WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

GARY PEACHEY, *Applicant*

vs.

CITY AND COUNTY OF SAN FRANCISCO, *Defendant*

Adjudication Number: ADJ12492033
San Francisco District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Defendant City and County of San Francisco seeks reconsideration of the Opinion on Decision and Findings (OD & F) issued on November 14, 2025 , wherein a workers' compensation arbitrator (WCA) found that applicant sustained an injury arising out of an occurring in the course of his employment (AOE/COE) to his left hand, a needlestick injury, and injury in the form of blood and Hematopoietic Purpura (ITP).

We have considered the allegations of the Petition for Reconsideration and the contents of the Report and Recommendation (Report) of the WCA with respect thereto. Based on our review of the record, and for the reasons stated in the WCA's Report, which we adopt and incorporate, we will deny reconsideration.

Former Labor Code[1] section 5909 provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.) Effective July 2, 2024, section 5909 was amended to state in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.

[1] All further reference are to the Labor Code unless otherwise noted.

> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a), the Appeals Board must act on a petition for reconsideration within 60 days of transmission of the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on March 16, 2026 and 60 days from the date of transmission is Friday, May 15, 2026. This decision was issued by or on May 15, 2026, so that we have timely acted on the petition as required by section 5909(a).

Section 5909(b)(1) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Section 5909(b)(2) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the WCA, the Report was served by email on December 19, 2025 to the Member Advocate/Ombudsperson Mariotto Solutions and "*e-filed only*" to the Workers' Compensation Appeals Board. The case was transmitted to the Appeals Board on March 16, 2026. Service of the Report and transmission of the case to the Appeals Board did not occur on the same day. Thus, we conclude that service of the Report did not provide accurate notice of transmission under section 5909(b)(2) because service of the Report did not provide actual notice to the parties as to the commencement of the 60-day period on March 16, 2026.

No other notice to the parties of the transmission of the case to the Appeals Board was provided by the district office. Thus, we conclude that the parties were not provided with accurate notice of transmission as required by Labor Code section 5909(b)(1). While this failure to provide notice does not alter the time for the Appeals Board to act on the petition, we note that as a result the parties did not have notice of the commencement of the 60-day period on March 16, 2026.

While we note that the Report of the WCA states that the Report along with the entire file "was transmitted to the Reconsideration Unit on December 19, 2025", this is not accurate. (Report

at p. 1.) While the documents were submitted to the district office and uploaded to EAMS on December 19, 2025, an external user of EAMS cannot transmit a file to the Appeals Board, which is the function of the district office having venue of the matter, and after which our 60-day period to act on the petition commences. Here, as stated above, the case was transmitted on March 16, 2026 as noted in EAMS under Case Events.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration of the OD & F of the WCA issued on November 14, 2025 is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ KATHERINE A. ZALEWSKI, CHAIR

I CONCUR,

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

/s/ JOSÉ H. RAZO, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

MAY 15, 2026

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

GARY PEACHEY
BROWN DELZELL
CITY AND COUNTY OF SAN FRANCISCO
CITY ATTORNEY SAN FRANCISCO
MARK L. KAHN, ARBITRATOR

TD/bp

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date.
BP

REPORT AND RECOMMENDATION OF WORKERS' COMPENSATION ARBITRATOR ON PETITION FOR RECONSIDERATION

I.

INTRODUCTION

. . .

This case involves the cause of the applicant developing Immune Thrombocytopenic purpura which will hereafter also be referred to as ITP.

The above-captioned matter proceeded to Arbitration on October 6, 2025, before Mark L. Kahn, Arbitrator, the parties reached Stipulations, Issues and admitted Exhibits into evidence and agreed to submit the matter on the present record.

On November 10, 2025, The Arbitrator found that the applicant, Gary Peachey, born [ ], while employed on September 4, 2018, as a Police Officer, Occupational Group Number 490, at San Francisco, California, by the City and County of San Francisco, sustained an injury arising out of an occurring in the course of his employment to his left hand, needlestick injury, and sustained an injury arising out of an occurring during his employment in the form of blood and Immune Thrombocytopenic Purpura (ITP)

The Arbitrator found based on the medical report of the primary treating physician, James Savage, M.D., the applicants developed ITP as a result of taking preventative medications [ ] that were administered because of the admitted needle stick injury.

On December 8, 2025, defendant filed a Petition for Reconsideration on the following Grounds:

1. The WCAB should not accept the factual findings in this case as they are unreasonable, illogical, improbable and unequitable when viewed in light of the stature story scheme of Labor Code §3202.5 which deems both parties, applicant and defendant equal before the law and requires applicant to bear the burden of proving industrial causation.

2. The opinion of Dr. Savage on upon which the Arbitrator relied is not substantial medical evidence as it is based on conjecture and not based on reasonable medical probability.

3. Applicant did not sustain the burden of proving that the ITP condition was work-related.

II.
FACTS

It was stipulated that applicant, Gary Peachey, born [ ], while employed on September 4, 2018, as a Police Officer, Occupational Group Number 490, at San Francisco, California, by the City and County of San Francisco, sustained an injury arising out of an occurring in the course of his employment to his left hand, needlestick injury and claims to have sustained an injury arising out of an occurring during his employment in the form of blood and Hematopoietic Purpura.

The issue being litigated was the applicant's development of ITP caused by his taking the preventative drugs [ ] because of the admitted needle stick injury.

The following facts were established by the applicant's testimony and the entire record including the medical record.

The applicant was employed as a Police Officer for the San Francisco Police Department beginning in September 1995. The applicant worked as a homeless outreach officer for approximately ten years.

On September 4, 2018, while the applicant was removing abandoned property and garbage from the sidewalk, he placed his hand on the windowsill and immediately felt pain. He suffered a needle stick injury to his left palm from a used hypodermic needle. Upon removing the needle, the applicant noticed blood on his palm.

On September 4, 2018, the applicant went to San Francisco General Hospital where he was prescribed two [ ] preventive medications...

. . .

The applicant underwent a blood drawn on September 18, 2018, and on September 19, 2018, the blood test showed a low GFR (glomerular filtration levels) which indicated a problem with kidney function, and the applicant was taken off the medication.

The applicant testified and the medical record support that the applicant started experience side effects from the medication pretty much immediately after he started taking the drugs. He started to experience shoulder joint pain, fogged brain, vision problems, and concentration problems. Later, he developed fatigue. The biggest issue was brain fog.

The symptoms were reported by the applicant according to the medical reports of San Francisco General Hospital of September 24, 2018, September 28, 2018, and October 1, 2018.

The applicant saw his own private primary treating physician, Dr. Savage, on October 2, 2018, complaining of the same symptoms. He went to see Dr. Savage, due to concerns regarding his treatment at San Francisco General Hospital and that they were releasing him to work despite his continued symptoms.

The applicant testified that he went to see his primary physician, Dr. Savage, who has been his doctor for the past 28 years. During the visit, he discussed his symptoms with Dr. Savage, who then granted him additional time off work.

He eventually returned to full duty in October 2018.

The applicant further testified, when he returned to work full duties, he was still experiencing the symptoms. He was having blurred vision, seeing floaters, the fatigue, being tired, lack of ability to concentrate, and pain in his joints, shoulder joints.

The symptoms never went away and continued to worsen between October 2018, when he first saw Dr. Savage, and May 2019.

The applicant testified that his symptoms continued to progress. He was so fatigued and exhausted that he requested additional days off on May 1, 2019.

The applicant testified that in May of 2019, he went to bed that night and had a nosebleed. In the morning, he had another blow nosebleed. He could not stop the bleeding for a while. He looked in his mouth and saw blood bisque blisters all around his cheeks.

He called Dr. Savage who told him to come in right away.

