I. H1N1 Overview.

Novel 2009 H1N1 flu, commonly known as swine flu, is a respiratory infection caused by an influenza virus.¹ This virus, first recognized in the spring 2009, is referred to as the swine flu, because it contains genetic material from human, swine, and avian flu viruses.² The initial outbreak of the 2009 H1N1 virus occurred in the state of Vera Cruz, Mexico in spring of 2009.³ On June 11, 2009, the World Health Organization labeled Novel Influenza A (H1N1) a global epidemic, not because of the severity of illness caused by the virus, but because of how quickly the virus spread to more than 70 countries.⁴ The World Health Organization also issued the influenza pandemic alert at a level six, the highest level alert, due to:

- Its global appearance at the community level.
- Infeasibility of testing all suspected cases since the chain of person-to-person transmission was no longer clear in certain areas.
- The most severely affected groups differed from those who typically developed seasonal flu complications.
- The rates of severe illness and death from Novel H1N1 Influenza may be unusually high in the developing world.⁵

The H1N1 virus is contagious. It spreads from human to human in the same or similar manner in which seasonal flu spreads. Influenza viruses infect the cells lining the nose,  

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² Id. (The 2009 virus is unrelated to human seasonal H1N1 that has been in general circulation among people since 1977)

³ Center for Disease Control and Prevention (“CDC”), Novel H1N1 Flu: Background on the Situation, available at www.cdc.gov/h1n1flu/background.htm.

⁴ Id.

throat and lungs. They are spread mainly from person to person contact through coughing and sneezing. The virus enters the body when an individual inhales contaminated droplets or transfers a live virus from a contaminated surface to the eyes, nose or mouth on the hand.

H1N1 symptoms in humans are similar to those of other flu viruses and include fever, cough, sore throat, body aches, headache, chills, fatigue, diarrhea and vomiting. Symptoms generally develop 3-5 days after exposure and continue for about eight days. Most individuals who get either the seasonal flu or H1N1 flu will have mild illness and will not require medical care or antiviral drugs.

However, there are risks for certain populations for both seasonal flu and H1N1. Children younger than five years of age, pregnant women, and individuals with certain chronic medical conditions such as diabetes, heart disease, asthma, chronic lung disease, blood disorders including sickle cell disease, liver disorders, metabolic disorders, weakened immune system due to AIDS and cancer are a greater risk with respect to both flu viruses. Interestingly, individuals over 65 years of age are at greater risk for complications with respect to the season flu virus; however, they are less likely to be infected with the H1N1 virus. This is because a significant percentage of people 65 and older have some immunity against the virus, which suggests that they may have cross protection from exposure to viruses that have circulated in the more distant past.

**Staying Healthy and Avoiding H1N1 Flu**

According to the CDC, the influenza vaccination is the first and most important step in protecting against the flu. Vaccination is particularly important for people at higher risk of serious complications from the H1N1 including people with certain health conditions and the very young. Health conditions that increase the risk of being hospitalized from

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7 Id.

8 Id.


10 Id.


12 Id.

13 Id.

14 CDC, 2009 H1N1, available at http://www.cdc.gov/h1n1flu/.

15 Id.
H1N1 include lung disease like asthma or chronic obstructive pulmonary disease, diabetes, heart or neurological disease, and pregnancy.\(^{16}\) If you are traveling to an area where the H1N1 might be circulating, you should get the vaccine at least two weeks before the start of your trip.\(^ {17}\)

The CDC also recommends other steps to prevent H1N1. These steps include:

