

APPEAL NO. 990003

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held in (City 1), Texas, on December 1, 1998. The appellant (carrier) and the respondent (claimant/beneficiary) agreed that the issue was "[w]as the death of [decedent] a direct result of the compensable injury that he sustained on \_\_\_\_\_?" They stipulated that the claimant is the only eligible beneficiary of the decedent; that the decedent sustained a compensable injury to several internal body parts when an oxygen line exploded on \_\_\_\_\_; and that he died on (date of death). The hearing officer made the following findings of fact and conclusion of law, all of which are appealed by the carrier.

**FINDINGS OF FACT**

6. On \_\_\_\_\_, the Decedent's compensable injury included, among numerous other injuries, injuries to his heart and lungs that quickly resulted in pericardial disease and swelling and adult respiratory distress syndrome.
7. From \_\_\_\_\_ through (date of death), the Claimant's [sic] cardiac, cardiovascular, and coronary problems gradually deteriorated and worsened.
8. The Decedent developed pulmonary problems in late 1997 and in 1998 that became serious and may have contributed in a minor way to the Decedent's heart problems that led to the Decedent's death.
9. The primary cause of the Decedent's death was heart failure in the form of a myocardial infarction.
10. The Decedent's injury to his heart, part of his compensable injury, began a series of natural and connected events that led to the deterioration and worsening of the Decedent's heart that caused his death.
11. Prior to \_\_\_\_\_, the Claimant [sic] had no heart condition or disease. Neither his heart injury nor his heart failure was triggered by emotional or mental stress.

**CONCLUSION OF LAW**

2. The death of [decedent] was a direct result of the compensable injury that he sustained on \_\_\_\_\_.

The carrier appealed. It contended that the evidence is not sufficient to support the findings of fact set forth in this decision or, alternatively, that those findings of fact are contrary to the great weight and preponderance of the evidence. It argued that the hearing officer was required to apply the provisions of Section 408.008, COMPENSABILITY OF HEART ATTACKS, and that he did not properly apply them. It also cited several cases concerning expert evidence and argued that the medical evidence is not sufficient to support the findings of fact and the conclusion of law made by the hearing officer. The claimant responded, urging that the evidence is sufficient to support the determinations of the hearing officer, and requesting that his decision be affirmed.

## DECISION

We reverse and render.

The claimant received serious, life-threatening injuries on \_\_\_\_\_, when he was struck in the right anterior lower chest wall by a valve that had been under high pressure. Emergency, exploratory surgery was performed by Dr. D at a hospital in (City 2), Texas. The decedent's spleen was removed, gastric lacerations were repaired, a chest wall laceration was repaired, and liver lacerations were treated. A discharge report from Dr. D dated July 23, 1991, indicates that an internal medicine consultation with Dr. KS was obtained because of an apparent cardiac contusion; that there was also a consultation with Dr. NS, a cardiologist; that an echocardiogram documented a large pericardial effusion; that the decedent was treated with Indocin; that 12 cubic centimeters of purulent material was removed from the subphrenic space; that culture of the material showed candida; and that the decedent's heart rate and rhythm were regular without murmur or gallop. The decedent was transferred to a hospital in City 1. Parts of the first report by Dr. T from that hospital, especially the part related to the heart, are difficult to read. A report from Dr. T dated September 9, 1991, states that the decedent was seen in the hospital for intra-abdominal infection, pericarditis, and fracture of the left hip; that it was felt that the decedent suffered a contusion injury to the heart without a perforating chest injury; that the heart revealed a regular rhythm with an apical three component friction rub; and that the anterior chest wall wound was not deep and appeared to be healing well. In a report dated October 29, 1991, Dr. T states that the decedent's chest is clear and there is no pericardial rub. In a note dated March 4, 1993, Dr. T recorded that the decedent had chest pain last fall, that he was evaluated by Dr. NS, that Dr. NS felt he did not have any intrinsic cardiovascular disease, and that the decedent's chest was clear and the heart revealed a regular rhythm.

Dr. R coordinated the treatment of the decedent. The decedent saw many doctors; it was stated that there are many medical records pertaining to the decedent and, apparently, there are many medical records that were not offered into evidence. In a follow-up office visit note dated December 11, 1992, Dr. R said that the decedent was there for follow-up regarding his overall condition regarding rehabilitation after a right rotator cuff tear, a left hip fracture, intra-abdominal injuries, pericardio contusion with effusion, posttraumatic contusion to the head with memory deficits and posttraumatic depression. In a note dated May 6, 1993, Dr. R states that the claimant had a total right hip replacement and mentioned other problems without stating anything related to the heart. A note from