Dr. Savage diagnosed the applicant with ITP.

The applicant was then sent to the emergency room by Dr. Savage.

Laboratory evaluation in the emergency room revealed a high platelet count, leading to a diagnosis of idiopathic thrombocytopenic purpura (IDP). The applicant received a platelet transfusion and was also administered steroids. He was subsequently kept in the hospital for two days.

Two days after the hospital discharge, the blood blisters on his mouth recurred and this time he went to Sutter Hospital ER was admitted for one week and began seeing a dermatologist, Dr. Damon, telling him that he had zero platelets.

The applicant again received platelet transfusion and steroid therapy. His platelets went up and down. Dr. Damon told him that because of the applicant's older age, there was less chance of inducting a permanent remission from ITP with treatment [ ]. The applicant underwent infusions. The applicant was also diagnosed with detachment of left eye.

The applicant was seen by Ira Fishman, M.D. as Qualified Medical Evaluator who found no industrial causation, finding that the development of the ITP was idiopathic, occurred 7 1/2 months after the pinprick incident, and within reasonable medical probability it could not be shown that the pinprick led to the ITP. Dr. Fishman concluded that the ITP was not caused by applicants taking the medications.

The Primary Treating Physician, Dr. Savage, opined that the ITP was reasonably medically caused by the pinprick incident and a reaction to the prescribed preventive medication [ ] given to the applicant [ ].

Dr. Savage did not believe the ITP was idiopathic in nature. Dr. Savage believed that the ITP was caused by the needlestick and the medication that was prescribed [ ].

The primary treating physician's conclusion was based on several factors: the applicant developed negative reactions and symptoms immediately after taking the prescribed medications; he continued to complain of fatigue, brain fog, and blurred vision with floaters from the time he began the medication until May 2019, when the symptoms worsened; there was no intervening cause between the needlestick and the diagnosis of ITP; and the physician found an article [ ]. Therefore, the primary treating physician concluded, with reasonable medical probability, that the needlestick and the prescribed medication were 80% likely to be the cause of the applicant's development of ITP.

The Arbitrator found the medical reports and deposition testimony of Dr. Savage to the better reasoned, and more persuasive based on a review of all the medical and factual evidence, then the reports of the Qualified Medical Evaluator.

The Arbitrator found that Gary Peachey, born [ ], while employed on September 4, 2018, as a Police Officer, County of San Francisco, sustained an injury arising out of an occurring in the course of his employment to his left hand, needlestick injury, and sustained an injury arising out of an occurring during his employment in the form of blood and Hematopoietic Purpura.

The defendants now file this Petition for Reconsideration on the grounds set forth above.

III.

SUMMARY OF MEDICAL EVIDENCE, TESTIMONY AND OTHER EVIDENCE TESTIMONY OF GARY PEACHEY AT ARBITRATION HEARING

On September 4, 2018, he was employed as a Police Officer by the City and County of San Francisco. His assignment on that date was homeless outreach officer. His job was to assist DPW

in clearing the sidewalk; to guide homeless people into services, into rehab; check on their physical well-being at the time.

On September 4, 2018, he got stuck by a needle in his hand while on duty. There was a homeless man down on the sidewalk sleeping in front of the building on the 300 block of Ellis Street. He woke him up; told him that he had to get up, DWP was on their way to clear him; he moved his back aside; reached out his hand to help him up; he put his hand on the window frame; and he guessed he was struck by a used syringe. It went right through the rubber glove into his hand.

He reported the incident to his supervisor, Capt. Fabbri. He also reported the incident to Sgt. Courtney Harris.

He was directed to seek medical attention at San Francisco General Occupational Health center.

The charge nurse recommended that he take a prophylactic drug [ ]. He took the drugs [ ]. They took a baseline blood test on that date.

He started experience side effects from the medication pretty much after he started taking the drugs. He started to experience fogged brain, vision problems, and concentration problems. Later, he developed fatigue. That was the big one.

He had to go back to San Francisco General because he did not have a spleen, and they wanted to do an additional blood draw. When asked if they did an explanation about his lack of a spleen necessitating another broad draw, he said it was because it had to do with the immune system and how he would react to the prophylactic drugs.

When he went back for the blood draw, approximately two weeks after the needlestick, he still was experiencing the symptoms he had previously described, and he also complained of an upset stomach.

They refilled his prescription, and he left the station. After reviewing the blood draw results, they called him at work and instructed him to stop taking the medication immediately. He was told to stop taking the medication apparently because his kidneys were not functioning right. His kidneys were shutting down.

At that time, he was still working full duties. He told his Sargent about what had happened, and because he was experiencing symptoms, he was asked to take some time off work. He believes he told him that it would be better if he took some time off and recovered from the symptoms.

He continued to do follow-ups at San Francisco General. Whenever they called him, he went in for blood draws and checkups. He told San Francisco General repeatedly about his symptoms every time he went in.

The symptoms continued to progress, leading to increased fatigue. He felt exhausted and struggled to understand what was happening to him. Although he had been informed that the medication he was taking would cause side effects, they were described as minor. San Francisco General subsequently placed him on leave from work. It was at this point that he met with the lieutenant, who offered him time off to recuperate.

His vision would go in and out, blurred on occasions. He would see floaters in his eye.

San Francisco General told him that he should not be experiencing these the symptoms from taking the drugs, but he was.

They informed him that the shelf life of the drug had expired and that he should not be experiencing any symptoms as a result. They stated that the average person would not have such symptoms; however, he insisted that he was not the average person and that everyone is different. He also emphasized that they should take into account that he does not have a spleen.

They told him he could return to full duty. He disagreed as he was telling them he did not feel right, and he should go back. They told him there was nothing they could do. He felt they were being pressured by his supervisors and if they made the decision to keep him off work they would be in trouble. They told him he would have to go to his own physician and maybe they could do something for him.

He then went to his own physician, Jim Savage, M.D. Dr. Savage had been his primary physician for 28 years. He discussed the symptoms with Dr. Savage. Dr. Savage gave them some additional time off. He eventually returned to full duty.

When he returned to work full duties, he was still experiencing the symptoms. He was having blurred vision, seeing floaters, the fatigue, being tired, lack of ability to concentrate, and pain in his joints, shoulder joints.

The symptoms continued to progress, and he was so fatigued and tired that he requested additional days off on May 1, 2019.

His symptoms of lack of concentration and fatigue were worsening, and he noticed bruising on his leg. He found this concerning because he typically does not bruise easily. The bruise was a deep color, which he considered unusual for him.

He went to bed that night and experienced a nosebleed, which happened again shortly afterwards. In the morning, he had another severe nosebleed that he could not stop for some time. Concerned, he looked in his mouth and noticed blood-filled blisters around his cheeks. He promptly called Dr. Savage, who advised him to come in right away.

Dr. Savage told him over the phone it sounded like ITP. He said you better come in right away. He told him he needed to admit himself to the hospital right away. He called ahead to the hospital on Van Ness, and he was admitted right away. They did a broad draw at the hospital and said his platelets were very low. They told him they were in a give him an emergency transfusion of platelets. They also gave him some steroids. They then sent him home.

About a week after the transfusion, he began experiencing severe nosebleeds, accompanied by blood clots coming from his sinuses. He reached out to his doctor again, who referred him to UCSF. There, a blood draw was performed, and the medical team informed him that they had never encountered this situation before: he had zero platelets remaining in his blood.

They told him they were going to see what they could do for him. That is when he meant Dr. Damon. He came in with a team of doctors. They suspected it might be leukemia. They also considered the possibility that when his spleen was removed, fragments of it may have been left behind, which could be growing and causing the issue

They then diagnosed him with ITP. He had to go through further treatment. He had taken fusions, which were to treat cancer. When the infusions ended, he started feeling a little better. He had to go for another infusion that was out another week. That continued until his blood platelets leveled out.

