

FINAL AWARD DENYING COMPENSATION
(Affirming Award and Decision of Administrative Law Judge
by Separate Opinion)

Injury No.: 05-140833

Employee: Stephen Smith, deceased
Substituted Claimant: Dorothy Smith
Employer: Capital Region Medical Center
Insurer: Self-Insured

This workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. We have read the briefs, heard the parties' arguments, reviewed the evidence, and considered the whole record. Pursuant to § 286.090 RSMo, we affirm the award and decision of the administrative law judge with this separate opinion.

Introduction

The parties stipulated the following issues for determination by the administrative law judge: (1) whether employee sustained an accident or occupational disease arising out of and in the course of his employment with employer on or about April 20, 2005; (2) whether the accident or occupational disease was a substantial factor in the cause of employee's death; (3) whether the claim for compensation is barred by § 287.430; (4) whether the claim for compensation is barred by § 287.420; (5) employer's liability for employee's past medical bills; (6) employee's entitlement to temporary total disability benefits; (7) dependency under § 287.240; (8) employer's liability for burial expenses; and (9) employer's liability for death benefits.

The administrative law judge denied the claim for compensation on a finding that employee did not sustain an accident or occupational disease arising out of and in the course of his employment with employer.

Claimant filed a timely Application for Review arguing the administrative law judge erred in failing to apply the law referable to occupational diseases as set forth in the case of *Vickers v. Mo. Dep't of Pub. Safety*, 283 S.W.3d 287 (Mo. App. 2009).

Employer also filed a timely Application for Review arguing the administrative law judge erred: (1) in analyzing this case as an occupational disease instead of an accident; (2) in analyzing this case under the pre-2005 version of the Missouri Workers' Compensation Law; and (3) in failing to issue findings of fact and conclusions of law as to the issues of statute of limitations and notice.

For the reasons set forth herein, we deny the claim for compensation.

Findings of Fact

From 1969 to 2006, employee worked in employer's hospital as a lab technician and phlebotomist. Employee's work involved handling blood and other bodily fluids and

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performing various medical tests and procedures. Employee worked for employer for a number of years before the implementation of safety measures which are commonplace today. For example, lab technicians worked without gloves or safety goggles and pipetted blood samples using their mouths. The latter process involved the lab technician placing a graduated glass pipe into their mouth and sucking a blood sample into the lower portion of the pipe.

Some of employee's coworkers experienced "needle sticks" (the act of accidentally stabbing oneself with a needle contaminated with blood or body products while attempting to replace the cap on a syringe). Claimant, who also worked for employer as a nurse, once got blood in her mouth while pipetting blood. It was not mandatory to report needle sticks to the employer until sometime in the 1980s or 1990s, when new scientific awareness as to the dangers of blood-borne pathogens prompted changes in workplace safety protocols in the lab where employee worked. None of the witnesses who testified were able to pinpoint exactly when these changes occurred, but they included the requirement that lab technicians wear gloves, the use of a rubber pump to pipette blood, and a new approach to handling and disposing of syringes that obviated the need for a technician to attempt to replace the cap on a used syringe.

In 1970, employee received a 6-unit blood transfusion following a hunting accident in which he was shot in the leg.

Employee sought medical treatment in December 1991 with complaints of severe epigastric pain. Blood tests revealed elevated liver enzymes and marked diffuse hepatocellular dysfunction. At least one treating doctor diagnosed hepatitis during the course of employee's hospitalization in 1991; the infection was later confirmed as hepatitis type C (hereinafter "HCV"). On April 20, 2005, claimant brought employee to the emergency room after he suffered a cognitive breakdown caused by hepatic encephalopathy. Employee continued to try to work full-time for employer after this event. Ultimately, though, due to health problems associated with liver failure, employee was unable to work after March 2006. Employee died on February 27, 2007, of sepsis, HCV, and acute tubular necrosis.

There is no evidence that any patient with HCV received treatment with employer or provided a blood or body tissue sample while employee worked there.

Expert medical testimony

The parties have provided competing expert medical evidence on the issue of causation of employee's HCV. Employee presents the testimony of Dr. Allen Parmet, who believes employee's work for employer was the likely cause of his contracting HCV. Dr. Parmet pointed out that employee worked for employer for many years handling blood and body products before the health care industry began to pay attention to the safety risks posed by blood-borne pathogens in the mid-1980s. Dr. Parmet identified the risk of blood splashing into employee's eyes, nose, and mouth and opined that needle sticks are a very significant risk factor for all phlebotomists and laboratory personnel. Dr. Parmet testified that employee reported multiple needle sticks to him.

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Dr. Parmet acknowledged that employee's receiving a blood transfusion in 1970 was a major risk factor, but ultimately opined that employee's work for employer and his daily exposure to blood and body products for many years was the largest risk factor and the most probable source causing employee to contract HCV, either through a needle stick or otherwise handling blood or body products.

Employer presents the testimony of Dr. Bruce Bacon, who believes the likely scenario is that employee contracted HCV when he got the 1970 blood transfusion and developed chronic liver disease by the time he was hospitalized in 1991. Dr. Bacon opined that it usually takes 20 or even 30 years after the initial infection with HCV to develop liver failure, and thus, the idea that employee contracted HCV from the 1970 blood transfusion fits well with the established timeline of employee's experiencing symptoms of chronic liver problems in 1991 and cirrhosis by 2004.

Dr. Bacon did not rule out employee's work as a risk factor, but opined that it is hard to implicate employee's work as a possible cause of his infection with HCV in the absence of documentation that he experienced any needle sticks.

Conclusions of Law

Date of injury and 2005 amendments

The appropriate date of injury is a threshold consideration in this matter, as it controls whether we apply the 2005 amendments to the Missouri Workers' Compensation Law to the facts of this case. See *Tillman v. Cam's Trucking, Inc.*, 20 S.W.3d 579, 585-86 (Mo. App. 2000). Employer argues that the 2005 amendments are applicable to this claim because employee was able to work up until March 2006. Claimant, on the other hand, argues the appropriate date of injury is April 20, 2005, the date she had to rush employee to the emergency room when he suffered a cognitive breakdown caused by hepatic encephalopathy.

