ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

KADE WOODELL, Employee, Claimant, v. ALASKA REGIONAL HOSPITAL, Employer, and INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, Insurer, Defendants.	FINAL DECISION AND ORDER AWCB Case No. 201901025 AWCB Decision No. 22-0051 Filed with AWCB Anchorage, Alaska on July 14, 2022.

Kade Woodell's February 5, 2019, November 13, 2019, and July 24, 2020 claims were originally heard on August 20, 2020. (*Woodell v. Alaska Regional Hospital*, AWCB Decision No. 20-0081 (September 21, 2020)(*Hughes VII*). *Hughes VII* was appealed to the Alaska Workers' Compensation Appeals Commission (Commission), which determined Employer's rights to due process were violated when *Woodell VII* admitted the opinion letters of four physicians without allowing Employer to cross-examine those four physicians regarding their opinions and the basis for those opinions. *Alaska Regional Hospital v. Woodell*, AWCAC Dec. No. 20-0081 (June 16, 2021)(*Woodell VIII*). *Woodell VIII* remanded the matter to afford Employer the right to cross-examine those physicians. Kade Woodell's (Employee) workers' compensation claims (WCC) were heard on May 18, 2022 in Anchorage, Alaska, a date selected on April 11, 2022. Employer's March 22, 2022 hearing request gave rise to this hearing. Employee appeared, testified, and

represented himself. Attorney Krista Schwarting appeared and represented Alaska Regional Hospital and Indemnity Insurance Company of North America (Employer). Witness Jenny Mayo, Employer's infection prevention coordinator, appeared and testified on behalf of Employer. The record closed at the hearing's conclusion on May 18, 2022.

ISSUES

Employee contends his treating physicians' opinion letters dated February 18, 2019, February 27, 2019, March 13, 2019, November 5, 2019, December 3, 2019, January 21, 2020, September 1, 2021, September 9, 2021, and January 27, 2022 should be admitted in evidence as an exception to hearsay to corroborate direct evidence.

Employer contends because Employee's physicians' opinion letters were prepared for litigation and are hearsay, they are not admissible. Employer had timely requested cross-examination of all these physicians but Employee had not made those physicians available for cross-examination as ordered by the Commission in *Woodell VIII* for the letters dated February 18, 2019 through December 3, 2019. Employer also contended Employee did not make the physicians who authored the January 21, 2020, September 1st, and 9th, 2021, and January 27, 2022 opinion letters available for cross-examination so those letters should also be excluded.

1) **Was the oral order excluding the Employee's physicians' letters correct?**

Employee contends the findings in *Woodell VII*, including credibility findings, made at the prior merits hearing, must stand.

Employer contends allowing the factual findings, including credibility findings, made in *Woodell VII* would result in manifest injustice as the board panel relied on inadmissible physician opinion letters in reaching its factual and credibility findings.

2) **Does the law of the case doctrine apply?**

Employee contends his Clostridium Difficile (C. difficile) infection arose out of and in the course of his employment with Employer and his work injury is the substantial cause of his disability and need for medical treatment.

Employer contends Employee's C. difficile infection did not arise out of and the course of his employment with Employer. It seeks an order denying Employee's claims based on lack of causation connection between the work Employee did for Employer and his C-difficile diagnosis. It seeks an order denying the claim.

3) Did Employee's C. difficile infection arise out of and in the course of his employment with Employer?

FINDINGS OF FACT

A preponderance of the evidences establishes the following facts and factual conclusions:

1) The decisions to date, both Board and Commission, are as follows:

(1) *Woodell v. Alaska Reg'l Hosp*., Alaska Workers' Comp. Bd. Dec. No. 19-0077 (July 26, 2019) (*Woodell I*) (Employee's claim was not time barred);

(2) *Alaska Reg'l Hosp v. Woodell*, Alaska Workers' Comp. App. Comm'n Order on Petition for Review in AWCAC Appeal No. 19-014 (Oct. 15, 2019) (*Woodell II*); (Petition for review accepted, but matter remanded to the Board for credibility determination. Motion for Stay granted *nunc pro tunc*);

(3) (*Woodell v. Alaska Reg'l Hosp*., Alaska Workers' Comp. Bd. Dec. No. 19-0122 (Nov. 27, 2019) (*Woodell III*)(On remand from the AWCAC, board panel found Employer's witness, vice president of Employer's human resources department Allie Miller's testimony not credible);

(4) *Alaska Reg'l Hosp*. *v. Woodell*, Alaska Workers' Comp. App. Comm'n Order on Petition for Review on Appeal AWCAC Appeal No. 19-014 (Jan. 21, 2020) (*Woodell IV*)(Employer's petition for review of *Woodell I* and motion for stay denied, *Woodell I* affirmed);

(5) *Woodell v. Alaska Reg'l Hosp*., Alaska Workers' Comp. Bd. Dec. No. 20-0018 (Apr. 2, 2020) (*Woodell V*)(Employer's petition for dismissal denied, Employee ordered to provide names of charge nurses or persons with whom he reported his C. Difficile exposure and persons with whom he discussed his C. difficile exposure);

(6) *Woodell v. Alaska Reg'l Hosp.,* Alaska Workers' Comp. Bd. Dec. No. 20-0060 (July 21, 2020) (*Woodell VI*)(Employee's appeal of May 12, 2020 discovery order denied);

(7) *Woodell v. Alaska Reg'l Hosp*., Alaska Workers' Comp. Bd. Dec. No. 20-0081 (Sept. 21, 2020) (*Woodell VII*)(Employer's requests for cross-examination untimely and not considered, Employee entitled to TTD, and medical costs);

(8) *Alaska Reg'l Hosp. v. Woodell*, Alaska Workers' Comp. App. Comm'n Decision No. 288 (June 16, 2021)(*Woodell VIII*)(Employer's requests for cross-examination timely, remand to afford Employer opportunity to cross-examine physician authors of opinion letters);

(9) *Woodell v. Alaska Reg'l Hosp*., Alaska Workers' Comp. Bd. Dec. No. 22-0019 (March 16, 2022) (*Woodell IX*)(Employee to make physician authors of opinion letters available for cross-examination and Employer to make EME physician Ventakachala Mohan available for cross-examination).

2) On May 9, 2016, John Price, M.D., evaluated Employee for headache and abdominal pain. Employee reported having abdominal pain and belching, which was relieved by vomiting. He had taken the proton pump inhibitor (PP inhibitor) [a gastric acid suppressant] for two weeks, but that had not helped. His symptoms seemed to occur for a week at a time and then he would be fine. Heavier foods seemed to provoke the symptoms. Employee also reported an injury to his right lower extremity after a fall. (Dr. Price's clinic note, May 9, 2016).

3) On June 25, 2016, Employee followed-up with Dr. Price for his headache, abdominal pain, and injury to the lower extremities. His leg was better. His headache was not much better with the pain medication Fioricet. His abdominal pain was felt to be possibly an ulcer although the proton pump inhibitor was not helping. (Dr. Price's clinic note, June 25, 2016).

4) On January 18, 2017, Employee was seen at Providence Alaska Medical Center emergency room (ER) with fever, cough, and night sweats complaints. He had not had his annual flu shot. A chest x-ray showed a left upper lobe pneumonia. He was given a dose of the antibiotic doxycycline as well as a prescription for doxycycline. He was diagnosed with an upper left lobe pneumonia due to an infectious organism. (Shannon Faber, M.D.'s ER note, January 18, 2017).

5) On May 5, 2017, Employee began working as a nurse for Employer in the cardiovascular stepdown unit (CVSU). He cleaned, bathed, medicated administered intravenous fluids, changed gowns and diapers, provided meals, and moved patients. (*Woodell I and VII*).

6) From September 26, 2018, through October 15, 2018, Employee traveled throughout Germany, France, Austria, and Switzerland. He began experiencing epigastric pain, in addition to other symptoms such as upper and lower abdominal pain, nausea, vomiting, and diarrhea. He thought it was another episode of irritable bowel syndrome (IBS). Employee sought help in a local pharmacy and was given some medication. He developed hemorrhoids due to frequent diarrhea. Upon return, he called in sick to work. (*Woodell I* and *VII*).

7) On October 18, 2018, Christopher Calvert, M.D., evaluated Employee at the Alaska Regional Hospital (ARH) emergency room (ER) for epigastric abdominal pain that had been present for about 24 hours. Employee gave a history of IBS. He reported regularly experiencing an irritated stomach after eating and having six to ten loose bowel movements per day. He also reported he has had chronic diarrhea with intermittent vomiting over the past ten years related to his IBS history. Employee stated he was taking 75mg of Viberzi for IBS and 30mg of the anxiolytic Celexa daily and 1mg of Ativan, also an anxiolytic, as needed for anxiety. Dr. Calvert ordered a computed tomography (CT) scan with contrast of the abdomen and pelvis to evaluate Employee's epigastric pain. (Dr. Calvert's ER report, October 18, 2018).

8) On October 18, 2018, the abdominal and pelvic CT scan was normal. (CT scan report, October 18, 2018).

9) On October 18, 2018, John Gillis, M.D., evaluated Employee for his complaints of mid-epigastric, non-radiating abdominal pain. Dr. Gillis noted Employee had a long history of IBS, but he had not been using Viberzi for the past three weeks. Employee reported he and his wife had been on a multi-week, multi-city European tour with 14 of his closest relatives. Employee stated it was chaotic and stressful with a lot of moving around. Employee reported he had been seen in the emergency room the prior night and had a CT scan of the abdomen and pelvis as well as labs done, all of which were normal. Dr. Gillis ordered an upprper gastrointestinal series x-ray and prescribed the antacid medications Carafate and Protonix, a proton pump inhibitor. (Dr. Gillis' clinic note, October 19, 2018).

10) On November 1, 2018, Employee's upper GI series was normal. (Harold Cable, M.D.'s x-ray report, November 1, 2018).

11) On November 2, 2018, on referral from Dr. Gillis, Eric Tompkins, M.D., evaluated Employee for his various GI symptoms. Employee reported his GI symptoms included an approximately 5-year history of epigastric pain. He also reported he had intermittent nausea and

vomiting. He had been taking the proton pump inhibitor Protonix for two weeks without any improvement. Dr. Tompkins noted Employee had several drinks of alcohol a day and took the nonsteroidal anti-inflammatory Ibuprofen occasionally. Employee reported a long history of loose bowel movements which had been occurring for approximately 10 years. He typically had anywhere between 5 and 12 bowel movements a day. He had never had any stool studies checked and had not had a colonoscopy. His weight had remained stable. (Dr. Gillis's clinic note, November 2, 2018).