MEDICAL EVIDENCE

Medical reports of San Francisco General Hospital.

Doctors First Report of Occupational Injury dated September 4, 2018.

The date of injury is listed as September 4, 2018. The applicant last worked September 4, 2018. The applicant states he picked up a bag on the sidewalk and the needle poked through the back, glove and into hand. The applicant was a calm demeanor with a visible puncture wound in the left central palm.

The applicant is 64-year-old male Police Officer, reports was cleaning up a homeless encampment, picked up bag on the sidewalk and needle poked through back, glove and into the palm of the left hand. The Needle was used and broken off. A small amount of blood oozed from

the puncture site. He cleaned the wound with hand sanitizer. He had previous BPP exposure years ago.

The applicant was provided counseling on transmission of HIV, HBV and HCV and the risks and benefits of PEP discussed. Applicant decided to take PEP, is concerned about having nausea. Applicant states he has no spleen.

Blood was drawn for panel [ ].

Applicant was to continue full duty.

Next visit was set for September 18, 2018.

Medical reports of Occupational Health Service, San Francisco General Hospital

Primary Treating Physicians Progress Report dated September 18, 2018

The report shows the applicant is to continue full duty. The next visit will be October 16, 2018. The report contains a liver panel and metabolic basic panel.

The report indicates the applicant presents at the clinic for a two-week follow-up visit after a needlestick incident that occurred on September 4, 2018. The applicant was given a prescription [ ]. The applicant states he is tolerating the PEP regime [ ].

The report indicates they reviewed the labs from two weeks ago, risks and benefits of PEP reviewed, and the applicant was provided a refill for the PEP regime. The applicant is to follow up on October 16. The applicant is to return to full duty on September 18, 2018.

Primary Treating Physicians Progress Report Dated September 24, 2018

The report shows the applicant was unable to work from September 20 to September 27, 2018.

The report contains laboratory results [ ].

The report gives a history as the applicant present at the clinic for follow-up visit after a needlestick incident that occurred on September 4, 2018. The applicant was given a prescription for PEP regime [ ] however, had to stop when his renal test became abnormal. He is rechecking his renal function today. The applicant states he is feeling fatigue, muscle aches and occasionally blurred visions.

Outpatient Consultation Request Dated September 28, 2018

The applicant was evaluated for a medical exam because of being stuck by a needle (unknown source) in the hand in a high-risk area while on his job on September 4, 2018. He reports his symptoms have been improving but he remains with foggy/headaches and left shoulder joint pain which do not appear to be related to his work injury.

He requested and started PEP [ ] on September 4, 2018, but then was directed to stop on September 19, 2018, because it was noted that his GFR decreased from a baseline taken here. The GFR then returned to baseline on September 24, 2018.

The applicant reports feeling slightly foggy-headed and experiencing discomfort in his left shoulder. He mentions that while he continues to have body aches, they have lessened. He has a cold, but it is improving, and he is unsure if the shoulder ache is related to the cold; he doubts it. Overall, he feels comfortable about returning to work.

The report indicated he should remain off work till October 1, 2018. He should have labs in six weeks for 3 to 6 months from date of injury. Consultation provided to EP for PMP.

The applicant is unable to work from September 28, 2018, through October 1, 2018.

Primary Treating Physicians Progress Report Dated October 1, 2018

The report shows an exposure date of September 4, 2018 [and test results]. No further testing or treatment is indicated. The follow-up is in three months on December 14, 2018. The applicant is returned to full duty October 3, 2018. The applicant was unable to work from October 1, 2018, through October 3, 2018.

The report shows the applicant is present in the clinic requesting more time off until he can be seen by his PCP. The applicant states he has scheduled an appointment with this PCP tomorrow October 2, 2018. The applicant states his previous symptoms of foggy, headaches, and occasional generalized joint pain have continued to improve. The applicant states he is still recovering from a cold and noticed pain in his joints mainly when working lifting weights.

Medical Reports and Deposition of Primary Treating Physician Jim Savage, M.D.

Medical report of Jim Savage M.D. (Primary Treating Physician) dated October 2, 2018

The medical certificate indicates that it certifies that the physician saw the applicant due to an acute medical condition on October 2, 2018. It was necessary that the applicant be excused from work from October 3, 2018, to October 4, 2018, for his faster recovery.

Medical report of Jim Savage, M.D. March 29, 2021.

The medical report contains a history of the applicant incurring a puncture wound from a used syringe on September 4, 2018. The applicant was sent to San Francisco General Hospital, Occupational Health Services where he was prescribed and given PEP [ ]. Within the day, the applicant complained to OHS about his side effects of fatigue, joint pain, blurred vision with floaters. Because the applicant had lost his spleen several years prior, he was directed by Occupational Health Center to come in for frequent blood draws to check his blood platelets. On

September 5, 2018, he had a second blood draw and then on September 18, 2012, he had a blood draw which on September 19, 2018, revealed that his kidney GFR had decreased from baseline. The applicant was ordered to stop taking the above listed PEP drugs. The GFR then returned to baseline on September 24, 2018. On October 4, 2018, the applicant was cleared to return to work, however, the applicant continued to complain about all the side effects listed above with increasing fatigue, brain fog and loss of vision On May 1, 2019, the applicant began experiencing symptoms with a diagnosis of Immune thrombocytopenic Purpura. The applicant is still under treatment as of this date.

Deposition of Dr. Jim Savage dated July 22, 2021

He is currently treating the applicant. He has been the applicant's primary care physician for 20 years.

He diagnosed the applicant with immune thrombocytopenic purpura (ITP). He diagnosed him when he first had the problem. He is not providing treatment for that condition.

The applicant came to see him for a work-related injury involving a needlestick. He was given [PEP medication].

When he came to see him on October 2, 2018, he told him about the needlestick injury. He then came for a follow-up for his blood pressure medicine. He went to San Francisco General for he saw him. He saw him starting October 2, 2018. He was the follow-up after he saw San Francisco General. He sent him to get lab tests.

He called on the phone and basically said he had rashes and bruises all over his body, so he told him to come in right away. When he examined him, he had blood blisters in his mouth, and he had many bruises on his body. That was on October 8, 2018.

The applicant got a needlestick and he got treated at San Francisco General. That was back in September 2018. He came to see him with a rash on May 3, 2019. He was also complaining about some floaters in his eyes and problems with his vision. He ordered lab tests right away. He went to the hospital the same day he saw him.

He diagnosed the applicant immune thrombocytopenic purpura (ITP).

The articles from his research, there is recent data in 2021, showing that [one medication prescribed] can cause a delay of immune thrombocytopenic purpura.

That is the duration since he first got treated. It was not six months, that period. Also, his age category is most likely.

The time it takes for someone to start [ ] and then develop these conditions is typically between 1 to 6 months, with the highest percentage 25% falling within that timeframe. The majority of those affected are male, accounting for 94% of cases, with the most common age groups being 40% in the 40-49 age range and 38% in the 50-59 age range. The applicant falls into this demographic, being slightly older than the main age categories noted.

. . .

The applicant was put on the drug in September 2018. That fits in that high probability window. The article is basically a phase for medical study from the FDA.

The history shows the applicant was first sent to San Francico General when he first got an injury. His symptoms improved. At that time, he also had headaches. He also indicated he felt like his head was foggy. He is just reading off the San Francisco General notes he was telling him at the time. He got the medicine on September 4, and he was told by the hospital to stop taking the medicine on September 19 after probably 15 days. Because at that time his kidney function went down when they did the blood testing, because these drugs need to be tracked, they check as to white blood cells and kidney and liver function. They stopped him taking the medication because of the issue of kidney function going down from the baseline.