A review of the relevant case law reveals that the courts have consistently linked the "date of injury" in occupational disease cases to the date the disease first becomes "compensable," which typically has been interpreted to mean the date an employee first experiences some disability or loss of earning capacity from the disease. See *Garrone v. Treasurer of State*, 157 S.W.3d 237, 242 (Mo. App. 2004) (holding that an employee's carpal tunnel syndrome did not become a "compensable injury" until the date he missed work for surgery, as he worked without restriction up until that date), and *Coloney v. Accurate Superior Scale Co.*, 952 S.W.2d 755, 759 (Mo. App. 1997) (noting that "Missouri courts have interpreted section 287.063 to provide that an employee with an occupational disease is 'injured' ... when the disease causes a 'compensable injury'").

Employer's argument asks us to focus on the last date employee worked for employer before health problems forced him to leave his position. But we are concerned here with determining the date employee first experienced some disability referable to the claimed injury, not the date that employee became unable to work at all. The claimed injury is liver failure resulting from employee's infection with HCV. The treatment note from

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employee's visit to the emergency room on April 20, 2005, does reveal considerable cognitive disability (or encephalopathy) referable to liver failure, and also reveals that treating physicians hospitalized employee in the intensive care unit in order to provide further treatments and perform diagnostic tests. Ultimately, we are more persuaded by the argument advanced by claimant that employee experienced some disability related to the claimed injury when he suffered a cognitive breakdown on April 20, 2005, and was subsequently hospitalized.

Accordingly, we find the appropriate date of injury to be April 20, 2005. As a result, we will apply the Missouri Workers' Compensation Law as it existed on April 20, 2005.

Occupational disease

Claimant argues that employee's contracting HCV and suffering subsequent liver failure constituted an injury by occupational disease caused by his work for employer. Section 287.067.2 RSMo sets forth the standard for a compensable occupational disease and provides, as follows:

An occupational disease is compensable if it is clearly work related and meets the requirements of an injury which is compensable as provided in subsections 2 and 3 of section 287.020. An occupational disease is not compensable merely because work was a triggering or precipitating factor.

The foregoing refers us to the "requirements of an injury which is compensable" under subsections 2 and 3 of § 287.020, which provide, as follows:

2. The word "accident" as used in this chapter shall, unless a different meaning is clearly indicated by the context, be construed to mean an unexpected or unforeseen identifiable event or series of events happening suddenly and violently, with or without human fault, and producing at the time objective symptoms of an injury. An injury is compensable if it is clearly work related. An injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor.

3. (1) In this chapter the term "injury" is hereby defined to be an injury which has arisen out of and in the course of employment. The injury must be incidental to and not independent of the relation of employer and employee. Ordinary, gradual deterioration or progressive degeneration of the body caused by aging shall not be compensable, except where the deterioration or degeneration follows as an incident of employment.

(2) An injury shall be deemed to arise out of and in the course of the employment only if:

(a) It is reasonably apparent, upon consideration of all the circumstances,

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that the employment is a substantial factor in causing the injury; and

(b) It can be seen to have followed as a natural incident of the work; and

(c) It can be fairly traced to the employment as a proximate cause; and

(d) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal nonemployment life;

(3) The terms "injury" and "personal injuries" shall mean violence to the physical structure of the body and to the personal property which is used to make up the physical structure of the body, such as artificial dentures, artificial limbs, glass eyes, eyeglasses, and other prostheses which are placed in or on the body to replace the physical structure and such disease or infection as naturally results therefrom. These terms shall in no case except as specifically provided in this chapter be construed to include occupational disease in any form, nor shall they be construed to include any contagious or infectious disease contracted during the course of the employment, nor shall they include death due to natural causes occurring while the worker is at work.

The courts have provided guidance as to how we are to analyze the question of causation in an occupational disease case:

In order to support a finding of occupational disease, employee must provide substantial and competent evidence that he/she has contracted an occupationally induced disease rather than an ordinary disease of life. The inquiry involves two considerations: (1) whether there was an exposure to the disease which was greater than or different from that which affects the public generally, and (2) whether there was a recognizable link between the disease and some distinctive feature of the employee's job which is common to all jobs of that sort.

Claimant must also establish, generally through expert testimony, the probability that the claimed occupational disease was caused by conditions in the work place. Claimant must prove "a direct causal connection between the conditions under which the work is performed and the occupational disease." However, such conditions need not be the sole cause of the occupational disease, so long as they are a major contributing factor to the disease. A single medical opinion will support a finding of compensability even where the causes of the disease are indeterminate...

Kelley v. Banta & Stude Constr. Co., 1 S.W.3d 43, 48-9 (Mo. App. 1999).

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The administrative law judge declined to apply the foregoing test and instead characterized this case as presenting a choice between two possible risk factors: (1) employee's work and (2) his receipt of a blood transfusion in 1970, and asked whether employee's work was "more likely than not" to have caused his HCV in light of the evidence regarding the blood transfusion. But the question is not which of two possible causative factors we believe was more likely to have caused employee to contract HCV, but rather whether claimant met her burden of proving the elements identified by the court in the foregoing quote from *Kelley*.

When we apply the *Kelley* test for proving causation of an occupational disease, we are convinced the claimant failed to meet her burden. Our analysis is informed by the recent and factually similar case of *Vickers v. Mo. Dep't of Pub. Safety*, 283 S.W.3d 287 (Mo. App. 2009). In *Vickers*, the employee claimed to have been injured by an exposure to clostridium difficile (or "C diff," a contagious bacterium passed via a fecal to oral route) through her work handling soiled laundry in employer's nursing home. *Id.* at 289. The court noted the employee proved, by undisputed evidence that she worked for employer while patients who were carrying C diff resided in the home. *Id.* at 292. She also proved, by undisputed evidence, that she handled soiled laundry and that the laundry from the patients with C diff was not segregated from the other laundry. *Id.* at 293. The court found that when such undisputed evidence was combined with a doctor's opinion that employee more likely than not contracted C diff while working for employer, employee met her burden. *Id.* at 295-6.

