

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

Injury No.: 04-102704

Employee: Barbara J. Vickers
Employer: Missouri Department of Public Safety
Insurer: Missouri Office of Administration, administered
By the Central Accident Reporting Office (CARO)
Date of Accident: August 1, 2004
Place and County of Accident: Cameron, Missouri

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by section 287.480 RSMo. Having reviewed the evidence, read the briefs, and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Act. Pursuant to section 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated March 5, 2007, as supplemented herein.

In his award, the administrative law judge states that employee only "worked in unit B, one of four units" at employer's facility. However, this is an incorrect statement. Employee performed services for employer in its laundry facility. Employer only had one laundry facility, and that facility handled all of employer's laundry needs. As such, employee's handling of laundry was not limited solely to laundry from unit B.

We do not believe that this supplemental information changes the administrative law judge's award. Employee still failed to produce competent evidence that she handled laundry from any patients infected with *C. diff* or that she contracted *C. diff* from environmental contact at employer's facility. We are in agreement with the administrative law judge that 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.

Therefore, the Commission still agrees with the ultimate conclusion reached by the administrative law judge that employee failed to meet her burden of proof to show that she sustained an injury by accident or occupational disease arising out of and in the course of her employment.

The award and decision of Administrative Law Judge Robert B. Miner, issued March 5, 2007, is affirmed, and is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 2nd day of January 2008.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

William F. Ringer, Chairman

Alice A. Bartlett, Member

John J. Hickey, Member

Attest:

Secretary

AWARD

Employee: Barbara J. Vickers

Injury No.: 04-102704

Employer: Missouri Department of Public Safety

Insurer: Missouri Office of Administration, administered by the Central Accident Reporting Office (CARO)

Hearing Date: December 5, 2006

Checked by: RBM

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: Alleged August 1, 2004.
5. State location where accident occurred or occupational disease was contracted: Alleged Cameron, 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? Yes.
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? Yes.
10. Was employer insured by above insurer? Yes.
11. Describe work employee was doing and how accident occurred or occupational disease contracted: Employee alleged that while working in employer's Veteran's home, employee became infected with clostridium difficile bacteria, ("*C. diff*"), causing her an infection resulting in a sub-total colostomy and ileostomy.
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: Alleged entire body, including colon, stomach and intestines.
14. Nature and extent of any permanent disability: Not determined. (Employee alleged total disability.)
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.
18. Employee's average weekly wages: \$344.54.
19. Weekly compensation rate: \$229.69 for temporary total disability, permanent partial disability, and permanent total disability.
20. Method wages computation: By agreement.

COMPENSATION PAYABLE

21. Amount of compensation payable: None.

Unpaid medical expenses: None.

No weeks of temporary total disability (or temporary partial disability).

No weeks of permanent partial disability from Employer.

No weeks of disfigurement from Employer.

No permanent total disability benefits from Employer.

22. Second Injury Fund liability: None

TOTAL: None.

23. Future requirements awarded: None.

FINDINGS OF FACT and RULINGS OF LAW:

Employee: Barbara J. Vickers

Injury No: 04-102704

Employer: Missouri Department of Public Safety

Insurer: Missouri Office of Administration, administered by the Central Accident Reporting Office (CARO)

Checked by: RBM

PRELIMINARIES

A final hearing was held on December 5, 2006, in St. Joseph, Missouri. Employee, Barbara J. Vickers ("Claimant") appeared in person and by her counsel, J. Michael Murphy and Mark Murphy. Employer, Missouri Department of Public Safety ("Employer") and Insurer, Missouri Office of Administration, administered by the Central Accident Reporting Office (CARO) ("Insurer") appeared by their counsel, Kristi L. Pittman. The Second Injury Fund is not a party to this claim. The parties acknowledged the previous consolidation of this case with a second case, Injury No. 04-109301. Both cases have been consolidated into Injury No. 04-102704.

STIPULATIONS

The parties stipulated to the following:

1. On or about August 1, 2004, Employer was an employer operating under the provisions of the Missouri Workers' Compensation Laws and that their liability under said law was fully insured Insurer.

2. On or about August 1, 2004, Claimant was an employee of Employer and was working under the provisions of the Missouri Workers' Compensation Laws;

3. Employer had notice of the alleged injury and the claim for compensation was filed within the time prescribed by law;

4. Claimant's average weekly wage was \$344.54 and the appropriate compensation rate for weekly benefits is \$229.69 for temporary total and permanent total disability benefits and \$229.69 for permanent partial disability benefits;

5. No compensation has been paid by Employer.

6. No medical aid has been furnished.

ISSUES

The parties agreed that the following issues were to be determined at the hearing:

1. Medical causation and whether Claimant's alleged injury was causally related to an alleged accident or occupational disease.

2. Employer/Insurer's liability for temporary total disability.

3. Employer/Insurer's liability for future medical aid.

4. Nature and extent of permanent partial disability.

5. Employer/Insurer's liability for permanent and total disability benefits.

The parties agreed to the admission of the following Exhibits subject to the objections contained in the depositions:

Employee's Exhibits:

C. Deposition of Brian Hunt dated October 6, 2005.

D. Deposition of Lois Rider dated October 6, 2005.

E. Medical Records from:

Dr. William Irby

Dr. Gina Sprague

Surgical Associates of St. Joseph

Heartland Regional Medical Center

Heartland East Hospital.

F. Letter from Dr. Scott Folk dated February 7, 2006 and Dr. Folk's Curriculum Vitae.

G. Deposition of Mary Titterington dated June 19, 2006.

H. Curriculum Vitae of Mary Titterington.

I. High School Transcript of Barbara Vickers.

J. Vocational Report of Mary Titterington dated April 8, 2006.

K. Claimant's List of Litigation Expenses.

M. Medical Supplies.

(Exhibits A, B and L were not offered.)

Employer's Exhibits:

1. Deposition of Dr. John Fried dated September 8, 2006.

2. Deposition of Dr. Scott Folk dated July 18, 2006.
3. Policy and Procedures from the Missouri Veteran's Home.
4. Policy and Procedures from the Missouri Veteran's Home.

The parties agreed that Employer's objections to questions posed to Dr. Folk (in Exhibit 2) beginning at line 9, page 30, through and including line 3 page 31, and Employer's objections to the questions and answers beginning at line 15, page 32 through and including line 7, page 33 be sustained, and they are sustained. The parties further agreed that proposed Awards would be submitted on or before December 29, 2006. The parties further advised that past medical expense was not an issue in dispute.

SUMMARY OF THE EVIDENCE

TESTIMONY OF CLAIMANT

Claimant testified that she was born on July 19, 1941 and was 65 years old. She had a ninth grade education and lived in Cameron, Missouri. She was hired by Employer on April 22, 2004. She was terminated by Employer in September or October 2004. She was paid on the first and 15th days each month. She worked in Employer's laundry second shift, from 3:00 p.m. until 11:30 p.m. Five employees worked on the day shift. When she was first hired, she had no helper. Later, Jackie Wheeler came. Claimant had a weekend off every other weekend.

Claimant said her work environment was pretty warm, and was warmer than 70° at times. The laundry was located in the basement. It had washers, dryers, and hoppers. Claimant picked up, sorted, folded, and hung clothes. She cleaned halls and swept floors. She laundered all personals, linens, pads, sheets, blankets, personal clothing, mops, rags, travel bibs, sweat suits, and bed pads. She laundered sheets and diapers that were soiled with human feces. She rinsed out the diapers.

When Claimant was first hired, she picked up dirty linens from each unit and threw them down a chute. She took bags, sorted items, and put them in hoppers, weighed them, and put them in the washing machines. There were four wings in the building—A through D. Laundry was red bagged if it contained blood. Laundry was wheeled to a chute and dropped to the floor below.

