant's entitlement to medical care, temporary disability, permanent partial impairment, and permanent disability benefits, the applicability of *Neel* decision to reimbursement of medical bills, as well as whether Claimant is totally and permanently disabled, are rendered moot by the Claimant's failure to prove causation.

53. Claimant has failed to prove an entitlement to attorney fees under Idaho Code § 72-804. Defendants did none of the prohibited activities under that statute, and did not act unreasonably under the circumstances.

CONCLUSIONS OF LAW

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.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Referee recommends that the Commission adopt such findings and conclusions as its own and issue an appropriate final order.

DATED this 7th day of September, 2016.

INDUSTRIAL COMMISSION

/s/
Brian Harper, Referee

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of September, 2016, a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon each of the following:

STEPHEN NEMEC
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/s/

jsk

BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO

RICHARD JOBE, Claimant, v. DIRNE CLINIC/HERITAGE HEALTH, Employer, and IDAHO STATE INSURANCE FUND, Surety, Defendants.	**IC 2014-014091** **ORDER** Filed September 23, 2016

Pursuant to Idaho Code § 72-717, Referee Brian Harper submitted the record in the above-entitled matter, together with his recommended findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendations of the Referee. The Commission concurs with these recommendations. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

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.

DATED this 23rd day of September, 2016.

INDUSTRIAL COMMISSION

/s/
R.D. Maynard, Chairman

/s/
Thomas E. Limbaugh, Commissioner

/s/
Thomas P. Baskin, Commissioner

ATTEST:

/s/
Assistant Commission Secretary

CERTIFICATE OF SERVICE

I hereby certify that on the 23rd day of September, 2016, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following:

STEPHEN NEMEC
1626 LINCOLN WAY
COEUR D ALENE ID 83814

JAMES MAGNUSON
PO BOX 2288
COEUR D ALENE ID 83816

/s/

jsk