

**NOT DESIGNATED FOR PUBLICATION**

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NOS. F412038 & F412039

GRAYSON W. ANDERSON, EMPLOYEE

CLAIMANT

ENTERGY ARKANSAS, INC.,  
A SELF-INSURED EMPLOYER

RESPONDENT

**OPINION FILED MAY 24, 2007**

Upon review before the FULL COMMISSION, Little Rock, Pulaski County, Arkansas.

Claimant represented by HONORABLE FREDERICK SPENCER,  
Attorney at Law, Mountain Home, Arkansas.

Respondent represented by HONORABLE JIM JULIAN, Attorney at  
Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed and Adopted.

**OPINION AND ORDER**

The claimant appeals from a decision of the  
Administrative Law Judge filed July 26, 2006.

The Administrative Law Judge entered the following  
findings of fact and conclusions of law:

1. The stipulations agreed upon by the parties are reasonable and are approved.
2. The employee-employer relationship existed on March 31, 2004; August 26, 2004; and at all other relevant times.

3. Respondent controverts these claims in their entirety.

4. Claimant's average weekly wage is \$546.72.

5. If Samantha Anderson, Claimant's wife, were called to testify, her testimony would corroborate Claimant's testimony.

6. Pursuant to prior Commission decisions and the rule of necessity, Claimant's Motion to Recuse is denied.

7. Because there is no evidence in the record that Gary Parker's violation of Rule 615 occurred with the consent, connivance, or procurement of Respondent or its attorney, Claimant's motion to strike his testimony is denied. However, Parker's violation of the witness exclusion rule is a factor in assessing the credibility of his testimony.

8. Claimant did not sustain his burden of proving by a preponderance of the evidence that he suffered a compensable injury arising out of and in the course of his employment on either March 31, 2004 or August 26, 2004. He repeatedly sought medical treatment for a preexisting back condition prior to his first alleged incident; an MRI taken shortly after March 31, 2004 reflected "[b]asically no change" from an MRI taken shortly before that date. He did not report a work related injury

following either date, despite knowledge of when and how to make such reports. Respondent's witnesses uniformly denied Claimant's contention that he had reported his incidents to one of them. No medical records report an injury on either date, until a doctor recorded on October 8, 2004 that Claimant "disclosed" a March 31, 2004 incident.

9. Because Claimant failed to prove a compensable injury on either alleged date, it is not necessary to discuss his requests for medical benefits, temporary total disability benefits, or an attorney's fee.

The claimant alleges that he sustained a compensable injury that is governed by the Arkansas Workers' Compensation Act, A.C.A. § 11-9-101 et seq. The claimant's alleged injury is, indeed, an injury that is covered by the Act; however, the claimant has failed to establish the elements necessary to prove a compensable injury by a preponderance of the evidence.

We have carefully conducted a de novo review of the entire record herein and it is our opinion that the Administrative Law Judge's decision is supported by a

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preponderance of the credible evidence, correctly applies the law, and should be affirmed. Specifically, we find from a preponderance of the evidence that the findings of fact made by the Administrative Law Judge are correct and they are, therefore, adopted by the Full Commission.

Thus, we affirm and adopt the decision of the Administrative Law Judge, including all findings and conclusions therein, as the decision of the Full Commission on appeal.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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KAREN H. MCKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully concur in part and dissent in part. Specifically, I concur with the Majority's affirmation

of the denial of the motion to recuse. However, I would have reversed the balance of the Administrative Law Judge's decision. In my opinion, the Majority arbitrarily disregards corroborative evidence of the claimant's injury. Specifically, I find that the Majority erroneously concludes the claimant failed to report either work-related incident to Dr. Peek until October 2004. This is simply not accurate. There is a medical note from Dr. Peek dated, April 5, 2004, indicating the claimant injured himself when climbing on March 31 and Dr. Peek specifically testified he was notified of each work-related accident contemporaneously with each event. In my opinion, the Majority's blatant disregard of the April 5, 2004, report and arbitrary refusal to accord any weight to Dr. Peek's testimony regarding the reporting of the work-related injuries and the cause for the claimant's aggravation constitutes reversible error.

The claimant, age 28, was in training to become a lineman for the employer. The claimant testified, and the medical records indicate, that the claimant had suffered

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back problems prior to working for the respondents. Specifically, the medical records indicate that in January 2004, the claimant was treated for right hip and joint pain that began in November. The claimant reported that he suffered from no weakness, numbness or paresthesia. The claimant was diagnosed with sciatica. The claimant returned on January 28, 2004, complaining of right hip and some pain in the back of his leg. He was referred for an MRI.