Nurses threw laundry at the end of a shift if they had time. Claimant wore gloves when she picked up laundry. She put on a gown and a mask, and kept her gloves on when she worked downstairs. She opened the bags and put the contents in hoppers. If the clothing had feces, she rinsed it before she put it in the hopper. Items in the hoppers were then put into the washing machines. There were four washing machines. Some of the items handled had urine on them. Claimant perspired down her face during work. Perspiration sometimes got on her lips. She wore protective clothing while loading items into the washers. She did not wear a hair net. Carts were used to move items to the laundry. At the end of the shift, she swept and mopped bathrooms, the laundry room, and the sorting room. She wiped down the washers and hoppers with bleach and water. She wore her protective clothing when she did cleaning. She used one gown per shift. She wore disposable paper masks. She used latex gloves in the laundry. There were some fans in the sorting room and the drying room in the basement. It was very hot in those areas. The director of nursing brought in a large fan in August or September.

Claimant weighed laundry before putting it into the washer. Some loads weighed one hundred thirty pounds. Some weighed sixty pounds. The washing machines were started at the same time. When the laundry was done, she would remove her mask, gown, and gloves, and then fold the laundry. After the laundry was folded, she put it in carts and took it upstairs.

Eight hundred to nine hundred pounds of laundry were done during a typical shift. About six loads were done per shift. Her work was physically hard. She usually only took part of her breaks. She had a thirty minute lunch break and fifteen to twenty minute breaks in the morning and afternoon. She did not take all of her breaks because she wanted to get her work done. She ate in the cafeteria.

She was taking the drug Cipro for a sinus infection during August 2004 under the direction of her doctor. Her prescription was for ten days, but she took the drug for eight days.

She last worked for employer on Friday, September 10, 2004. On September 12, 2004 she was brought to Heartland Health hospital in St. Joseph with a fever and diarrhea that had started while she

was working on September 7 or September 8, 2004. A doctor had told her to take Lomotil. She was treated at Heartland Health by Dr. Gita Sprague, Dr. Andres, and Dr. Scott Folk, an infectious disease doctor. She had surgery on September 15, 2004, and was in intensive care. All but six to eight inches of her colon was removed while she was in the hospital. She was in the hospital for eleven days. She now has a colostomy bag. She weighed 140 pounds when she went into the hospital. Her current weight was 110 pounds. She lost most of her weight when she was in the hospital. She did not want to have the surgery at first. Her doctor said if she did not have the surgery, she would not make it. She then decided to go ahead with the surgery.

She now has difficulty sleeping and sleeps about two hours per night. She takes pain pills every six hours at night, but not during the day. She wakes up after ten to fifteen minutes after she goes to sleep. Some nights she does not sleep. She said she does not nap during the day. She never feels rested. She has difficulty eating. She cannot eat vegetables or seeds, and milk products bother her. She eats a little meat once in a while, but only has one to two tablespoons. She does not eat macaroni and cheese, citrus, apples, or potato chips. She does not eat out. She has to be careful not to get an infection. She eats bread occasionally. She eats mostly chicken noodle soup and saltines. If food does not agree with her, she gets stomach cramps. She is supposed to walk thirty minutes per day and tries to do that.

She now gets Medicare and Medicaid. She does her own laundry and cooking. Her health before August 1, 2004 was good. She liked her work for Employer. She raised six children. Past work included bartending for seventeen years, working at a gas station, and working at a nursing home. Before September 2004, she did not have any limits on how much weight to lift. Now she has a five pound lifting limit. She empties her pouch or bag two to three times per night and five times per day. Her pouch has a one to two inch opening. It is about four inches square. It sets against her stomach. Glue strips keep it next to her. Powder is used on the pouch. She has an open wound on the right side of her abdomen. If the pouch is not empty, it blows up after it fills with air and fluid. Medicaid supplies her with eight pouches per month. She changes the pouch every three or four days. She also rinses it out. She has a high chance of infection.

Her injury has affected her emotionally because she cannot do things she used to do. She used to work and enjoy time with her children and grandchildren. She does not camp with her children and grandchildren anymore. Her strength is not as good as it used to be before September 2004. She has less stamina and tires easily. She usually travels with her daughter-in-law and son. She can stand between fifteen and twenty minutes. She can kneel, but needs a firm surface. She can climb stairs, but it is more difficult now. Her balance, hearing, and eyesight are all right. She can drive from Cameron to St. Joseph and Liberty. She is able to shower, sit on a stool, and dress herself at home. Her dentures are now too big for her, and are loose. She cannot put weight back on. She cannot eat firm foods like before. She was hospitalized a second time for two to three days for stomach cramps. She said she has not been able to work since September 2004. She stays at home and reads, walks, and talks to her neighbors. She said she could not work unless she sat next to a bathroom. She knew of no one who would hire her.

She cleans her stoma, the opening in her abdomen, two to three times per day. She now takes a thyroid medication, Fosamax, once a month for osteoarthritis, vitamin B12 for iron, Zantac for her stomach, hydrocodone pain pills, and another medication for her stomach. She stated she was asking the court to award past disability benefits, future disability benefits, future medication expenses, and to allow her attorney a fee of one fourth after the attorney is reimbursed his out-of-pocket expenses. She said she was not asking the employer to pay the attorney's expenses.

On cross examination, Claimant said she did not have a GED and did not attempt to get one. She was required to wash her hands whenever she took off her gloves. She washed her hands every time she touched dirty laundry. She worked at the Veterans Home from September through November 2003. She was given a one-week orientation that included education regarding proper procedures to handle laundry. She always followed the procedures as instructed regarding hand washing, and wearing gloves, masks and gowns. She acknowledged that she had seen Dr. Irby in June 2004, and that his record showed she weighed 124 pounds. She also acknowledged that his record in June 2004 showed she complained of fatigue, hair falling out, and allergies. She was referred to a cardiologist a little later. She was given a B4 shot in June 2004.

Claimant acknowledged that she testified in her October 2005 deposition that she did not want to go back to work. At the hearing, she said she did not think she was able to go back to work. She acknowledged that she had not attempted to go back to work full-time or part-time.

Claimant said that she took vitamin B12 in September 2004, but not every month like she does now. She said she took none between June 2004 and her surgery. She has more fatigue now than in

June 2004. She said she did not want to go back to work because of her age and her colostomy bag. She has to go to the bathroom often and empty and clean the bag. She said Dr. Andres told her that he preferred she not work.

TESTIMONY OF PATRICIA SIMS

Claimant called Patricia's Sims. She lives in Cameron Missouri and is a licensed LPN at Cameron Manor and has been for 13 years. She is Claimant's daughter-in-law. She worked for Employer from 2001 until June 2004 as a floor charge nurse. She directed patient care and was responsible for medication, treatment, and helping patients with going to the toilet, feeding, and dressing. She said that in May and June 2004, Employer had four to five patients that had *C. diff* and diarrhea. She had seen that diagnosis in their charts. She said nursing employees were not required to red tag laundry of *C. diff* patients. She said *C. diff* is a contagious disease.

TESTIMONY OF CELIA REED

Celia Reed is Administrator of Employer, and has been since April 2006. She was Assistant Administrator for Employer before that. She has Bachelors in Nursing, Masters in Education Nursing, and Ph.D. in Administration degrees. She had been at the Veterans Administration Home since it opened in 2000. She is familiar with Claimant and this case. She said that blood borne pathogens used to be put in bags. Now all body substances are bagged. Employer no longer uses red bags. They follow universal or standard precautions. They are also concerned with other body fluids. They treat every piece of linen as if it is contaminated, and all linen is bagged in plastic bags. Those procedures were in place when Claimant worked for Employer. The bags used are see through linen. They do not allow for leakage. They are tied and put in a large container for transport to the laundry chute. That procedure was used when Claimant worked for Employer. Each piece of laundry was treated as if it was contaminated in 2004.