- Cover your nose and mouth with a tissue when you cough or sneeze. Immediately throw the tissue in the trash after use.
- Wash your hands often with soap and water. If soap and water is not available, use any alcohol based hand rub.
- Avoid touching your eyes, nose or mouth. Germs spread this way.
- Try to avoid close contact with sick people.
- If you are sick with flu-like symptoms, the CDC strongly recommends that you stay home for at least 24 hours after your flu is gone (except to get medical care and other necessities.)
- The CDC has also referenced that Employees who are well but have an ill family member at home with H1N1 can go to work as usual. However, the individual should monitor their health every day and take necessary cautions including covering their coughs and sneezes and washing their hands on a regular basis.
- Follow public health advice regarding school closures, avoiding crowds and other social distancing measures.
- Stay informed on H1N1’s prevalence in your community.\(^ {18}\)

**Emergency Warning Signs**

Although most individuals who contract H1N1 have mild symptoms, CDC has noted there are emergency warning signs that signal an individual needs immediate medical attention. For children, these signs are: fast breathing or trouble breathing; bluish skin color; not drinking enough fluids; not waking up or not interacting; being so irritable that the child does not want to be held; flu-like symptoms improve, but then return with fever

\(^{16}\) Id.
\(^{17}\) Id.
\(^{18}\) Id.
and worse cough; and/or fever with a rash.\(^\text{19}\) In adults, the following symptoms require immediate medical care: difficulty breathing or shortness of breath; pain or pressure in the chest or abdomen; sudden dizziness; confusion; severe or persistent vomiting; and/or flu-like symptoms that improve but then return with fever and worse cough.\(^\text{20}\)

**H1N1 Vaccination Information**

When the H1N1 vaccine first became available, supplies were limited.\(^\text{21}\) For this reason, the CDC recommended that high risk groups receive the vaccine first, including pregnant women, people who live with or care for children younger than 6 months of age, health care and emergency medical services personnel, anyone 6 months through 24 years of age, and people ages of 25 through 64 years of age at higher risk for H1N1 influenza because of certain chronic health conditions or compromised immune systems.\(^\text{22}\)

However, now that the vaccine has been made readily available, it is recommended as the best preventative measure for H1N1. It is also recommended that children younger than 10 years old receive two doses of the vaccine, separated by at least 21 days, but ideally 28 days, based on studies of immune response to the vaccine as measured by protective antibodies in the blood.\(^\text{23}\) Older children and adults only need one dose of the vaccine.\(^\text{24}\)

It should be noted, however, that there are certain individuals who should **not** receive the H1N1 vaccine, specifically, people who have a severe (life-threatening) allergy to chicken eggs or to any other substance in the vaccine.\(^\text{25}\)

**Potential Side Effects Of The H1N1 Vaccine**

Millions of vaccines have been administered without problem; however, there are certain side effects that occur infrequently. Mild side effects have included soreness, redness, or swelling at the location where the shot was given, fainting (mainly adolescents), headache, muscle aches, fever, and nausea.\(^\text{26}\) If these problems occur,

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\(^{19}\) CDC, *What To Do if You Get Sick: 2009 H1N1 and Seasonal Flu*, available at [http://cdc.gov/h1n1flu/sick.htm](http://cdc.gov/h1n1flu/sick.htm)

\(^{20}\) Id.

\(^{21}\) CDC, *Vaccination Against H1N1 Influenza Virus*, available at [http://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm](http://www.cdc.gov/h1n1flu/vaccination/public/vaccination_qa_pub.htm)

\(^{22}\) Id.

\(^{23}\) Id.

\(^{24}\) Id.

\(^{25}\) CDC, *General Questions and Answers on 2009 H1N1 Influenza Vaccine Safety*, available at [http://www.cdc.gov/h1n1flu/vaccination/vaccine_safety_qa.htm#b](http://www.cdc.gov/h1n1flu/vaccination/vaccine_safety_qa.htm#b)

\(^{26}\) Id.
they usually begin soon after the shot and last 1-2 days. ²⁷ Life-threatening allergic reactions to vaccines are very rare. ²⁸ If they do occur, it is usually within a few minutes to a few hours after the shot is given. ²⁹