This case involves a fundamental distinction when compared to the factual situation in *Vickers*. Here, there is no evidence that any person with HCV resided or treated in employer's facility while employee worked there. Nor is there evidence that any person with HCV provided a blood or tissue sample that was handled in the lab where employee worked. Claimant adduced testimony from Susan Hill (a coworker of employee), Dorsey Shackelford (employee's supervisor), and also provided her own testimony about her time working for employer. None of these witnesses testified that any patient with HCV resided in the hospital or received treatment from employer while employee worked there, or that any such patient provided a blood or tissue sample that was handled in the lab where employee worked.

Employee did work for employer for many years (from 1969 until 2006) and so it would certainly *seem* that one or more patients with HCV must have, at some point, treated at the hospital. But we cannot speculate as to these pivotal facts, nor can we fill in the gaps in the evidence with our own conjecture. As it stands, we are faced with a claim for occupational disease where there is no evidence that the disease was ever present in the workplace. We conclude that, absent such evidence, the case for exposure fails.

This is not the only problem with employee's case, however. Employee's expert, Dr. Allen Parmet, offered a causation opinion that depends, for the most part, upon what he considers to be a likely timeline of events from employee's exposure to HCV to his developing liver damage. Dr. Parmet testified that he didn't believe the 1970 blood transfusion was likely to be the cause of employee's HCV because employee did not develop cirrhosis until 2002 or 2004. This was more than 30 years after the transfusion;

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Dr. Parmet believes that 15 years is the average time that most people, after contracting HCV, develop liver damage and related symptoms.

On cross-examination, counsel for employer asked Dr. Parmet about the medical records from employee's hospitalization in 1991. Dr. Parmet characterized these records as showing the onset of an "acute phase" of HCV infection, which he described as involving flu-like symptoms. Dr. Parmet opined this acute phase usually occurs six weeks after the initial HCV infection, and reasoned that employee was probably exposed to HCV about six weeks before the 1991 hospitalization. But the records do not suggest flu-like symptoms at all but instead reveal that employee sought treatment due to complaints of severe epigastric pain. And the records unmistakably reveal evidence of liver damage in that the treating physicians identify and diagnose marked diffuse hepatocellular dysfunction. Dr. Parmet failed to address these findings.

Counsel for employer also asked Dr. Parmet about lab tests during that same hospitalization that demonstrated that employee had elevated liver enzymes. Dr. Parmet appeared to be unable to explain why this was not evidence of liver damage in 1991. Instead, Dr. Parmet noted that if a person drinks about six beers, they will have elevated liver enzymes. This odd testimony suggests one of two possibilities: either Dr. Parmet asks us to assume that employee drank a lot of alcohol before he went to the hospital in 1991, or Dr. Parmet was essentially admitting that his timeline neither conforms to the evidence nor provides a reason to discount the 1970 blood transfusion. The medical records, at least, do not contain any suggestion that employee was drinking excessive amounts of alcohol at the time of his 1991 hospitalization.

Dr. Bruce Bacon, on the other hand, did not ignore or downplay the evidence of elevated liver enzymes in the medical records from employee's 1991 hospitalization. Rather, Dr. Bacon noted that employee was showing signs of chronic liver failure at that time, and reasoned that the typical 20-year latency period for HCV corresponds to the 1970 blood transfusion. Dr. Bacon also noted that there was no actual evidence of employee having been exposed to HCV in his work, as there is no documentation of employee ever having been stuck with a needle—contaminated or otherwise.

Ultimately, we find Dr. Bacon's opinion that employee demonstrated signs of chronic liver failure in 1991 to be more credible than Dr. Parmet's view that employee was suffering the effects of an acute reaction to HCV. Because Dr. Parmet evidently misinterpreted or disregarded the medical record, we find his causation opinion lacking credibility. In light of the failure to provide evidence that employee was exposed to HCV in the workplace, and because Dr. Parmet's causation opinion depends on a timeline that turns a blind eye to the medical records, we conclude that claimant failed to meet her burden of proof.

We conclude that employee's HCV was not an occupational disease for purposes of § 287.067 RSMo. We affirm the award of the administrative law judge denying compensation with this separate opinion.

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Conclusion

Based on the foregoing, the Commission concludes and determines that claimant failed to demonstrate that employee's work for employer exposed him to HCV or that there was a direct causal connection between HCV and the conditions in which he performed his work. Accordingly, claimant has failed to demonstrate employee sustained a compensable injury by occupational disease.

The claim for compensation is denied.

The award and decision of Chief Administrative Law Judge Robert J. Dierkes, issued February 18, 2011, is attached solely for reference.

Given at Jefferson City, State of Missouri, this 16th day of March 2012.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

James Avery, Member

DISSENTING OPINION FILED

Curtis E. Chick, Jr., Member

Attest:

Secretary

Employee: Stephen Smith, deceased

DISSENTING OPINION

I have reviewed and considered all of the competent and substantial evidence on the whole record. Based on my review of the evidence as well as my consideration of the relevant provisions of the Missouri Workers' Compensation Law, I believe the decision of the administrative law judge should be reversed.

I am convinced the majority misreads *Vickers v. Mo. Dep't of Pub. Safety*, 283 S.W.3d 287 (Mo. App. 2009). In that case, the court reversed a credibility determination by this Commission and found that employee met her burden of proving she sustained an occupational disease when she provided "medical evidence establishing a *probability* that working conditions caused the disease." *Id.* at 295 (emphasis in original) (citation omitted). After carefully and thoroughly considering the meaning of the court's holding in *Vickers*, I am convinced the testimony from Dr. Parmet establishes a probability that employee's working conditions caused his HCV. I am further persuaded that the testimony from Dr. Bacon does not, as a matter of law, provide any basis for denying compensation, and that as a result, claimant ultimately met her burden of proof.