New employees go through an orientation when hired to work for Employer. There is a section on infection control. All employees are instructed not to clean up blood without taking precautions. Laundry personnel have other precautions. Employees are instructed in the use of body protection. New employees are given a copy of an orientation plan (Exhibit 3). A copy was given to Claimant. It covers exposure control, disposal of waste, use of masks, vaccinations, use of gloves, soiled linens, body substance precautions, and other matters. Employer's infection control policy for long-term care (Exhibit 4) is also available to employees. Employees are expected to know that policy. The orientation plan and infection control policy would have been covered in Claimant's general orientation and laundry supervisor's orientation. There is also a mandatory annual review.

Patients with *C. diff* have been at the Veterans Home. Patients with other infectious diseases have also been there. Ms. Reed has seen between 700 and 800 employees at the Veterans Home since 2000. There are between 220 and 230 employees there at any one time. She was not aware of any other employee who alleged she contracted *C. diff* besides Claimant. There may still have been red bags at the Veterans Home in 2004.

Ms. Reed testified that *C. diff* is in all of our bodies. It is a normal bacteria found in the bowels. She is more concerned with hepatitis and HIV in the Veterans Home.

TESTIMONY OF LOIS RIDER

Lois Rider was deposed by Claimant's attorney on October 6, 2005 (Exhibit D). Ms. Rider is a licensed registered nurse. She has worked as a registered nurse for twenty-six years. She was employed by the Veterans Commission from February 2002 to May 6, 2005. She was the night shift supervisor and reported to the Veterans Home in Cameron Missouri. The Veterans Home is a nursing home. She had active military experience and had been commissioned as a first lieutenant in the Army Nurse Corps.

Her duties as night shift supervisor at the Cameron Veterans Home included making sure staffing was appropriate, taking care of any emergency situations, intervening if the staff on the floor had a problem, intervening with families, calling doctors, and calling the ambulance. She was the person in charge after the office personnel went home. In the beginning of 2005, she transferred to a day shift position. There are four units in Cameron--A, B, C, and D. D is the dementia unit. C is a unit that is heavier care and includes paralyzed patients. B is less heavy care, and A is the lightest of the four. She was unit supervisor of the B unit. When asked if in July and August of 2004, there were patients at the Cameron home who were afflicted with *Clostridium difficile* bacteria, she said she could not say for definite, but it would not have been unusual for them to have at least one to two cases during that period. Her judgment on that was based on getting reports from the supervisors, and supervising the nurses. The Home had on average probably 150 patients during the months of July and August 2005.

She said that *C. diff* bacteria are fairly contagious. During July and August 2004, she requested her staff to take precautions to minimize the spread of *C. diff* to staff and other patients. The biggest thing would be to wear gloves when intervening with the patients due to the massive amounts of diarrhea. If it was really severe, they would tell them to put on gowns, and definitely the hand washing protocol. She did not recall them isolating the linen per se in a special manner, regardless of the infection. It would be a good practice to isolate linen with a bright red bag with a poison emblem on it saying take precautions more so than normal. That is what is meant by "red bagging." She did not know how much of the time during July and August 2004 that linen was red bagged.

Claimant did laundry on the three to eleven shift. She could not say for sure whether Claimant had anyone helping her. Four or five people did laundry during the day shift. There was no one in laundry on the graveyard shift. Masking was not normally something she wanted her people to do. She did not recall any particular records being kept with regard to patients who had *C. diff*. She was infection control nurse as well as night shift supervisor. She could not think of any records, other than individual charge, that might show the number of patients that had *C. diff*. There were between forty-five and fifty patients on B unit. It was not unusual for the laundry room to be hotter than seventy degrees during May through August. One of her people on the three to eleven shift passed out there because it got too hot. Bacteria can flourish in very hot and humid conditions. She tried to cool down the laundry room by getting fans and opening the back door. She could not say whether any of the patients or residents at the home died of *C. diff* during August and July 2004.

TESTIMONY OF BRIAN HUNT

Brian Hunt was deposed by Claimant's attorney on October 6, 2005 (Exhibit C.) All objections contained in Exhibit C are overruled. He was the Administrator of the Veterans Home. They treated six patients with *C. diff* in July and August 2004 at the Veterans Home. He did not recall how many of those patients might have been in units A, B, C, or D. To his knowledge, no one died as a result of *C. diff* bacteria affliction. In July and August 2004, they advocated, trained, and enforced the use of universal precautions in regards to protecting other residents and their workforce from the spread of infectious diseases. They provided the necessary personal protective equipment in easily accessible areas. They trained on the location and proper use of that equipment. They trained on proper hand washing techniques, proper glove usage, or any of the other personal protective equipment that somebody might be required to use. They trained on the usage of equipment, gloves, gowns, goggles, and a mask. They were made available to the staff. Proper hand washing was something they trained on very regularly throughout the whole year. Ongoing training was always done, particularly in the area of laundry and housekeeping, on cross contamination of soiled linen, and proper ways to get it to the laundry, processed, and back up on the floor.

Mr. Hunt said that the proper way of handling linen was any time a staff member was handling soiled linen, they were trained to wear gloves and to bag the linen as they get it from the room, and then is taken to the laundry chute, and transported down to the laundry. The workers there, using the gloves, gowns, goggles, and masks, will then take the soiled linen out of the bags, separate it for processing if something needs special attention, and after the laundry has been processed, it is taken out into the clean linen room where it is folded and either stored or redistributed. When laundry is collected at the individual rooms it is bagged per individual resident, or if there is too much, or you are dealing with soiled bed linen, you might use several bags. Certain linen that may be deemed hazardous sometimes is red bagged, if it contains blood, most commonly a bloody sheet. The staff was not trained in July and August to red bag *C. diff* patient linen unless it contained blood. The soiled linen is dirty linen.

They do not differentiate *C. diff* linen from any other type unless it contains blood. He did not recall if anyone helped Claimant in July and August 2004. He did not recall training laundry personnel received from July and August, but knew that the training was done regularly throughout the year, through an orientation, and then at regular intervals, or as needed. Training was provided by the laundry supervisor, Rita Clingsworth. He did not know the specifics of the training she provided. The laundry room could get to be more than seventy-five degrees. They did not have a protocol or procedure to notify staff personnel that a particular patient had *C. diff* because of confidentiality. That is why they enforce universal precautions for everyone all year round. They trained that you should treat everyone like they have an infectious disease. There had been no changes about red bagging procedures since Claimant left employment. Nothing had been done since September 2004 to improve upon or change the procedure to control the spread of *C. diff*. He stated that he felt their procedures were adequate last year and were still adequate.

Exhibit 3 is Employer's Lesson Plan for Infection Control, New Employee Orientation. It notes that topics of disposal of regulated wastes from resident rooms, gowns, aprons, protective apparel, housekeeping, and linen and laundry are addressed in Body Substance Precautions. Exhibit 4 is Employer's Body Substance Precautions. It describes recommended use of gloves, hand washing, face

and eye protection, and use of apron or gown. The section dealing with Apron or Gown states:

Protect clothing with a plastic apron or gown when it is likely that clothing will be soiled with body substances. These items are primarily designed to reduce the soiling of the clothing of personnel with moist body substances. They should be worn any time soiling of clothes is anticipated. They should be removed and discarded after completion of each resident contact task. Lab coats when soiled with blood or body fluids should be removed as soon as feasible and placed in the facility laundry for cleaning.

The section dealing with Soiled Linen states:

Laundry workers, whose job entails sorting or handling contaminated linens, should wear gloves and other protective apparel as appropriate to prevent linens coming into contact with skin and clothes. No special procedures are needed for laundry from persons known to be infected. Therefore, if linen is processed within the facility, it need not be labeled except to identify all used linen as contaminated. If a commercial laundry that does not utilize Universal Precautions processes linen, then the transportable containers must either be red or have a biohazard label.

