APPEAL NO. 950206
FILED MARCH 28, 1995

On November 18, 1994, a contested case hearing was held. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The issues at the hearing were: (1) whether the respondent (claimant) was injured in the course and scope of his employment on _____; (2) whether the claimant's heart attack was the result of or was causally related to the _____, injury; and (3) whether the claimant suffered any disability as the result of a compensable injury on _____. The appellant (carrier) disagrees with the hearing officer's decision in favor of the claimant on all three issues. The claimant requests affirmance.

DECISION

We affirm the hearing officer's determinations that the claimant was injured in the course and scope of his employment on ____, and that the claimant has had disability as a result of his compensable injury from June 7, 1993, to the date of the hearing. We reverse the hearing officer's determination that the claimant's myocardial infarction resulted from the treatment for the compensable injury and render a decision that there is insufficient expert medical evidence to establish that the claimant's heart attack was caused by medical treatment he received for his compensable foot injury.

Dr. C gave testimony in an oral deposition. He stated that he began treating the claimant in 1970, that he diagnosed the claimant as having high blood pressure in 1970 for which medication was taken until 1985 when the claimant had no more blood pressure problems; that he diagnosed the claimant as having diabetes mellitus in 1976 for which the claimant takes daily injections of insulin, that the claimant gradually developed pain and numbness in his legs which was diagnosed as diabetic neuropathy in 1978, and that he talked to the claimant about skin and foot care soon after the claimant was diagnosed with diabetes.

The claimant, who speaks a limited amount of English and whose testimony was translated by a Spanish-speaking translator at the hearing, testified that he had no problem with his feet on June 3, 1993, and that on the morning of _____, he did not notice any screw in his boots when he put them on. The claimant's wife testified that she helps the claimant put on his socks every morning and that on the morning of _____, she helped the claimant put on his socks and that there was nothing wrong with the claimant's feet at that time.

The claimant worked for the employer as a heavy equipment operator for several years. The claimant testified that on the morning of _____, he drove straight from his home to a job site where he had worked before and that prior to _____ the site had contained "a trailer there with a lot of screws and a lot of kinds of parts, you know, to fix things." He said "when they moved the trailer from there, you know, they left all those things you know, on the ground." He said that he spent the day of _____ using a large machine to load sand into trucks. He said he was the only person from the employer at the

site. He said he got off and on the machine about three or four times during the day. When he was asked whether he walked "back and forth where the trailer had been on _____," he replied "yes, because one of the sand stockpiles was down to where the trailer had been." He testified that he was working on the machine and that when he "stepped out" he stepped on a screw; however, he also testified that he did not see the screw until he got home. He said that at about 5:00 p.m. he drove straight home from the job site. He testified that when he got home he found that a screw had punctured the bottom of his right boot and that he could not take off his right boot until the screw was removed from the boot. He testified that he had a yellowish puncture hole in his foot. In a written, signed, statement in evidence, the claimant described the location of the puncture hole as being in the ball of his foot about an inch from his amputated toes. He said he did not have any kind of wound on the top of his foot and he denied having any kind of foot infection before this. He said that over the weekend he was "feeling bad," and did not go anywhere, but that he worked a full day on (the following Monday). He said that evening he was feeling really bad and had a temperature, and that the next day he called Dr. C's office but was told there were no openings and to come in the following day.

The claimant said he and his wife went to Dr. C's office on June 9, 1993, and that Dr. C examined his foot, gave him half a tetanus shot, sent him home, and told him to come back in two weeks for the other half of the tetanus shot. He said he told Dr. C that he stepped on a screw while working. He said he returned to Dr. C's office before the two weeks were up because he could not handle the pain, that he arrived in a wheelchair, and that when Dr. C unwrapped his foot, Dr. C told him that he was going to have him flown to (city) because they were going to amputate his foot. The claimant said he did not see Dr. C after that visit. He said he went to see Dr. M who gave him shots and put him in the hospital. He said he told Dr. M that he had punctured his foot with a screw. The claimant said he was in the hospital for about 46 days and that three of the toes on his right foot were amputated in two operations. He also testified that one day while he was in the hospital he began feeling dizzy and had back pain after he had treatment in what he described as a "boat" where he felt air, and that he was told he had a light stroke. He said the hospital did not continue with that type of treatment after his stroke. When the claimant was asked whether any doctor had told him what caused the stroke in the hospital, he replied that "they said it would be caused by the infection in the foot." He said after he was discharged from the hospital he continued to see Dr. M and had medical treatment for his foot at home. He said that his foot is now healed but that he sometimes has a lot of pain and that he is not able to work. He also said that he has been taking heart medication since he left the hospital.