On February 9, 2004, an MRI was performed and revealed,

Findings of degenerative disk disease, L4-5 and L5-S1, most pronounced at the latter. What appears to be more of a generalized annular bulge at L4-5 is noted. A more focal disk protrusion at the L5-S1 is seen. It effaces the dural sac and may be slightly effacing the S1 nerve root on the left side.

On February 16, 2004, Dr. Bruce Safman treated the claimant. He noted the claimant reported right gluteal pain that radiates down his right lower extremity and the posterior aspect of his thigh to his knee since September or

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October. Dr. Safman noted the claimant's MRI revealed degenerative disc disease and a focal disc protrusion. However, he concluded that because the claimant's symptoms were right sided, they were not significant. Finally, he diagnosed the claimant with Piriformis syndrome and with a lumbosacral/sacral illiac strain.

The claimant continued treatment with Dr. Safman. On March 19, 2004, he was noted to have no spasms but to have ongoing complaints of pain. Dr. Safman gave the claimant cream and a sacroiliac belt. He also discussed the use of epidural shots with the claimant.

The claimant testified that he suffered an aggravation to his condition on March 31, 2004. The claimant said that the injury occurred while he was climbing down a pole. The claimant described that pain went go down his leg and that he had never felt similar pain. He indicated he was close to the bottom of the pole so he was able to shimmy down it, but that once off the pole, he was hardly able to stand or bear weight.

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The claimant testified that he reported the injury to one of the instructors, but that he was in pain during the incident, and did not remember which particular supervisor. The claimant said the supervisor indicated it was probably just a pulled muscle. The claimant said he was able to finish the remainder of the shift because they spent it observing or in class. The same evening the claimant was laying down and could not get out of bed. He then went to the emergency room and was given pain medication.

The claimant testified that the following day, he took a doctor's note to Kenny Mitchell, Trainer. The claimant said that he told Mitchell he had some problems with the day before, that he had been to the hospital the previous night, and that he could not work.

Mitchell testified that the claimant did bring him a doctor's note. However, Mitchell testified that he was unaware the claimant had injured himself while working. Curiously, though, Mitchell also testified that he and David Geran, Senior Safety Specialist, called Vicky McAllister,

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who was over workers' compensation, to see which doctor the claimant needed to see. Additionally, Mitchell testified that, "It was assumption that in the process the reason he'd had this because we had been climbing, so that's the reason I went ahead and got with David to fill out paperwork so that we could get him medical attention, if that's what he (sic)." The claimant also described that he also called Cheryl Sibley, Construction Supervisor after the incident, and that she did seemed to already know of his injury from Kenny Mitchell.

On April 5, 2004, Dr. Richard Peek treated the claimant for right sided back, buttock, and leg pain. The report indicates the claimant's symptoms had occurred since October 2003 and that the claimant denied any precipitating event. However, he also noted the claimant's symptoms seemed to be worsening and were increased with activity. Additionally, Dr. Peek wrote on the intake form, "acute, March 31 when UAMS climbing."

Dr. Peek diagnosed the claimant with herniations at L4-5 and L5-S1. He noted, "While he does have an L4-5 and L5-S1 herniated nucleus pulposus, his symptoms are more L5 in nature. On MRI scan, the L4-5 disc is more to the left, so it is probably L5-S1." Dr. Peek requested another MRI to see the claimant's current condition.

On April 12, 2004, the claimant submitted to another MRI. It gave the following impression, "Basically no change from prior study. The patient's L4-L5 disk protrusion may cause mild mass effect on left L5 nerve root as it passes inferiorly. The L5-S1 disk bulge causes no significant nerve root (sic) compression." The claimant was noted to have improved symptoms as of April 13, 2004. Dr. Peek noted the claimant's pain was 90% improved but indicated that the claimant would be unable to return to work. He indicated that the claimant could do light duty and that, "once he gets over his back problem we will see about getting him back into a more extensive program and start physical therapy." Finally, Dr. Peek noted the claimant was

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to be treated at a pain clinic. On April 27, 2004, the claimant was noted to have more radicular symptoms but not to have any pain. Dr. Peek released the claimant to perform regular work and indicated that the claimant should finish his injections and remain on antiinflammatory medications. The claimant continued to have some residual symptoms.