12) On November 2, 2018, Employee underwent an abdominal ultrasound ordered by Dr. Tompkins. The impression was the gallbladder and kidneys appeared within normal limits, as did visualized portions of the pancreas. (ARH's diagnostic imaging result, November 2, 2018).

13) On November 3, 2018, Employee again presented at Alaska Regional Hospital emergency room for progressively worsening epigastric tightness with chest pains. Mark Shephard, M.D., treated Employee in the ER. (Dr. Shephard's ER note, November 3, 2018).

14) On November 7, 2018, the hepatobiliary scan with ejection fraction ordered by Dr. Tompkins was performed. The findings were normal. The gallbladder visualized normally and contracted appropriately in response to a fatty meal. It was noted Employee did complain of increased nausea with the fatty meal. (Julee Holayter, M.D.'s scan report, November 7, 2018).

15) On November 9, 2018, Employee underwent a colonoscopy performed by Dr. Tompkins. A sessile polyp was found in the recto-sigmoid colon and removed. Normal mucosa was found in the entire colon. Biopsies for histology were taken from the left and right colon for evaluation of microscopic colitis. Dr. Tompkins also performed an upper GI endoscopy, which revealed an LA Grade A esophagitis (one or more mucosal breaks less than 5 mm, not extending between tops of two mucosal folds). No bleeding was found 39 cm from the incisors. The stomach and duodenum were normal. Biopsies were taken to evaluate celiac disease. (Dr. Tompkins' colonoscopy and upper GI endoscopy reports, November 2018).

16) On November 14, 2018, Dr. Tompkins saw Employee in follow up. Dr. Tompkins noted Employee had epigastric pain of unclear origin. He noted the only remotely positive study was the recreation of his pain following a fatty meal. He stated they were still waiting on the second and third samples of ova and parasites given the problems with diarrhea, which sounds like IBS more than anything else. Dr. Tompkins planned to discuss Employee's case with a surgeon to see whether he though a cholecystectomy would be of any benefit. He explained to Employee he was

not at all certain his pain was related to his gall bladder but had largely exhausted the evaluation he could do. (Dr. Tompkins' clinic report, November 14, 2018).

17) On November 18, 2018, the ova and parasite tests performed on Employee's stool specimen were negative. (Quest Diagnostics lab report, November 18, 2018).

18) On November 28, 2018, surgeon Mahdu Prasad performed a cholecystectomy and Employee's gallbladder was normal. (Dr. Prasad's operative report, November 28, 2018).

19) On December 29, 2018, Employee's polymerase chain reaction (PCR) stool test for C. difficile toxin A+B was positive. (Medical Park Family Care, Inc. laboratory report, December 29, 2018).

20) On February 18, 2019, Employee's stool test for C. difficile toxin gene nucleic acid amplification (NAA) test was positive. (LabCorp test results, February 18, 2019).

21) On February 19, 2019, Employee's stool test for C. difficile toxins A+B, enzyme linked immunosorbent assays (EIA) was positive. (LabCorp lab report, September 19, 2019).

22) On April 2, 2019, on referral from Dr. Cedeno, gastroenterologist Allan Weston, M.D., evaluated Employee for his recurrent C. difficile. Employee complained of ongoing diarrhea and reported a history of chronic diarrhea and IBS. Employee reported he began to get sick with nausea, vomiting and diarrhea in September 2018 after he was exposed to a patient with C. difficile in the hospital in Alaska. Employee reported he was found to have C. difficile in January 2019. He had been treated with the antibiotics Vancomycin, Flagyl and Dificid. He reported he had a prior esophagogastroduodenoscopy and colonoscopy in Alaska, and was told they were normal, although one polyp was removed. Dr. Weston noted Employee had a camera capsule on February 21, 2019 in which the mucosa was found to be normal to the cecum. Employee continued to complain of recurrent night sweats, low grade fever, and diffuse abdominal cramping. Employee stated he worked in the medical field in Alaska and felt that was why he continued to get C. difficile. Dr. Weston's impression was C. difficile, IBS with diarrhea and weight loss. Dr. Weston prescribed the GI medicine IBgard and planned to perform a stool transplant. (Dr. Weston's clinic note, April 2, 2019).

23) On April 8, 2019, Employee underwent a colonoscopy with fecal transplant using OpenBiome, an FDA-approved stool, for his recurrent C. difficile performed by Dr. Weston. Dr. Weston noted Employee had been treated with the antibiotics Vancomycin, Flagyl and Dificid. Dr. Weston noted the colonic mucosa was normal throughout. Biopsies were obtained throughout

the colon to look for microscopic collagenous colitis. The terminal ileum appeared normal. Half the OpenBiome fecal transplant was delivered to the terminal ileum and the other half was delivered to the cecum. (Dr. Weston's procedure report, April 8, 2019).

24) On April 9, 2019, Employee's colon mucosal biopsies taken during the April 8, 2019 colonoscopy were reported as benign, without significant histopathology observed. (Michael Kane, M.D.'s pathology report, April 9, 2019).

25) On April 29, 2019, Emil Bardana, Jr., M.D., an employer medical evaluation (EME) reviewed Employee's medical records and performed a history and physical examination. Employee told Dr. Bardana he had had problems with food intolerance earlier in his life, which had regressed during adolescence. The episodes occurred up to three times per week and usually lasted a day or two. He would have abdominal cramps and diarrhea, with diarrhea being prominent. He would also have bloating and indigestion following meals. He was eventually told he had IBS. He needed to manage his diet to reduce the symptomatology. In 2015, Employee was employed at Northwest Hospital in Bentonville, Arkansas. He had no health problems but continued to have episodes of IBS including bloating and indigestion. He tried to control the symptoms by eating bland foods. Employee recalled taking Protonix during this time, but his symptoms continued. Employee believed he developed a C. difficile infection in September 2018 when he was exposed to one or more patients with C. difficile infection. Employee specifically isolated one incident in which infection control measures were lifted prematurely on a patient who still had active infection with C. difficile. He had cared for this patient over a 12-hour shift. Employee also claimed there was a shortage of health aides and orderlies on the ward so he had to bathe and feed the patient and change bed linens. Employee said he reported this to his shift supervisor, but there were no medical records of this in the documents Dr. Bardana was provided. (Dr. Bardana's EME report, May 13, 2019).

26) Dr. Bardana diagnosed Employee with the following: (1) protracted history of irritable bowel with abdominal cramping, bloating and diarrhea, and at times nausea and vomiting. This began at either age 14 or 18, since the records conflict on the starting date; (2) history of pilonidal disease as a young adolescent; (3) gastroesophageal reflux disorder (GERD) with Grade A esophagitis consistent with reflux disease, treated with Protonix and Zantac (acid reducing medications); (4) acute gastroenteritis in the summer of 2017 with acute diarrhea of 5 to 10 movements a day and abdominal cramps; (5) probable clostridium difficile enterocolitis diagnosed

with stool positive toxin A + B on December 29, 2018; (6) documented anxiety disorder, treated with Ativan; (7) documented depression treated with Celexa; (8) history of recurrent headaches which have been suspected as having migrainous features; (9) bilateral inguinal hernias which have not been surgically repaired; (10) status-post laparoscopic cholecystectomy in December of 2018; (11) status-post colonoscopy with removal of a sessile polyp (benign) in November of 2018; (Marijuana use disorder (ingestion of edibles and smoking cigarette and pipe) for the past two years; (13) occasional hypertension possibly associated with stress of his work and/or disease; (14) documented acute sinusitis in February of 2019 requiring antibiotic therapy (Augmentin); (15) history of probable pneumonia in early 2017 for which he received emergency care at Providence ER. (*Id*.).

27) Dr. Bardana stated the major risk factors for the development of C. difficile infection include hospitalization, prolonged length of stay in a hospital, age greater than 65, and antibiotic exposure, in particular Clindamycin, Fluoroquinolones, and Cephalosporins, although any antibiotic taken within the preceding three to four months can produce a C. difficile infection. Other secondary factors include co-morbidity conditions such as renal disease and inflammatory bowel disease (Crohn's disease or ulcerative colitis), acid reducing therapy, and gastrointestinal surgery or procedures. He noted Employee's only hospitalization might have come from his pilonidal disease surgery in 2012, although medical records are unavailable for review. He was exposed to antibiotics for his pilonidal disease and again in 2017 for treatment of his pneumonia, He was also exposed to antibiotics for his protracted maxillary sinusitis in February 2019. He had a cholecystectomy in December 2018 and has been treated with acid reducing therapy for significant periods of time for his GERD in 2018 into 2019. Therefore he had multiple risk factors for C. difficile infection. Dr. Bardana stated the significant lack of detailed medical records as well Employee's long history of IBS, GERD, and acute gastroenteritis made pinpointing the commencement of his C. difficile infection almost impossible. Dr. Bardana was unable to select a likely time and a likely pathogenesis for Employee's C. difficile infection. However, he opined the most compelling incidents were his pneumonia in 2017 for which he received antibiotics and his cholecystectomy in late December of 2018. He could not exclude his contact with infected patients at Alaska Regional Hospital or at Northwest Medical Center in Bentonville, Arkansas. Dr. Bardana again opined Employee's history of antibiotic therapy and gastrointestinal procedures or surgery were much more likely to be the inciting cause for the C. difficile enterocolitis. He also

noted Employee had undergone multiple antibiotic treatments for C. difficile in the form of Flagyl, Vancomycin, Dificid, and a fecal transplantation, all without benefit. This would indicate he may have been misdiagnosed. He also noted stool assays may remain positive during or after clinical recovery. Dr. Bardana recommended Employee be evaluated by a board-certified gastroenterologist and/or a board-certified infectious disease specialist to further elucidate the medical issues in Employee's case. (*Id*.).

28) At hearing on June 17, 2019, Employee testified he worked all day on September 21, 2018 with a C. Diff infected patient without "personal protective equipment," such as gown and gloves, due to the lack of "contact precautions" on the patient. When he returned the next day or shift after September 21, 2018, he testified contact precautions were placed for the same patient he had cared for on September 21, 2018. Employee testified he had informed the charge nurse he had treated a patient with C. Diff without "personal protective equipment" on September 21, 2018. (*Woodell I*).

29) On July 2, 2019, Employee underwent colonoscopy and fecal transplant for treatment of recurrent C. difficile diarrhea. The entire examined colon appeared normal. The donor stool was instilled in the cecum. No specimens were collected. (Dr. Wigington procedure report, July 2, 2019).