After vaccination, any unusual condition like high fever or behavior changes should be brought to medical attention. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, swelling around the eyes or lips, hives, paleness, weakness, a fast heart beat or dizziness. ³⁰

As for the flu nasal spray (LAIV), the viruses have been weakened and do not cause severe symptoms typically associated with influenza. However, side effects from the LAIV spray have occurred. In children, these have included runny nose, wheezing, headache, vomiting, muscle aches, and fever. ³¹ In adults, side effects have included runny nose, headache, sore throat, and coughing. ³²

Statistics

According to the World Health Organization, as of April 4, 2010, more than 213 countries and oversea territories or communities had reported laboratory confirmed cases of pandemic influenza H1N1, including over 17,000 deaths. ³³ The most active areas for H1N1 infection are Southeast Asia, West Africa, and the tropical zones of Central and South America. In the northern zones of the Americas, overall transmission has remained low as the virus continues to circulate at very low levels. ³⁴

Due to the difficulty of testing for H1N1 in undeveloped or developing nations, the CDC has issued a wide range of estimates with regard to cases of H1N1 and resulting deaths. The CDC estimates that from April 2009 through January 16, 2010, between 41 million and 84 million cases of H1N1 occurred. ³⁵ The CDC estimates between 183,000 and 378,000 H1N1 hospitalizations occurred during this period. ³⁶ Finally, the CDC

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²⁷ Id.
²⁸ Id.
²⁹ Id.
³⁰ Id.
³¹ Id.
³² Id.
³³ World Health Organization, Pandemic (H1N1) 2009 - Update 95, available at http://www.who.int/csr/don/2010_04_09/en/index.html. (This may be an underrepresentation as many deaths are never tested or recognized as influenza related).
³⁴ Id.
³⁵ CDC, CDC Estimates of 2009 H1N1 Influenza Cases, Hospitalizations and Deaths in the United States, April 2009 – January 16, 2010
³⁶ Id.
estimates that between 8,330 and 17,600 H1N1-related deaths occurred during this time period.\textsuperscript{37}

**H1N1 Myths and Realities**

A number of H1N1 myths have circulated via the internet and word of mouth. It is important to distinguish those myths from facts. The following are some a few myths or falsehoods that have circulated the internet, as well as corrections to the false information in italics:

- The CDC has implemented a state vaccination program requiring registration at [www.cdc.gov].\textsuperscript{38} Clicking on emails with such a link puts you at risk of having malicious code installed on your computer system.\textsuperscript{39}

- All H1N1 flu products are safe. *Use only FDA-approved or authorized medical products for the prevention, treatment, or diagnosis of the virus.*\textsuperscript{40}

- It is not safe for children and pregnant women to receive a flu vaccine that contains the preservative thimerosal.\textsuperscript{41} *Thimerosal is safe for both children and pregnant women.*

- The federal government has mandated vaccination. *While vaccination is highly recommended as a precautionary measure, the federal government has not mandated it.*\textsuperscript{42}

- You can get H1N1 from eating pork, drinking water, or swimming pools.\textsuperscript{43} *H1N1 is not transmitted through any of these activities.*

- The H1N1 vaccine is unsafe and/or ineffective. *Clinical trials conducted by the National Institute of Health and vaccine manufacturers have shown the vaccine is both safe and effective. The FDA has licensed it, and there have been no safety shortcuts.*\textsuperscript{44}

\textsuperscript{37} Id.

\textsuperscript{38} Flu Myths and Realities, available at [http://www.flu.gov/myths/index.html](http://www.flu.gov/myths/index.html) (to the contrary, clicking on emails with such a link puts you at risk of having malicious code installed on your computer system).

\textsuperscript{39} Id.

\textsuperscript{40} Id.

\textsuperscript{41} Id.

\textsuperscript{42} Id.

\textsuperscript{43} Id.