The medical evidence presently before us is strikingly similar to that provided by the parties in the *Vickers* case. In *Vickers*, the employee provided testimony from a doctor who opined that her work duties of handling laundry soiled with human fecal matter on a daily basis put her at a higher risk of C diff exposure and that she more likely than not contracted C diff at employer's facility. *Id.* at 293. The employer, on the other hand, provided a doctor who opined that, because there was no specific documentation that employee was exposed to or came into contact with feces from a C diff infected patient, he could not say with certainty when the employee acquired C diff or whether it was acquired from her work environment. *Id.* at 294. The court reversed this Commission's determination crediting the employer's doctor and finding the employee's doctor lacking credibility. *Id.* at 295. The court stated unequivocally that the employee in *Vickers* had met her burden, and pointed out that "Chapter 287 does not require a claimant to establish, by a *medical certainty*, that his or her injury was caused by an occupational disease in order to be eligible for compensation." *Id.* at 295 (emphasis in original).

Here, Dr. Parmet provided testimony on behalf of employee that established (1) that employee's work involving more than 30 years of daily exposure to blood and body products put him at a higher risk of contracting HCV than that faced by the general public, and (2) that there is a recognizable link between HCV and needle sticks or blood splashes which are distinctive features of employee's job that are common to all jobs of that type. Finally, Dr. Parmet provided his expert opinion that employee's work for employer was the largest risk factor and the most probable source for his contracting HCV—thus establishing the probability that the claimed occupational disease was caused by conditions in the workplace. In this way, claimant met each of the elements of the test (quoted in the majority's opinion) for causation set forth in *Kelley v. Banta & Stude Constr. Co.*, 1 S.W.3d 43, 48-9 (Mo. App. 1999). I turn now to the opinion provided by Dr. Bacon.

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Dr. Bacon, like the employer's doctor in *Vickers*, does not purport to rule out employee's work as a risk factor, but instead rests his opinion on the fact that "it is hard to implicate" employee's work as a possible cause of his infection with HCV, because "there is no documentation that there ever were any needle sticks or blood exposures." *Transcript*, page 974. Dr. Bacon thus appears to believe that documentation of a specific exposing event is necessary before we can implicate employee's work as a causative factor. Based on this testimony from Dr. Bacon, employer argues that claimant needed to show evidence of a specific needle stick or otherwise identifiable event wherein employee was exposed to HCV.

Employer's argument ignores the holding of the *Vickers* court rejecting such a proposition. The *Vickers* court made clear that such evidence is not necessary in the context of occupational disease—and in fact, specifically identified and reversed a finding by this Commission holding that the employee "needed to prove that she was in fact exposed to C diff while working for employer and not merely show that she potentially had a greater risk of exposure." *Id.* at 290. I am convinced that if the decision is properly read, the *Vickers* holding has the effect that Dr. Bacon's opinion is insufficient, as a matter of law, to rebut the evidence from Dr. Parmet that establishes each of the elements of causation.

Nor do I find the "timeline" argument—that employee demonstrated symptoms of liver failure about 20 years after the 1970 transfusion—persuasive. This is yet another attempt to draw the discussion away from the established analysis for occupational disease and into an inappropriate attempt to identify the "actual" cause of employee's HCV. This argument does not even provide a reason to credit Dr. Bacon over Dr. Parmet because employee was working for employer as early as 1969, and if he contracted HCV at work at that time, he would demonstrate the same "timeline" as employer argues supports its theory.

Ultimately, when I apply the well-established law relating to the elements of proving causation in the context of occupational disease, and when I consider the meaning of the holding in *Vickers*, I find the testimony from Dr. Bacon unhelpful and ultimately ineffectual in rebutting the evidence from Dr. Parmet. I credit Dr. Parmet's testimony establishing each of the elements of the claim.

I conclude that employee's HCV constituted an injury by occupational disease arising out of and in the course of his work for employer. Because I am convinced that claimant prevailed on the other disputed issues, I am convinced she met her burden of demonstrating her entitlement to compensation from employer for employee's past medical expenses, temporary total disability benefits, and burial and death benefits. I would reverse the award of the administrative law judge and enter an award of benefits.

Because the majority of the Commission has determined otherwise, I respectfully dissent.

Curtis E. Chick, Jr., Member

AWARD

Employee: Stephen Smith (Deceased)

Injury No. 05-140833

Substituted Claimant: Dorothy Smith

Employer: Capital Region Medical Center

Before the
**DIVISION OF WORKERS'
COMPENSATION**
Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

Insurer: Self-insured

Hearing Date: November 30, 2010

Checked by: RJD/cs

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No.
2. Was the injury or occupational disease compensable under Chapter 287? No.
3. Was there an accident or incident of occupational disease under the Law? No.
4. Date of accident or onset of occupational disease: N/A.
5. State location where accident occurred or occupational disease was contracted: Alleged to be Cole County, Missouri.
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes.
7. Did employer receive proper notice? N/A.
8. Did accident or occupational disease arise out of and in the course of the employment? No.
9. Was claim for compensation filed within time required by Law? N/A.
10. Was employer insured by above insurer? Employer is self-insured.
11. Describe work employee was doing and how accident occurred or occupational disease contracted: It is alleged that Stephen Smith contracted hepatitis C in his years of working as a laboratory technologist.
12. Did accident or occupational disease cause death? No. Date of death? N/A.
13. Part(s) of body injured by accident or occupational disease: N/A.
14. Nature and extent of any permanent disability: N/A.
15. Compensation paid to-date for temporary disability: None.
16. Value necessary medical aid paid to date by employer/insurer? None.
17. Value necessary medical aid not furnished by employer/insurer? None.