His kidney function before September 2018 was significantly higher. Since the incident, his kidney function declined and has hovered around baseline, never returning to the pretreatment levels. There are instances where kidney function changes with this medication, and it largely depends on an individual's genetic immune response. Some people experience severe immune reactions, while others do not.

The applicant may have been more susceptible to the immune disorder from that drug. The applicant has never had any other immune disorders, but he was probably more sensitive to this particular drug group.

The applicant never had a history of complaining of immune related bruises and low platelets in the past. He is not taking any other external medications including supplements that can trigger that. This is the only time he developed it. The highest probability for the window is his age and sex. When you look at the development of time and severity, there is no other trigger that can pretty much do that. He was bad because he was hospitalized twice.

In Workers' Compensation they use the term reasonable medical probability. In his opinion it is 80% certain that the medication [ ] is what caused the onset of ITP within reasonable medical probability.

Having treated the applicant for over 20 years he does not see any other correlation [ ].

It is now his opinion that the needlestick was the cause within reasonable medical probability.

The applicant told him about the hematologist in 2019 telling him that he basically had not seen too many people that got ITP from [the medication]. But it is his opinion he probably did not have the data that he had from this article from the FDA phase for study which probably has not been published yet. It is new.

When asked if ITP is idiopathic, meaning is unclear as to the cause, the witness testified that is correct. Half of the time they use the latest data for characterizing what it is, or that when people do not know what it is, they just call it that, idiopathic. But if they really search for it, they probably find it negative. Acquired means you acquired the infection and then the infection, then the damage goes to your immune system. That is an acquired immune deficiency.

When asked if scientific determination of causation is based on statistical analysis, the witness testified yes. It is based on that. But in a real clinical case, looking at the models, you know, sometimes it does not apply to these individuals. You say it is this percentage of people that are exposed versus not exposed. However, there are different populations.

When asked if the applicant's platelet levels returned to normal, the witness testified the last time he saw it was back to normal, but it took quite a while. It took over a year. The applicant received a treatment [ ]. It's a type of medicine that basically suppresses the immune system, so it does not become so active. He not still taking the medication because he is pretty much normal.

The physicians that treat ITP are in the field of hematology.

When someone has ITP, their bone marrow can become damaged due to an immune reaction that causes ongoing harm. The first step in treatment is to stop this damage. Immunosuppressive drugs are prescribed to allow the bone marrow time to heal. If the bone marrow successfully heals, platelet levels can be restored, and they may return to normal.

He is aware that the drugs the applicant was prescribed do not list ITP as a side effect. If you look at it, it is not a common one, ITP. However, the data from the one that he was pulling the article, these are new data from FDA, from June 27, 2021, is still in phase 4 clinical study data, so it is new. It is not going to be in the drug insert. Most companies do not want to put that out fast.

Basically, phase 4 clinical study means it is pretty much in the final stage. It was published to let people know in a group of people that take the drug [ ] that there is definitely a delayed reaction, that is most common in this particular population.

For it to be statistically significant there must be a certain confident interval. When they publish the article goes into detail of the statistical method. The article indicates what percentage of the patients developed the condition. It says [ ] when people develop ITP, is less than one month from starting the drug is almost nobody. 1 to 6 months is 25%. 6 to 12 months it is zero. And then also did 2 to 5 years it's 75%. And then they refer to males 94.4% compared to female. And there's an age category cluster around 40 to 60 plus.

The manifestation of ITP is usually bleeding, getting blisters, decreasing platelets and skin bleeding.

This is a Phase IV clinical study analyzing individuals taking [the medication] who also have ITP. The study indicates that approximately 41,830 individuals have reported side effects [ ], according to FDA data. Researchers are utilizing data and an AI algorithm to examine these adverse events. Additionally, a study published in The Lancet by the Mayo Clinic reported that about 18 to 25 individuals developed ITP as a result. While this number is noteworthy, it is relatively small in the context of the overall population.

It is his opinion there is an 80% chance that applicant's ITP developed as a result of taking [the prophylactic drug].

Medical Reports and Deposition of Lloyd E. Damon, M.D.

Medical Report of Dr. Lloyd E. Damon dated July 13, 2021.

There is no way to predict the rapid onset of symptoms of immune thrombocytopenic purpura (ITP). ITP symptoms can occur suddenly without warning. Those symptoms include the dropping of blood platelets which can lead to bleeding in the skin, from the nose, or urine or even into the brain. Should the drop of platelets reach a critical low point without warning, what happened before, the result could be serious and possibly fatal. Your ITP treatments thus far have stabilized the blood platelet levels at a normal level. Relapses of ITP are expected but the timing and trigger are unpredictable. Being in a stressful occupation which includes the potential for physical contact and injury could trigger a relapse of ITP and result in excessive bleeding. He is concerned that returning to his occupation could be detrimental to his health.

Deposition of Dr. Lloyd E. Damon dated January 11, 2022.

His specialty is predominantly hematology, although he is also board certified in oncology; however, his practice primarily focuses on hematology.

He is currently treating the applicant. He is treating the applicant for immune thrombocytopenic purpura.

He first met the applicant in May 2019, at which time the applicant was experiencing nosebleeds, bleeding in the mouth, fatigue, and headaches.

Immune thrombocytopenic purpura (ITP) is an autoimmune disease in which a person's immune system produces antibodies that target platelets, the blood cells responsible for clotting. As a result, these platelets are rapidly cleared from circulation, leading to a decrease in platelet count. Consequently, bleeding becomes a primary manifestation of this disorder.

The symptoms presented by the applicant were consistent with ITP. When asked in May 2019 if he could determine how long he had been suffering from ITP, he testified that he could not say with certainty. However, he did mention that he had been admitted to an outside hospital about a week prior to their meeting, where treatment for ITP was initiated.

When asked about the common causes of ITP, usually he stated it is unknown, which is called idiopathic. It can be associated with other rheumatic or other autoimmune diseases, for example, systemic lupus, as an example. Sometimes is associated with certain blood cancers usually of the lymphoid side of the hematology blood cancer spectrum, and occasionally it is due to drugs. Medication is what he means.

. . .

His first symptoms that were recorded in his chart began on May 2, 2019, and he is not aware of the previous symptoms or blood count. When asked what is the cause of someone suddenly becoming symptomatic, he testified that usually it is a very low platelet count. When your plate count is low, then spontaneous bleeding can begin.

When asked what causes someone to start dropping a platelet count, if it is ITP, they are developing antibiotics directed against their platelets. They should have those, and for whatever trigger happens, the process gets started. We really don't understand beginning to end in most cases.

When asked what about the applicant's occupation that could potentially trigger a relapse of ITP, the witness testified a lot of patients with ITP will say that stressful events or other medical events in their life seem to trigger a relapse. Those are very difficult associations to prove. His description of his Police work to me is that it is very stressful occupation, and he thinks the public

recognizes physical contact and other potential injury is a real issue with that profession. He was concerned that something could happen with his routine work as a Police Officer that could possibly trigger a relapse.

The applicant is still having a lot of fatigue, but he is having no bleeding. If he returns to work, he thinks it is possible that it could trigger a relapse, which would mean a drop in platelets, and therefore, the risk of bleeding.

When asked if his work as a Police Officer would have triggered the onset of the symptoms back in May 2019, the witness testified he cannot say it could, and he cannot say it would not. He is not sure.

Medical Report of Remo Morelli, M. D. Dated April 6, 2023

The applicant was diagnosed with ITP and its complications many years ago, which led to him losing his job. Following his recent divorce, he is now facing significant financial hardship. He reports that the onset of ITP occurred after he received [ ] prophylaxis following a needlestick injury. Since recovering from ITP, he has not experienced any further issues. However, because ITP was deemed not work-related and considered an unexplained occurrence, he has been unable to secure Workers' Compensation, further exacerbating his financial difficulties.