Dr. R dated August 18, 1993, mentions contusions involving the chest but does not mention the heart. In a report in September 1993, six reports in 1994, and reports in February and June 1995, Dr. R does not mention the heart. In a discharge summary dated September 23, 1995, Dr. R states that the decedent had chronic obstructive pulmonary disease; that Dr. A performed pulmonary consultation; and that Dr. A said the decedent had adult respiratory distress syndrome after the compensable injury and as a result of it. Four more notes do not mention the heart. In a note dated September 23, 1996, Dr. R states that the decedent is there for follow-up from the 1991 incident and lists conditions including chest injuries. The next two notes from Dr. R do not mention the heart. In a follow-up office visit note dated June 3, 1997, Dr. R does not mention the heart as being a reason the decedent is there, but, in a note that is longer than most previous notes, states that the heart rhythm is regular without murmur and that the decedent's wife reported he had been drinking on a regular basis. In another lengthy note dated September 16, 1997, Dr. R wrote:

He also had pericardial injury with the development of pericardial contusion and pericarditis that has now progressed to cardiomyopathy and will need specific evaluation and treatment by [Dr. NS] who was the cardiologist treating him at the initial injury. He also had pulmonary contusion with respiratory difficulties which have been documented and had follow-up visit with [Dr. A] on a limited basis and will need ongoing follow-up with [Dr. A] pertaining to his pulmonary complications.

\* \* \* \*

His chest shows diffuse rhonchi with decreased breath sounds on both sides of the chest. HEART: Shows an irregular rhythm with present S1, S2, no S3 could be auscultated today.

\* \* \* \*

At this point, I am putting [decedent] into the hospital . . . .

A hospital admission report by Dr. R dated September 16, 1997, states that as a result of the 1991 injury the decedent has pericardial contusion and pericarditis treated by Dr. NS; that his heart has irregular rhythm without a murmur; and that he has multiple problems of a urologic, musculoskeletal, cardiovascular, and pulmonary nature all related to his work injury. In a note dated December 2, 1997, Dr. R said that the claimant requested assistance with smoking cessation. In a note dated February 4, 1998, Dr. R said that the decedent was there for follow-up on listed things, including pericardial contusion with restrictive pericarditis secondary to his 1991 injury. In a physician's statement dated April 6, 1998, Dr. R noted that the chest showed a few rhonchi, that the heart had regular rhythm, and that there was telemetry monitoring of the heart condition to make sure there were no significant arrhythmias. In a letter dated May 26, 1998, Dr. R wrote:

[Decedent] encountered numerous injuries in that accident involving pulmonary contusion with consequent pulmonary fibrosis. He also had

pericardial injury with pericarditis and a finding of restrictive pericarditis documented by [Dr. NS], his cardiologist. In addition to this, he had impaired output with congestive heart failure.

\* \* \* \*

[Dr. R lists problems the decedent had, including impaired cardiopulmonary function.]

It was this impaired cardiopulmonary function on the basis of the restrictive pericarditis, pericardiac contusion and then the pulmonary contusion that would lead to a shortened life span with congestive heart failure and higher risk of death such as from myocardial infarction at an earlier age than would normally have occurred.

In a letter dated June 10, 1998, Dr. R wrote:

Pertaining to [decedent]Bhis multiple injuries incurred in a work-related accident included head injury with cognitive dysfunction, depression. He also had intra-abdominal injury with infection and requirement of splenectomy. He also had pulmonary contusion and pericardial injury with pericarditis and restrictive carditis leading directly to congestive heart failure. This, combined with his pulmonary injury being significant components in acceleration of risk factors for cardiac death from myocardial infarction.

Consequently, at this point, my conclusion would be that the components of his chest, pulmonary and cardiac injuries from the work related accident would be contributory to the eventual cause of demise.

The earliest dated report from Dr. NS in the record is dated September 17, 1997. That report states that tests were conducted and indicated that the decedent had cardiomyopathy. The conclusions were:

1. Dilated left ventricular cavity with regional wall motion abnormality involving the lateral wall suggesting underlying coronary artery disease.
2. Mild to moderate mitral insufficiency.
3. Mild pulmonary hypertension.

Dr. J conducted a stress test on September 18, 1997. The conclusion was “[n]o symptoms or ST-T wave changes during Adenosine infusion suggestive of myocardial ischemia. Cardiolute images are pending.” Dr. NS performed left heart catheterization and left and right coronary angiography on September 19, 1997. He reported the following findings:

Left Ventricle: Markedly depressed contractility.

Left Main: Within normal limits.

Left Anterior Descending: Within normal limits.

Circumflex: Within normal limits.

Right: Within normal limits.