\textsuperscript{44} Id.
OSHA and CDC Guidelines for Workplace Pandemic Flu Planning

OSHA and the CDC have issued a number of guidelines to help employers prepare for and combat against H1N1. These guidelines include:

• Develop an H1N1 plan;
• Connect with your local health department to ensure all relevant information is being properly conveyed;
• Review and revise sick leave policies to encourage employees to stay home when they have flu symptoms;
• Allow employees to stay home to care for sick family members;
• Encourage sneezing and coughing etiquette and hand washing;
• Add a link to the company website so employees can check the latest flu information;
• Purchase supplies like touchless garbage cans, alcohol-based soap and hand cleaners, and workplace sanitizers;
• Perform routine environmental cleaning;
• Require personal protective equipment such as respirators and/or surgical masks;
• Develop “social distancing programs” to limit face-to-face contact such as developing telecommuting programs and policies, using webcasts, and teleconferencing for meetings; and
• Encourage vaccinations against the flu.45

II. Compensability of H1N1 Workers’ Compensation Claims.

Infectious diseases such a H1N1 can be compensable as either a personal injury or occupational disease. For example, other jurisdictions have found compensable a nurse who contracts tuberculosis in a hospital,46 polio in a polio ward of a hospital,47 a teacher who contracts mumps during an epidemic of that disease at the school,48 and a daycare worker who contracts herpes.49 A causal connection with employment is needed in all types of infectious-related occupational diseases.50 To establish a


46 In re Gaites, 251 A.D. 761.


50 For example, the Texas case Vore v. Colonial Manor Nursing Center, 2004 WL 2348229 (N.D. Tex. 2004). In Vore, charge nurse at a long-term care facility, sued under the ADA for failure to accommodate
personal injury, the Employee essentially has to satisfy a two-step test. The Employee has to prove that the work exposure created an increased risk. He also has to prove medical causation.

An occupational disease means a disease arising out of and in the course of employment peculiar to that occupation which the employee is engaged. Occupational disease excludes ordinary diseases of life. An ordinary diseases of life is defined as one to which the general public is equally exposed outside the employment field. However, ordinary diseases of life may be compensable if the employment peculiarly exposes the employee to an increased risk or special hazard of developing the disease.

To prevail on an occupational disease theory, the employee must prove a direct causal connection between the conditions under which the work is performed and the disease. The relevant provision of the statute contained in Minn. Stat. § 176.011, subd. 15 is as follows:

Occupational disease means a disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards of ordinary employment and shall include undulant fever. Ordinary diseases of life to which the general public is equally exposed outside of employment are not compensable, except where the diseases follows as an incident of an occupational disease, or where the exposure peculiar to the occupation makes the disease an occupational disease hazard . . . An employer is not liable for compensation for any occupational disease which cannot be traced to the employment as a direct and proximate cause and is not recognized as a hazard characteristic of and peculiar to the trade, occupation, process, or employment or which results from a hazard to which the worker would have been equally exposed outside of employment.

In reality H1N1 influenza is an ordinary disease of life. It is important to note that other ordinary diseases of life such as tuberculosis, polio, HIV, mumps and herpes have been

51 Minn. Stat. § 176.011, subd. 15.
52 See Tofte v. Hubert J. Tofte, P.A., 39 W.C.D. 10 (1986) (Workers’ compensation benefits were awarded when employee, a dentist, developed herpes keratitis as a result of exposure from his patients).
found to be compensable by workers' compensation courts under specific conditions or situations.  

A. Minnesota Infectious Disease Claims Brought as Personal Injury

It is well established in Minnesota that infection disease claims can be found to be compensable based upon the concept of a personal injury. As referenced previously, the employee has to establish that the injury arises out of the employment. The employee has to satisfy the increased risk test. Under this test, an employee must show an increased risk which the employee as distinct from the general public, was subjected to by his or her employment. Additionally, an employee must also establish the medical link between the alleged exposure and the actual illness or disease.