The claimant denied that his diabetes had caused him to lose feeling in his feet, but testified that he didn't feel the screw going into his foot. He testified that it was not possible for him to have stepped on the screw in his truck which he drove to and from work because he keeps the inside of the truck clean, and that his walk from his house to his truck and from his truck to his house is "pretty close" and that the "patio" is always clean. He said Mr. M is his supervisor and that he did not tell Mr. M that he was injured at work but that his son informed Mr. M of that. The parties agreed at the benefit review conference that there was no dispute that timely notice of injury was given to the employer.

The claimant's wife testified that when the claimant got home on the evening of _____, she had trouble taking off his boot so she lifted it up and saw a screw in it. She said she took the screw out of the boot, took off the claimant's boot, and checked his foot and saw a hole in his foot. She described the hole as having something dark inside of it. She said she did not keep the screw; however, the boots were brought to the hearing and testimony reflects that the right boot has a hole through the sole of the boot. She said she cleaned the foot with alcohol, wrapped it up, and put ice on it. She said the claimant had never had a wound like that before. Over the weekend she said the claimant had a little fever and that she continued to clean his foot. When the claimant got home from work on (the following Monday), she said he had a burning fever and his foot was swollen. She said she called Mr. M's home that evening to tell him what happened but he wasn't home and that when she talked to Mr. M about three days later she told him that the claimant had stepped on a screw and could not work, but did not tell him it happened at work because the claimant didn't want to get fired.

She said she tried to get the claimant an appointment with Dr. C on June 8th but was told to come in on June 9th. On June 9th she said she told Dr. C's nurse that the claimant had stepped on a screw at work and that Dr. C read that "on the paper." She said Dr. C cleaned the foot, gave the claimant half a tetanus shot, and told him to come back in two weeks for the other half of the shot. She said the claimant's foot began getting worse so they returned to Dr. C's office on June 18th and Dr. C told them that the claimant would have to have his foot amputated. She said they went to see Dr. M on June 21st. She said she was with the claimant while he was hospitalized and that the claimant suffered his "stroke" just after getting out of the "HBO." (Hyperbaric oxygen treatment is referred to as "HBO" in some of the medical records). When the claimant's wife was asked if she discussed with the doctors what caused the stroke, she said "they said it could have been that thing that they put him in there because it was like some kind of gas or something . . . ."

The claimant's son, Mr. RA, testified that his mother called him on a Friday evening and told him the claimant had stepped on a screw at work and that that Sunday he visited his parents and saw the claimant's foot. He said the claimant had a "puncture on the bottom of his sole," and that the claimant had an infection around the puncture. He said he did not see anything on the top of the foot. He said the claimant told him at that time that he was getting off the loader and he stepped on a screw but that he hadn't really noticed it until later that evening. He said that the claimant parks right in front of the house, that there is no debris in front of the house, and that the front yard is a hard packed caliche pad. He said that the week after the claimant was admitted to the hospital he told Mr. M that the claimant had injured his foot at work when he stepped on a screw. Mr. N, who is the father-in-law of the claimant's daughter, testified that about a week after the injury he visited the claimant and saw a "puncture in the bottom of his foot." He said the right foot was "swollen, black, and punctured." He said the claimant's wife showed him a screw she said had come out of the claimant's boot.

Mr. M stated in a transcribed recorded statement dated July 15, 1993, that the claimant's son told him on June 11th that the claimant had stepped on a nail at work. When Mr. M was asked whether it was possible that "nails or bolts" were at the work site

where the claimant was working, he said he didn't know because "we moved the plant and everything from that location probably three months ago and there's nothing out there."

The medical records regarding the claimant's visits to Dr. C on June 9th and 18th are largely illegible. Dr. C deciphered the records in his deposition. Dr. C stated that on June 9th the claimant had swelling, redness, and pain in his right foot, that the claimant had developed a fever the day before, but that the pain and problems had been there for three days. He said the claimant appeared to have a tiny puncture wound on the top of the foot that had become infected. He said the claimant did not have a puncture wound on the bottom of the foot. He diagnosed cellulitis of the foot, which he said means "tissue infection with an infected puncture wound." He acknowledged that he did not note in his record of the June 9th visit where the puncture wound was located but said he remembered that it was on top of the foot. He said he asked the claimant what happened and the claimant told him he had no injury and that he wrote in the record "no known injury" followed by question marks. He said he gave the claimant a full tetanus booster, continued the claimant on pain medication which he had prescribed for the claimant's back pain on May 10, 1993, continued the claimant on insulin, started the claimant on oral penicillin, and started the claimant on antibiotic ointment applications. He said he told the claimant to come back in a few days.