Guidelines for appropriate management of soiled linen include:

- Place all soiled linens in laundry bags provided at the point of use.
- Avoid contact with your uniform/clothing and surrounding patient care equipment.
- Do not shake or place linen directly on the floor.
- For linens lightly to moderately moist, fold and/or roll in such a way as to contain the moist area in the center of the soiled linen.
- For soiled linens that are **saturated** with moisture, place them in a plastic bag followed by tying or knotting the open end. The plastic bag containing wet linens should then be placed in an approved laundry bag and closed before transporting to the proper designated area.
- **DO NOT OVERFILL BAGS** more than 2/3 of the capacity as overfilled bags tend to rupture if they are dropped.

MEDICAL TREATMENT EVIDENCE

Exhibit E contained medical records pertaining to Claimant. Some of the pages in Exhibit E had post-it notes attached to them. Those post-it notes were on the pages at the time Exhibit E was admitted into evidence. They were not affixed to the pages by the Administrative Law Judge.

Exhibit E included medical records of Dr. William Irby. Dr. Irby's June 16, 2004 progress notes stated that Claimant came in "complaining of fatigue, hair is falling out, allergies and arthritis." His assessment was fatigue, arthritis, pernicious anemia, osteopenia, and medication monitoring. He noted he would like to set her up with a cardiologist for her bradycardia. A progress note dated July 28, 2004 of Dr. Sharma assessed atypical chest discomfort with negative echocardiogram and stress test, and hypothyroidism. Dr. Irby's August 30, 2004 progress note stated that Claimant came in stating "she has been sick since Thursday. Aching all over, headache, frontal and maxillary in particular, productive cough, as a greenish discharge. She has had chills and fever at home." He assessed sinusitis and bronchitis and prescribed Cipro and a cough medicine.

Exhibit E contained records of Heartland Health. Claimant was admitted to Heartland Health's Emergency Department on September 12, 2004 for abdominal pain, nausea, and diarrhea. The Emergency Department record noted in the history of Claimant's present illness that Claimant was given Cipro for possibly a sinus infection several weeks ago, about two weeks ago. After completing the Cipro, she developed diarrhea which had persisted. Over the past 24 hours she had developed fever, severe abdominal pain, profound nausea, and marked increase in the stool frequency and volume with lots of mucus. The Clinical Impression was abdominal pain, nausea and diarrhea, probably secondary to *Clostridium Difficile* Enterocolitis.

Claimant was admitted to Heartland on September 13, 2004. Heartland's History and Physical dated September 13, 2004 noted that Claimant had taken two weeks of Cipro for a sinus infection and then the diarrhea started. She had had no fever or chills. Past medical history was noted to be unremarkable. She was seen by Dr. Scott Folk at Heartland. His Consultation report dated September 13, 2004 noted Claimant was well until approximately August 28, 2004 when she was placed on Ciprofloxacin for sinusitis. She believed she took that orally for 10 days to September 7, 2004. His

impression was Pan Colitis, likely due to *C. difficile* toxin. Claimant was seen by Dr. Edward Andres in consultation on September 15, 2004. His note stated that she had a 35 pound weight loss over the past six weeks and two weeks of diarrhea. Clostridium difficile studies were positive. A colonoscopy by Dr. Patel was consistent with pseudomembranous enterocolitis. Dr. Andres had initially offered Claimant total abdominal colectomy, but she initially refused that. She now stated she does not want to die and is willing to have the operation. Total abdominal colectomy with ileostomy was performed on September 15, 2004 by Dr. Andres.

Heartland Health's Discharge Summary of Dr. Gita Sprague dated September 28, 2004 noted that Claimant was admitted on September 12, 2004 and discharged on September 23, 2004. The chief complaint was abdominal pain. History of present illness was described as Claimant had had diarrhea for two weeks, increasing abdominal pain. She had been febrile. She was admitted to the hospital and started on IV fluids, antibiotics, stool cultures were obtained and came back positive for *C. difficile*. She was toxic. Medications were adjusted. She did not improve. On September 15, 2004 she had a subtotal colectomy, and ileostomy, and procto done. Postoperatively she started to improve rapidly. Her diet was slowly advanced. She was mobilized and taught colostomy care. A pathology report was noted to be consistent with pseudomembranous colitis. She was discharged to go home with medications.

Notes of Dr. Gita Sprague dated October 7, 2004 noted that Claimant had chronic back pain, was trying to eat better, and was still losing weight. She weighed 114 pounds and was 5'2" tall. Dr. Sprague's impression was pseudomembranous colitis, status post colectomy. Trying to gain weight and eat better; weight loss related to anorexia; degenerative joint disease of the spine; hypothyroidism on replacement therapy. Dr. Sprague's December 6, 2004 note stated that Claimant came in with excessive fatigability, dyspnea on exertion and hypothyroidism. Claimant stated she did not have the stamina to pick things up and get back to normal life. Dr. Sprague's February 8, 2005 note stated that Claimant still has chronic intermittent pain. She had a lot of abdominal bloating and pain, and food intolerances. Her weight was 120 pounds. Her impression was irritable bowel and osteoporosis.

Claimant was admitted to the Heartland Health Emergency Department on January 20, 2005 (Exhibit E.) Her chief complaint was stomach cramping and diarrhea. She was admitted to the hospital and seen by Dr. Andres. His impression was acute gastroenteritis with nothing to suggest bowel obstruction. She was discharged on January 22, 2005 with a discharge diagnosis of gastroenteritis.

MEDICAL EXPERTS

The medical report of Dr. Scott Folk dated February 7, 2006 addressed to Claimant's attorney (Exhibit F) noted that his patient, Claimant, was admitted to Heartland Regional Medical Center on September 12, 2004 for the evaluation of fever to 103°F orally, chills, sweats, and nausea. A stool specimen was positive for *Clostridium difficile* toxin. He followed Claimant in the hospital for several days. He noted that on September 15, 2004, she was taken to surgery by Dr. Ed Andres for a total abdominal colectomy with ileostomy. Claimant was dismissed from the hospital on September 23, 2004. He had not seen Claimant since hospital dismissal on September 23, 2004. His report noted that Claimant was employed in the laundry at the Veterans Home in Cameron Missouri in September 2004 on a full-time basis. The report noted that patients in long-term care facilities frequently develop diarrhea due to *Clostridium difficile* toxin. The report stated that Claimant's employment at the Veterans Home, including her handling of laundry of residents who may have contracted *Clostridium difficile* bacteria, put her at greater risk of exposure than members of the general public. The report also noted that Claimant's risk of acquiring *Clostridium difficile* infection was heightened because she was taking ciprofloxacin as therapy for sinusitis. The report stated that acquisition of *Clostridium difficile* bacteria in Claimant's intestinal tract resulted in toxin production by those bacteria that, in turn, resulted in severe colitis that ultimately necessitated removal of her colon by Dr. Andres and placement of an ileostomy. He was not aware that Claimant was wearing gloves when she was handling the contaminated laundry at the Veterans Home.

His report noted that according to Mandell's *Principles and Practice of Infectious Diseases* (Sixth edition), most *Clostridium difficile* infections are acquired from environmental sources. The report stated that as a result of her need for an ileostomy, Claimant is unable to have normal bowel movements. He believed that it would be very difficult, if not impossible, for her to perform manual labor on a daily basis. The report stated that he also believed that it was more likely than not that Claimant contracted *Clostridium difficile* infection at the Missouri Veterans Home in Cameron Missouri, and in turn, this necessitated medical care and resulted in her current condition. Dr. Folk's curriculum vitae noted that he is board certified by the American Board of internal medicine, subspecialty in infectious diseases. He is medical director, adult infectious diseases, Heartland Regional Medical Center, St. Joseph Missouri.

Dr. Folk was deposed on July 18, 2006 by Employer's attorney (Exhibit 2). The parties agreed that Employer's objections to questions posed to Dr. Folk (in Exhibit 2) beginning at line 9,

page 30, through and including line 3 page 31, and employer's objections to the questions and answers beginning at line 15, page 32 through and including line 7, page 33 be sustained, and they are sustained. All other objections contained in Exhibit 2 are overruled.