Employee: Stephen Smith (Deceased)

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18. Employee's average weekly wages: \$1,120.00.
19. Weekly compensation rate: \$675.90 for temporary total disability benefits and death benefits.
20. Method wages computation: Stipulation.

COMPENSATION PAYABLE

21. Amount of compensation payable from Employer: None.

Employee: Stephen Smith (Deceased)

Injury No. 05-140833

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Stephen Smith (Deceased)

Injury No: 05-140833

Substituted Claimant: Dorothy Smith

Before the
**DIVISION OF WORKERS'
COMPENSATION**

Employer: Capital Region Medical Center

Department of Labor and Industrial
Relations of Missouri
Jefferson City, Missouri

Insurer: Self-insured

Checked by: RJD/cs

ISSUES DECIDED

An evidentiary hearing was held in this case on November 30, 2010 in Jefferson City. Counsel for the deceased employee, Stephen Smith, orally moved to substitute Dorothy Smith, widow of the deceased employee, as Claimant in this action, which oral motion was sustained. The parties requested leave to file post-hearing briefs, which leave was granted, and the case was submitted on February 4, 2011. The hearing was held to determine the following issues:

1. Whether the deceased employee, Stephen Smith sustained an accident or occupational disease arising out of and in the course of his employment with Capital Region Medical Center on or about April 20, 2005;
2. Whether the death of Stephen Smith was caused by an accident or occupational disease arising out of and in the course of Stephen Smith's employment with Capital Region Medical Center;
3. Whether the statute of limitations, §287.430, RSMo, serves as a bar to this action;
4. Whether the alleged failure to comply with the notice requirement of §287.420, RSMo, serves as a bar to this action;
5. Whether Employer shall be ordered to reimburse substituted Claimant for certain medical bills incurred by the deceased employee, Stephen Smith;
6. Whether Employer shall be ordered to pay substituted Claimant for temporary total disability benefits allegedly owed to the deceased employee, Stephen Smith;
7. A determination as to who is/are the proper dependent(s) of the deceased employee, Stephen Smith, pursuant to §287.240, RSMo;
8. Whether Employer shall be ordered to reimburse substituted Claimant for burial expenses as set out in §287.240, RSMo; and

Employee: Stephen Smith (Deceased)

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9. Whether Employer shall be ordered to pay weekly death benefits, pursuant to §287.240, RSMo, to substituted Claimant.

STIPULATIONS

The parties stipulated as follows:

1. That the Missouri Division of Workers' Compensation has jurisdiction over this case;
2. That venue is proper in Cole County;
3. That both Employer and Employee (i.e., Stephen Smith, now deceased) were covered under the Missouri Workers' Compensation Law at all relevant times;
4. That Employer has paid no medical benefits and no temporary disability benefits;
5. That Stephen Smith's average weekly wages were \$1,120.00, resulting in compensation rates of \$675.90/\$354.05; and
6. That Capital Region Medical Center was an authorized self-insured for Missouri Workers' Compensation purposes at all relevant times.

EVIDENCE

The evidence consisted of the testimony of Dorothy Smith; the testimony of Susan Hill; the testimony of Dorsey Shackelford; marriage certificate; death certificate; funeral bill; medical records; copy of "Notice of Award" from the Social Security Administration; 1993 and 1994 job evaluations for Stephen Smith; claims for compensation; Employer's answers to claims; the deposition testimony and narrative reports of Dr. Allen Parmet; reports and correspondence from Dr. Bruce Bacon; and miscellaneous correspondence.

DISCUSSION

The employee, Stephen Smith, filed a Claim for Compensation on April 28, 2006, alleging that on or about April 20, 2005, he suffered an accident, a series of accidents, or an occupational disease as a result of occupational exposure that caused an injury to his body as a whole. Employer filed a Motion for More Definite Statement, and an Amended Claim for Compensation was filed on June 8, 2006, identifying the injury as to the hepatic system (liver) body as a whole. A timely Answer to the Claim for Compensation was filed denying all allegations.

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Mr. Smith was diagnosed with hepatitis C in 1991. He worked until he became unable due to the condition in March of 2006. A Certificate of Death offered into evidence states that the employee, Stephen Smith, died on February 27, 2007. The cause of death was sepsis, hepatitis C, and acute tubular neurosis. A Marriage Certificate was offered into evidence indicating that Stephen Smith had married Dorothy Smith in 1971. Upon oral motion at the hearing, Dorothy Smith was allowed to substitute herself for Stephen Smith as Claimant. No new or Amended Claim for Compensation was ever filed naming Dorothy Smith or any other party as a claimant to this case, nor was a new or Amended Claim ever filed claiming death resulted from the alleged accident or occupational disease. Nevertheless, it was clear from the evidence (including, but not limited to, Employer's Exhibit 8) that the claim was being pursued as a claim for death benefits.

Stephen Smith worked for Employer, Capital Region Medical Center¹, from 1969 until March 2006 as a laboratory technologist. He was described by Susan Hill and Dorsey Shackelford, both former supervisors of Stephen Smith, as a "very good worker" and "an excellent employee". In this position, Mr. Smith withdrew blood from patients every day. He worked with blood and blood products every day. For several years, Mr. Smith and his co-workers did not wear gloves while working. Thus, if Mr. Smith had a lesion of any kind on his hand, the possibility existed of blood coming into contact with that lesion. For several years, Mr. Smith and his co-workers prepared blood slides by use of a "pipette", essentially a narrow glass straw. Mr. Smith would place one end of the pipette into a vacuum tube of blood, and then place his mouth to the other end of the pipette to suction some of the blood into the pipette. Thus, the possibility of accidentally suctioning blood into the mouth also existed. The possibility of a needle stick or cut was present during Stephen Smith's entire tenure with Employer. Only a portion of the blood with which Mr. Smith and his colleagues worked was contaminated (i.e., carried a blood-borne illness such as hepatitis C); Mr. Smith and his colleagues did not know which blood samples were contaminated and which were not. For several years, Mr. Smith and his co-workers were not provided with face shields. Thus, the possibility existed of blood being splattered into Smith's face, particularly when blood was being centrifuged.