He asked whether the ITP could have been the result of the medication used for [ ] prophylaxis. Apparently, he was recently told by Dr. Savage that his potassium was so severely elevated, dangerously so. He changed his diet and apparently it has come down. None of his laboratories are available for review.

He needs more information from the patient to conclude that the ITP was caused by the [prophylactic] medications. However, the temporal relationship, and the fact that the ITP resolved within a short period of time, and without explanation, certainly begs the question of cause and effect.

Medical reports and deposition of Ira Fishman M.D. (QME)

Medical Report of Ira Fishman M.D. dated February 17, 2020

The history of the injury indicated applicant's occupational exposure occurred on September 4, 2018. On the date of this injury, the applicant was across from the Light Church and noted that a heroin addict had passed out on the street. The applicant woke up the homeless individual, and he picked up his belongings.

Unfortunately, the applicant rested his left palm on a window seal and, despite wearing plastic gloves, he punctured the palm of his left hand with the used hypodermic needle attached to a syringe that had been left on the windowsill.

The applicant notes that he had a previous needlestick injury but did not receive any prophylactic drug therapy for that occurrence and does not recall when the incident occurred. There were no consequences from the prior needlestick.

After a specified time on these medications, the applicant noted multiple drug side effects and was told that he had diminished renal function for which reason both medications were stopped. Drug side effects included joint pain, blurred vision and fatigue. The joint pain has improved, the vision has improved somewhat, but the applicant was told at one point that he had a detached retina that had subsequently resolved.

He also there was a sign of hemorrhage in his eyes, but the retinal bleeding and resolving.

The fatigue has improved but has not resolved. The applicant also notes diminish memory and states that he has mental fog periodically.

The applicant was told that the half-life of the [ ]prophylactic drugs was such that those drugs were no longer in his system and that any such previous drug side effects experienced by the applicant resolve over time.

Over the time from approximately the fall of 2018 to May 2019 the joint pain improved, vision worsened, and fatigue was unchanged. He had difficulty reading.

In approximately May 2019, the applicant had a particularly stressful day at work. Later that evening the applicant noticed a bruise on his leg before he went to bed. That night he had a nosebleed and woke up with persistent nosebleed. In addition, upon waking up he noted blood blisters around his mouth and his tongue and bruising all over his body. For these complaints he went to see his primary care physician Dr. Savage who referred him to San Francisco General Emergency Room.

Laboratory evaluation in the emergency room revealed a platelet count of 7,000, leading to a diagnosis of idiopathic thrombocytopenic purpura. The applicant received a platelet transfusion and was administered steroids. He remained in the hospital for two days for further observation and treatment.

Two days after the hospital discharge, the blood blisters on his mouth recurred and this time he went to Sutter Hospital ER was admitted for one week and began seeing a dermatologist, Dr. Damon, telling him that he had zero platelets. The applicant again received platelet transfusion

and steroid therapy. His platelets went up and down. Dr. Damon told him that because of the applicant's older age, there was less chance of inducting a permanent remission from ITP with treatment with rituximab. The applicant's last infusion was two months ago.

The physician's diagnosis was occupational high-risk needlestick injury with appropriate administration of drug prophylaxis, idiopathic thrombocytopenic purpura (ITP), chronic anxiety post-occurrence of significant drug side effects, diminish memory/cognition, fatigue, question ideology; rule out a brain disease, and visual complaints, question ideology.

The applicant has filed a circulatory system and body systems claim. That portion of the claim is his responsibility to evaluate as the internal medical legal evaluator for this case.

The physician indicated that idiopathic is defined as spontaneous or from an obscured or unknown cause.

In dealing with ITP, he carefully reviewed the FDA package insert for [one medication] and there is no mention of the judge causing ITP. Any constitutional symptoms caused by the medication would be expected to dissipate over time and eventually resolved entirely.

He carefully reviewed the FDA package for [the other medication], noting that [ ] is primarily eliminated by the kidneys. Renal impairment, including causes of acute renal failure and Fanconi syndrome (a type of renal tubular injury associated with severe hypophosphatemia), has been reported. Consequently, it was appropriate to discontinue antiviral drug prophylaxis in September 2018 due to an increase in serum creatinine levels

There is no mention in the FDA package insert of this two-drug combination causing ITP.

After reviewing the studies provided by applicant's attorney and indicated he would not consider the site to be part of a peer-reviewed medical literature that evaluators such as himself would commonly site in a defense medical legal opinion.

His own review of the medical literature indicates some relevant medical literature discussing a potential relationship between tenofovir and ITP.

Any constitutional symptoms caused by this medication would be expected to dissipate over time and eventually entirely resolved.

The physician concluded that, unfortunately, the two case reports do not meet the threshold of reasonable medical probability for establishing an association between the applicant's ITP and his individual use of tenofovir. Furthermore, these cases did not involve otherwise healthy individuals who received short courses of prophylactic antiviral therapy, unlike the applicant's situation.

Furthermore, drug-induced immune ITP generally resolves after the offending drug causing the ITP has been discontinued.

At this time, he cannot state with reasonable probability that the short course of tenofovir for antiviral prophylaxis administered 7.5 months prior to the onset of applicant's ITP was contributory to the ideology of the ITP.

Deposition of Ira Fishman, M. D., dated October 9, 2020.

The physician was asked about an article cited in his report titled a novel association between anti-retroviral therapy and drug-induced immune thrombocytopenia purpura and indicated it was a case report which is a letter to the editor, so it is not a peer-reviewed report.

He tried his best to find evidence and to look at cases from both sides of the coin, and what he came up with was a case report reported as a letter to the editor. He probably should have emphasized this is a little more, although it did say case report, this is not peer-reviewed. This does not reach the level of reasonable medical probability. This is some doctor writing a letter to a publication alerting the medical community that there might be a possible new finding or association between a drug and a subsequent medical disease.

He is familiar with the criteria used to determine whether an ITP diagnosis is drug-induced. In his report, he notes that most cases of ITP are idiopathic and provides a medical dictionary definition of the term "idiopathic." Therefore, excluding other causes is essentially meaningless in this context. As far as is known, the applicant did not have any other identifiable causes, which he discusses in his report on ITP.

In the article or letter to the editor cited in his report the writer goes through other possible causes that were ruled out [ ]. That is something he would consider as to whether there were other causes. He acknowledged that he could not identify any other causes, nor could the treating physicians.

When asked in his report when he states the applicant's physician believes the cause could have been produced by the prescribed medication, and later in his report it states that there is no ITP that is work-related, this is under the review of record and is actually authored by the applicant. So, it is the applicant's perception of what his doctors told him.

He does not think he has reviewed a report by either of his positions that states the ITP was drug-induced.

He does not have any statements from treating physicians indicating that, within reasonable medical probability—our standard of proof in the administrative law system—the drug caused the

ITP. Therefore, there is no contradiction in his report. He was summarizing the applicant's account regarding his doctors, and, in other instances, he was presenting information based on his personal review of the medical records provided to him.

When asked if he would want to consider if his treating physician changed his diagnosis from idiopathic ITP to drug-induced, he said he would always be interested. He is the most flexible man in one way and the most inflexible medical expert in the other. When he makes a medical-legal conclusion, he deals with finality and does not change his opinions just because he has been deposed, however, if he is provided with entirely new information, he is always willing to consider that.

He understands that the attorney is saying that he is going to be sent some new additional medical records, including a report from Dr. Savage, which they would want him to review the records and write a supplemental report.

When asked if he wrote in his report that the onset was approximately 7 1/2 months after taking the drug, and is it possible that the onset was actually shorter than that given the fact that he had some immediate side effects which caused him to be taken off the drug, then he had complaints of fatigue for the entire 7 1/2, So is it possible, the witness testified yes.