On May 6, 2004, the claimant submitted to an IME with Dr. Scott Carle. Dr. Carle opined that the claimant's condition was due to idiopathic degenerative disc disease. Dr. Carle indicated that the claimant's condition did not appear to be permanent and that the claimant's clinical status in eight weeks would ultimately determine his ability to perform his job. Dr. Carle further indicated that the probable duration of medical absence would be eight weeks. Finally, in response to the question, "Identify each function that he is unable to perform", Dr. Carle indicated, "Lifting or carrying of objects weighing up to 100 pounds occasionally and or fifty pounds frequently; pushing or

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pulling on poles; walking up to five miles a day; or pulling on wench lines with up to eight pounds of force."

The claimant continued treatment with Dr. Peek and was noted to have improvement. As of July 19, 2004, the claimant's diagnosis had been changed to "Piriformis syndrome", and "status post herniated disc". On July 26, 2004, the claimant submitted to another IME. Dr. Kevin J. Collins indicated that the claimant was able to return to work immediately. However, he indicated, "My only reservation would be that with some of the heavy lifting, he would be at a risk of possible herniation, but I suspect if he uses the right technique which he is able to identify today, that might not be an issue."

The claimant testified that he returned to work around the first of August and begin with a new class. The claimant testified that after he had been there approximately a week and a half, he injured himself again. The claimant described,

A. Again, I had been there not more than a week, I think it was about a week and

a half, and the second week and the same, same thing. I mean, it was like a mirror image. When I came down that same exact way again, it happened again.

Q. What happened?

A. I'm sorry. I had the pain, the exact pain that I had had the time before go down to my foot.

The claimant testified that he told Kenny Mitchell of the injury immediately after it occurred.

Dr. Peek also testified that the claimant called his nurse the night of the injury and that the claimant reported injuring himself at work. Dr. Peek also said that he started the claimant on steroids and requested an MRI.

The claimant described that he also had a conversation with Sibley about his second injury. The claimant said that around the first of September, Sibley came to his home to discharge him. The claimant said that his wife went inside and Sibley told him he was being discharged for excessive absenteeism. At that point, the claimant said he told her, "I'm doing the job that you asked

me to do, I get injured doing that job and you fire me." The claimant said that Sibley had little response.

The claimant returned to Dr. Peek on September 3, 2004. He was assessed with, "back and right radicular pain in a S1 distribution, and to a lesser degree at L4."

Dr. Peek indicated that the claimant had also been administered another MRI. He indicated, "Followup MRI scan shows enlarging L5-S1 herniated nucleus pulposus and to a lesser degree at 4-5." Dr. Peek discussed surgery and further injections with the claimant.

The MRI report from that date indicates,

Disk bulge at L5-S1 with a superimposed central and left paracentral disk herniation, which appears to impinge upon the left S1 nerve root as it exits the thecal sac.

Mild-to-moderate disk bulge at L4-5 with mild spinal stenosis at L4-5.

The claimant underwent a two level decompression surgery to correct his herniated discs at levels L4-5 and L5-S1. The claimant returned for treatment in October 2004,

and Dr. Peek specifically noted that the claimant reported he had sustained an injury when he was climbing down a pole on March 31, 2004. The claimant returned for treatment on November 5, 2004. The claimant was noted to have a decrease in pain but some residual pain. The note indicates the claimant was injured when he was coming down a pole.

Dr. Peek also indicated that while he typically did not handle workers' compensation cases, he was treating the claimant because he was a pre-existing patient. On the same date Dr. Peek performed a trigger point injection on the claimant's right piriformis.

On December 9, 2004, Dr. Peek treated the claimant and noted the claimant was suffering from weakness in dorsiflexion of the left leg and diminished range of motion. The claimant was diagnosed with spondylolisthesis at L4-5. Dr. Peek indicated the claimant had transient increased sciatica, and that the claimant was having difficulty with an MRI scan. He indicated he was going to see about a CAT scan and have the claimant complete a series of injections.

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He also drafted a letter indicating as follows,

It is my opinion, with reasonable medical certainty, the need for Mr. Anderson's surgery was that he sustained a herniated disc in an injury he sustained on 3/31/04 and I saw him immediately after that. He had further injury on 8/26/04 while he was climbing down a pole. After the August injury, he required urgent surgical intervention. On both occasions, he was being trained as a lineman for Entergy.

Another MRI was performed on December 14, 2004, and the claimant was noted to have a broad-based disk protrusion at L4-5. Dr. Peek noted that the claimant was better than before the surgery, but that he continued to have back and right leg pain. Dr. Peek indicated that he would be treating the claimant with medications. Finally, he also indicated the claimant was still off work and that, "He is disabled from employment and is filing for social security." Despite this, the claimant testified that he returned to work with his father around January or February after his surgery.