Witness Susan Hill worked alongside Stephen Smith for a portion of his tenure with Employer and also was his supervisor for a few years. Ms. Hill recalled that she got blood into her mouth one time when using a pipette. She was not aware of any occasion where Steve Smith got blood into his mouth. Ms. Hill did witness blood on Stephen Smith's lab coat on at least one occasion. She also testified that Stephen Smith would have been required to clean up blood spills. Ms. Hill was not aware of any Stephen Smith reporting a needle stick or needle cut. Ms. Hill testified that Stephen Smith was very skilled and very careful with needles and with blood. Ms. Hill socialized with Stephen and Dorothy Smith, and Ms. Hill believes that Mr. Smith did not engage in any activities outside of work that would have exposed him to blood or bodily fluids. Ms. Hill has not contracted hepatitis C.

Witness Dorsey Shackelford also worked with Stephen Smith for many years and was Smith's supervisor for several years. Shackelford testified that he had gotten blood into his

¹ When Stephen Smith began his employment, the hospital was known as Still Hospital. At some later point in time, Still Hospital merged with another facility, and the name of both facilities was changed to Capital Region Medical Center.

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mouth using pipettes on at least one occasion. He also testified that he is sure he has had “nicks or needle sticks”. Shackelford testified that he worked alongside Stephen Smith “in the early days”, and while he is not aware of any incident involving Stephen Smith (such as needle sticks or blood in mouth), “the risk was there”. Mr. Shackelford has not contracted hepatitis C.

Dorothy Smith testified that she and Stephen Smith were married on June 4, 1971, and lived together continuously as husband and wife until Stephen Smith’s death. Mrs. Smith testified that she is a registered nurse and worked for Employer from 1968 to 1995. She testified that she was quite familiar with her husband’s work and how it was performed, as well as how the protocols changed over the years. She visited her husband in the lab over the years and witnessed how he performed his job. As a nurse at the same facility, she would perform blood draws, insert IV needles, give shots and perform dressing changes on patients. The precautions she used as a nurse, over the years, mirrored the precautions used by her husband and his colleagues in the lab, thus giving her additional familiarity with potential job-related risks faced by her husband. Mrs. Smith testified that she saw blood spots on Mr. Smith’s lab coat or shirt on several occasions. She also testified that she saw blood on her husband’s face on at least one occasion. She testified that her husband, away from his work, had no contact with bodily fluids, did not use IV drugs, had no tattoos, had not been in the military, and had not traveled to the Orient. Mrs. Smith also testified that she, personally, had experienced numerous needle sticks during her career, and she also had blood on her clothing or on her person at various times in her career. Mrs. Smith has not contracted hepatitis C.

Mrs. Smith testified that her husband was wounded with a shotgun in a hunting accident in 1970. He underwent surgery and was given blood transfusions, with six units of blood.

Mrs. Smith testified that her husband was diagnosed with hepatitis C in 1991. She testified her husband was diagnosed with hepatic encephalopathy in April 2005. She also testified that her husband began to lose time from work on or about April 20, 2005, when his symptoms became acute. She testified that she took her husband to the emergency room on April 20, 2005 when he became lethargic and confused. She testified that her husband continued to try to work after that time until he could no longer work in March 2006. She testified that she and her husband were not aware of the possibility or probability that her husband’s hepatitis C was work-related until a meeting with her husband’s physicians in 2005.

Accident; occupational disease. Mrs. Smith and her counsel do not suggest that Stephen Smith sustained an accident. They cannot point to an identifiable incident where Mr. Smith was likely exposed to the risk of contracting hepatitis C. The claim of Mrs. Smith hinges entirely on a finding of occupational disease.

While there is some suggestion by Employer that this case should be determined by under the “prevailing factor” standard under the current post-SB1 law, there is really no question that the occupational disease (if indeed sustained) would have been sustained prior to August 28, 2005, and that Claimant’s disability therefrom began no later than April 20, 2005. Therefore, this case must be analyzed using “a substantial factor” as the standard.

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At all times relevant herein, Section 287.067, defining occupational disease, provided, in pertinent part:

1. In this chapter the term “occupational disease” is hereby defined to mean, unless a different meaning is clearly indicated by the context, an identifiable disease arising with or without human fault out of and in the course of employment. Ordinary diseases of life to which the general public is exposed outside of the employment shall not be compensable, except where the diseases follow as an incident of an occupational disease as defined in the section. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a rational consequence.

2. An occupational disease is compensable if it is clearly work related and meets the requirements of an injury which is compensable as provided in subsections 2 and 3 of section 287.020. An occupational disease is not compensable merely because work was a triggering or precipitating factor.

6. Any employee who is exposed to an contracts any contagious or communicable disease arising out of and in the course of his or her employment shall be eligible for benefits under this chapter as an occupational disease.

At all times relevant herein, subsection 2 of section 287.020, provided, in pertinent part:

An injury is compensable if it is clearly work related. An injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor.

At all times relevant herein, subsection 3 of section 287.020, provided, in pertinent part:

- (1) In this chapter the term “**injury**” is hereby defined to be an injury which has arisen out of and in the course of employment. The injury must be incidental to and not independent of the relation of employer and employee. Ordinary, gradual deterioration or progressive degeneration of the body caused by aging shall not be compensable, except where the deterioration or degeneration follows an incident of employment.
- (2) An injury shall be deemed to arise out of and in the course of the employment only if:
 - (a) It is reasonably apparent, upon consideration of all the circumstances, that the accident is a substantial factor in causing the injury; and
 - (b) It can be seen to have followed as a natural incident of the work; and
 - (c) It can be fairly traced to the employment as a proximate cause; and
 - (d) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal nonemployment life.

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Testimony of Dr. Parmet. Dr. Allen Parmet testified by deposition on behalf of Mr. and Mrs. Smith. Dr. Parmet performed an independent medical examination on Stephen Smith prior to his death on November 17, 2006.