Dr. C said the claimant returned on June 18th and at that time the claimant had gangrene of a couple of the toes and across the top of the foot. He said he told the claimant he probably needed amputation of one or two toes and maybe the whole foot and offered to get him to a hospital in (City) because the claimant did not have insurance. He said the claimant declined the offer and said he wanted to get a specialist. Dr. C said that diabetics are more prone to get an infection in their extremities than the general population, particularly if they get a scratch or abrasion to the skin. He opined that, based on reasonable medical probability, the cause of the claimant's infection and gangrene is from his diabetes. He said that it is common in a diabetic for an infection to occur spontaneously. He has not seen the claimant since June 18, 1993. Two letters in evidence from Dr. C reflect portions of what he said at his deposition.

In a letter dated August 6, 1993, Dr. M stated that he examined the claimant on June 21, 1993, for a "grossly infected necrotic foot," that the claimant told him that he stepped on a screw at work on _____, and that he hospitalized the claimant. He said the claimant entered the hospital with an impression of "gas gangrene from a puncture wound on the bottom of the foot." In a letter dated January 10, 1994, Dr. M stated that he examined the claimant's foot on June 21, 1993, and that "it was evident that he had sustained injury to the bottom of his foot as there was a puncture wound at that site." At the hospital the claimant was diagnosed as having an "infected right foot with gangrene, second and third toes and dorsal surface of the right foot," and on June 22, 1993, the second and third toes of his right foot were amputated.

On June 26th Dr. B recommended "HBO" treatment daily until the infection resolves. Hospital notes dated July 7th record that the claimant stated that he began having back pain and left arm pain after hyperbaric treatment. In a consultation report dated July 8, 1993, Dr. MO wrote that on July 7th, immediately following hyperbaric oxygen

chamber treatment, the claimant had an onset of hard pressure pain in the left chest, radiating to the left arm and back. Dr. MO said that questioning revealed that the claimant had had similar pain over the last several months, typically occurring with exertion and relieved by rest. An EKG was done. Dr. MO's impression was that the claimant had evolving acute inferior myocardial infarction, coronary artery disease, insulin-dependent diabetes mellitus, and cellulitis of the right foot. A July 22nd hospital note states that there is a desire to resume hyperbaric therapy, but "some concern about risk . . . ." (the rest of the sentence is done in medical notations but appears to indicate that the risk concerned about was the claimant's "MI," which would mean myocardial infarction, with "CAD," which would mean coronary artery disease). In another hospital note dated July 22nd, Dr. J wrote "would hold off on hyperbaric O2 for now." Then on July 23rd an unidentified author wrote that he agreed with Dr. J's "note above." Also on July 23rd an unidentified author wrote "HBO note: will hold off on HBO Rx for now. Can resume when indicated." On August 2, 1993, the claimant had the fourth toe on his right foot amputated.

Dr. K's hospital discharge summary of August 3, 1993, reports that the claimant had an "acute myocardial infarction" while in the hospital on July 7th, and that after testing the claimant was found to have "100% occlusion of the left anterior descending [artery]." He also reported that test results were consistent with an "inferior wall MI." In a report dated August 9, 1993, Dr. K stated that the claimant had no prior history of vasculitis or diabetic foot ulcer or ulcers of any kind. He also stated "[a]s far as other problems he had an MI while in the hospital last month. This is while he was in HBO and the cardiologist according to the patient attributed to this." Dr. K diagnosed a "diabetic foot ulcer." According to another medical report the claimant was hospitalized again in October 1993 for a postoperative infection of the right foot.

On January 10, 1994, Dr. M reported that he believed that the claimant could do light duty work at a desk with no prolonged walking or standing, but he advised that the claimant was still undergoing "rehabilitative processes." On March 1, 1994, Dr. M reported that the claimant "will be limited to a light duty work situation," and that he should not be subjected to any prolonged walking, climbing, or operating any heavy duty equipment.

The carrier represented that the claimant was examined by Dr. KE under a required medical examination order. On June 15, 1994, Dr. KE reported that the claimant reached maximum medical improvement on June 15, 1994, with an eight percent impairment rating.