When asked if the onset occurred sooner than 7 1/2 months before the official diagnosis, he affirmed that it did.

Witness testified this is actually a common problem that we have in many cases of this type and internal medicine. We have somebody who for a long period of time and then abruptly shows up with a significant deterioration. He cannot exclude that the ITP started at some point before it became clinically manifest. The problem is that we have no way to document that. Part of the reason is because he is a male public safety officer, and generally those officers like to continue working, they don't like to go to the doctor, and often they will ignore mild, even moderate, symptoms and keep working. That is one problem. On the other hand, the symptoms that he mentioned were related to the medication with closer contiguity, those are not necessarily the symptoms of ITP. That remains what we know.

Regarding the applicant's spleen removal prior to this event, it is important to note that such a procedure can lower the immune response to certain bacteria, which is why individuals are often given the pneumonia vaccine, or Pneumovax. Additionally, the spleen plays a crucial role in filtering various blood cells; without it, the platelet count can increase due to the lack of normal filtering and processing of platelets and other blood cells. However, this increase in platelet count

does not cause ITP, and he does not believe that the absence of a spleen would make an individual more prone to developing ITP.

He does not think it is an eggshell plaintiff in that regard.

When asked if the side effects that he has that cause the medication to be discontinued, are those side effects that resolve, or that is what he understood to be an ongoing issue up until his official diagnosis of ITP, he testified no. It was his understanding no symptoms resolved. If that's not the case or a need to reevaluate it, that may be.

The kidney issue and create an account [sic] resolved.

In his report he indicates the applicant remains TTD from the consequences of ITP and/or multiple subjective complaints, although the ideology of symptoms manifesting as persistent visual disturbance, fatigue, and cognitive dysfunction remain unclear. Such symptoms could even be manifestations of post-drug side effects, psychiatric illness, that will require psychiatric medical-legal evaluation. Chronic fatigue is well described in the medical educator to be associated with ITP. That is his pronouncement on his ongoing symptoms. He did have ongoing symptoms. The ideology of it was not clear by any stretch.

Medical Report of Ira Fishman, M.D. dated March 11, 2022

The physician prepared a supplemental report after reviewing records and depositions sent by the parties.

According to the applicant, he remains in ITP remission to the present without further medical maintenance treatment for ITP. He is not aware that the applicant experienced any permanent drug side effects from either the administration of [medication].

He is not aware of the applicant manifesting any secondaries disease states that would be associated with ITP. He did not find the applicant had been exposed to any other toxic substances that are associated with ITP.

Review of the current medical records provided did not indicate a statement from any treating physician that the applicant's ITP was in any way related to his brief September 2018 course of antiviral prophylaxis multiple drug treatments.

The treating physicians were uniform in diagnosing the applicant with idiopathic ITP.

The Webster's dictionary definition of [idiopathic] is arising spontaneously or from an obscure or unknown cause.

He has carefully reviewed the FDA package insert for [one medication taken] and it makes no mention of the drug causing ITP. Any constitutional symptoms caused by this medication would be expected to dissipate over time and eventually resolve entirely.

He has carefully reviewed the insert package for [the other medication taken] and the onset of the ITP (5/2/2019) was approximately 7.5 months after cessation of the approximate 15-to-20-day course of antiviral drug prophylactics (9/24/2018) And the drugs are principally eliminated by the kidney. Renal impairment, including causes of acute renal failure and Fanconi syndrome, have been reported. Thus, it would be appropriate to discontinue antiviral drug prophylaxis in September 2018 when serum creatine was increased.

There is no mention in the FDA package insert of this two-drug combination causing ITP.

He reviewed the reports and conclusions of Dr. Savage and does not agree [the medication] contributed to the onset of applicant's primary ITP. The applicant had only been on [the medication] briefly and stopped it for a different reason (transient decline of renal function) and over seven months of not taking [the medication] elapsed before the onset of applicant's ITP. Dr. Damon in his January 11, 2022, deposition testimony concluded there was no relation [with] subsequent onset of ITP 7.5 months after discontinuation of the breeze course [ ].

Dr. Savage clearly indicated in his deposition testimony he did not preserve the link between stress and ITP.

He disagrees with Dr. Damon statement that physical contact and injury could trigger a wee relapse of primary ITP. He is not aware of any medical literature supporting a relationship between physical contact and relapses of ITP. Dr. Damon did not even mention any concepts related to the applicant's alleged emotional stress in his March 29, 2021, letter.

In his original February 2020 IME report, he presented the parties a definition of primary ITP, which is not triggered by any apparent associated condition. He is not aware of any medical literature to support a conclusion that the initial onset of ITP is caused or triggered by emotional stress.

He was asked to review all four of the documents and provided an opinion as to whether this material changes his opinion regarding causation of ITP, and indicated that after reviewing these documents, there's no change in his previously issued medical legal conclusions regarding the unknown ideology of applicant's primary ITP. Within reasonable medical probability, the applicant's primary ITP, subsequently inappropriate treatment is in remission, does not have industrial ideology.

He was specifically asked to comment on whether it is possible that either the stress of applicant's occupation as a Police Officer for the City and County of San Francisco could have potentially "lit up" or aggravated his ITP causing it to then emerge and be diagnosed and indicated in general autoimmune disease states can theoretically be aggravated by emotional stress. However, each autoimmune disease state to be considered needs to be specifically and individually evaluated. Dr. Damon and Dr. Savage's comment when reviewed actually support his previous issued internal medical conclusions. Either himself, Dr. Damon or Dr. Savage concluded that emotional stress contributed to the applicant's initial onset of ITP. They are in unanimous agreement about the lack of substantial evidence linking the applicant's alleged police work associated with emotional stress with initial onset of primary ITP. Dr. Damon and Dr. Savage's deposition testimony strongly support his previously issued internal medical legal conclusions as contained in his report of February 20, 2020.

As far as he knows, absent evidence to the contrary the applicant's previously and successfully treated ITP remains in remission.

As originally stated, he cannot state with reasonable medical probability that occupational factors, such as emotional stress associated with being a police officer, contributed to the original onset of applicant's ITP. Furthermore, he was unable to locate any medical literature that supports a conclusion that either the presence of police work or taking [the medication] on industrial basis, contributed to, or aggravated the initial onset and subsequent clinical course of applicant's ITP.

As to the question could the stress of his occupation as a police officer of accelerated his ITP, his answer is no. Not by the proof standard of reasonable medical probability required in the adjudication of industrial claims such as this one.

Medical Report of Ira Fishman, M. D. dated December 19, 2022.

He has received additional defense attorney legal correspondence as well as the deposition of Dr. Savage and additional scientific data.

He has now been asked to review these documents and pride [sic] opinion is to whether this materially changes his opinion regarding causation of ITP, and states after reviewing these documents, there is no change in his previously issued medical legal conclusions regarding the unknown ideology of applicant's primary ITP. With reasonable pedicle probability the applicant's primary ITP, subsequently with appropriate treatment in remission does not have industrial ideology.

He was being asked to comment on whether is possible that either stress of the applicant's occupation as a Police Officer could have lit up or aggravated his ITP, causing it to change and emerge and be diagnosed, and states in general, autoimmune disease states can theoretically be aggravated by emotional stress. However, each autoimmune disease to be considered needs to be specifically evaluated individually. Dr. Damon and Dr. Savage comment when reviewed support his previously issued internal medical conclusions. Neither physician has concluded that emotional stress contributed to applicants' initial onset of ITP. They are in unanimous agreement about the lack of substantial medical evidence linking applicant's alleged police work to the onset of his ITP. As far as he knows, absent any evidence to the contrary the applicant's previously and successfully treated ITP remains in remission. A medical legal discussion of ideology of primary ITP differs from discussions regarding the potential contributions to an ITP relapse in the indeterminate future that has not even occurred yet. He cannot state with reasonable medical probability that occupational factors, such as emotional stress associated with being a Police Officer, contributed to the original onset of applicant's primary ITP. Furthermore, he is unable to locate any medical literature supports the conclusion that in the presence of police work or taking [the medication] on industrial basis because contributed to or aggravated the initial onset and subsequent clinical course of applicant's ITP.