30) On July 26, 2019, *Woodell I,* made the following factual finding:

> On September 21, 2018, Employee developed a Clostridium Difficile (D-Diff) infection while working for Employer. (Employee; Telephonic Deposition of Kade Woodell, at 26; Medical Summary, John Price, M.D., letter, February25, 2019; Medical Summary, John Gillis, M.D., letter; Phillip Cedeno, M.D., letter, March 19, 2019.

(*Woodell I*).

31) On September 21, 2019, Employee's stool test collected on September 19, 2019 tested positive for C. difficile toxin A+B. (LabCorp Lab report, September 21, 2019).

32) On September 30, 2019, Employee followed up with Dr. Wigington. Employee reported he still was having six to twelve loose stools a day. He had had his second fecal microbiota transplantation (FMT), but stated he was unable to hold it long and worried it didn't do any good because of diarrhea soon after awakening from anesthesia. Dr. Wigington noted Employee was understandably frustrated with his lack of improvement. Employee opined he has not improved with any of the previous antibiotics either, including Vancomycin, Flagyl, and Dificid. He was also continuing to lose weight. Dr. Wigington's impressions were persistent C. difficile infection

vs. C. difficile colonization with post-infectious irritable bowel syndrome. Dr. Wigington recommended another FMT with biopsies to evaluate for inflammation. (Dr. Wigington's clinic note, September 30, 2019).

33) On November 8, 2019, Employee underwent a colonoscopy and fecal microbiota transplant using the commercial donor stool product from OpenBiome. The entire examined colon appeared normal on direct and retroflexion views. Biopsies were taken for histology. The donor stool was instilled in the cecum. The examined portion of the ileum was also normal. (Dr. Wigington's procedure report, November 8, 2019).

34) On November 11, 2019, the terminal ileum and colon biopsies were normal, with no histopathologic abnormality. (Lucas Campbell, M.D.'s pathology report, November 11, 2019).

35) On December 3, 2019, Employer filed its request for cross-examination of Dr. Wigington on his November 5, 2019 letter regarding the opinions he expressed, the basis for these opinions, the records in the provider's possession which were a basis for his opinions, and the provider's qualifications to express such opinions. (Employer's request for cross-examination, December 3, 2019).

36) On June 2, 2020, Employee followed up with Dr. Price for his chronic abdominal pain. He had been scheduled to go to the Mayo Clinic, but the trip fell through. He complained of diffuse joint pain. He had been diagnosed with chronic C. difficile colitis and had had a fecal transplant. He also had depression and insomnia. He reported no nausea, vomiting, diarrhea or constipation or abdominal pain. His appetite had been normal. Dr. Price planned a follow-up appointment in three months. (Dr. Price clinic note, June 2, 2020).

37) On July 21, 2020, Dr. Bardana submitted a supplementary EME report after having the opportunity to review more of Employee's medical records, including the June 1, 2019 record of a positive C. difficile toxin PCR test and a September 30, 2019 positive test for C. difficile toxin A + B. To his list of diagnoses developed in the May 13, 2019 EME report, Dr. Bardana added the development of probable C. difficile enterocolitis diagnosed with stool positive toxin A+B on December 29, 2018. He noted Employee had diarrhea, cramps, bloating, diminished appetite, weight loss for which he had undergone multiple treatments with antibiotics including Vancomycin, Flagyl, Dificid and three fecal transplants, all of which failed to improve his situation. Intravenous gammaglobulin infusion also failed to improve his symptoms. Dr. Bardana opined there was no compelling medical data which would support Employee's belief his work

exposure contributed to the development of C. difficile enterocolitis. Dr. Bardana noted Ms. Jenny Mayo's letter indicated Employee had not assisted with any of the four patients diagnosed with C. difficile between August 1, 2018 and September 30, 2018. Employee claimed he reported his exposure to his shift supervisor, but there was no verification of this in the medical records. There was no epidemiological or other data directly supporting Employee's claim his work exposure caused the onset of his C. difficile enterocolitis. None of Employee's preexisting conditions of IBS, GERD, acute gastroenteritis in 2017 or removal of a colonic sessile polyp were the substantial cause of Employee's C. difficile enterocolitis. Dr. Bardana opined there were a number of likely alternatives that could have participated in causing Employee's infection, namely antibiotics given for his 2017 pneumonia, and acid-reducing medications for his GERD. Contact with an asymptomatic carrier at the hospitals where Employee had worked in Arkansas or Alaska were much less likely causes of his infection. Dr. Bardana again recommended consultation with a gastroenterologist, ideally with a specific interest in C. difficile enterocolitis. He opined this would be helpful to confirm the diagnosis and suggest alternative management approaches. (*Id*.).

38) On August 11, 2020, Dr. Bardana testified by deposition. He completed his residency training in internal medicine at Oregon Health and Science University in 1968, then did a fellowship in allergy and immunology. He was recruited back to Oregon Health and Science University in 1972 where he spent his entire career until 2014. He is board certified in both internal medicine and allergy and immunology. Dr. Bardana testified the key symptoms of C. difficile can mimic other conditions such as non-C. difficile gastroenteritis or IBS. Celiac disease is another condition that may have some of the same symptoms. Employee told Dr. Bardana he had a prior diagnosis of pilonidal disease with subsequent infections of the pilonidal cysts and that he had problems with IBS since either 2008 or 2014. He also had a history of anxiety and depression and he was on medication for those. Dr. Bardana requested that some blood tests be done that might be helpful in supporting the diagnosis at the time of his evaluation of Employee in April 2019, but Employee did not arrive at the laboratory phlebotomy area so the tests were not done. Dr. Bardana reviewed the results of the colonoscopies done in July 2019 and November 2019, both of which were normal. The biopsies done during the colonoscopy were also normal. There was a disparity between Employee's very significant symptomatology and the negative colonoscopies, no recorded fevers in the medical records other than Employee's complaints thereof, and no significant rise in the white blood cell counts. Dr. Bardana was unable to find any evidence of

fever, elevated white counts, or any pathological findings documented either by colonoscopy or by histopathology of biopsies taken during the colonoscopy. Employee's antibiotic use with the 2017 pneumonia, and the gastric acid suppressant Protonix he was given for the esophagitis are well known to precipitate C. difficile infection. (Dr. Bardana's deposition, August 11, 2020).

39) On cross examination, Dr. Bardana testified even without Ms. Mayo's memorandum stating Employee had not participated in the care of any of the four patients with C. difficile in the hospital from August 1, 2018 to September 30, 2018, he still would not be able to determine when Employee developed the infection. This is because there were other elements of his care in 2017 that could have caused this, including antibiotic use and the gastroenteritis that developed. Having Ms. Mayo's memorandum caused him to question the importance of Employee's description versus Ms. Mayo's findings, but it did not go further than that. When questioned about Dr. Gillis's March 13, 2019 four-line memorandum stating it was entirely likely Employee had contracted the diagnosed C. difficile infection from his job as a nurse with Employer as he daily came in contact with various bodily fluids from various patients, Dr. Bardana stated Dr. Gillis did not give any rationale, he just says that is his speculation. Dr. Bardana testified he himself did not speculate. In terms of a definite diagnosis and where it was caused, he himself could not come to a conclusion. That was Dr. Gillis' opinion, but he did not have to agree with it. (*Id*.).

40) At the August 20, 2020 hearing, Employee testified he was not aware if contact precautions were placed on the patient he cared for on September 21, 2018, the same patient from whom he believes he contacted C. difficile. He testified he was not involved with the care of that patient subsequently and it would have been the other nurse's duty to ensure it was documented. His knowledge this patient was infected with C. difficile and precautions needed to be placed was based on the discussion he overheard between the patient's physician and the nurse caring for the patient that day. (Hearing transcript, August 20, 2020).

41) On September 21, 2020, *Woodell VII*, relying on Dr. Price's February 18, 2019 opinion letter, Dr. Cedeno's February 27, 2019 opinion letter, and Dr. Gillis' March 13, 2019 opinion letter, found Employee raised the presumption he had sustained a compensable injury when he acquired C. difficile while working for Employer. (*Woodell VII*, September 21, 2020).

42) On November 19, 2020, Employee followed up with William Wigington, D.O., who noted Employee had a history of recurrent C. difficile colitis, but he had had two recent stools that were negative for C. difficile. Biopsies were negative for inflammatory bowel disease (IBD). Past stool

studies were negative for calprotectin and other infectious etiologies. Employee reported having multiple bowel movements a day, but his weight had been stable. He also reported quite of bit of reflux that is not improved with proton pump inhibitors. In addition, Employee reported diffuse joint pain in his knees, wrists and back. He was to be scheduled for knee surgery soon. Employee expressed fears about going back to work as a nurse and contracting C. difficile again. He requested a letter regarding his disability and ability to work in the near future. Dr. Wigington's impressions were a history of recent C. difficile, now negative, but with persistent diarrhea. He stated the differential diagnoses included post-infectious IBS, small bowel inflammatory bowel disease (IBD), celiac, post-cholecystectomy diarrhea, malabsorption, and joint pain that might be related to an inflammatory process. Dr. Wigington prescribed the medication cholestyramine for possible bile acid reflux and diarrhea. (Dr. Wigington's clinic note, November 19, 2020).

43) On December 11, 2020, the following laboratory test results ordered by Dr. Wigington, were all within normal limits or negative: (1) the transglutaminase IGA antibody, a test for celiac disease; (2) celiac disease antibodies; and (3) the C-reactive protein, a test for inflammation. (Laboratory test results, December 11, 2020).

44) On February 15, 2021, Employee followed up with Dr. Wigington and reported the medication cholestryramine, which he had started taking, had helped his reflux and also helped his diarrhea some. He was down to about six bowel movements a day. Employee stated he was having some joint pain and was worried it might be associated with his diarrhea. Dr. Wigington noted Employee had a colonoscopy in November 2019 that had normal biopsies, a negative celiac panel, negative stool studies, negative inflammatory bowel disease (IBD) panel, and negative stool calprotectin. (Dr. Wigington's clinic note, February 15, 2021).

45) Fecal calprotectin is a very sensitive marker for inflammation in the GI tract and useful for the differentiation of inflammatory bowel disease (IBD) from IBS. (www.ncbi.nlm.nih.gov).

46) From May 12, 2021 through August 9, 2021 Employee treated with chiropractor Ryan Carlson, D.C. for back and cervical pain. On May 17, 2021, Dr. Carlson opined there was degenerative arthritis in the cervical spine. (Dr. Carlson's clinic notes, May 12 through August 9, 2021).