Dr. Folk said that Claimant was diagnosed with *Clostridium difficile* colitis. *Clostridium difficile* refers to an inflammation or infection of the colon, the large bowel. *Clostridium difficile* was the primary organism that caused the colitis. It is often referred to as *C. diff*. Not all patients develop symptoms when they have *C. diff*. When they do develop symptoms, those symptoms can consist of things such as fever, chills, diarrhea, abdominal pain, sometimes nausea, sometimes vomiting. Claimant presented with fever to 103°F, chills, sweats, and nausea. She also had some diarrhea. Dr. Folk saw her daily in the hospital from September 12 to September 23, 2004. *C. diff* is a bacteria that can be found in the intestine in healthy people. A lot of people have that and never become symptomatic. Claimant's diagnosis was confirmed by a latex test done in the stool specimen in the microbiology laboratory. Alternative diagnoses were considered and excluded. She was tested for other bacterial infections, such as salmonella and shigella that were negative. Claimant gave a history of just completing a round of antibiotics when she was admitted into the hospital. She had been given ciprofloxacin for a sinus infection. The history in the emergency department record noted upon admission that Claimant had been given a prescription for the antibiotic about two weeks before the report, and after completing the Cipro, she went on to develop diarrhea which was persistent. Subsequently over the twenty-four hours prior to coming in to the emergency room, she had also developed fever and severe abdominal pain and nausea and an increase in her stool frequency, and no blood in her stools.

Dr. Folk treated patients with *C. diff*. virtually every day or every other day. *C. diff* disease is caused by a bacterial infection known as *Clostridium difficile*. That is a bacteria that produces at least two major toxins, both of which have been incriminated in producing diarrhea. The toxins are produced directly by a bacteria themselves, and the toxins, in turn, are what elicit the inflammatory response in the diarrhea. He noted there are certain patient subgroups that tend to be at higher risk for *C. difficile* infection: notably patients that have been on any antibiotic in the prior four to six weeks; patients who are elderly, that is to say, 65 years or older; patients who have undergone gastrointestinal surgery or had enemas; patients who had a recent stay in the ICU; debilitated patients; patients on chemotherapy. Antibiotics get out the site of infection, but also, to a varying degree, strip away some of the normal bacteria that are normally found inside the lumen of the colon. And when you take away some of the normal good bacteria that are in the colon, it makes it easier for any *Clostridium difficile* that happens to be there to set up shop and start producing toxins that cause the diarrhea. So by getting rid of the good bacteria, the bad bacteria are allowed to flourish. About 3% of adults are normally colonized with *Clostridium difficile* bacteria. If these normal adults already have a colonization of the *C. diff* bacteria and they take antibiotics, it makes them more susceptible to the overgrowth of the *C. diff*.

Dr. Folk stated that it is fair to say that a fair number of patients with *C. difficile* infection acquired that through contact with environmental surfaces. That contamination has to occur through a fecal-oral route. Typically, what happens is patients get exposed to *C. difficile* in some fashion through the fecal-oral route or contaminate. They get it into their mouth and the organisms get down into the intestinal tract. From there, they may or may not develop symptomatic disease. They may remain totally asymptomatic. They may, on the other hand, especially with antibiotic use, develop symptoms of fever, diarrhea, and so forth. *C. diff* organisms that get into their tract can be from a variety of different ways, such as hygiene. There is no way to tell when that *C. diff* got into that person's system. Because it is asymptomatic, it can reside in a system for a matter of months or years. There is no way to tell how long a *C. diff* has resided in a person's system.

Dr. Folk's report stated that it would be very difficult if not impossible for Claimant to perform manual labor on daily basis. He testified by manual labor, he meant physical work as opposed to sitting behind a desk and working at the computer. He testified that if Claimant wore a gown, mask, and gloves when she was handling the laundry and sorting the laundry and putting the laundry into the washing machine, and she wore gloves, but no gown, when she took the laundry from the time it was clean in the washing bin until she was done with it, those procedures would have reduced her risk of personal exposure to *C. diff*, but not necessarily eliminated it completely. He stated there are still numerous other ways to contract *C. diff* from clean laundry, and at the end of the day, we cannot tell when Claimant contracted *C. diff* bacteria in her system, and we cannot tell how she contracted the *C. diff* bacterium in her system. Procedures such as using hand washing, gloves, and gowns while handling the laundry would significantly reduce the risk of acquisition of *C. diff*. He stated that if she carefully washed her hands frequently while handling the laundry, both dirty and clean, and wore gloves and gowns appropriately, those things would significantly reduce risk of acquisition of *C. diff*. He said that by handling grossly fecally contaminated laundry day in and day out, that consistently put Claimant in a higher risk to exposure of *C. diff*, relative to someone who does not handle fecally contaminated laundry every day. He stated that she got the *C. diff* almost assuredly through a fecal-oral route. He stated there

was no way of knowing when she was initially infected with *C. diff*. He stated that he would probably agree that the triggering factor, the substantial factor in causing her to develop the symptoms, was the antibiotic use.

Dr. John S. Fried was deposed by Employer's counsel on September 18, 2006 (Exhibit 1). All objections contained in Exhibit 1 are overruled. Dr. Fried is an infectious disease consultant. He is licensed to practice medicine. He mostly sees patients in the hospital. He sees infectious disease patients in his office two and one-half days a week. He is chairman of the Infection Control Committee at Shawnee Mission Medical Center and Overland Park Regional Medical Center. His main practice is doing consultations for hospitalized patients with infectious disease problems. He is board certified as an infectious disease specialist. He is also board certified in internal medicine. He treats patients with *C. difficile* colitis as part of his practice. Deposition Exhibit 2 was a letter he wrote to Diane Kehres. He reviewed medical records in preparing his report. *C. difficile* is a bacteria that lives in places that have no oxygen and can live in the colon of people and other higher animals. Normally it is mixed in with other bacteria in the colon, and can be part of the normal bacteria flora. *C. difficile* has two characteristics which caused disease. First, it produces a toxin which can poison the colon and cause a toxic colitis. Second, it is resistant to most antibiotics. The typical scenario is a patient who may have a low level of *C. difficile* in their colon, will get an antibiotic which will kill all the bacteria which are sensitive to the antibiotic. *C. difficile* will then overgrow, and when it reaches a certain level, it produces enough toxin to cause a toxic colitis. The treatment involves using an antibiotic which will kill the *C. difficile*. In the most severe cases, the colon is so severely poisoned, it has to be removed in order to prevent it from rupturing and poisoning the whole patient. In the last two or three years, *C. diff* has mutated, causing it to produce a much higher level of toxin than it used to. As a result, *C. diff* cases are much more virulent, complicated, and prone to relapse.

In some studies, one percent, to as high as three percent, of normal healthy people carry *C. diff* in their stool. *C. diff* can be spread person to person. For any individual case, it is always very hard to tell was this one percent of the people that had *C. diff* in their bowels anyway, or was it someone who acquired a case from a certain exposure. *C. diff* can be transmitted typically through a fecal to oral transmission. Someone who works with stool, does not wash their hands and then eats, can introduce the live bacteria into their mouth. Bad hygiene can increase one's exposure to all kinds of bacteria in the environment. It can come from someone who works in the food industry who does not properly use gloves or properly wash their hands themselves. *C. diff* can remain asymptomatic for months. When one presents with the clinical disease, you really cannot say where they actually acquired the germ.

Dr. Fried reviewed medical records pertaining to Claimant that indicated she had *C. diff*. He was asked to determine whether Claimant contracted *C. diff* bacteria through her employment at Missouri Veterans Home. He felt that one could not say that she acquired her bacteria through employment. He felt that because of the prevalence of *C. diff* in the environment, one just could not say whether she was one of the one percent of the population that carries *C. diff* anyway, or whether she had some specific exposure at work. He said there was no documentation of exposure to stools from an infected patient. As a laundry worker, she would have minimal exposure to secretions and excretions, and it should be in a controlled environment. Clean laundry is considered to be clean and is considered not to be a risk for *C. diff*. Soiled laundry would be contaminated, so the main way to prevent the transmission of *C. diff* is to prevent the fecal/oral transmission. Using gloves and washing hands is the key to that. Masks would be useful and gowns can be helpful.