1. Olson v. Executive Travel MSP, Inc.

In Olson v. Executive Travel MSP, Inc., the employee traveled to the Orient on work-related business and contracted Influenza-type B. The evidence showed that this particular virus was not present in the United States. The infection impaired the employee's immune defenses, and the developed bilateral staphylococcal pneumonia. The pneumonia resulted in chronic bronchiectasis, a permanent impairment.

The claim was denied as an ordinary disease of life. Both the compensation judge and Workers' Compensation Court of Appeals addressed the claim as an occupational injury. The Minnesota Supreme Court applied the personal injury test to award compensation. The Employee, who was in the Orient because of her employment, became infected by a specific virus. The Minnesota Supreme Court held because this was a specific virus with a specific origin of infection, this is a personal injury and not an occupational disease. The issue of ordinary disease of life was not addressed.

2. Baker v. Farmers Union Mktg. & Processing Ass'n

In Baker v. Farmers Union Mktg. & Processing Ass'n, an individual contracted histoplasmosis through exposure at work with dead animals being processed for dog and cat food. Histoplasmosis is associated with turkeys, which the employee testified he worked extensively with. The court reaffirmed in Minnesota, “the unexpected

54 See notes 38–42.


56 437 N.W.2d 645 (Minn. 1989).

57 Id. See also Lemire v. Montgomery Ward, 45 W.C.D. 296 (W.C.C.A. 1991) (No showing that stress was more than ordinary during period atherosclerosis was developing. Notably, whether work produced greater than ordinary hazard is factual determination by compensation judge that will be affirmed by appellate court if substantial evidence supports finding); Dessin v. Minnehaha Super Valu, 1985 WL 47428 (W.C.C.A. June 3, 1985) (viral myocarditis disease of ordinary life).
contraction of an infectious disease may be compensable as a personal injury whether or not the disease could also be characterized as an occupational injury.”

3. **Ebert v. Yellow Freight System**

In *Ebert v. Yellow Freight System*, an over-the-road truck driver was successful in claiming a compensable personal injury in the nature of a streptococcal infection. The infection eventually lead to cellulitis and toxic shock syndrome. The employee claimed that he contracted the streptococcal infection when he stayed in a dirty motel room in the course of his employment. He had cracks or fissures in his foot because of athlete’s foot (non-work related condition). The defense argued that the causation opinion relied upon by the employee was speculative. The compensation judge awarded benefits pursuant to the personal injury theory. On appeal, the Workers’ Compensation Court of Appeals noted that the employer did not allege that this was an ordinary disease of life. Implicit in the *Ebert* decision is the potential defense that an infection may be an ordinary disease of life even when the employee claims it as a personal injury, not an occupational disease. Notably, the *Ebert* decision treated the infection as a personal injury, not an occupational disease.

All three of the above-referenced cases illustrate the “increased risk” test. Their employment subjects them to an increased risk of infection. Additionally, the work-related exposures were found to be substantial causal factors to their infections. As such, the claims were found to be compensable.

As of the date of this article, there are no reported cases in Minnesota regarding H1N1 as a workers’ compensation claim.

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60 *Id.* The employee was required by the employer to stay at the particular hotel. The employer also admitted the employee was in the course of employment at the time he contracted the infection. *Id.* at *2.
61 *Id.* The doctor’s report was handwritten and stated the employee’s illness “likely began in the 24 hours prior to admission . . . and the portal of entry for his infection most likely related to the cracks between the toes from (athlete’s foot), although this is speculative.” *Id.* at *2.
62 *Id.* at n.1. “The employer did not argue that the employee had contracted a noncompensable ordinary disease of life.”
63 *Id.* On appeal, the employer argued that the lack of further explanation from the treating doctor, it was just as likely the employee contracted the infection at some time prior to the trip or from his clothing of some other personal item. However, at oral argument the employer admitted the employee was in the course of employment when he contracted the infection. The employer also did not have a medical expert.
B. Minnesota Infectious Disease Claims brought as Occupational Disease

Minnesota courts have rendered decisions on the compensability of other infectious diseases, such as tuberculosis. In the tuberculosis cases discussed below, employees brought claims for an occupational disease in the nature of tuberculosis infection. The success or failure of these claims depended on whether the contraction of the disease was peculiar or a natural incident of the employment.