47) On June 16, 2021, *Woodell VIII* found Employer's due process rights were violated as it had timely requested the right to cross-examine Employee's physicians Philip Cedeno, M.D., on his February 27, 2019 opinion letter, John Gillis, M.D., on his March 13, 2019 opinion letter, William

Wigington, D.O., on his December 3, 2019 opinion letter, and John Price, M.D., on his February 18, 2019 opinion letter. However, Employee had not made these physicians available for cross-examination. *Woodell VIII* remanded the matter to the Board to afford Employer the right to cross-examine these doctors. (*Woodell VIII*).

48) On September 14, 2021, Employee submitted a medical summary including: (1) chiropractor Dr. Carlson's August 10, 2021 opinion letter prepared for litigation, in which he opined Employee's mid-back pain was due to the severe dehydration Employee remembered having experienced after he worked as a registered nurse in Alaska. Dr. Carlson stated he could not definitely say this was the cause for Employee's degeneration in his spine, but dehydration can cause the disc spaces between the spine to compress, causing pain; (2) Dr. Price's September 9, 2021 opinion letter prepared for litigation, in which he opined Employee continued to complain of GI symptoms due to his recent C. difficile infection. He further opined as a result of the C. difficile infection and diarrhea, he was recently diagnosed with degenerative arthritis and subluxations by Dr. Carlson. (Medical summary, September 14, 2021).

49) On September 14, 2021, Employer timely filed its request to cross examine both chiropractor Dr. Carlson on his September 1, 2021 opinion letter and Dr. Price on his September 9, 2021 opinion letter. Employer wished to examine them both on their opinions expressed in their letters, the basis for these opinions, the records in their possession which were a basis for their opinions, and the provider's qualifications to express such opinions. (Employer's request to cross-examine, September 14, 2021).

50) On October 29, 2021, EME physician board-certified internist and gastroenterologist Venkatachala Mohan, M.D., performed a records review. He diagnosed Employee with IBS with diarrhea, a history of bile acid diarrhea secondary to cholecystectomy and past history of C. difficile carrier state. He opined Employee's September 21, 2018 work injury is not the substantial cause of his current condition. Dr. Mohan noted Employee had a long history of chronic IBS with diarrhea. Employee was noted on stool testing for evaluation of his chronic diarrhea to have C. difficile toxin A + B. However, he did not have polymerase chain reaction (PCR) testing and enzyme immunoassay (EIA) for toxin B. He was treated with the antibiotic Vancomycin without benefit. His endoscopy and colonoscopy evaluations showed no mucosal abnormality. Subsequent colonoscopies have also been normal. Fecal transplants have also not worked. As Employee had no clinical evidence of mucosal damage of C. difficile, his C. difficile was probably

in a chronic carrier state. Dr. Mohan stated Employee's main problem is chronic IBS with diarrhea, evidenced by numerous normal colonoscopies and endoscopies and the tests for inflammatory markers have been negative. In addition, Employee tested negative for celiac disease. Dr. Mohan stated this is classic IBS. Therefore the reported September 21, 2018 work injury suggesting C. difficile as a cause of his symptoms is not medically supported by the clinical evidence. Employee's pre-existing IBS is longstanding with exacerbations and remissions. Dr. Mohan also opined Employee's post-cholecystectomy bile acid diarrhea condition is not the main cause of his current condition, which is chronic IBS. He opined Employee did not have any restrictions to resuming and performing the job of a nurse he had at the time of his reported work injury from a GI standpoint and there were no restrictions from a GI standpoint. Dr. Mohan also stated neither C. difficile nor chronic IBS with diarrhea nor post-cholecystectomy bile acid diarrhea can cause degenerative orthopedic or hemorrhoidal problems. Regarding Employee's medical provider's opinion that dehydration caused by diarrhea could cause the disc spaces between the vertebrae to compress, Dr. Mohan stated there is no pathological explanation between fluid volume status of the body and disc degeneration. He also stated a doctor's opinion the C. difficile infection caused degenerative arthritis and hemorrhoids is not supported by any accepted medical authority. (Dr. Mohan's EME report, October 29, 2021).

51) On November 1, 2021, board certified orthopedic surgeon Darin Davidson, M.D., performed a record review EME focused on whether or not Employee's C. difficile enterocolitis caused Employee's orthopedic diagnoses of right knee meniscal tear and plica syndrome, left knee pain, neck pain or back pain. Dr. Davidson opined none of the above conditions could be attributed to a C. difficile infection on a more probable than not basis. A C. difficile infection could not be considered the substantial cause of Employee's orthopedic conditions. There was no objective evidence the C. difficile infection caused or aggravated the above orthopedic conditions. Dr. Davidson performed a thorough medical literature review and found no objective evidence to support Employee's orthopedic conditions were caused by his C. difficile enterocolitis. He stated he would be happy to review any of Employee's physicians' sources of evidence to support their claims the degenerative orthopedic conditions are related to a C. difficile infection. Dr. Davidson stated dehydration in disc spaces between the vertebrae can lead to degenerative changes in the spine, but the dehydration ("desiccation") in the intervertebral discs is not related to systemic dehydration as would occur in a C. difficile infection. The dehydration in degenerative disc disease

is related to abnormalities in the molecular and biochemical composition of the intervertebral discs, which results in loss of water from the intervertebral disc and/or articular cartilage. He performed a thorough medical literature review and found no objective definitive medical evidence that dehydration on a systemic level would cause degenerative joint changes. Dr. Davidson opined the September 21, 2018 work injury is not the substantial cause of Employee's right and left knees' musculoskeletal conditions, neck pain or back pain. (Dr. Davidson EME report, November 1, 2021).

52) On December 27, 2021, Dr. Davidson testified by deposition. Dr. Davidson worked at the University of Washington from 2011 through 2018, at which time he started his own clinical consulting and second opinion concierge care practice. Dr. Davidson conducted a record review of Employee's case. He stated he reviewed approximately 400 pages of medical records and felt he had adequate information to arrive at conclusions and diagnoses pertaining to the orthopedic or the musculoskeletal components of the case. The first time there was discussion of musculoskeletal symptoms was on June 2, 2020 when Employee reported to Dr. Price, he was having bilateral knee pain. Subsequently on September 1, 2021, Employee underwent surgery on his right knee and it was noted he might need surgery on his left knee as well. Neck and back pain were also listed. Dr. Davidson testified he could not attribute a C. difficile infection to be a substantial factor or a substantial cause in the development of a meniscal tear or plica syndrome. He ruled out C. difficile as the substantial cause of Employee's various orthopedic conditions, left and right knee pain, neck pain and back pain. After researching medical literature, orthopedic literature, and orthopedic textbooks, he was unable to find any information to link a C. difficile infection to any of Employee's orthopedic diagnoses. He stated the dehydration within the intervertebral disc is microscopic dehydration and does not occur because of loss of water. It occurs because of molecular microscopic changes within the composition of the intervertebral discs. It can be the result of normal aging or as a result of a traumatic injury which causes scarring that changes the molecular composition and structure. But is not the result of dehydration at a systemic level. Dr. Davidson testified persistent diarrhea due to C. difficile or IBS would not cause disk degeneration. He testified he was able to rule out the work and the reported C. difficile exposure as the substantial cause of Employee's orthopedic musculoskeletal conditions, disability or need for medical treatment. (Dr. Davidson's deposition, December 27, 2021).

53) In response to Employee's questions on cross examination, Dr. Davidson testified he had cared for post-surgical patients who get C. difficile infections and typically the infection would be managed by an infectious disease specialist. He explained at length and in detail the difference between systemic dehydration as one would see in diarrhea and the dehydration in an intervertebral disc, in which molecules of water are just no longer in the disc itself because the composition of the disk has changed such that the water no longer, in a sense, binds to the matrix of the cartilage itself. The mechanism is completely different. Dr. Davidson stated again, as he noted he had stated throughout his testimony, any degenerative arthritis changes to Employee's spine and neck cannot be attributed to a C. difficile infection on a substantial cause basis. When asked whether he had seen the x-rays taken of the spine and neck, Dr. Davidson testified he had not. He also testified when asked about a causal link between a C. difficile infection and degenerative arthritis, he did not need the radiology reports to provide an answer to that. He had sufficient information to state there is no objective medical evidence to support a causal link between a C. difficile infection and degenerative arthritis. (*Id*.).

54) Dr. Davidson testified none of the questions Employee asked on cross-examination changed any of his opinions. As for any connection between C. difficile and orthopedic conditions, his review of the medical literature was extensive. It was at a level of thoroughness he would apply to any medical literature review he would perform for either research or clinical care purposes. (*Id*.).

55) On December 28, 2021, EME physician Dr. Mohan testified by deposition. Employee's diagnosis was IBS with diarrhea, a history of bile acid diarrhea secondary to gallbladder removal and a history of C. difficile carrier state. Since there was no evidence of any mucosal damage to the inside of Employee's intestines, it is presumed to be a C. difficile carrier state. Mucosal damage to the colon is determined by endoscopic visualization and taking random biopsies of the colon, which has been done three times on Employee, all by different providers and read by different pathologists. All have been reported as normal. Therefore the underlying diagnosis when the endoscopic evaluation is completely normal is IBS. Dr. Mohan explained IBS is a very chronic condition, a remitting and relapsing condition. The most common symptoms are lower gastrointestinal (GI) abdominal pain, discomfort, cramping and diarrhea. When the condition's severity lessens, patients may think it is gone, but there is always symptomatology that keeps going on and on and on. Dr. Mohan testified he did not see any connection with Employee's GI condition

resulting from his reported exposure at work with Employer. He noted that in the treatment of IBS, the first thing to understand is that it is a symptomatic disease and all the organs are intact. When patients get IBS with symptomatology, the first thing that pops up is what is damaged inside, what needs to be fixed. So colonoscopies are done. When the pain is above the bellybutton people think it is an ulcer and upper GI endoscopies are done. Imaging such as computerized tomography (CT) scans or ultrasounds will be done. Yet all the tests come back normal. The problem is although all the organs work normally, they do not work in a coordinated manner. Dr. Mohan testified in his 25 years or longer of practice, the triggers for IBS have always been stress issues or diet. IBS can cause nausea or functional dyspepsia, or "irritable bowel of the stomach". When it is extreme, there is also vomiting. The cause is the signal for nausea and vomiting comes from the brain and there is an imbalance in the chemicals within the gut to the brain. Dr. Mohan testified the treatment is to identify triggers, if possible, and address those triggers. As anxiety is linked with the job and family issues, these are difficult to control from the medical standpoint. Often psychiatrists and counselors can assist in the management of these triggers. (Dr. Mohan's deposition testimony, December 28, 2021).