The carrier contends that the evidence does not support the following findings of fact and conclusions of law:

FINDINGS OF FACT

4. Claimant stepped on a screw at work on _____.
5. The screw made a puncture would in the ball of his foot which became infected due to Claimant's diabetic condition.

6. As the result of the infection in Claimant's foot and its resulting gangrenous condition, Claimant had 3 toes and a portion of his foot

amputated.

7. The amputations were causally related to the puncture injury caused by the screw Claimant stepped on at work on _____.

11. The myocardial infarction was caused by the increased air pressure treatment of Claimant's compensable injury.

12. The medical evidence reveals that although Claimant suffers from coronary artery disease, the treatment was a substantial contributing factor of the attack.

13. The myocardial infarction suffered on July 11, 1993 [sic], was a single episode in a series of similar episodes Claimant had been experiencing over the previous several months, and although precipitated by Claimant's treatment, was not a significant factor in any disability suffered by Claimant.

14. Claimant has been off work due to his foot injury since June 7, 1993.

CONCLUSIONS OF LAW

3. Claimant suffered a foot injury which resulted in partial amputation of that foot in the course and scope of his employment on _____.

4. Although he suffered from a preexisting heart condition, Claimant's heart attack of July 11, 1993 [sic], a myocardial infarction, resulted from the treatment of his compensable injury and was therefore causally related to his injury of _____.

5. Claimant suffered disability as the result of his compensable injury from June 7, 1993 until the date of this hearing.

The claimant has the burden to prove that he was injured in the course and scope of his employment. Johnson v. Employers Reinsurance Corporation, 351 S.W.2d 936 (Tex. Civ. App.-Texarkana 1961, no writ). "Injury" means damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. Section 401.011(26). The employer takes the employee as he finds him. Texas Workers' Compensation Commission Appeal No. 941328, decided November 17, 1994. We observe that Dr. C opined that diabetics are more prone to get an infection in their extremities, particularly if they get any kind of injury to their skin. In Appeal No. 941328, *supra*, we stated "[t]he fact that some underlying disease enhanced the affects of a work-related injury does not render the amplified consequences of an injury noncompensable." *See also* Sowell v. Travelers Insurance Co., 374 S.W.2d 412 (Tex. 1963). There is conflicting evidence as to whether the claimant suffered an injury at work and whether that injury resulted in an infection and gangrene which led to the amputation of three toes. The

hearing officer is the judge of the weight and credibility of the evidence. Section 410.165(a). As the trier of fact the hearing officer can believe all, part, or none of any witness's testimony, and he or she resolves conflicts in the evidence and determines what facts have been established from the evidence. Texas Workers' Compensation Commission Appeal No. 950084, decided February 28, 1995. An appellate level body is not a fact finder and does not normally pass upon the credibility of witnesses or substitute its own judgment for that of the trier of fact. Appeal No. 950084, *supra*. We conclude that the evidence is sufficient to support Findings of Fact Nos. 4 through 7, and that those findings are not so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. *See* Appeal No. 941328, *supra*, where we upheld a hearing officer's determination in favor of the claimant who was a diabetic and who sprained his ankle at work which led to gangrene and amputation of part of his left leg.

We observe that at the hearing the carrier contended that the claimant's diabetes "in and of itself caused this." A carrier that wishes to assert that a preexisting condition is the sole cause of an incapacity has the burden of proving this. Texas Employers' Insurance Ass'n v. Page, 553 S.W.2d 98 (Tex. 1977). While Dr. C saw no puncture wound on the bottom of the claimant's foot and opined that the cause of the claimant's gangrene was his diabetes, the hearing officer was not required to accept such evidence as establishing sole cause, especially in light of Dr. M's finding of a puncture wound on the bottom of the foot and the impression upon admittance to the hospital that the claimant had gangrene from a puncture wound to the bottom of the foot.

We find Texas Workers' Compensation Commission Appeal No. 94103, decided March 7, 1994, which is cited by the carrier, to be distinguishable from the facts of the instant case. Appeal No. 94103, *supra*, involved a claim of hepatitis C and we affirmed the hearing officer's denial of benefits because, as the hearing officer noted, it could not be ascertained from the evidence when or how the claimant in that case became infected with hepatitis C. Texas Workers' Compensation Commission Appeal No. 93049, decided March 1, 1993, which is also cited by the carrier, involved a claim of hepatitis B, and there was conflicting medical evidence on whether there was a causal relationship between a nail wound to the claimant's foot and his hepatitis B, and we found the evidence sufficient to support the hearing officer's decision that the nail wound did not cause the claimant to contract hepatitis. The hearing officer in the instant case resolved the conflicting evidence in favor of the claimant on the issue of injury in the course and scope of employment and we have concluded there is sufficient evidence to support his determination on that issue.