Over ninety-nine percent of *C. diff* cases are antibiotic related. He understood Claimant had been taking Cipro for a sinus infection. The Cipro is in a class of drugs that has been implicated as one of the more common antibiotics to cause clinical *C. difficile* colitis. He did a literature search and could not find any data that hospital workers had a higher rate of *C. difficile* carriage. One cannot say where an individual acquired the *C. diff* in the vast majority of cases. He stated the antibiotic Claimant took caused the *C. diff* to become symptomatic. He concluded that he could not say, within a reasonable certainty, that Claimant acquired *C. diff* at work and that her work was the cause of her ultimate problems.

C. diff produces toxins that inhibit the colon's ability to reabsorb water. It can also damage the cells and create holes in the colon. Dr. Fried reviewed medical records including some clinical notes summarizing Claimant's course and a lab report documenting *C. diff*. He did not know if he had reviewed Dr. Scott Fockes' (sic) report. When he was asked whether or not it was more probable than not that Claimant did acquire the *C. diff* through nosocomial acquisition, he said that one would not be able to say more likely than not where Claimant got the disease because of the high prevalence in the community. He agreed with the statement environmental contamination by *C. difficile* is particularly common in hospitals and facilities providing long-term care. He recommended that to minimize the spread of *C. diff* in hospitals, patients with *C. diff* be put in a private room, or if that is unavailable, with another person that already has *C. diff*. They recommend that when the staff cares for those patients,

they use gloves for the contact. They recommend when leaving the patient room, that the gloves be removed and the hands be washed with soap and water. They recommend that patients wash their hands before leaving the room. They recommend that visitors having contact with those patients wear gloves and gowns and wash their hands when they leave the room.

Masking is generally not required for *C. diff* except to act as another barrier so one does not touch one's mouth. *C. diff* patients' linens that have diarrhea in their sheets are put into impervious bags and taken to the laundry and cleaned with a strong detergent, hot water, machine laundered, and dried. The bags are red in color to show that there is infectious waste. They look like high quality red trash bags with little biohazard signs on them. One can still get *C. diff* in spite of all precautions. It is possible that one could be working in the laundry room where the temperature is 100 to 105°, be perspiring, be masked, gowned and gloved, touch the diarrhea soiled linens, wipe one's forehead, and then the perspiration runs right down the mask into one's mouth. The key to hand hygiene for spores is simple--mechanical soap and water friction to physically remove the spores because you are not going to be able to kill them with anything your hands can tolerate. Cipro makes us more susceptible to allow the *C. diff* that we already had to cause disease. One can document a higher prevalence of *C. diff* in roommates of patients who were diagnosed with *C. diff*. Caring for a patient with *C. diff* increases your exposure and risk of acquiring asymptomatic *C. diff*. The proper use of a gown, gloves, and soap and water between every contact should greatly lower the risk of acquiring *C. diff* after caring for a *C. diff* patient. It lowers the risk but does not totally eliminate it.

A person that worked at the Qwik Trip has less exposure to *C. diff* than a lady working in the laundry room at a nursing home where there are patients that have *C. diff*. Dr. Fried testified that we are in the middle of a *C. diff* epidemic. Isolating laundry in nursing homes would be appropriate. He said that even if it is assumed that Claimant was at a higher risk for contracting the *C. diff*, at the end of the day, they still cannot tell when she contracted that *C. diff* or where she picked it up. All of his opinions were made within a reasonable degree of medical certainty.

VOCATIONAL EXPERT EVIDENCE

Mary Titterington performed a vocational evaluation of Claimant on April 5, 2006. Her deposition taken on June 19, 2006 was admitted as Exhibit G. All objections contained in Exhibit G are overruled. Ms. Titterington has been in the field of vocational rehabilitation counseling and consulting for twenty-nine years. She has a Master's degree in guidance and counseling. She estimated that she had given her testimony as a vocational rehabilitation expert probably 500 times.

Her April 8, 2006 report (Deposition Exhibit 3), noted that Claimant's attorney referred Claimant to her for an evaluation to determine Claimant's ability to compete for work in the open labor market. Claimant presented as a thin frail depressed woman with low energy. Ms. Titterington reviewed Claimant's school transcript, medical evaluations, and treatment records. She described Claimant's medical history, physical limitations, current emotional status, activities of daily living, post-injury activities, education, work history, and testing. Ms. Titterington's summary conclusion was that Claimant is a 64-year-old woman with a past history of unskilled, and low-level semi-skilled labor-intensive jobs. Her current functioning level is so low that there is no prediction that she could sustain work on a forty hour a week basis. She concluded that Claimant cannot consistently perform in a job as it is customarily performed in the open labor market. She is unemployable and will remain so unless substantial improvement is demonstrated in her physical and emotional functioning. Given the permanent nature of her impairment, that is not probably (sic).

Ms. Titterington noted that Dr. Folk had indicated Claimant cannot return to any laboring type of job. Claimant does not have a high school diploma and is computer illiterate. One of the major factors noted in Claimant's inability to return to work is her excessive fatigue. The report noted that Claimant could not sustain a full eight hour a day job. The report also noted that Claimant could not perform the essential requirements of work currently that are the ability to report to work on a daily basis (after two nights of no sleep, she would not be a reliable worker); the ability to stay on task throughout the day (she requires rest breaks after performing routine tasks, as frequently as every 15 minutes); get along with customers, coworkers or supervisors. The report noted that Claimant is not a good candidate for vocational services as there is no expectation that any services would restore her employability. Currently, her functional level was noted to be so low that she is being provided with a home health aide. Ms. Titterington testified that Claimant is permanently and totally disabled. Her opinions were within a reasonable degree of vocational certainty.

DISCUSSION

The attorneys advised at the beginning of the hearing in this case that one issue in dispute

was medical causation, or whether Claimant's alleged injury was causally related to an alleged accident or occupational disease. Claimant in her proposed Award filed on January 5, 2007 identified one issue as "Incidence of occupational disease (exposure and medical causation). Claimant's proposed Award did not identify "accident" as an issue, and it did not assert that Claimant sustained an injury by accident arising out of and in the course of employment. Claimant did not offer evidence that she sustained an accident in the course of her employment for Employer, and I find that she did not sustain an accident in the course of her employment for Employer.

Occupational diseases are compensable under the Missouri Workers' Compensation Act.^[1] The statute requires that the condition be an "identifiable disease arising with or without human fault and in the course of the employment."^[2] For an injury to be compensable under the Act, the work performed must have been a substantial factor in causing the medical condition or disability.^[3]

An employee's claim for compensation due to an occupational disease is to be determined under Section 287.067, RSMo. It defines occupational disease as:

an identifiable disease arising with or without human fault out of and in the course of the 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 this 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.