56) Dr. Mohan testified Employee's symptoms as reflected in his medical records are consistent with IBS. His gut issues have been up and down and he has been in treatment for many, many years and has been treated for IBS. Employee has had IBS based on the medical records for a long period, by some reports as long as ten years. He has had both lower GI and upper GI symptoms. Dr. Mohan ruled out any reported work exposure as the cause of his current condition. The allegation has been he acquired C. difficile at work, but he is colonized with C. difficile, which can be acquired almost anywhere in the world. Community-acquired C. difficile is when people have never been admitted to a hospital, never been to the hospital or visited someone in the hospital. C. difficile exists in the form of spores so it can exist as spores as long as six months. In public restrooms people often don't wash their hands, so if someone touches something and you subsequently touch it, then didn't wash your own hands, then touch your lips, you can get it. The second group of people who get C. difficile are hospital patients who are elderly and/or who undergo a lot of instrumentation. This is why there are universal precautions in the hospital. The split now between community-acquired C. difficile and hospital-acquired C. difficile is between 40 and 50 percent in the community and 50 to 60 percent in the hospital. As many as ten to twenty percent of people in the community have been colonized with C. difficile. Dr. Mohan could not

pinpoint a place or a time frame for when Employee acquired C. difficile. The colonoscopies, endoscopies, and biopsies show the C. difficile had not caused any damage, which is why it is called colonization. Dr. Mohan testified doctors want patients to understand IBS is a durable diagnosis and to tell other doctors they have it. Otherwise there are a lot of unnecessary procedures and operations done. IBS cannot be seen on any type of imaging. There have been lots and lots of research done on this. IBS is a constellation of symptoms and the current definition falls under the Rome criteria, which were designed to allow doctors to recognize this as soon as possible because this will prevent them from over testing, operating, doing unnecessary procedures and unnecessary things. The Rome IV criteria were promulgated by all of the societies, internal medicine, family practice, and gastroenterology. IBS is a constellation of symptoms without any objective evidence. Among the Rome IV criteria are that a patient has to have had symptoms for at least three months out of six months, with those symptoms occurring at least once or twice a week. Employee's symptoms as reflected in his medical records are consistent with IBS. His IBS symptoms have been up and down and he has IBS treatment for many years with various treatment options. He has had symptoms pertaining to both the upper GI tract and lower GI tract. He himself has done a lot of things over the years to help himself, as he has a diagnosis of anxiety, which is a trigger for IBS. Dr. Mohan testified Employee's IBS preexisted the reported work exposure of September 21, 2018. Dr. Mohan ruled out any work exposure as the cause of Employee's current condition, disability and need for medical treatment. Employee is colonized with C. difficile which can be acquired almost anywhere in the world. He stated he could not tell where Employee got the C. difficile or when he got it. However, the C. difficile has not caused any damage, which is why it is called colonization. Employee's physicians failed to distinguish between diarrhea related to C. difficile and diarrhea related to IBS. (*Id*.).

57) Dr. Mohan testified IBS does not respond to fecal transplants. Employee has had three fecal transplants and did not respond to them. Although Employee claimed he could not hold the stool, the gastroenterologists who performed the stool transplants placed the transplant in the cecum, which is the at the end of the six-and-a-half-foot long colon. Even with diarrhea, only half the contents of the colon are passed out a day. (*Id*.).

58) Dr. Mohan testified based on his experience and the medical literature there was nothing that connected Employee's gut condition and an orthopedic condition. There was no connection between chronic IBS and any degenerative orthopedic condition. (*Id*.).

59) On cross-examination by Employee, Dr. Mohan testified he had treated roughly 50 patients with C. difficile in the last two or three years. He testified a positive result for EIA for toxin B would not change his medical opinions as Employee had not had any mucosal damage to his colon. Dr. Mohan testified he would not recommend any further testing be done as Employee had already had the ultimate gold standard, which was to look at the biopsies of the colon. (*Id*.).

60) On February 12, 2022, Dr. Mohan again testified by deposition to allow Employee to complete his cross-examination that was begun at the previous December 28, 2021 deposition. Dr. Mohan testified when he is asked to treat C. difficile, he does not differentiate from the medical standpoint where the acquisition was. C. difficile is found in the community and in the hospital in a roughly 50/50 basis. Therefore the origin of the C. difficile acquisition is not clinically important. C. difficile is a fecal-oral transmission. It can be acquired by touching a contaminated surface then somehow also touching the mucous membrane of one's mouth. His job as a gastroenterologist is to help the other doctors taking care of the patient to help ascertain and decide what treatment to give. Dr. Mohan explained the two-step diagnosis for C. difficile is first identification using either the NAAT or the GDH testing to identify whether C. difficile is present or not. The NAAT testing helps to understand if it is a toxin-producing C. difficile or a non-toxin-producing C. difficile. The second part of the toxin test is to identify whether it is an A toxin or a B toxin. The two steps have to be done on the same stool sample. In reviewing Employee's record, the testing was done haphazardly with one test being done at one time and the other test at another time. Thus he reported the testing had not been done correctly. Dr. Mohan testified enterocolitis is inflammation of the small and large bowel. Based on his review of Employee's exhaustive medical records, there was no evidence of enterocolitis due to C. difficile in his small or large intestine. (Dr. Mohan's deposition, February 12, 2022).

61) Dr. Mohan testified in clinical practice IBS is the most commonly diagnosed lower GI symptom. In the United States, roughly 30 to 35 million people have IBS. In IBS the diarrheal episodes can vary from five times to ten times a day. But there is no specific number. Fever and weight loss are not a sign of IBS, but in severe IBS people may stop eating, which can lead to weight loss. The difference between active C. difficile and carrier state or colonization with C. difficile is evidence of mucosal damage. Carrier state or colonization is the patient carrying C. difficile, either in a spore or vegetative form, with or without toxin production, for a long period of time. Symptomatology may happen with both conditions, but if there is mucosal inflammation

the symptomatology tends to be severe. The classic differentiation is lack of mucosal injury and any sign of inflammatory markers. Dr. Mohan clarified the PCR test is a modern term that is used for the NAAT test. It is a test for the identification of an organism which can produce a toxin. The EIA is the toxin test. Employee had a colonoscopy in 2018, showing no mucosal damage and the symptoms were continuing in 2019. Employee had more colonoscopies, again showing no mucosal damage. This is classic for a carrier state. (*Id*).

62) On direct examination Dr. Mohan testified hospital-acquired C. difficile in the clinical literature refers to patients who are admitted to the hospital. Mucosal damage is a pathologic diagnosis, which means the pathologist has to review the biopsy. The lining of the colon is biopsied because, even though it might look normal, the pathologist can tell if there is microscopic inflammation. It is almost impossible to miss mucosal injury after a combination of visualization and biopsy. Employee's IBS was not caused by his occupation at the hospital nor did any exposure at the hospital aggravate Employee's IBS. (*Id*.).

63) On February 16, 2022, Employee filed a medical summary with Dr. Price's January 27, 2022 opinion letter prepared for litigation stating he had come to the conclusion Employee was not able to sit for 30 minutes, walk over a block or lift over 10 pounds without inflicting pain to the back, neck, and knees. (Medical summary, February 16, 2022).

64) On February 17, 2022, Employer timely filed its request to cross-examine Dr. Price regarding the opinions expressed in his January 27, 2022 letter, the basis for these opinions, the records in the provider's possession which were a basis for his opinions, and the provider's qualifications to express such opinions. (Employer's request for cross examination, February 17, 2022).

65) On March 16, 2022, *Woodell IX* ordered Employer to make Dr. Mohan available for Employee to complete his cross-examination and for Employee to make his treating physicians Drs. Cedeno, Gillis, Wiginton and Price available for cross-examination if he intended to rely on their opinion letters. *Woodell IX*.

66) On May 18, 2022, Jenny Mayo, infection prevention coordinator at ARH testified at hearing. She stated her education includes a bachelor's degree in microbiology, and a diploma in laboratory science. She is also board-certified in infection control. Her primary duty is to prevent the spread of infection in the hospital, so her work touches most areas of the hospital. She participates in multidisciplinary rounds, consultation, education, risk-assessment, and policy development. Ms.

Mayo reviews how the hospital is doing with equipment cleaning, compliance with infection control guidelines for central lines, foley catheters and isolation. She clarified whether a patient is colonized with C. difficile or infected with C. difficile, infection control is concerned about both situations. If a patient admitted to the hospital is known to have colonization or infection with C. difficile, infection control would find out about that with stool testing if the patient has diarrhea. There is a redundant system to notify employees about the situation. First, following the Centers for Disease (CDC) guidelines, precautions would be placed at the onset of new diarrhea. A medical doctor, any staff member, or a certified nursing assistant (CNA) can wheel up a cart, put an isolation sign on the door and initiate the process. Another way is for the physician to put an order in EPIC (the trade name for the hospital electronic health record system). Another way is for the laboratory to call the unit where the patient is to notify the unit of a positive result. The call is mandatory and the action required is to start isolation precautions for that patient. There is also a system that alerts her as the infection prevention coordinator, so she goes to check and puts a yellow banner on the chart. All those systems are in play at once to draw attention to the situation. Employees can use all those methods. There also will be notification on the board that shows the health care staff their assignments indicating the patient has isolation precaution in place. The frontline nursing staff are usually the first people who become aware of new onset diarrhea. They would acknowledge a physician's order the moment it took place. Whenever they looked at the computer screen or bed board, they would be notified of the new lab results and would implement precautions. (Ms. Mayo hearing testimony, May 18, 2022).

67) Employee worked on the cardiovascular step-down unit (CVSU) on the fourth floor. He was not assigned to any other floor during September 2018. Ms. Mayo checked Employee's timecard for the ten days around the time period Employee claimed he had been exposed to C. difficile and determined he did not work on any other floor aside from CVSU with the exception of two hours he served as a sitter with a patient for two hours in another room. This patient did not have was not symptomatic with C. difficile. Employees swipe their badges on the unit, which tracks where they work within the hospital. If they are assigned to another unit, they will swipe their badge into an electronic system as they leave their current unit and swipe it again as they enter the second unit. Employer is also able to review a patient's care team to see which nurses were assigned to which patients. They can review a patient's chart to track which nurses wrote in

the patient's chart. Ms. Mayo said the hospital had a comprehensive log of where Employee worked in the hospital based on the electronic system. (*Id*.).