After reviewing the medical records and interviewing and examining Mr. Smith, Dr. Parmet concluded in his report that the *specific* source of hepatitis C infection could not be determined. The earliest laboratory test for hepatitis C was not even available until 1990, and while Mr. Smith might have had hepatitis C prior to 1991, this cannot be stated to a reasonable degree of medical certainty because no test for it existed before then. Potential sources of hepatitis C infection include transfusions, something Mr. Smith underwent in 1970. Dr. Parmet rated Mr. Smith's prior disability to the right leg at 40%, to the low back from his surgery in 2004 at 15% of the body as a whole, and to the low back following surgery in 2006 at 10% of the body as a whole. He did not rate any particular disability related to the hepatitis C infection. It was Dr. Parmet's opinion that Mr. Smith would not be able to return to gainful employment and would eventually be permanently and totally disabled.

Dr. Parmet testified that he participated in advance training in the area of hepatitis as a Public Health Officer for the military. He retired from the Army in 1992. Dr. Parmet worked at St. Luke's Hospital in Kansas City as the Employee Health Director from 1993 to 1995, and again from 2001 through the present.

The number one cause of hepatitis C is through the transfusion of blood or body products. It can also be transmitted by needle sticks, sexually, or from mother to newborn during the birthing process or breastfeeding.

The number one cause of hepatitis C is through the transfusion of blood or body products. It can also be transmitted by needle sticks, sexually, or from mother to newborn during the birthing process or breastfeeding. (Exhibit C, Dr. Parmet Depo. p. 11-12). The minimum time from infection of hepatitis C to actual liver disease is seven years, and the average is 15 years. (Exhibit C, Dr. Parmet Depo. p. 13-14). Mr. Smith suffered a gunshot wound in 1970 requiring a transfusion with six units of blood which would be considered a major risk factor. (Exhibit C, Dr. Parmet Depo. p. 15). Absent any symptoms of cirrhosis or liver disease prior to the 1990's, and no development of cirrhosis until after 2000, Dr. Parmet felt it highly improbable that the blood transfusion in 1970 would have been the cause of Stephen's Smith hepatitis C.

Dr. Parmet testified that he was involved in a San Francisco Combined Study in the late 1980's that looked at the statistical risk of acquiring infection comparing HIV/AIDS to hepatitis B/C. Dr. Parmet claimed that the study found that there was about a 2% risk of HIV/AIDS infection from a needle stick, whereas the risk of infection with hepatitis C was 10% to 20% per stick *with a known positive donor*. Dr. Parmet testified that according to this study, there is a 10% to 20% risk of hepatitis C, and even higher for hepatitis B (Exhibit C, Dr. Parmet Depo. p. 20).

According to Dr. Parmet, the risk of contracting hepatitis is 20% if you receive a needle stick from a known hepatitis C patient. (Exhibit C, Dr. Parmet Depo. p. 26). Not everyone who gets the infection develops acute syndrome. Half to two-thirds of people don't have anything at

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all, or are completely asymptomatic, and never know when the initial infection was acquired. Mr. Smith had two known risk factors, the *assumed* blood to blood contamination in a hospital setting, and the *known* blood transfusions from 1970. (Exhibit C, Dr. Parmet Depo. p. 28). The latency minimum is seven years, and the average is 15 years. (Exhibit C, Dr. Parmet Depo. p. 29). On cross-examination, however, Dr. Parmet testified that the St. Luke's website is accurate, and it indicates that the average onset for infection to become symptomatic is 15 years, and liver damage and cirrhosis does not occur until 20 years. So half of the people become symptomatic before 15 years, and half become symptomatic after 15 years. (Exhibit C, Dr. Parmet Depo. p. 48-49). If Mr. Smith was one of those people who usually develop liver damage over a period of 20 years or longer, that would date back from his confirmed diagnosis in 1991 to 1971, practically the exact year that he underwent the blood transfusions. (Exhibit C, Dr. Parmet Depo. p. 52).

Dr. Parmet was not aware of any specific infected needle sticks that occurred to Mr. Smith. Mr. Smith was not aware of any specific infected needle sticks. (Exhibit C, Dr. Parmet Depo. p.53-54). Dr. Parmet testified that with no infected needle, the risk of contracting hepatitis C would be 0% after a needle stick. Dr. Parmet testified we are not aware of any specific instance where he was stuck by a needle and we do not know of any specific infected needle that he could have been stuck with. All we do know is that Mr. Smith had a blood transfusion in 1970, and was diagnosed with hepatitis 20 years later in 1991. (Exhibit C, Dr. Parmet Depo. p. 55-57).

Dr. Parmet testified: "It is more likely than not that Mr. Smith acquired his hepatitis C infection due to his occupational exposure at Capital Region Medical Center, either by a needle stick or by handling blood and body products." (Exhibit C, Dr. Parmet depo. p. 29). He further testified: "The work is clearly the largest risk factor and the most probable source." (Exhibit C, Dr. Parmet depo. p. 31).

Report of Dr. Bruce Bacon. Dr. Bruce Bacon reviewed Stephen Smith's medical records and produced a report dated January 7, 2009, which report is in evidence as a portion of Exhibit 3. Dr. Bacon's report is addressed to Richard Montgomery, Employer's counsel, and reads as follows:

I am in receipt of your request for a report on the above-mentioned case. I have had an opportunity to review the records that I received and I believe you and I discussed this case several months ago. To summarize briefly, Mr. Stephen Smith had chronic hepatitis C which progressed to cirrhosis and liver failure and he died of complications of chronic liver disease. As a younger man, he worked in a laboratory and had potential exposure to blood products and possible needle sticks. My understanding is that there is no record of him every (sic) reporting a needle stick or any blood product exposure while he was employed. It is also known that Mr. Smith had a blood transfusion following a gunshot wound back in 1970. At that time, he received 6 units of blood. It is well known that blood transfusions prior to 1992 were frequently contaminated with hepatitis C. In fact, 7% to 10% of individuals who received blood transfusions prior to 1992 contracted hepatitis C from the blood transfusion.