These cases are relevant to H1N1 cases. While healthcare providers will undoubtedly come into contact with H1N1 infected patients, H1N1 is also a disease of ordinary life. In determining the compensability of an H1N1 claim, an investigation is needed as to whether there was some occupational hazard (such as caring for an H1N1 patient) which distinguishes it from other occupations. If, however, there is no evidence of an occupational hazard peculiar to or incidental to the job, the claim will and should be denied.

1. **Gray v. City of St. Paul**

The Minnesota Supreme Court determined that a tuberculosis infection was actually an occupational disease and awarded compensation. In *Gray v. City of St. Paul*, the employee, a police officer, contracted tuberculosis. 64 The claim was that he was in close proximity to a fellow police officer who actually had tuberculosis and as such contracted the disease. The court noted that tuberculosis is normally a disease of ordinary life. However, the employee’s exposure to tuberculosis was contracted because of the peculiar nature of the occupation. The Employee was forced to be in close proximity to his partner. The court determined that the disease was a natural incident of the occupation. 65 The occupation presented a hazard which distinguished it from other occupations. Essentially, the court determined that the criteria set forth in the occupational disease statute were satisfied. 66

2. **Parle v. Henry Boos Dental Laboratories**

The Minnesota Supreme Court was faced with another tuberculosis claim several years later in *Parle v. Henry Boos Dental Laboratories*. 67 In *Parle*, the employee worked in a dental laboratory with three other employees. The employees were subsequently found to be infected with tuberculosis. 68 The employee had contacts with these employees during coffee breaks, lunch, and in the elevator. The contacts were casual and

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64 84 N.W.2d 606 (Minn. 1957).

65 *Id.* at 615.

66 *Id.* at 616.

67 153 N.W.2d 344 (Minn. 1967).

68 *Id.* at 344.
sporadic. They generally worked in the same area although they were separated by distances of 10 or 20 feet.

Initially, the compensation judge found that the employee contracted an occupational disease of tuberculosis as a result of exposure which was peculiar to her occupation. The compensation judge distinguished this exposure from diseases of ordinary life.

The Supreme Court reversed. The court noted that the employee’s disability resulted entirely from an exposure to an infected employee and was in no way connected with the hazards inherent in the employment. There was no evidence that the nature of her duties or the conditions under which she was required to work had any connection with her contracting tuberculosis. Her disability resulted from exposure which could have occurred outside of her employment. The court further noted that there was no evidence presented that the co-workers’ tuberculosis was a “natural incident” of their occupation. As such, the claim was denied as not being an occupational disease.

3. **Gray and Parle as Personal Injury Claims?**

In both *Gray* and *Parle* cases, Plaintiffs sought benefits pursuant to the occupational disease section of the statute. They did not plead that the infection or illness was due to a personal injury. However, in evaluating *Gray* and *Parle* as personal injuries, it is submitted that undoubtedly *Gray* would be found to be compensable and *Parle* would undoubtedly be denied. In personal injury cases, the employee has the burden of establishing that the job placed them at an increased risk. In *Gray*, the employee was placed at an increased risk. In *Parle*, she was not. In *Parle*, contraction of tuberculosis as a direct result of employment was speculative at best. The employee would have failed in her burden of proof to establish that her injury arose out of and in the course of employment.

C. **Possibility of H1N1 as a Consequential Injury**

As H1N1 is prevalent in hospitals and nursing homes, it is very possible injured workers hospitalized for other conditions could contract H1N1 while hospitalized, leading to greater illness and disability. In Minnesota, injury caused by medical treatment is compensable, even when injury is to different body part. *Calkins v. United Parcel Service*, slip. op. (WCCA Nov. 5, 2003).