Dr. Peek was also deposed in preparation for the hearing. Dr. Peek testified that the claimant disclosed that both injuries were work related and that such information was given contemporaneously with each injury. He noted the April 5 note indicating the claimant had an acute injury from climbing. When further questioned as to why his medical records did not reflect more detail regarding the reason for the claimant's injuries, Dr. Peek testified,

A. And if your patient informs you about some event that has taken place in their life that might shed light on their medical condition, you're going to include it in their history, aren't you?

A. I may or may not. Right, I mean, if it's significant to my treatment at that point.

Q. If it's an event that you believe might have contributed to his physical condition, you would note it in the history wouldn't you?

A. No, not necessarily, not every event that occurred.

Q. Okay.

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A. Like, for instance, the trip to the ER, which he put down in his worksheet, I didn't include that in my dictation.

Q. Okay. If Mr. Anderson had told you that five days before your visit with him on April 5, 2004 he had injured himself coming down a pole, don't you think that would have been something that would have gone down into your history?

A. In fact, I think that he did tell me that. He told me later, and also at that time he told me about having to go to the ER. It wasn't germane to my treatment. I do not accept new workmen's compensation patients. So, I - - I'm sure if I was looking at it in a venue as workmen's compensation, I would have gotten into the nitty-gritty details.

Dr. Peek also testified that after the March 31 incident, the claimant's condition had changed in that he had lost reflex. He indicated that such was an objective change.

Likewise, Dr. Peek testified that after the second incident, there was an apparent, objective change in the claimant's condition. He testified that the claimant's MRI revealed the claimant's disc protrusions had increased in size and that the disk fragment at L5-S1 had become larger

and was impinging on the nerve root. He also testified the claimant's condition had become bad enough to warrant surgery. Finally, he related the claimant's need for surgery to the work injury in August 2004.

In denying the claimant benefits, the Majority, by affirming and adopting the decision of the Administrative Law Judge, opines that the claimant's condition was pre-existing in nature and that he had allegedly failed to notify the employer of his injuries, showing that his conditions are not work related. They also find that the Dr. Peek's notes did not contain any indication the claimant's injury was work-related until October 2004. However, after reviewing the record, it is apparent that the Majority failed to adequately consider the testimony of the respondents' witnesses and the medical records indicating the source of the claimant's pain and the aggravation of his pre-existing condition. Furthermore, the Majority failed to weigh the medical report of April 5, 2004 or the testimony of Dr. Peek, which absolutely indicate the claimant reported

his injuries and sustained an aggravation. Finally, and perhaps most curiously, the Majority seems to virtually ignore the various medical records indicating that the claimant sustained an aggravation as shown by the September MRI showing the claimant's disk protrusion had become larger.

In the present case, the claimant contends that while he had a pre-existing back problem, he sustained aggravations in March and September. A pre-existing disease or infirmity does not disqualify a claim if the employment aggravated, accelerated, or combined with the disease or infirmity to produce the disability for which compensation is sought. See, Nashville Livestock Commission v. Cox, 302 Ark. 69, 787 S.W.2d 664 (1990); Conway Convalescent Center v. Murphree, 266 Ark. 985, 585 S.W.2d 462 (Ark.App. 1979); St. Vincent Medical Center v. Brown, 53 Ark. App. 30, 917 S.W.2d 550 (1996). The employer takes the employee as he finds him. Murphree, supra. In such cases, the test is not whether the injury causes the condition, but rather the test

is whether the injury aggravates, accelerates, or combines with the condition. However, although a disabling symptom of a pre-existing condition may be compensable if it is brought on by an accident arising out of and in the course of employment, the employee's entitlement to compensation ends when his condition is restored to the condition that existed before the injury unless the injury contributes to the condition by accelerating or combining with the pre-existing condition. See, Arkansas Power & Light Co. v. Scroggins, 230 Ark. 936, 328 S.W.2d 97 (1959).

In workers' compensation law, an employer takes the employee as he finds him, and employment circumstances that aggravate preexisting conditions are compensable. Heritage Baptist Temple v. Robison, 82 Ark. App. 460, 120 S.W.3d 150 (2003). An aggravation of a preexisting non-compensable condition by a compensable injury is, itself, compensable. Id. An aggravation is a new injury resulting from an independent incident. Id. An aggravation, being a new injury with an independent cause, must meet the

definition of a compensable injury in order to establish compensability for the aggravation.