68) Ms. Mayo testified there were no patients on the CVSU during the period from August 20 to September 23, 2018 who were on isolation precautions for C. difficile. There were four patients who were diagnosed with C. difficile in the hospital during the period from August 20, 2018 to September 30, 2018 as follows, using only the patients initials to protect their privacy:

(1) A.W. was admitted on August 12, 2018 to the intensive care unit (ICU). This patient was diagnosed with C. difficile on August 16, 2018, transferred to a Medical 5 on August 18, 2018 and discharged from the hospital on September 7, 2018. This patient was never in the CVSU.
(2) M.C. was admitted to the operating room on August 22, 2018 and then to the surgical progress care unit (SPCU) on the third floor on August 22, 2018. M.C. tested positive for C. difficile on August 26, 2018 and was discharged on August 28, 2018. M.C. was never in the CVSU.
(3) S.C. was admitted to the hospital on August 28, 2018 and discharged on September 4, 2018. S.C. was in inpatient rehabilitation on the fifth floor. The date of the positive test was August 31, 2018. S.C. was never in the CVSU.
(4) J.W. was admitted to the hospital on September 17, 2018 to the surgical progressive care unit (SPCU) on the third floor. J.W. tested positive for C. difficile on September 23, 2018 and was discharged on October 10, 2018. J.W. was never on the CVSU.

Ms. Mayo testified Employee could not have been exposed to these patients. He was not assigned to their care teams, he did not do any vitals or assessments on them, and he did not write any progress notes on them. The only patient who tested positive for C. difficile within the time Employee alleges he was exposed to a patient with C. difficile on the CVSU is J.W. J.W. was on the SPCU and he was also on airborne isolation. Going into those airborne isolation rooms is very restricted and someone from another unit would not be going into those rooms to assist. (*Id*.).

(46) There were no patients with C. difficile precautions in the CVSU during the time period from August 20, 2018 to September 30, 2018. To the best of her knowledge, none of Employee's coworkers stated they had been exposed to C. difficile during the time period from August 20, 2018 to September 30, 2018. She consulted with the employee health department and human resources to confirm there were no other employees who reported having been exposed to C. difficile during that time period. (*Id*.).

(47) Ms. Mayo testified that from August 20, 2018 to September 23, 2018, there were no isolation precautions for C. difficile on any patient on the CVSU where Employee worked. This indicated there were no nurses or physicians who felt or had knowledge of any patient on the CVSU during that time that had C. difficile. When a hospitalized patient is suspected of having C. difficile a PCR test will be done. If it is negative, no further testing is done. If it is positive, an enzyme immunoassay (EIA) test to detect toxin would be done. If both tests are positive, it will tell the health care providers both that the organism is there and it is producing toxin. If the testing is positive, there will be a report to the physician and isolation precautions will be instituted. The isolation required is called "contact plus". That means people entering the room would wear gowns and gloves, soap and water hand hygiene and beach-based cleaning products would be used to clean the room. After the patient has formed stool for three days, they would be treated like a colonizer. Even if the patient is colonized, but not symptomatic, precautions will still be undertaken. The patient would be in isolation, which is called "modified contact," and means all of the same precautions would be undertaken, except wearing a gown would not be necessary. (*Id*.).

(48) Ms. Mayo testified she had been in her position as the infection prevention coordinator for ARH since 2018 and during that time there had been no outbreaks of C. difficile at the hospital. She also stated she inquired of human resources if any other employees had made a claim for having contracted C. difficile at ARH and was told none had. Ms. Mayo testified if a patient in the hospital had symptoms of C. difficile, it is not medically probable that it would not have been noted in the patient's medical record. (*Id*.).

(49) Ms. Mayo testified she was able to determine Employee worked with one patient with active diarrhea close to the time period he claimed he was exposed to C. difficile. On September 23, 2018, Employee cared for a patient with active diarrhea. The patient was diagnosed with intermittent gastrointestinal upset and irritable bowel syndrome. This

patient tested negative for C. difficile on September 23, 2018. The PCR test, which is part of the testing for C. difficile, is extremely accurate with only a 0.1 percent chance of a false negative. (*Id*.).

(50) Ms. Mayo is credible. (Experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above).

(51) On May 18, 2022, Employee testified at hearing he was exposed to C. difficile while taking care of one patient, whose name he cannot remember, on September 21, 2018. Employee testified this patient had C. difficile, but it was never documented. Therefore, Employee stated when Ms. Mayo looks in the records to determine whether Employee came into contact with a patient with C. difficile on September 21, 2018, this information is not in the records as the patient had an unknown case of C. difficile. He worked with this patient for 12 hours without being aware they had diarrhea. There were no precautions on the door or in the electronic medical records. There was no yellow banner on the chart. There was no diagnostic code submitted by the physician. Being unaware this patient had C. difficile, he did not wear gown and gloves when going into the room. He did follow universal precautions when working with the patient. Employee testified the patient's physician, whose name he also cannot remember, did not put the C. difficile code into the record. Employee testified that at the following shift he heard the patient's physician discussing the patient with the nurse. The physician was upset the patient was not under precautions. Employee then notified the charge nurse that he had taken care of this patient when no precautions were in place. Employee testified he was unaware if the patient ever tested positive for C. difficile in the hospital setting. Employee's belief was the physician had diagnosed the patient with C. difficile but had not entered the diagnostic code into the electric medical records. Employee's belief this patient had C. difficile was based on the conversation he overheard between the patient's physician and the nurse caring for the patient on that day. Employee was unaware if precautions were placed on the patient as he did not care for the patient again. (Employee's hearing testimony, May 18, 2022).

(52) Employee is very sincere in his belief he contracted C. difficile on September 21, 2018 while working for Employer. However, important inconsistencies in his testimony detract from his credibility. In *Woodell I* Employee testified he overheard the conversation between the physician and the nurse caring for the patient from whom he believes he

contracted C. difficile discussing the need for contact precautions being placed on that patient. When he returned to work the next day or next shift, he testified contact precautions had been placed on the patient he cared for on September 21, 2018. Subsequently in *Woodell VII* Employee testified when he returned to work on the next day or next shift, he took care of another patient and was unaware whether contact precautions had been placed on the patient. (*Woodell VII* hearing record, August 8, 2020; Experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above).

PRINCIPLES OF LAW

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.010. Coverage**. (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

In *Morrison v. Alaska Interstate Construction, Inc*., 440 P.3d 224 (Alaska 2019), the Alaska Supreme Court for the first time construed AS 23.30.010(a) and its relationship to the *DeYonge* doctrine and the "last injurious exposure rule." *Morrison* found the legislature did not abrogate

the *DeYonge* rule when it amended the coverage statute in 2005. It held the Commission's inquiry improperly focused on what qualifies as an injury, "which is not how the legislature chose to reduce the number of potentially compensable claims." *Id*. at 233. Interpreting AS 23.30.010(a), *Morrison* held the board decides whether "the employment" was "the legal cause," *i.e.*, "a cause important enough to bear legal responsibility for the medical treatment needed for the injury," by looking at the "*causes* of the injury or symptoms" rather than considering the injury type. *Id*. at 233-234; emphasis in original

Morrison held AS 23.30.010(a) is not complex and requires the board to consider different causes "of the benefit sought" and the extent to which each contributed to the need for the specific benefit. The board must then identify one cause as "the substantial cause," meaning, the cause which "is the most important or material cause related to that benefit." Based on legislative history, Morrison found the legislature did not intend to require that the substantial cause be a "51% or greater cause, or even the primary cause, of the disability or need for medical treatment." The comparison made is "among the causes identified, not in isolation or in comparison to an abstract idea." It is a "flexible" and "fact dependent" determination. (*Id*. At 237-238). *Morrison* held the board has the right and responsibility to interpret evidence and draw its own inferences. (*Id*. at 239). Finding no error, *Morrison* reversed the Commission and remanded the case with instructions to reinstate the board's award. (*Id*. at 240).

Traugott v. ARCTEC Alaska, 468 P.3d 499 (Alaska 2020) held the new causation standard in AS 23.30.010 required the board to identify factors contributing to the disability and need for medical treatment and decide which among them was the most material or important one. *Id*. At 514. *Traugott* held "the statute permits the board to determine which cause among all those identified is the most important or material cause of the current disability and need for medical treatment, even if an expert does not regard it as having more than 50% responsibility for the condition." *Id*. At 511, citing *Morrison*. The board, and not a medical expert, is required to consider the possible causes of an employee's disability and need for medical treatment and determine which of the possible causes is the most important in causing the disability and need for medical care. And the board, not a medical expert, is charged with determining legal responsibility. The board as the fact finder has the authority to interpret an expert's opinion and decide what weight to give it. (*Id*.

at 514).

In *Rife v. B.C. Excavating, LLC*., AWCB Dec. No. 19-0001 (January 2, 2019) the board panel agreed with the EME physician opinions that the employee sustained only soft tissue lumbar strains, which would resolve over several months. The board panel found the employee had failed to present sufficient medical evidence of causation. The Commission affirmed the board panel's decision and noted both the Commission and the Board had "previously rejected the use of post hoc, ergo propter hoc, as a basis for workers' compensation cases." The Commission stated proof of a causal relationship is necessary. *B.C. Excavating, LLC., v. Rife*, AWCAC Dec. No. 274 (December 31, 2019).

> **AS 23.30.120. Presumptions**. (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (e) the claim comes within the provisions of this chapter
> . . . .

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing substantial evidence to the contrary is placed on the employer. *Miller v. ITT Arctic Services*, 577 P.2d 1044 (Alaska 1978). The presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski v. Best Western Golden Lion Hotel,* 813 P.2d 286, 292 (Alaska 1991).

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks*, 172 P.3d 782, 788 (Alaska 2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981).

In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Smallwood*. To rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). To produce substantial evidence necessary to overcome the presumption, it is imperative that the employer be given an opportunity to cross-examine the claimant's medical experts and produce its own medical evidence of lack of aggravation or causation. *Smallwood* at 316. "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after it is determined the employer has produced substantial evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870. When evidence offered to rebut the presumption is uncertain or inconclusive, the presumption is not overcome. *Bouse v. Fireman's Fund Insurance Co*., 932 P.2d 222 (Alaska 1997).