The claimant claimed that his heart attack at the hospital was causally related to the hyperbaric oxygen treatment he received for his foot injury. In Texas Workers' Compensation Commission Appeal No. 92540, decided November 19, 1992, we affirmed a hearing officer's decision that the deceased employee suffered a fatal heart attack as a result of treatment for a compensable back injury and her award of death benefits to the claimant. In that case we observed that "[i]t is widely accepted in workers' compensation law that incapacity, or disability . . . resulting from medical treatment instituted to cure or relieve an employee from the effects of an injury is properly compensable." We held that Article 8308-4.15, relating to compensability of heart attacks [now Section 408.008], was not applicable because the claim was for a heart attack that occurred as a result of

treatment for a compensable injury, and not a heart attack that occurred in the course and scope of employment. In affirming the hearing officer's decision in favor of the claimant we stated "[t]here was expert medical evidence presented that the surgery for the work-related back injury was a producing cause of the heart attack. . . ."

It has been held that "when a subject is one of such scientific or technical nature that the jury or court cannot properly be assumed to have, or to be able to form, opinions of their own based upon the evidence as a whole and aided by their own experience and knowledge of the subject of inquiry, only the testimony of experts skilled in that subject has any probative value." Houston General Insurance Company v. Pegues, 514 S.W.2d 492, 495 (Tex. Civ. App.-Texarkana 1974, writ ref'd n.r.e.). In our opinion expert medical evidence was required to establish whether the claimant's heart attack in the hospital was causally related to his hyperbaric oxygen treatment. *See e.g.* Appeal No. 92540, *supra*. While there is evidence that the claimant suffered a heart attack immediately after hyperbaric treatment and that the doctors at the hospital discontinued that treatment because they were concerned about the claimant's heart attack and coronary artery disease, no expert medical opinion was presented which connected the claimant's heart attack to his hyperbaric treatment. We note that the hospital notes reflect that hyperbaric treatment could resume "when indicated." Without such expert medical evidence establishing a causal connection between the heart attack and the medical treatment, we are left to conclude that there is insufficient evidence to support the hearing officer's Findings of Fact Nos. 11 and 12 and that portion of Finding of Fact No. 13 which finds that the heart attack was precipitated by the treatment. *See* Schaefer v. Texas Employers' Insurance Association, 612 S.W.2d 199 (Tex. 1980); Parker v. Employers Mutual Liability Insurance Company of Wisconsin, 440 S.W.2d 43 (Tex. 1969). Since the findings in support of Conclusion of Law No. 4 are not supported by sufficient evidence, that conclusion cannot stand. We observe that while Dr. K noted that the claimant told him that a cardiologist attributed his heart attack to his hyperbaric treatment, the claimant did not present evidence from an expert medical witness as to the causal relation, if any, between his heart attack and his treatment for his compensable foot injury. We note that the medical evidence revealed that the claimant has 100% occlusion of the left anterior descending artery.

Lastly, in regard to the issue of disability, the carrier asserts that the hearing officer erred because there was no issue as to whether "the claimant's heart attack caused disability." The carrier argued at the hearing that the claimant did not have disability because he had no compensable injury. "Disability" means the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage. Section 401.011(16). We conclude that the carrier has not asserted grounds for reversal of the hearing officer's findings and conclusions in favor of the claimant on the disability issue. The hearing officer specifically found that the claimant's heart attack was not a significant factor in any disability he suffered, and that the claimant has been off work due to his "foot injury" since June 7, 1993. Having reviewed the record we conclude that the hearing officer's findings and conclusions on disability are supported by sufficient evidence and are not so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

That portion of the hearing officer's decision and order which determines that the claimant suffered a compensable foot injury on _____, and that the claimant has had disability from June 7, 1993, until the date of the hearing is affirmed. That portion of the hearing officer's decision which determines that the claimant's myocardial infarction resulted from treatment for the compensable foot injury is reversed and a decision is rendered that there is insufficient expert medical evidence to support that determination.

Robert W. Potts
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Joe Sebesta
Appeals Judge