APPEAL NO. 92242

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 1.01 through 11.10 (Vernon Supp. 1992). On April 24, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. He found that claimant, appellant herein, was injured on (date of injury) in the course and scope of her work but that no disability resulted therefrom. Appellant asks that she be paid for time lost from work, stating that the injury made her unable to work and that she has no history of mental illness.

DECISION

Finding that the decision is against the great weight and preponderance of the evidence, and that the hearing officer made no finding concerning the sole cause defense, we reverse and remand.

Appellant had worked for four years at (employer) as a service assistant (attended to personal needs of patients) when injured on (date of injury). She was bathing a patient who was in her mid 70s and weighed under 100 pounds when "she hit me in the head with her knee." No one disputed that this injury occurred. Appellant's supervisor, (CG), testified that appellant reported the injury to her that day but she could see no bruise. Appellant worked that day and the next.

Appellant testified that she first saw (Dr. N) at the medical unit of the state hospital, but did not say when that was. (Dr. N) told her to see her family doctor. She then saw her doctor, (Dr. B), on July 23, 1991, one week after the injury. She reported to him that her head ached as a result of being hit. His plan called for x-ray and CT scan but noted "she wants to wait." He noted that bruising was not severe, prescribed Fioricet for the headache, and called for follow-up in a "few days." He did not hospitalize her but considered her past history at the time he treated her for the injury and noted as his #8 assessment "possible admission to the hospital prior to any further nervous breakdown." On July 29, 1991 Dr. B noted that she complained of headaches and that her history included nervousness, tremors, depression, difficulty in sleeping and insomnia. His assessment at that time was post-traumatic depression that was probably secondary to trauma. His plan for her included both a psychological and a psychiatric evaluation "into depression because of previous history of a nervous breakdown." He noted that he would hospitalize her.

On October 25, 1990 appellant's husband had been in a car wreck in which he sustained a head injury. He died on April 7, 1991 after aspiration of a foreign object. Appellant received counselling at (Center) beginning March 29, 1991 because of the critical condition of her husband. An entry dated July 26, 1991 in the records of that center shows that appellant had not attended counselling since May 17, 1991 and said that her case will be closed.

After Dr. B's decision on July 29, 1991 to hospitalize appellant, a consult was written

by (Dr. W) on July 31, 1991 at (Center) in (city). He noted her injury on (date of injury), headaches since that time, and medication of Prozac and BuSpar. Dr. W then says, in part:

> Since being injured, patient has obsessed about dying like her husband who was in an auto accident in Oct 1990, had a concussion, was seen in a hospital ER and released, then suffered progressive neurologic problems -headaches, deafness, blurred vision, numbness in L arm & fingers, and finally had a seizure on Mar 17, 1991, became comatose & expired April 7. Patient says she had too much to cope (with) at work, at home, "then this patient hit me in the head." Pt. has hx of previous hospitalization for 2 weeks (with) emotional problems in 1972 (with) treatment (with) valium. She took valium for a year afterward.
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> Mood is quite depressed - affect appropriate to mood. No delusions or hallucinations. Denies suicidal & homicidal ideas. Immediate memory poor; recent memory adequate. Remote memory impaired. Very poor concentration. Thinking tends toward concretness. (sic) Poor insight. Poor judgment.
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> (Impression): 1) Post-traumatic stress disorder, 2) Major depression. (Emphasis added)

Dr. B wrote two letters, dated September 3, 1991 and November 27, 1991. In the September letter, medications are said to be appropriate for appellant's "conditions." Vasotec, Tenormin and Clonidine are stated to be for hypertension. BuSpar is for anxiety and Prozac is for depression. He then says "you were undermedicated given the amount of trauma you received from the injury." He does not indicate whether the hypertension, anxiety, or depression were tied to the trauma, but seems to imply it and does not list other medications. In November, Dr. B wrote that appellant was unable to work "because of loss of memory due to the injury to her head." At that time she had not had the tests done that Dr. B wanted done when she first saw him after the injury and he states no basis for concluding that her memory loss was caused by the (date of injury) injury. On January 24, 1992 various psychological tests were administered to appellant by (Dr. J), PhD. His report noted in part:

> While (appellant) tended to demonstrate poor performance on tasks requiring the greatest attention concentration, she also showed poorer performance on subtests which are traditionally viewed as resistant to brain injury induced cognitive dysfunction, such as Picture Completion and Comprehension, while scoring higher on those subtests which tend to reflect the lowest scores in cognitively impaired patients.
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> SUMMARY. (Appellant) was alert and well oriented and demonstrated moderate to marked anxiety and a pronounced concern that her injury had resulted in self-

> perceived impairment in concentration and memory. Hence, although evidence of moderate cognitive dysfunction is noted in (appellant's) current evaluation performance, it should also be noted that her MMPI profile and general observable behavior reflect a pattern which is often suggestive of depression with exaggeration of psychiatric complaints including loss of efficiency, inability to concentrate, and possible borderline somatic delusions.

Also on January 24, 1992 an MRI was conducted of appellant's head which resulted in "Negative MRI examination of the brain except for some deep white abnormalities on T2W as described above. On February 7, 1992 (Dr. M), a neurosurgeon, wrote that appellant's EEG was "unequivocally normal." He acknowledged her depression and then stated "(t)here is no definitive evidence of impairment of specific brain functions."

The only evidence offered by respondent except for the testimony of CG, supervisor of appellant, were records of appellant as an employee, forms relative to the injury, and medical records. No statements or testimony by medical personnel were offered. In addition to stating that she saw no bruise where appellant was hit, CG primarily testified to appellant's problems on the job before the injury, how she was upset and depressed by the loss of her husband. She testified that she was present when appellant resigned, recalling that appellant said she was too nervous and upset to work and said she had to quit. (Appellant's resignation was dated September 4, 1991.) CG also stated that while appellant had many problems with work before the injury she met standards overall as reflected in her performance evaluation. This evaluation also has the following under "Comments:" "(i)n my opinion, this employee is/xxx physically and otherwise capable of performing the duties of xx/her position at this time." This is the only evidence offered by respondent as to appellant's ability to retain work after the injury. (The performance evaluation by CG is dated 9/16/91--after appellant's resignation).

Respondent stated that it would show that appellant's anxiety and problems prior to the injury were the sole cause of the hospitalization and that there was no evidence that the head injury caused hospitalization. While respondent did not accurately state the extent of what it needed to prove in the use of sole cause as a defense to disability, it did indicate an understanding that it needed to do the showing.

The employer accepts the employee as she is. A preexisting condition or infirmity can be aggravated by an injury. Liability arising through aggravation cannot be defeated by showing that the employee was not a well person at the time of the injury. Gill v. Transamerica Ins. Co., 417 S.W.2d 720 (Tex. Civ. App.-Dallas 1967, no writ). Baird v. TEIA, 495 S.W.2d 207 (Tex. 1973) added that an injury does not have to be the sole cause of disability and said "a predisposing bodily infirmity will not preclude compensation." *Also see* Texas Workers' Compensation Commission Appeal No. 92189 (Docket No. redacted) decided June 25, 1992.

The respondent has to show that disability is due solely to the former disease or injury

to prevail on the basis of a sole cause defense. Home Ins. Co. v. Gillum, 680 S.W.2d 844 (Tex. App.-Corpus Christi 1984, writ ref'd n.r.e). In reversing an implicit jury finding of preexisting injury as against the great weight and preponderance of the evidence, the court in Gonzalez v. TEIA, 772 S.W.2d 145 (Tex. App.-Corpus Christi 1989, writ denied) said that the carrier must show that the prior illness is the sole cause and that the existence of a preexisting disease which aggravates an injury does not defeat a claimant's right to benefits. The appeals panel has applied case law arising under prior law that dealt with the sole cause defense to cases arising under the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No 92018 (Docket No redacted) decided March 5, 1992.