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of her case by a preponderance of the evidence. *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 at 8 (March 25, 2011) (reversed on other grounds); *Huit v. Ashwater Burns, Inc*., 372 P.3d 904 (Alaska 2016)). At this last step of the analysis, evidence is weighed, inferences are drawn, and credibility considered. To prevail, the claimant must "induce a belief" in the factfinders' minds the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

Norcon involved an employee who had been working long hours and died after a sudden cardiac event. Physicians testified working long hours was not recognized as a risk factor for sudden cardiac death and they did not believe there was "any reasonable possibility that the two are related." *Norcon* concluded the employer rebutted the presumption. *(Norcon).*

In *Safeway, Inc. v. Mackey*, 965 P.2nd 22 (Alaska 1998), the employee claimed her fibromyalgia was caused by her work. Two EME physicians opined the fibromyalgia was not work related. A second independent medical evaluation (SIME) panel reached the same conclusion. SIME physician Dr. Weber stated the causes of fibromyalgia are unknown and any statement on its cause is speculative. *Mackey* found "Dr. Weber's testimony that Mackey's employment was not a substantial factor in her development of fibromyalgia is evidence that 'directly eliminates any reasonable possibility that employment was a factor in causing the disability.'" *Mackey* noted the dispositive question was "whether a reasonable person could accept Dr. Weber's opinion that Mackey's employment was not a substantial factor in causing her fibromyalgia even though he admitted that the cause of fibromyalgia is unknown." *Mackey* found Employer had rebutted the presumption. (*Id*.).

If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of her case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1381 (citing *Miller v. ITT Services*, 577 P.2d 1044, 1046). At this last step of the analysis, evidence is weighed, inferences are drawn and credibility considered. To prevail, the claimant must "induce a belief" in the factfinders' minds the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

> **AS 23.30.122. Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. The findings of the board are subject to the same standard of review as a jury's finding in a civil action.

The board's credibility finding "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). When doctors' opinions disagree, the

board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision No. 087 (August 25, 2008).

Alaska Rules of Evidence

Rule 801. Definitions. The following definitions apply under this article:

(a) Statement. A statement is (1) an oral or written assertion or (2) nonverbal conduct of a person, if it is intended by the person as an assertion.

(b) Declarant. A declarant is a person who makes a statement.

(c) Hearsay. Hearsay is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted . . . .

8 AAC 45.120. Evidence.
. . . .

(e) Technical rules relating to evidence and witnesses do not apply in board proceedings, except as provided in this chapter. Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. . . .

(f) Any document . . . that is served upon the parties, accompanied by proof of service, and that is in the board's possession 20 or more days before hearing, will, in the board's discretion, be relied upon by the board in reaching a decision unless a written request for an opportunity to cross-examine the document's author is filed with the board and served upon all parties at least 10 days before the hearing. The right to request cross-examination specified in this subsection does not apply to medical reports filed in accordance with 8 AAC 45.052; a cross-examination request for the author of a medical report must be made in accordance with 8 AAC 45.052.
. . . .

(h) If a request is filed in accordance with (f) of this section, an opportunity for cross-examination will be provided unless the request is withdrawn ….
. . . .

Employers Commercial Union Insurance Group v. Schoen, 519 P.2d 819 (Alaska 1974) held the statutory right to cross-examination is absolute and applicable to the Board.

In *Commercial Union Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976) an employer had objected to the admission of reports by the employee's doctor unless employer was given the opportunity to cross-examine the physicians. The doctor was not made available for cross examination, and Board declined to consider the reports. The superior court remanded the case to the Board holding the employer had waived its right to cross-examine the doctor by not deposing him in the several months between the objection and the Board hearing. The Supreme Court reversed the superior court, holding that when a party introduces a written medical report in evidence before the Board, that party must provide his opponent with an opportunity to cross examine the author of the report. *Id.* at 1266. Further, since the right of cross-examination should not carry a price tag, the party introducing the report must bear the cost of providing the opportunity for cross-examination. The superior court's remand to the Board should be modified to include the right of cross-examination and the right of either party to adduce additional medical evidence. The claim was based on highly technical medical considerations on causation in which it is impossible to form a judgment on the relation of the employment to the disability without medical analysis. (*Id*.).

Burgess Const. Co. v. Smallwood, 623 P.2d 312 (Alaska 1981), quoting *Commercial Union Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976), affirmed its holding the remand to the Board should include the right of Employer to cross-examine Employee's medical witnesses and "the right of either party to adduce additional medical evidence." (*Id*.).

> **8 AAC 45.900. Definitions**. (a) in this chapter
> . . . .
>
> (11) "Smallwood objection" means an objection to the introduction into evidence of written medical reports in place of direct testimony by a physician; see *Commercial Union Insurance Companies v. Smallwood*, 550 P.2d 1261 (Alaska 1976);
> . . . .

The law of the case doctrine prevents re-litigation of issues previously decided in a case. *Wolff v. Arctic Bowl, Inc*., 560 P.2d 758 (Alaska 1977) at 763, held:

> The doctrine of the Law of the Case prohibits the reconsideration of the issues that have been adjudicated in a previous appeal in the same case. . . . . Even issues not explicitly discussed in the first appellate opinion, but directly involved with or "necessarily inhering" in the decision will be considered the law of the case.

Robertson v. American Mechanical, Inc., 54 P.3d 777,779 (Alaska 2002), held res judicata, or claim preclusion, applies to workers' compensation cases; however, it is not always applied as rigidly in administrative as in judicial proceedings. *Id*. at 779-80. When applicable, res judicata precludes a subsequent suit between the same parties asserting the same claim for relief when the matter raised was, or could have been, decided in the first suit. *Id*. at 780. Application of the principle requires the subject issue to be identical to that already litigated and requires a final judgment on the merits. *Id*.

Derringer, Jr. v. Martin, 187 P.3d 468, 474 (Alaska 2008), held:

> The law of the case is both a doctrine of economy and of obedience to judicial hierarchy. The doctrine applies to all previously litigated issues unless there are "exceptional circumstances presenting a clear error constituting manifest injustice."

Beal v. Beal, 209 P.3d 1012 (Alaska 2009) held the law of the case doctrine, which is "grounded in the principle of stare decisis" and "akin to the doctrine of res judicata," generally "prohibits the reconsideration of issues which have been adjudicated in a previous appeal in the same case." Previous decisions on such issues - even questionable decisions -become the "law of the case" and should not be reconsidered on remand or in a subsequent appeal except "where there exist 'exceptional circumstances' presenting a clear error constituting a manifest injustice." (*Id*.)

The law of the case doctrine applies in workers' compensation cases. *See*, e.g., *Failla v. Fairbanks Resource Agency, Inc*., AWCAC Decision No. 162 (June 8, 2012).

Nash v. Matanuska-Susitna Borough 239 P.3d 692 (Alaska 2010) held the borough's Board of Adjustment and Appeals violated Nash's due process rights by not affording him a full opportunity to be heard nor providing procedures consistent with the essentials of due process. *Nash* noted Article I, section 7 of the Alaska Constitution guarantees the right of due process. Due process in the administrative context does not require every hearing comport to the standards a court would follow, but the administrative process must afford an impartial decision-maker, notice, an

opportunity to be heard, and procedures consistent with the essentials of a fair trial, and a reviewable record. *Nash* held the board's restrictions on testimony at its hearing did not comport with due process. *Nash* remanded the case to the superior court for a trial de novo. (*Id*.)

Jones v. Jones, 505 P.3d 224, 231 (Alaska 2022) defined the law of the case doctrine as limiting "redetermination of rulings" made in a claim. *Jones* found it is not a firm rule, and that relitigating issues should be permitted "where there exist exceptional circumstances presenting a clear error constituting a manifest injustice."

ANALYSIS

1) Was the oral order excluding the Employee's physicians' letters correct?

When a party introduces an opinion letter in evidence, that party must provide his opponent with an opportunity to cross examine the author of the letter and the right of cross-examination should not carry a price tag, so the party introducing the report must bear the cost of providing the opportunity for cross-examination. *Smallwood*. Employer timely filed Smallwood objections and demanded its right to cross-examine Employee's physicians Drs. Price, Cedeno, Gillis, and Wigington, and Carlson on their opinion letters written to support Employee's workers' compensation claim. 8 AAC 45.120; 8 AAC 45.900(11); *Smallwood*. Employee did not make these physicians available for cross-examination. Any relevant evidence is admissible if it is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. 8 AAC 45.120(e). Employee's physicians' opinion letters are hearsay statements sent concerning Employee's illnesses and conditions. Their opinions concern the cause of those illnesses and Employee's ability to return to work. Hearsay is defined as a statement, other than one made by the declarant while testifying at hearing, offered in evidence to prove the truth of the matter asserted. Evidence Rule 801(c). These physician opinion letters contain statements not made while testifying at hearing and are offered to prove the truth of the matters asserted therein. Therefore, these statements are hearsay. *Id*. Employee seeks to use these physician opinion letters prepared for litigation to prove he contracted his illness while working for Employer and as proof of his

disability and need for medical treatment. As such they are not medical reports kept in the ordinary course of business and are not exceptions to the hearsay rules. *Schoen*; *Smallwood*. Thus they are not admissible over Employer's request to cross-examine the letters' authors.

Employee was informed of his responsibility to make his treating physicians Drs. Price, Cedeno, Gillis, Wigington available for cross-examination in *Woodell IX*. *Smallwood*; *Schoen*. The opinion letters written by Dr. Cedeno on January 21, 2020, Dr. Carlson on September 1, 2021, and Dr. Price on September 9, 2021, and February 16, 2022, were also prepared for litigation and do not fall under the exception to the hearsay rules. Employer timely filed requests for cross-examination on the physician authors of these opinion letters.

Employee did not make these physicians available for cross-examination. The oral order excluding these letters was correct. *Id.*

2) Does the law of the case doctrine apply?

Employee contends even if he does not provide Employer an opportunity to cross examine his physicians who authored opinion letters on his behalf, the findings of fact, conclusions of law and orders in *Woodell VII* cannot be altered on remand. Employer argues it was denied due process and the law of the case doctrine does not apply.