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Further, laboratory studies done of February 21, 1990, showed mildly elevated liver enzymes with an ALT of 64 and alkaline phosphatase of 112. At this same time, a liver scan was done which showed diffuse hepatocellular dysfunction and laboratory studies at the Still Regional Medical Center from a hospitalization in December of 1991 to January of 1992, showed a low albumin level of 3.0 with a total bilirubin level that was increased at 3.2. Both of these findings along with the elevated liver enzymes are consistent with chronic liver disease. His anti-HCV was found to be positive at that time, again indicating evidence to prior exposure to hepatitis C.

There is no evidence that this illness in 1991/1992 was an acute infection with hepatitis C. Rather, these findings are consistent with chronic hepatitis C and would be consistent with someone having been exposed at the time of blood transfusion 20 years previously. The average time for progression from exposure of hepatitis C to cirrhosis is usually on the order of 20 to 30 years. The natural history of hepatitis C infection is well described with a proportion of patients who are going to develop cirrhosis usually doing so within 20 to 30 years. Further complications and premature death occur when patients have had chronic liver disease for many years. In Mr. Smith's situation, the likely scenario is that he contracted hepatitis C at the time of blood transfusions in 1970, had developed chronic liver disease by the time of his admission to the Still Regional Medical Center in 1991 and then developed complications that ultimately caused his death in 2006. Since there is no documentation that there ever were any needle sticks or blood exposures during his employment, it is hard to implicate this as a possible cause of his infection with hepatitis C.

These opinions are to a reasonable degree of medical certainty and are based on my experience as a hepatologist of over 25 years, and the care of over 3,000 patients with hepatitis C.

Analysis. Despite there being no evidence whatsoever that Stephen Smith sustained even one potentially injurious exposure to the hepatitis C virus in his working career with Employer, the circumstantial evidence is overwhelming that Stephen Smith's work for Employer exposed him to the risk of potentially injurious exposure significantly greater than the risk to which the public at large is exposed. Thus, it is altogether possible that Stephen Smith contracted hepatitis C due to his work. In other words, the possibility of an occupational disease exists in this case. It is Mrs. Smith's burden to prove, with medical or scientific evidence that it is more likely than not that Stephen Smith's work exposure caused him to contract hepatitis C. A part of that proof is to exclude or minimize non-work risk factors. This is why Mrs. Smith's counsel presented evidence that Mr. Smith was not an IV drug user, did not have tattoos, had not traveled to the Orient, etc. While these other non-work risk factors did not exist, an extremely significant non-work risk factor did exist: Mr. Smith received a blood transfusion consisting of six units of blood in 1970 after being shot in a hunting accident. That significant non-work risk factor must be weighed against the work-related risk factor. Both Dr. Parmet and Dr. Bacon each attempted to do so and each came to opposite conclusions.

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At the risk of over-simplifying a complex case, it appears to me the issue is whether the 1970 blood transfusion or Mr. Smith's occupational exposure was the more likely cause of his hepatitis C. There are multiple factors in this analysis, including the timing of the exposures, Mr. Smith's symptoms in 1991 when the hepatitis C was first discovered, the results of the laboratory testing in 1991, a determination of the chronicity of the infection in 1991, the relative statistical risks of the exposures, the latency periods, and others. While both Dr. Parmet and Dr. Bacon considered, weighed and analyzed these factors, it is clear to me that Dr. Bacon's analysis is more likely correct. First of all, Dr. Bacon is clearly the more expert of the two in this area of medicine. Second, Dr. Parmet's analysis of the timeline, in order to exclude the 1970 blood transfusion as a probable cause, assumes incorrect latency periods, and is anchored by a belief that Mr. Smith's symptoms in 1991 evidenced an "acute" hepatitis viral syndrome, which belief is belied by the contemporaneous testing and laboratory results. Third, Dr. Bacon's analysis is consistent with the known medical facts, and is well-reasoned and well-explained.

I find that the 1970 blood transfusion is clearly the more likely cause of Stephen Smith's hepatitis C. I find that Stephen Smith's occupational exposure to the risk of hepatitis C infection was not a substantial factor in his contraction of hepatitis C. I find, therefore, that Stephen Smith did not sustain an occupational disease arising out of and in the course of his employment with Capital Region Medical Center.

Mootness of remaining issues. As Mr. Smith did not sustain a compensable accident or occupational disease, the remaining issues are moot.

FINDINGS OF FACT

In addition to those facts to which the parties stipulated, I find the following facts:

1. Stephen Smith was diagnosed with hepatitis C in 1991;
2. Stephen Smith died on February 27, 2007 as a direct result of hepatitis C;
3. Stephen Smith worked for Employer from 1969 until March 2006 as a laboratory technologist;
4. In his job Stephen Smith was exposed on a daily basis to the risk of needle cuts, needle sticks, contact with blood, and contact with other bodily fluids;
5. There was no direct evidence adduced that Stephen Smith sustained a potentially injurious exposure to the hepatitis C virus in his working career with Employer; and
6. In 1970, Stephen Smith was shot with a shotgun in a hunting accident, underwent surgery and received blood transfusions consisting of six units of blood.

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RULINGS OF LAW

In addition to those legal conclusions to which the parties stipulated, I make the following rulings of law:

1. Stephen Smith did not sustain an accident arising out of and in the course of his employment with Capital Region Medical Center; and
2. Stephen Smith did not sustain an occupational disease arising out of and in the course of his employment with Capital Region Medical Center.

ORDER

The claim for compensation in this case is denied in full.

Date: February 18, 2011

Made by: /s/Robert J. Dierkes

ROBERT J. DIERKES
Chief Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

/s/Naomi Pearson
Naomi Pearson
Division of Workers' Compensation