As stated above, Dr. B, in his note of July 29, 1991, decided to put appellant in the hospital after assessing "post-traumatic depression, probably secondary to trauma." While she was hospitalized, Dr. W, as stated above, listed two "impressions" of appellant, "post-traumatic stress disorder" and "major depression." Director, State Employees Workers' Comp. Div. v. Camarata, 768 S.W.2d 427 (Tex. App.-El Paso 1989, no writ) found a "post-traumatic stress disorder" to be compensable. Appellant testified that she was able to function prior to the injury of (date of injury). Dr. B in his letter dated September 3, 1991, shows that in using the word "trauma" regarding appellant, he referred to the (date of injury) injury, not some general mental trauma; he said "you were undermedicated given the amount of trauma you received from the injury." According to Dr. B, appellant's hospitalization was for post-traumatic depression "probably" because of trauma. *See* Colonial Penn Franklin Ins. Co. v. Mayfield, 508 S.W.2d 449 (Tex. Civ. App.-Amarillo 1974, writ ref'd n.r.e.), which combined a physician's testimony that injury could have precipitated symptoms with lay testimony to conclude that the injury, "aggravated by precipitating symptoms," disabled Mayfield.

Dr. B at the time of hospitalization did not take appellant off work. He addressed this question later in his November 27, 1991 letter of reply to an unknown query. He said therein "(t)he patient is unable to work because of loss of memory due to the injury to her head which she acquired." This statement by Dr. B as to why appellant is unable to work is never contradicted by any medical evidence of record. (Nor does any medical evidence say that appellant is able to work.) Dr. J on January 24, 1992 wrote about "brain injury," the MRI was normal, and Dr. M on February 7, 1992 referred to the EEG as normal. All these statements address organic damage to the brain, but none say that there was no post-traumatic depression and none appear to address whether the injury contributed to or aggravated appellant's depression or state that preexistent depression was the sole cause of appellant's condition. In addition, Oswald v. TEIA, 789 S.W.2d 636 (Tex. App.-Texarkana 1990, no writ) in reversing as against the great weight and preponderance of the evidence, cited favorably Weicher v. Ins. Co. of North America, 434 S.W.2d 104 (Tex. 1968) which found evidence of disability at least in the period of hospitalization involved. Whether or not Dr. B is accurate in stating that loss of memory comes from the injury, his conclusion is unassailed by other evidence, and the case of Peeples v. Home Indem. Co., 617 S.W.2d 274 (Tex. App.-San Antonio 1981, no writ) found that it was necessary to psychiatrically treat depression that resulted from a knee injury and reversed as against the great weight

and preponderance of the evidence when there was no medical evidence that such care was not required as a result of the injury. *See also* Clayton v. Employers Mutual Liability Ins. Co. of Wisconsin, 480 S.W.2d 487 (Tex. Civ. App.-Waco 1972, no writ) holding not only that a "traumatic neurosis" resulting from an eye injury produced disability and was compensable but that lay testimony should have been allowed as to claimant's nervousness and whether it "affected his ability to get and keep employment."

A finding that addresses the sole cause defense needs to be made. In the absence of a finding that appellant's condition prior to the (date of injury) injury was the sole cause of her hospitalization, the conclusion of law that no disability has resulted from claimant's injury of (date of injury) is against the great weight and preponderance of the evidence. Unless the sole cause defense prevails on the disability issue, the form entry in the Performance Evaluation that appellant was capable of performing her duties after she quit, is not sufficient to support the conclusion that she was able to retain her job as against her testimony, the hospitalization, and the November letter of Dr. B. In returning the file to the hearing officer for further consideration of the evidence and, if he so chooses, further development of the evidence, we note that a finding was made that appellant voluntarily resigned her job. The only evidence in the record as to the resignation is from CG and appellant, with CG referring to appellant at the time saying that she was too nervous and upset and had to quit. Appellant, on the resignation, simply referred to health reasons, but in her testimony said she tried to go back to work but got nervous. *See* Texas Workers' Compensation Commission Appeal No 91045 (Docket No redacted) decided November 21, 1991, in considering whether the appellant could not obtain and retain employment because of the compensable injury. *Compare to* Texas Workers' Compensation Commission Appeal No 91098 (Docket No. redacted) decided January 15, 1992, in which the claimant quit, not because an injury dictated that recourse, but because he considered a suspension to be unfair and chose to quit.

Reversed and remanded for a finding whether appellant's condition prior to the injury was the sole cause of disability and, as needed, consistent with the finding as to sole cause, a finding as to the duration of disability. Other findings may be made at the discretion of the hearing officer. Pending resolution of the remand, a final decision has not been made in this case.

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Joe Sebesta
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Susan M. Kelley
Appeals Judge