OTHER EVIDENCE

Applicant's memorandum to Captain Carl Fabbi dated September 4, 2018, regarding needlestick injury.

The memorandum of September 4, 2018, indicates on September 4, 2018, the applicant placed his hand on a window seal on the front window frame and felt a sharp prick. Upon looking at his hand, he saw the needle from the use a ridge had penetrated his glove. He removed the glove and saw a dot of blood where the needle punctured the skin of his left hand.

Incident report dated September 4, 2018

The incident report shows the applicant reporting an injury consisting of a hypodermic needle stick to his left palm. The applicant was treated at San Francisco General Hospital.

Applicant's memorandum to Captain Carl Fabbi dated July 25, 2019, regarding needlestick injury.

The memorandum indicates that on September 4, 2018, the applicant sustained a needlestick injury when a used hypodermic syringe left on a window frame by an unknown intravenous drug user punctured his left hand.

The applicant reported his injury and was sent to the Occupational Health Center at San Francisco General Hospital, where a blood draw was ordered. He was prescribed two potent preventive medications [ ]. The nurse practitioner informed him of minor side effects associated with these medications.

After starting the medications, he began to experience side effects, including shoulder joint pain, fatigue, vision changes, and brain fog. Because he had no spleen due to an unrelated injury, he was required to undergo a second blood draw the following day, September 5, 2018, at San Francisco General Hospital. During this visit, he reported his side effects, but the medical staff informed him that he should not be experiencing them and dismissed his claims regarding the side effects from the prescribed medications.

On September 18, 2018, he saw another occupational health nurse, and had another blood draw. He again mentioned the side effects to the nurse who gave them a computer printout regarding the medications. The print outs for the two drugs listed the symptoms he was experience.

He was sent back to work and then received a call from San Francisco General to stop taking the medication because the blood work was causing problems with his kidneys and causing them to fail. He was then taken off work from September 20, 1018, to October 1,2018.

On May 5, 2019, the fatigue and gotten so bad he decided to take off work. On May 2, 2019, he saw bruising on his leg that was not there before. That day experience to nosebleeds in the middle of the night. Upon waking up the next morning he called his personal physician who ordered him to see him immediately.

He saw his private physician Dr. Savage who diagnosed him with ITP. He was sent to Sutter Health Hospital on Van Ness.

IV.

DISCUSSION

The parties stipulated that applicant, Gary Peachey, while employed on September 4, 2018, as a Police Officer, by the City and County of San Francisco, sustained an injury arising out of an occurring in the course of his employment to his left hand, needlestick injury, and claims to have sustained an injury arising out of an occurring during his employment in the form of blood and Hematopoietic Purpura.

The applicant developed Immune Thrombocytopenic purpura also referred to as ITP.

The issue in this case is whether the Immune Thrombocytopenic Purpura also referred to as ITP was caused by the admitted needle stick injury applicant sustained while he was employed

as a Police Office and the applicant taking preventive prescribed medications [ ] because of that needle stick injury.

The Qualified Medical Evaluator found that the causes ITP are idiopathic (unknown) and that the applicants' development of ITP could not within reasonable medical probability be tied to the pinprick incident. The physician concluded that drug-induced immune ITP generally resolves after the offending drug causing the ITP has been discontinued. He cannot state with reasonable probability that the short course of [ ] antiviral prophylaxis administered 7.5 months prior to the onset of applicant's ITP was contributory to the ideology of the ITP. He disagreed with the opinions of the Primary Treating Physician on causation.

The Primary Treating Physician concluded that the ITP was reasonably medically caused by the pinprick incident and a reaction to the prescribed preventive mediation [ ] given to the applicant because of the pinprick injury [ ].

The primary treating physicians conclusion was based on the fact the applicant immediately developed the negative reaction and symptoms immediately after taking the prescribed medications, the applicant continued to complain of those complaints of fatigue, brain fog and blurred vision/floaters from the time of the taking of the prescribed medications through May 2019 when the symptoms got worse, there was no intervening cause between the needlestick medication and the diagnosis of ITP, the physician found an scientific and reliable article correlating ITP with [the preventative medication], the applicant developed ITP in September 2018 and it was not diagnosed until May 2019, rather than the ITP first occurred in May 2019, and the primary treating physician concluded within reasonable medical probability the needle stick and taking the propriety medication was 80% the likely cause of the applicant's development of ITP.

The Arbitrator had to determine based on the facts and the medical evidence whether the report of the Primary Treating Physician or the Qualified Medical Evaluator was better reasoned and more persuasive.

Because the issue involves a dispute between the opinions of the Primary Treating Physician and the Qualified Medical Evaluator, based on the law neither physician is given greater weight, as in the case of an Agreed Medical Evaluator. The Arbitrator must find which report is better reasoned and more persuasive based on the facts of the case, the medical evidence and the analysis contained in the medical reports.

The WCAB has held in several cases that there is no presumption in favor of a panel QME. The board stated that the opinion of the panel QME is not entitled to a presumption of accuracy.

The panel QME's opinion is entitled to no more or less weight than the opinion of a treating physician. In another case, the Appeals Board stated that the Panel Qualified Medical Evaluator's opinion is entitled to no more or less persuasive weight than the opinion of the treating physician, and that the trial judge must consider the entire record and decide the facts and controversy based upon substantial evidence in light of the entire record. *Willette v. Au Electric Corp.* (69 CCC 1563, 1565 (appeals board en banc); *Felix v. Verizon Wireless* ,2008 Cal. Wrk. Comp. P.D. LEXIS 541; *Cruz v. Petaluma Poultry Processors*, 2009 Cal. Wrk. Comp. P.D. LEXIS 574; and *Fields v. The Regents of the University of California*, 2024 Cal. Wrk. Comp. P.D. LEXIS 269 (PTPs to be given same weight as QME's reporting).

When there are conflicting opinions between a primary treating physician and a Qualified Medical Evaluator, according to the case of *Place v. WCAB* (35 CCC 525), the relevant and considered opinion of one physician may constitute substantial evidence, even if inconsistent with other medical opinions.

The Appeals Board has the power to choose among conflicting medical reports that it deems most persuasive. The relevant and considered opinion of one physician, although inconsistent with other medical opinions, might constitute substantial evidence in support of a factual determination of the Board. *Jones v. WCAB* (1968) 33 CCC 221, 223; *Painter v. WCAB* (1985) 50 CCC 224, 228; *Standard Rectifier Corp. v. WCAB* (Whiddon) (1966) 31 CCC 340; and *Fred Gledhill Chevrolet v. IAC* (Allison) (1964) 29 CCC 263.

The Arbitrator determined that both the medical reports of the Qualified Medical Evaluator (Dr. Fishman) and the primary treating physician (Dr. Savage) were based upon substantial medical evidence.

The Arbitrator determined that the medical report and note from Dr. Savage were not in and of themselves substantial evidence. However, when the report and note are read along with the detailed deposition of Dr. Savage taken on July 22, 2021, by both parties, combining both the medical reports, notes, and the deposition makes the opinions of Dr. Savage based upon substantial medical evidence.

It should also be noted that Dr. Savage was applicant's primary treating physician for many years prior to his industrial injury and evaluated the applicant because the claim for ITP was denied, and the physician is not a workers' compensation reporting or evaluating physician.