**Discussion/Recommendations:** Congestive cardiomyopathyNeeds ACE  
intubation.

A myocardial perfusion scan was performed and on October 2, 1997, Dr. NS reported that his impression was “[n]onspecific chamber dilatation with abnormal perfusion suggesting three vessel disease and/or a cardiomyopathic state.” In a letter to the carrier dated December 11, 1997, Dr. NS apparently responded to questions and wrote:

Number 10Bwith regard to his cardiac treatments and its relationship to his 1991 work injury, that association is unclear.

He had cardiomyopathy of unclear etiology and understands the need to abstain from alcohol. He does smoke, but does not have any associated coronary artery disease. Therefore, the association with his current illness is not clear. It is not really possible to give some estimate as to the contribution of his current illness based on his age of 65 and hypertension. However, a congestive cardiomyopathy could be a late sequelae to a systemic hypertension, but is not necessarily associated with age 65. As noted, smoking does not seem to be related.

In a report dated March 11, 1998, Dr. NS stated:

**COMMENTS:** The aortic and mitral valves are normal anatomically, with normal leaflet motion.

No significant obstruction or insufficiency is noted, with the exception of tricuspid regurgitation, consistent with a pulmonary artery pressure of 40 mmHg.

The left ventricular cavity is markedly dilated at 69mm. The left artium is mildly dilated.

The inter-ventricular septal motion is quite normal. The lateral wall appears to be markedly hypokinetic, resulting in a depressed left ventricular fraction of 40%. There is significant improvement in overall contractility noted from previous examinations.

**CONCLUSIONS:** Dilated left ventricular cavity with regional wall motion abnormality involving the lateral wall. Pulmonary hypertension secondary to above.

In none of the reports does Dr. NS state what the cause for the decedent's condition may be.

In a letter dated October 28, 1997, to Dr. R, Dr. A said that the decedent was smoking, that he was told that smoking could complicate his injury-induced lung disease, that the decedent's lungs have diminished breath sounds bilaterally, and that his heart had a regular rhythm without a murmur. In a report dated March 7, 1998, Dr. H stated that his impression was that the decedent had minimal cardiomegaly (enlarged heart) and questionable mild congestive failure. The decedent was admitted to a hospital the next day, and a discharge report by Dr. W dated March 12, 1998, indicates that the decedent's chest was clear and his cardiac examination showed a regular rhythm with a Grade II/IV systolic ejection murmur without a gallop and that it was felt that he most likely had an untoward reaction to medications.

In a report dated July 15, 1993, Dr. HH, the designated doctor who assigned a 37% impairment rating, noted that the decedent had cardiac and pulmonary contusions; that the pulmonary contusion had resolved; that the cardiac contusion had resulted in congestive heart failure and pericardial effusion that had since resolved; and that the heart rhythm was regular with no murmurs, bruits, or rubs.

The decedent was also treated at a (VA) hospital in City 1. An echocardiographic evaluation was performed on March 27, 1997, and the impression was moderately dilated left ventricle with severely depressed left ventricular function, mild aortic valve sclerosis, dilated right-sided chambers, severe mitral regurgitation, and mild tricuspid regurgitation with mild pulmonary hypertension. A single chest x-ray taken on April 14, 1998, revealed cardiomegaly and mild pulmonary vascular congestion and two x-rays taken the next day revealed cardiomegaly with normal vessels and no acute cardiopulmonary disease. Reports dated April 25, 1998, indicate that the decedent had been treated by a private urologist for bladder and prostate cancer; that bladder tumors were removed on April 24, 1998; that he was given four units of packed red blood cells; and that the decedent's heart rate and rhythm were regular. A radiology report dated May 15, 1998, states that there was a single chest x-ray, that the heart was bulbous, that no edema or pneumonia was evident, and that the impression was "[o]bstructive lung change with cardiomegaly, not changed from 4/15/98." A nuclear medicine report dated May 20, 1998, states that the decedent had prostate and bladder cancer; that there was increased uptake at the right temporal, the cervical, thoracic and lumbosacral spine, multiple bilateral ribs, both scapula, the shoulders, the sternum, pelvis, bilateral femurs, and left tibia; and that the findings are consistent with metastatic disease. The decedent was discharged from the hospital on May 21, 1998, with a diagnosis of diffuse metastatic cancer within the skeleton. A death certificate signed by a doctor at the VA hospital states that the decedent died on (date of death), and the immediate cause of death was probable massive myocardial infarction. The death

certificate also states “[s]equentially list conditions, if any, leading to immediate cause” and provides three spaces with “[d]ue to (or as a likely consequence of)” under the lines on which to make an entry. Bladder tumor is the only condition listed.