The law of the case doctrine prevents re-litigation of issues previously decided in a case. *Wolff*. The law of the case doctrine can apply in workers' compensation cases. *Failla.* However, it is not always applied as rigidly in administrative as in judicial proceedings. *Robertson*. *Woodell VII* denied Employer's request for cross-examination of Employee's physicians Drs. Price, Cedeno, Gillis, and Wigington's opinion letters prepared for litigation yet relied on those opinions to conclude Employee's claim was compensable. In *Woodell VIII* the Commission found it was clear error and a violation of Employer's due process rights for *Woodell VII* to have denied Employer the right to cross examine Drs. Price, Cedeno, Gillis, and Wigington on their opinion letters. The Commission recognized Employer's right to cross-examine the authors of opinion letters introduced by Employee. Therefore the Commission remanded the case to the Board to allow Employer to cross-examine these doctors. However, Employee did not make these doctors

available for cross-examination. *Woodell VII* factual and credibility findings relied on the inadmissible opinion letters. This was clear error as it denied Employer its due process rights. *Nash*. If Employer is not allowed to relitigate the issues of whether Employee contracted C. difficile while working for Employer and whether he proved entitlement to any benefits by a preponderance of the evidence, it would result in manifest injustice, as Employer might be liable for substantial benefits based on inadmissible evidence. *Beal*; *Jones*. *Woodell VII* based its opinion on inadmissible hearsay evidence and no further evidence supports Employee's claims. Therefore, the law of the case doctrine will not be applied in this case. The issues of whether Employee's reported work injury arose out of and in the course of his employment and whether it is the substantial cause of any disability and need for medical treatment must be decided without considering or giving weight to Employee's physicians' opinion letters.

Woodell VIII found Employer's due process rights were violated when it was denied the opportunity to cross-examine relevant and material witnesses who had drafted opinion letters for the purposes of Employee's litigation. Employer was then unable to present its case. Although procedurally distinct from *Nash*, where the Court remanded the case to the trial court specifically for a trial de novo, the principle is the same. Where a party is unable to present its case because of a significant denial of its right to due process, that party is entitled to a hearing de novo. *Id.* To deny Employer a trial de novo would be manifest injustice because its denial of due process in *Woodell VII* would not be rectified. *Jones*; *Nash*; *Derringer, Jr.*

3) Did Employee's C. difficile infection arise out of and in the course of his employment?

Whether Employee's claims are compensable raises a factual dispute to which the statutory presumption applies. *Meek*; *Sokolowski*. If Employee's C. difficile infection arose out of and in the course of his employment and the reported work injury is the substantial cause of Employee's disability and need for medical treatment, Employee will prevail. If however the pre-existing pathologies are ultimately found to be substantial cause of the need for medical treatment, then Employer will prevail. AS 23.30.010(a); *Morrison*.

At the first step of the analysis Employee must show a preliminary link between his C. difficile infection and his employment. *McGahuey*; *Smith*; *Cheeks*. At this stage neither credibility nor

evidence's weight is considered. *Resler*. Employee's claim he contracted a C. difficile infection and C. difficile enterocolitis while caring for a patient on September 21, 2018 is a highly technical medical consideration and medical evidence is necessary to make that connection. *Smallwood*. Employee is unable to raise the presumption he contracted a C. difficile infection through his testimony he believed he cared for a patient with an undocumented C. difficile infection without the proper personal protective equipment as the precautions which should have been placed were not in fact in place. *Smallwood*.

However, in the alternative, if Employee's testimony and his physician's reliance on his reports regarding how he believed he contracted C. difficile are sufficient to raise the presumption, Employer must rebut it and may do so with substantial evidence that either: (1) provides an alternative explanation excluding work-related factors as a substantial cause of the disability; or (2) directly eliminates any reasonable possibility employment was a factor in causing the disability. *Tolbert*; *Huit*. Substantial evidence is the amount of relevant evidence a reasonable mind might accept as adequate to support a conclusion. *Miller*. Again, neither credibility nor the weight of the evidence is considered at the second step. Employer rebutted the presumption with Ms. Mayo's unequivocal testimony there were no C. difficile patients in the CVSU on or even around September 21, 2018, the day Employee alleged he cared for a patient with C. difficile without protective equipment. *Bouse*. Ms. Mayo's testimony standing alone constitutes substantial evidence sufficient to rebut the presumption of compensability because her testimony ruled out any exposure to Employee. Employee has been adamant he worked and was exposed in the CVSU on September 21, 2018. The evidence is not weighed at this stage nor is credibility determined. Whether the evidence is persuasive and/or credible is weighed at the third stage in determining whether a claim is compensable.

As Employer rebutted the presumption, the analysis proceeds to the third step and Employee must prove by a preponderance of the evidence his C. difficile diagnosis arose out of and in the course and his employment and was the substantial cause of his disability and need for medical treatment. *Koons*; *Runstrom*; *Huit*. To prevail, Employee must "induce a belief" in the factfinders' minds the facts being asserted are probably true. *Saxton*. In making this determination, credibility is considered, the evidence weighed, and the relative contribution of other causes is considered.

Norcon; *Morrison*.

Employee relies on a discussion he overheard between a patient he cared for and that patient's nurse to assert he contracted C. difficile on September 21, 2018. His testimony regarding the conversation he overheard is not credible. AS 23.30.122. Employer's hospital infection prevention coordinator Jenny Mayo's testimony is given great weight. AS 23.30.122; *Rogers and Babler*. Ms. Mayo described in detail the redundant systems in place to notify employees if a patient is known to be colonized or infected with C. difficile so that contact precautions can be placed on that patient. She testified that during the period from August 20, 2018 to September 23, 2018, there were no patients in the CVSU who were on isolation precautions for C. difficile and this indicated there were no nurses or physicians who felt or had knowledge of any patient in the CVSU during that time that had C. difficile. There were four patients in the entire hospital who tested positive for C. difficile during this time, but none in the CVSU, and Employee had not participated in the care of any of these patients. Ms. Mayo's credible testimony rules out the possibility Employee contracted C. difficile from the patient he cared for on September 21, 2018. *Rife*.

EME physician board-certified internist and immunologist Dr. Bardana's opinion is given weight. AS 23.30.122. His EME reports and deposition testimony revealed a thorough examination of Employee and his medical history related to longstanding IBS and any C. difficile infection and its cause. He opined there was a disparity between Employee's very significant symptomatology and the negative colonoscopies, lack of recorded fevers or significant rise in white blood cell counts. There was no evidence of any pathological findings by colonoscopy or by histopathology of biopsies taken in the colonoscopies. Dr. Bardana opined Employee's long history of IBS, GERD, and acute gastroenteritis made pinpointing the commencement of his C. difficile infection almost impossible. Although he could not exclude Employee's contact with infected patients at Northwest Medical Center in Arkansas or Alaska Regional Hospital in Anchorage, Employee's history of antibiotic therapy for pneumonia in 2017, and GI procedures were much more likely to be the inciting cause for any C. difficile infection. He also noted Employee had been treated extensively with multiple antibiotics and three fecal transplants for C. difficile enterocolitis but none were successful to alleviate his symptoms. This indicated Employee's symptom inciting

condition may have been misdiagnosed. Dr. Bardana recommended an evaluation by a board-certified gastroenterologist.

The EME physician Dr. Mohan, is a board-certified internist and board-certified gastroenterologist who has treated numerous patients with C. difficile infections. He is also a clinical professor at the tertiary medical center the University of Washington in Seattle. Dr. Mohan diagnosed Employee with IBS with diarrhea, a history of bile acid diarrhea secondary to cholecystectomy and history of C. difficile carrier state. He opined Employee's September 21, 2018 reported work exposure suggesting C. difficile is the cause of his symptoms is not supported by the clinic evidence and is not the substantial cause of his current condition. He noted Employee had a long history of chronic IBS with diarrhea with exacerbations and remissions. He has had the lower GI symptoms of abdominal pain, discomfort, cramping and diarrhea as well as the upper GI symptoms nausea, vomiting and functional dyspepsia. Although Employee had been treated with the antibiotics and fecal transplants for a C. difficile infection, those treatments had not been successful. Employee had three colonoscopies which were normal with no evidence of C. difficile mucosal damage. Dr. Mohan noted the colonoscopies and biopsies were the ultimate gold standard for diagnosing C. difficile infection and Employee's colonoscopy did not reveal inflammation and biopsies of his colon were negative for inflammatory markers. The underlying diagnosis when the endoscopic and colonoscopy evaluations are completely normal is IBS, which is a very chronic remitting and relapsing condition. Dr. Mohan also stated neither C. difficile nor chronic IBS with diarrhea nor post-cholecystectomy bile acid diarrhea can cause degenerative orthopedic problems, including degenerative arthritis or disc degeneration. Dr. Mohan's opinions are given great weight. *Moore*; AS 23.30.122.

EME orthopedic surgeon Dr. Davidson's opinions Employee's C. difficile infection did not cause Employee's orthopedic diagnoses of right knee meniscal tear and plica syndrome, left knee pain, neck pain and back pain are given great weight. *Moore*; AS 23.30.122. After performing extensive medical literature review Dr. Davidson found no evidence a C. difficile infection could cause disc degeneration or joint pain in knees or wrists. He opined a C. difficile infection cannot be the substantial cause of Employee's orthopedic conditions nor did it aggravate those conditions. He further opined the desiccation or dehydration found in degenerative disc disease is not related to

systemic dehydration as occurs in a patient with C. difficile, but rather to abnormalities in the molecular and biochemical composition of the intervertebral discs which results in the loss of water from the intervertebral disc and/or articular cartilage. The mechanism described by Dr. Davidson is completely different from what is seen in systemic dehydration. Dr. Davidson stated he did not need to see any x-rays taken of Employee's spine and neck to determine there was no objective medical evidence to support a causal link between a C. difficile infection and degenerative arthritis.

Employee's physicians did not articulate a basis for their opinions other than Employee's reports to them. Employer was not provided an opportunity to cross-examine Employee's physicians to delve into the underlying reasons for the conclusions they reached. Employee's reports to his physicians and his testimony are not credible and his physicians relied upon his reports to arrive at their opinions, which are given no weight. AS 23.30.122. Based on the Ms. Mayo's credible testimony and Dr. Bardana's, Dr. Mohan's and Dr. Davidson's credible reports and testimony, Employee is unable to prove by a preponderance of the evidence his claimed work injury arose out of and in the course of his employment or is the substantial cause of his disability or need for medical treatment. *Moore*; *Morrison*; *Traugott*; *Rogers and Babler*.

CONCLUSIONS OF LAW

1) The oral order excluding the Employee's physicians' opinion letters was correct.
2) The law of the case doctrine does not apply.
3) Employee's C. difficile infection did not arise out of and the course of his employment with Employer.

ORDER

1) Employee's claim is denied and dismissed.

Dated in Anchorage, Alaska on July 14, 2022.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Judith A DeMarsh, Designated Chair

/s/
Michael Dennis, Member

/s/
Bronson Frye, Member

APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of KADE WOODELL, employee / claimant v. ALASKA REGIONAL HOSPITAL, employer; INDEMNITY INSURANCE COMPANY OF NORTH AMERICA, insurer / defendants; Case No. 201901025; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on July 14, 2022.

/s/
Rachel Story, Office Assistant