The Arbitrator found based upon the facts, the applicant's credible testimony, as supported by the medical evidence, the Arbitrator found the medical report, note, and deposition of Dr.

Savage were the most persuasive and although in conflict with the report of the Qualified Medical Evaluator (Dr. Fishman), the Arbitrator found the opinion of Dr. Savage, finding the ITP was caused by the applicant taking the preventative drug [ ]. because of the industrial injury to better reasoned and more persuasive, especially considering the fact the applicant developed symptoms immediately after taking the drugs and the additional facts set for above.

The applicant has the burden of proof on the issue of injury.

An injury as a resulting of talking medication for an industrial injury is be considered a compensable consequence of the industrial injury

If an employee experiences a side-effect injury or death from medication prescribed for an industrial injury, it will be considered a compensable consequence of that injury. Generally, internal injuries, such as gastroesophageal reflux disease, caused by medication taken for orthopedic injuries, are considered industrial in nature.

In the case of *South Coast Framing, Inc. v. WCAB* (Clark), the California Supreme Court held that an employee's death from an accidental drug overdose was compensable. The applicant died from a combination of drugs taken for his work-related injury and drugs prescribed by his private physician. The QME testified that the medications taken for his injury had about "the minimum level of causation," a "small role" in causing the death, possibly "one percent causation." He also testified that the contribution from the industrial medications was "not zero," and he could not rule out that the medication "put it over the edge." The Supreme Court held that because the industrially prescribed medications were a contributing cause of the death, it was industrial. It explained that even if the employee might have died from an overdose of the privately prescribed medications alone, it was reasonably probable that the industrial medications made the death more likely. Alternatively, the court adopted the WCAB's finding that the medications were prescribed by the personal doctor to address the worker's inability to sleep through pain from his work injury, so the overdose was causally related to the work injury. (*South Coast Framing, Inc. v. WCAB* (Clark) (2015) 80 CCC 489).

The Arbitrator in this case found, in Dr. Savage's opinion, that the applicant's use of the drug [ ] was a contributing factor to the development of ITP.

The Arbitrator rejected the opinions of the Qualified Medical Evaluator that the applicant development ITP was idiopathic and could not within reasonable medical probability be based at all on the applicant taking the drug [ ].

The Arbitrator rejected the QME's opinions that ITP developed 7 ½ months after taking the medication based on the facts and opinion of Dr. Savage that the applicants symptoms developed immediately after taking the preventative drugs and the IPT was not diagnosed until 7 ½ months later, the applicant having the ITP the entire time, Dr. Savage opined the cause was taking the preventative drugs within 80% probability, he found a reliable medical study supporting that conclusion this drug causes ITP, the fact there was no other intervening cause between September 2018 when the applicant developed symptoms and May 2019 when the ITP was diagnosed, according to Dr. Savage the applicant appeared to be more susceptible to side effects of the drug, the applicant had no other underlying conditions that would have triggered ITP, and most importantly there is no intervening cause between the needlestick medication and the applicant developing symptoms and the diagnosis of ITP.

The Arbitrator rejected the opinion of the QME because the physician concluded that drug induced ITP generally resolves after the offending drug causing the ITP has been discontinued.

The issue in this case is not what generally occurs, but what happened to this applicant. The opinion of Dr. Savage that the applicant was more susceptible to ITP and there was an 80 % probability based on all the facts that ITP was caused by the medication taken as a result of the needle stick injury is better reasoned than the QME opinion of what generally occurs and there is no known cause of ITP.

The Arbitrators' basis for finding the medical report of the Primary Treating physician being the better reasoned and more persuasive and for rejecting the opinion of the Qualified medical evaluator and the basis for finding the applicant's development of ITP was at least in part caused by his pinprick incident and taking the drug [ ] and the Arbitrator's basis for finding that the applicant met his burden of proof regarding the issue of injury and that the ITP was caused by his employment as a police officer, the pinprick injury he sustained, and the subsequent use of preventive medication [ ] in response to that injury and the medical report of the PTP is more persuasive for the following reasons:

The applicant developed the symptoms immediately after taking the medications, which consisted of fatigue, brain fog, blurred vision, floaters, and shoulder joint pain, The symptoms and reaction started immediately after the applicant took the medications and the symptoms never abated and continued to worsen from September 2019 through May 2019 when the diagnosis of ITP was made, there was no intervening cause that could have caused the ITP between the

applicant taking the prescribed medication and the diagnosis. The Primary Treating Physician found an article linking the drugs to ITP [ ].

The Arbitrator rejected the opinion of the QME because the basis his opinion was that the causes of ITP are unknown, and the ITP developed 7 1/2 months after taking the prescribed medications, and he disputed the article cited by the PTP. The QME ignores the symptoms the applicant had from September 2018 through May 2019, or finds the symptoms are coincidental not related to ITP, for his basis that the ITP developed 7 1/2 months after taking the medications. The Arbitrator rejected this opinion. The Arbitrator rejected the opinions of the QME that the article and conclusions of Dr. Savage were unreliable.

In the opinion of the Arbitrator, based on the credible testimony of the applicant, the medical record and medical report of Dr. Savage the applicant developed symptoms in September 2018 when the applicant first took the prescribed medication and the symptoms continued for 7 1/2 months and continued to worsen until the symptoms got worse and new symptoms developed in May 2019, that according to Dr. Savage it was not until the applicant's condition got worse that the diagnosis was made, the disease was present the entire time, the diagnosis was not made until May 2019, according to Dr. Savage the applicant appeared to be more susceptible to side effects of the drug, the applicant had no other underlying conditions that would have triggered ITP, and most importantly there is no intervening cause between the needlestick medication, the applicant developing symptoms and the diagnosis of ITP.

Labor Code §3600(a) provides liability for injuries sustained "arising out of and in the course of employment." An employer is liable for workers' compensation benefits "without regard to negligence." (Lab. Code, § 3600(a).)

An employee bears the burden of proving injury AOE/COE by a preponderance of the evidence. (*South Coast Framing, Inc. v. Workers' Comp. Appeals Bd. (Clark)* (80 CCC 489); Lab. Code, §§ 3600(a),3202.5.)

Whether an employee's injury arose out of and in the course of employment is generally a question of fact to be determined in light of the particular circumstances of the case. (*Wright v. Beverly Fabrics* (67 CCC 51)

For the purpose of meeting the causation requirement in a workers' compensation injury claim, it is sufficient if the work is a contributing cause of the injury. (*South Coast Framing, Inc. (Clark), supra,* at pp. 298-299.) The applicant in a workers' compensation proceeding has the burden of proving industrial causation by a 'reasonable probability. That burden manifestly does

not require the applicant to prove causation by scientific certainty. (*Rosas v. Workers' Comp. Appeals Bd.* (58 CCC 313)

Medical evidence that industrial injury was reasonably probable, although not certain, constitutes substantial evidence for the finding of injury AOE/COE. (*McAllister v. Workers' Comp*. Appeals Bd. (33 CCC 660)

The Arbitrator finds that based on the evidence cited above and the medical reports and deposition testimony of the primary treating Dr. Savage that the applicant met his burden of proof that the applicant developed ITP because of taking preventive drugs [ ] as a result of the admitted needle stick injury.

The Arbitrator finds that the applicant sustained an injury arising out of an occurring in the course of his employment to his blood and in the form of ITP based on the applicant's credible testimony, the supported medical records and the opinions of the primary treating physician Dr. Savage that are found more persuasive than the opinions of Dr. Fishman, the Qualified Medical Evaluator.

V.
RECOMMENDATION

For the foregoing reasons it is recommended that reconsideration be denied.

DATED: December 19, 2025

MARK L. KAHN,
ARBITRATOR