At the request of the carrier, Dr. K, a cardiologist, reviewed medical records of the decedent. He testified that he would not expect pulmonary contusion to have long-term effect; that there is no evidence to assume that the myocardial contusion played a significant role throughout the ensuing years of the life of the decedent in creating problems; that when a catheterization was done in September 1997, there was no evidence of significant obstruction; that an autopsy was not performed; that he did not have any special reason to believe that the decedent’s death seven years after a myocardial contusion had anything to do with the myocardial contusion; that he does not have the key information at the time of death to state in reasonable medical probability the cause of death; that based on the history of decedent, a pulmonary embolism is every bit as likely and perhaps more likely to have caused the death than his heart; and that if he had an embolism, the most likely cause was the metastatic cancer. Letters from Dr. K dated July 7 and October 9, 1998, are in the record and are consistent with his testimony.

Before considering the sufficiency of the evidence to support the determinations of the hearing officer, we first consider some arguments made by the carrier on appeal. The carrier cited Burroughs Wellcome Co. v. Crye, 907 S.W.2d 497 (Tex. 1995), a products liability case against the manufacturer of an antibiotic spray. A doctor based his opinion on assumed facts that were not true. The Supreme Court held that when an expert’s opinion is based on assumed facts that vary materially from the actual, undisputed facts, the opinion is without probative value and cannot support a verdict or judgment. In the case before us, there has not been a showing that the opinion of Dr. R or any other doctor is based on facts that vary materially from actual, undisputed facts. The Court in Crye also said that reasonable medical probability is determined by the substance and context of the opinion of the expert witness and does not turn on semantics or on the use of a particular term or phrase.

The carrier also argued that the doubling of the risk aspect of Merrell Dow Pharm., Inc. v. Havner, 953 S.W.2d 706 (Tex. 1997) be applied. That case involved taking Bendectin, birth defects, and epidemiological studies. The Supreme Court stated that the issue before it was whether the evidence is scientifically reliable and some evidence to support the judgment. It stated that epidemiological studies cannot establish that a condition or disease is due to exposure to a particular drug or agent. Briefly, the Court stated that if a condition naturally occurs in six out of 1,000 people when not exposed to a drug; that if the condition occurs in nine out of 1,000 people who take the drug, that would amount to evidence that the drug could have caused the condition; that if more than 12 out of 1,000 who take the drug contract the condition, then it may be statistically more likely than not that a given individual’s disease was caused by the drug; and referred to this as the doubling of the risk requirement. Under the facts before us, the doubling of the risk requirement does not apply. There are other court cases that hold that evidence of causation from whatever source must be scientifically reliable and that speculative

testimony will not suffice, and we need not specifically address the applicability of the decision in Havner to workers' compensation contested case hearings.

The hearing officer properly placed the burden on the claimant to prove by a preponderance of the evidence that the compensable injury sustained on \_\_\_\_\_, was a producing cause of the decedent's death on (date of death). The hearing officer is the trier of fact and is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given to the evidence. Section 410.165(a). The trier of fact may believe all, part, or none of any witness's testimony because the finder of fact judges the credibility of each and every witness, the weight to assign to each witness's testimony, and resolves conflicts and inconsistencies in the testimony. Taylor v. Lewis, 553 S.W.2d 153 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Texas Workers' Compensation Commission Appeal No. 93426, decided July 5, 1993. This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). In his Decision and Order, the hearing officer stated "[t]he decedent's death came not so much a by a >heart attack' as by a heart failure." However, in that Decision and Order he referred to Appeals Panel decisions concerning heart attacks and in Finding of Fact No. 11, the hearing officer made findings that are required to be made under the provisions of Section 408.008 for a heart attack to be compensable. In Finding of Fact No. 7 he found "[f]rom \_\_\_\_\_ through (date of death), the Claimant's [sic] cardiac, cardiovascular, and coronary problems gradually deteriorated and worsened." (Emphasis added.) In Finding of Fact No. 10 he found "[t]he Decedent's injury to his heart, part of his compensable injury, began a series of natural and connected events that led to the deterioration and worsening of the Decedent's heart that caused his death." The medical evidence has been summarized and quoted earlier in this decision. A hearing officer may accept or reject medical evidence in whole or in part; however, in the case before us, that the compensable injury was a producing cause of the decedent's death had to be proved to a reasonable medical probability. After reviewing the record, we do not find the evidence to be sufficient to support Findings of Fact Nos. 7 and 10 and hold that they are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986). We reverse them and Conclusion of Law No. 2 that the death of the decedent was a direct result of the compensable injury.

We reverse the decision of the hearing officer that the decedent died on (date of death), as a direct result of injuries he sustained in his compensable injury of \_\_\_\_\_, and render a decision that the decedent's death on (date of death), was not a result of the compensable injury sustained on \_\_\_\_\_.

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Tommy W. Lueders  
Appeals Judge

CONCUR:

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Philip F. O'Neill  
Appeals Judge

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Elaine M. Chaney  
Appeals Judge