Section 287.067.2, RSMo, provides that 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." Section 287.067.6, RSMo provides: "Any employee who is exposed to and 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." A communicable disease is defined as "a disease that may be transmitted directly or indirectly from one individual to another" or a "disease due to an infectious agent or toxic product."^[4] "Contagious" is defined as "[r]elating to contagion; communicable or transmissible by contact with the sick or their fresh secretions or excretions."^[5]

Claimant must present substantial and competent evidence that he or she has contracted an occupationally induced disease rather than an ordinary disease of life. The Courts have stated that the determinative 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."^[6] In proving up a work-related occupational disease, "[a] claimant's medical expert must establish the probability that the disease was caused by conditions in the work place."^[7] There must be medical evidence of a direct causal connection between the conditions under which the work is performed and the occupational disease.^[8] Even where the causes of the disease are indeterminate, a single medical opinion relating the disease to the job is sufficient to support a decision for the employee.^[9]

Section 287.020.2, RSMo requires that the injury be "clearly work related" for it to be compensable.^[10] The employee must establish a causal connection between the accident and the claimed injuries.^[11] Section 287.020.2, RSMo (2000) requires that the injury be "clearly work related" for it to be compensable. 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."^[12] Injuries that are triggered or precipitated by work may nevertheless be compensable if the work is found to be a "substantial factor" in causing the injury.^[13] A substantial factor does not have to be the primary or most significant causative factor.^[14] An accident may be both a triggering event and a substantial factor in causing an injury.^[15] Further, there is no "bright-line test or minimum percentage set out in the Workers' Compensation Law defining 'substantial factor.'"^[16] The claimant in a workers' compensation case has the burden to prove all essential elements of her claim,^[17] including "a causal connection between the injury and the job."^[18] Although all doubts should be resolved in favor of the employee and coverage in a workers' compensation proceeding, if an essential element of the claim is lacking, it must fail.^[19]

The quantum of proof is reasonable probability.^[20] "Probable means founded on reason and experience which inclines the mind to believe but leaves room to doubt."^[21] Such proof is made only by competent and substantial evidence. It may not rest on speculation.^[22] Expert testimony may be required where there are complicated medical issues.^[23] "Medical causation of injuries which are not within common knowledge or experience, must be established by scientific or medical evidence showing the cause and effect relationship between the complained of condition and the asserted cause."^[24] Compensation is appropriate as long the performance of usual and customary duties led to a breakdown or a change in pathology.^[25]

Where there are conflicting medical opinions, the fact finder may reject all or part of one party's expert testimony which it does not consider credible and accept as true the contrary testimony given by

the other litigant's expert.^[26] The Commission's decision will generally be upheld if it is consistent with either of two conflicting medical opinions.^[27] The acceptance or rejection of medical evidence is for the Commission.^[28] The testimony of the Claimant or other lay witnesses as to facts within the realm of lay understanding can constitute substantial evidence of the nature, cause, and extent of disability when taken in connection with or where supported by some medical evidence.^[29] The trier of facts may also disbelieve the testimony of a witness even if no contradictory or impeaching testimony appears.^[30] The testimony of the employee may be believed or disbelieved even if uncontradicted.^[31]

After carefully considering the evidence, including the testimony at the hearing and the exhibits, I find that Claimant failed to sustain her burden of proof in this case. I find that *C. diff* is a communicable disease as contemplated by Section 287.067.6, RSMo. However, I find that Claimant did not establish, based on reasonable probability, that she was exposed to *C. diff* at Employer and that she contracted *C. diff* there. I find that Claimant did not prove that she worked around or handled soiled laundry of persons who had *C. diff* and became infected with *C. diff* as a result of her work for Employer.

Claimant did not produce competent and substantial evidence of the nature or extent of an exposure to *C. diff* that would show the cause and effect relationship between *C. diff* and the asserted exposure to it. I find that it is not enough for Claimant to show merely that she worked at the Veteran's home and may have been exposed to *C. diff* while working there. I find that in order to sustain her burden, she should have produced credible evidence that she was in fact exposed to *C. diff* while working for Employer and that she contracted the disease as a result of an exposure there. I find that she did not. Claimant failed to satisfactorily prove that she came into contact with and became infected by *C. diff* while working for Employer. I find that Claimant failed to prove that she had an exposure to *C. diff* at work that caused her to be infected with *C. diff*, and that she therefore did not prove that there was an exposure to the disease that was greater than or different from that which affects the public generally. Further, the medical experts stated that there was no way to tell when, how, or where Claimant contracted *C. diff*. In addition, Claimant testified that she always followed the procedures as instructed regarding hand washing, and wearing gloves, masks, and gowns. She had been instructed in proper procedures to handle laundry. She washed her hands every time she touched dirty laundry. In July and August 2004, Employer advocated, trained, and enforced the use of universal precautions in regards to protecting other residents and their workforce from the spread of infectious diseases.

Claimant worked in unit B, one of four units at the Veteran's home. She did not produce competent evidence that any patients infected with *C. diff* were in her unit when she worked there. Brian Hunt, Employer's Administrator, testified that the Veteran's Home treated six patients with *C. diff* in July and August 2004 at the Home. He did not recall how many of those might have been in units A, B, C, or D. Lois Rider, night shift supervisor at the Veteran's Home, testified that she could not say for definite, but it would not have been unusual for the Home to have at least one to two cases of patients with *C. diff* in July and August 2004. The Home had on average probably one hundred fifty patients during those months. Patricia Sims, Claimant's daughter in law, testified that in May and June 2004, Employer had four to five patients that had *C. diff* and diarrhea. She had seen that diagnosis in their

charts. None of these witnesses testified that any *C. diff* infected patients were in unit B where Claimant worked. There was no evidence presented as to how long those infected patients were at the Home. No one testified that Claimant handled any soiled laundry of any patients who were infected with *C. diff*.

Further, Claimant did not prove that *C. diff* was otherwise in her unit when she worked there, or that she contracted *C. diff* from environmental contact at Employer as opposed to from some other location. Although there may have been a greater risk of exposure at Employer, I find that a greater risk of exposure in and of itself is not enough for Claimant to meet her burden. I find that she needed to prove that she was in fact exposed to *C. diff* while working for Employer and contracted the disease as a result of an exposure there, and that she failed to carry her burden.

Claimant asserts in page 44 of her proposed Award that her “employment at the Veterans’ Home, including her handling the laundry of residents who had contracted *Clostridium difficile* bacteria, put her at greater risk of exposure than members of the general public.” However, as noted above, the competent evidence in this case does not establish that Claimant in fact handled the laundry of residents who had contracted *C. diff* bacteria.

Dr. Fried concluded that he could not say, within reasonable certainty, that Claimant acquired *C. diff* at work and that her work was the cause of her ultimate problems. He also stated that even if it was assumed that Claimant was at a higher risk for contracting *C. diff*, at the end of the day, they still cannot tell when she contracted that *C. diff* or where she picked it up. Dr. Fried noted that there was no documentation of exposure to stools from an infected patient. He also noted that as a laundry worker, Claimant would have minimal exposure to secretions and excretions. He noted that one cannot say where an individual acquired the *C. diff* in the vast majority of cases. I find Dr. Fried’s conclusions credible. Although Dr. Fried agreed with the statement that environmental contamination by *C. difficile* is particularly common in hospitals and facilities providing long term care, that does not sustain Claimant’s burden. Greater risk of exposure does not translate to actual exposure while working for Employer. And Dr. Folk’s statement that “Claimant’s employment at the Veterans Home, including her handling of laundry of residents who may have contracted *Clostridium difficile* bacteria, put her at greater risk of exposure than members of the general public,” does not document any actual exposure to *C. diff*.

Dr. Folk’s statement in his report that it was more likely than not that Claimant contracted *Clostridium difficile* infection at the Missouri Veteran’s Home in Cameron, Missouri is conclusory. I do not find Dr. Folk’s statement credible. It is not based upon evidence of any specific exposure by Claimant to *C. diff*. His report and deposition testimony were not based upon any specific evidence that there were any infected patients in the area where Claimant worked, that Claimant handled any laundry of infected patients, or that Claimant otherwise had contact with infected persons. His report and deposition testimony were not based upon any evidence that Claimant in fact encountered conditions at work that exposed her to *C. diff*, or engaged in any conduct at work that resulted in her becoming infected.

The evidence established that *C. diff* enters into the system through a fecal to oral route. Poor hygiene is one way to spread the disease. However, there is no way to tell how the disease entered into one’s system, whether it was naturally occurring, through poor hygiene, or

through a source completely unrelated to exposure at work. Further, because *C. diff* can remain asymptomatic, it can reside in a person's body for months or years.