D. **Compensability of Injuries as a Result of Vaccination**

Employers, especially those in the healthcare industry, may encourage, request, or even mandate that their employees receive the H1N1 vaccine. Many employers provide on-site and/or free vaccinations. Encouragements often include onsite and/or

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69 *Id.* at 345.

70 *Id.* at 346.
free vaccinations. As discussed above, vaccination may, in rare circumstances, result in side effects. The issue arises, then, as to whether complications from a vaccination would be considered compensable under workers’ compensation laws.

If an employer mandates the H1N1 vaccination, any complication as a result of the vaccination would likely be compensable. Of course, the employee would have to prove medical causation between the vaccination and the alleged side effects. It should be noted, however, that in order to be eligible for indemnity benefits, an employee would have to show her disability extended beyond the three-day waiting period. In all likelihood, any adverse side effects to the vaccination would be mild and would not constitute a significant disability. At most, there probably would be minimal medical treatment.

Merely encouraging workers to receive the vaccination or even providing on-site vaccinations or free vaccinations should not result in workers’ compensation liability. It is common knowledge that the H1N1 vaccination is important to the good health of the population as a whole. This act of good will on behalf of an employer, would probably not be viewed as creating any sort of increased risk associated with the employment.

E. Nature and Extent of H1N1 Claims

The CDC estimates from April 2009 through January 16, 2010, between 41 million and 84 million cases of 2009 H1N1 occurred. Only 183,000-378,000 resulted in hospitalization. Only 8,330 and 17,600 resulted in death. While this wide range illustrates uncertainty of testing and diagnosis in undeveloped or undeveloped countries, even the high end of the range clearly shows that only a small percentage of H1N1 patients have serious medical complications from the virus.

F. Prevention

Most U.S. Healthcare workers do not get immunized against seasonal flu; only 44% were immunized against seasonal flu in 2006-2007.\textsuperscript{71} In Minnesota, 70% of hospital and nursing home workers received the seasonal flu vaccine.

There is no law in Minnesota forcing health care providers to get the flu vaccine. The New York State Health Commission mandated vaccinations for health care workers in 2009, though shortly after the law went into effect, the New York Supreme Court issued a restraining order against the state enforcing the controversial mandatory vaccination.\textsuperscript{72}

While vaccination is the best prevention, any mandate will likely be challenged in court.


\textsuperscript{72} See \url{http://www.nytimes.com/2009/10/17/nyregion/17vaccine.html?_r=1&pagewanted=print}. Within a week of the restraining order, the health commissioner suspended the mandate, given the short supply of vaccine.
IV. Conclusion

There is yet to be any reported decisions regarding H1N1, though past decisions regarding infectious disease certainly give guidance. In evaluating any H1N1-type case, it will be necessary to retain an expert in the area of infectious diseases. All pertinent information and data must be obtained and provided to the expert.

Obtaining information and data from the employer regarding the prevalence of H1N1 infected patients and co-workers will be critical. Possible personal avenues of contraction will also need to be explored. Alternative theories of exposure can lead to viable defenses.

The burden of proof is always with the employee. The employee has the burden of establishing when, where and how the infection arose. The reality is that there will be H1N1 infections. Some infections will be work related. Some infections will not. In some situations, there will be very clear cut cause and effect between the exposure and contraction. Those cases will undoubtedly be picked up and paid without any dispute. Others will be contested.

There is no universal rule on the compensability of H1N1 claims. Just as in the tuberculosis claims, some H1N1 claims will be compensable and others will not. Each H1N1 claim will be determined on its own facts. An early, exhaustive and thorough investigation is needed in order to determine compensability. As an ordinary disease of life, an H1N1 illness can be contracted through any number of different methods, including at work and away from work. The key is simply good investigation and common sense.