Reasonable probability may not rest on speculation. Claimant failed to prove that she contracted *C. diff* as a result of an accident or an occupational exposure in the course of her employment for Employer. Claimant failed to satisfactorily prove that she was exposed to and infected by *C. diff* while working for Employer.

CONCLUSION

In conclusion, based upon substantial and competent evidence and the application of The Missouri Workers' Compensation Law, I find in favor of the Employer/Insurer and deny Claimant's request for benefits. I find that Claimant failed to sustain her burden of proof that she sustained an injury by accident or occupational disease arising out of and in the and course of her employment for Employer on or about August 1, 2004. Claimant failed to show that her injury was clearly work related and failed to show that work was a substantial factor in the cause of her alleged occupational injury and the resulting medical condition. Claimant's claim for benefits is denied, and all other issues are moot.

Date: March 5, 2007 Made by: /s/ Robert B. Miner
Robert B. Miner
Administrative Law Judge
Division of Workers' Compensation

A true copy: Attest:

/s/ Patricia "Pat" Secret
Patricia "Pat" Secret, Director
Division of Workers' Compensation

[1] Sections 287.067.1, 2, RSMo (2000). All statutory references are to the Revised Statutes of Missouri 2000, unless otherwise noted.

[2] *Id.*

[3] *Kent v. Goodyear Tire and Rubber Company*, 147 S.W.3d 865, 867-68. (Mo.App 2004).

[4] *Sharon Twitty vs. St. Louis County et al.*, 2003 WL 22702482 (Mo.Lab.Ind.Rel.Com. November 13, 2003), citing, *American Jurisprudence Proof of Facts, 3d Series, Taber's Cyclopedic Medical Dictionary*, 16th Edition, page 392 (1989). See also, *Stedman's Medical Dictionary*, 28th Edition, page 554 (2006) which defines "communicable disease" as any disease "that is transmissible by infection or contagion directly or through the agency of a vector."

[5] *Stedman's Medical Dictionary*, 28th Edition, page 435 (2006).

[6] *Polavarapu v. General Motors Corp.*, 897 S.W.2d 63, 65 (Mo.App 1995); *Dawson v. Associated Elec.*, 885 S.W.2d 712, 716 (Mo.App 1994), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 228; *Hayes v. Hudson Foods, Inc.*, 818 S.W.2d 296, 300 (Mo.App 1991); *Prater v. Thorngate, Ltd.*, 761 S.W.2d 226, 230 (Mo.App 1988); *Sellers v. Trans World Airlines, Inc.*, 752 S.W.2d 413, 415 (Mo.App 1988); *Jackson v. Risby Pallet and Lumber Co.*, 736 S.W.2d 575, 578 (Mo.App 1987).

[7] *Smith v. Donco Const.*, 182 S.W.3d 693, 701 (Mo.App.2006) (citing *Brundige v. Boehringer Ingelheim*, 812 S.W.2d 200, 202 (Mo.App.1991) (quoting *Sheehan v. Springfield Seed & Floral, Inc.*, 733), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 226 S.W.2d 795, 797 (Mo.App.1987)); *Dawson*, 885 S.W.2d at 716.

[8] *Dawson*, 885 S.W.2d at 716; *Estes v. Noranda Aluminum, Inc.*, 574 S.W.2d 34, 38 (Mo.App.1978).

[9] *Dawson*, 885 S.W.2d at 716; *Prater v. Thorngate, Ltd.*, 761 S.W.2d 226, 230 (Mo.App.1988).

[10] Section 287.020 provides: "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, 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."

[11] *Thorsen v. Sachs Electric Company*, 52 S.W.3d 611, 618 (Mo.App. 2001), *overruled in part on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220, 225 (Mo. 2003); *Williams v. DePaul Ctr.*, 996 S.W.2d 619, 625 (Mo.App. 1999), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 226; *Fisher v. Archdiocese of St. Louis*, 793 S.W.2d 195, 198 (Mo.App 1990), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 230.

[12] *Kasl v. Bristol Care, Inc.*, 984 S.W.2d 852 (Mo. 1999).

[13] *Kasl*, 984 S.W.2d at 853; *Cahall v. Cahall*, 963 S.W.2d 368, 372 (Mo.App 1998), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 226.

[14] *Bloss v. Plastic Enterprises*, 32 S.W.3d 666, 671 (Mo.App 2000), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 225; *Cahall*, 963 S.W.2d at 372.

[15] *Bloss*, 32 S.W.3d at 671.

[16] *Cahall*, 963 S.W.2d at 372.

[17] *Royal v. Advantica Restaurant Group, Inc.*, 194 S.W. 3d 371, 376 (Mo.App 2006), citing *Cook v. St. Mary's Hosp.*, 939 S.W.2d 934, 940 (Mo.App. 1997), *overruled on other grounds by Hampton*, 121 S.W.3d at 226.

[18] *Royal*, 194 S.W. 3d at 376, citing *Williams v. DePaul Health Ctr.*, 996 S.W.2d 619, 631 (Mo.App. 1999), *overruled on other grounds by Hampton*, 121 S.W.3d at 226.

[19] *Thorsen*, 52 S.W.3d at 618; *White v. Henderson Implement Co.*, 879 S.W.2d 575, 579 (Mo.App. 1994), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 228.

[20] *Thorsen*, 52 S.W.3d at 620; *Downing v. Willamette Industries, Inc.*, 895 S.W.2d 650, 655 (Mo.App 1995), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 227; *Fischer v. Archdiocese of St. Louis*, 793 S.W.2d 195, 199 (Mo.App. 1990), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 230.

[21] *Thorsen*, 52 S.W.3d at 620; *Tate v. Southwestern Bell Telephone Co.*, 715 S.W.2d 326, 329 (Mo.App 1986); *Fischer*, 793 S.W.2d at 198.

[22] *Griggs v. A. B. Chance Company*, 503 S.W.2d 697, 703 (Mo.App. 1974).

[23] *Goleman v. MCI Transporters*, 844 S.W.2d 463, 466 (Mo.App. 1992), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 229.

[24] *Thorsen*, 52 S.W.3d at 618; *Brundige v. Boehringer Ingelheim*, 812 S.W.2d 200, 202 (Mo.App 1991).

[25] *Bennett v. Columbia Health Care*, 134 S.W.3d 84, 87 (Mo.App. 2004).

[26] *Kelley v. Banta & Stude Constr. Co. Inc.*, 1 S.W.3d 43, 48 (Mo.App. 1999); *Webber v. Chrysler Corp.*, 826 S.W.2d 51, 54 (Mo.App. 1992), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 229; *Hutchinson v. Tri-State*

Motor Transit Co., 721 S.W.2d 158, 162 (Mo.App. 1986), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 231.

[27] *Klietheremes v. Abb Power T & D*, --- S.W.3d ----, 2007 WL 45643 (Mo.App. W.D.); *Smith v. Donco Const.*, 182 S.W.3d 693, 701 (Mo.App. 2006).

[28] *Klietheremes*, 2007 WL 45643; *Smith*, 182 S.W.3d at 701; *Bowers v. Hiland Dairy Co.*, 132 S.W.3d 260, 263 (Mo.App. 2004).

[29] *Pruteanu v. Electro Core, Inc.*, 847 S.W.2d 203, 206 (Mo.App. 1993), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 229; *Reiner v. Treasurer of State of Mo.*, 837 S.W.2d 363, 367 (Mo.App 1992); *Fischer*, 793 S.W.2d at 199.

[30] *Hutchinson*, 721 S.W.2d at 161-2; *Barrett v. Bentzinger Brothers, Inc.*, 595 S.W.2d 441, 443 (Mo.App. 1980), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 231.

[31] *Weeks v. Maple Lawn Nursing Home*, 848 S.W.2d 515, 516 (Mo.App. 1993), *overruled in part on other grounds by Hampton*, 121 S.W.3d at 229.