In the present case, there is no dispute that the claimant suffered from a pre-existing condition and that he suffered from herniations prior to March 31. However, the claimant credibly testified that he had sustained an aggravation when climbing down a pole on March 31. While the respondents' witnesses denied the claimant reported the injury, that is simply not consistent with the evidence in the record. It is undisputed that the claimant stopped working the day after the March 31 incident. It is also undisputed that he went to the emergency room and reported such the following day. In fact, the respondents' own witnesses, Mitchell and Geran both testified that they contacted MacAllister, who is in charge of workers' compensation benefits to see which doctor the claimant should see. Additionally, Mitchell testified that he assumed the claimant's injury was from climbing the day before. In my opinion, it is simply not logical that Mitchell and Geran

would contact MacAllister unless they believed the claimant had sustained a work-related injury.

Likewise, when the claimant returned to Dr. Peek he reported going to the emergency room shortly after working, which is consistent with the claimant having aggravated his condition at work. Even more convincing though, is the notation on the report from that date indicating, "acute, March 31 when UAMS climbing". Furthermore, Dr. Peek's testimony that the claimant reported sliding down the pole and sustaining an aggravation to his back on March 31 simply corroborates all the aforementioned evidence. Dr. Peek testified that the claimant had an objective change in his condition in that he had, "lost his reflex".

Additionally, I find that even if one does not believe the claimant sustained a compensable aggravation on March 31 (a finding which I do not make), there is simply no way one could review the medical records and conclude that he did not sustain an aggravation on August 26, 2004.

Dr. Peek testified that after the second incident, the claimant contacted him and told him of the re-injury. Dr. Peek also testified the event caused an aggravation to the claimant's condition. Even prior to the time of the claimant's release from the first incident, he was noted to have a possible chance of a recurring injury. Specifically, I note that on July 26, 2004, Dr. Collins expressed reservation that the claimant could sustain another herniation if he performed heavy lifting. Certainly, it would only be logical that climbing up and down a pole would also be an activity that would make the claimant vulnerable to sustaining another herniation. Additionally, this notation by Dr. Collins seems to reinforce Dr. Peek's testimony that the claimant's work caused him to sustain an aggravation.

Additionally, I note that the MRI results are consistent with an aggravation as described by the claimant. The MRI report, dated September 3, 2004, provides that the claimant suffered from , "Disk bulge at L5-S1 with

superimposed central and left paracentral disk herniation..." (Emphasis added). When reviewing the language of this report in comparison with the claimant's past MRI reports, it is abundantly clear the claimant's condition had become worse.

Likewise, Dr. Peek testified that the claimant's herniation had become larger after the August 26, 2004, event. The only explanation presented for this change in condition is the claimant's return to work and sliding down a pole. As the claimant had only been at work for a period of less than a month and his condition changed in a manner that was similar to that predicted by Dr. Collins, the only logical explanation for his re-injury was that he injured himself sliding down the pole. Finally, I note that Dr. Peek also testified and drafted a letter indicating that the claimant's injury directly caused his enlarged herniation and need for surgery.

The Majority denies benefits on the basis that the claimant had allegedly not reported his injuries and had

failed to report any injuries from working. However, when reviewing the testimony of the witnesses, it is apparent that the claimant did report both injuries and that he did sustain aggravations at work.

Claimant has the burden of proving by a preponderance of the evidence that he is entitled to compensation. Jordan v. Tyson Foods, Inc., 51 Ark. App. 100, 911 S.W.2d 593 (1995). Questions of credibility and the weight and sufficiency to be given evidence are matters within the province of the Workers' Compensation Commission. Swift-Eckrich, Inc. v. Brock, 63 Ark. app. 118, 975 S.W.2d 857 (1998). Although the Commission is not bound by medical testimony, it may not arbitrarily disregard any witnesses's testimony. Reeder v. Rheem Mfg. Co., 38 Ark. App. 248, 832 S.W.2d 505 (1992).

The claimant credibly testified that he told an instructor of his first injury and that he told Kenny Mitchell that he injured himself while coming down a pole on August 24. Likewise, Mitchell testified that after March 31

he contacted the workers' compensation coordinator about the claimant's injury to see who he needed to seek treatment from. Furthermore, he explicitly said he assumed the claimant had injured himself from climbing the previous day. Likewise, the claimant explicitly testified that he told the employer of the second injury on the day it occurred.

Likewise, the claimant returned for treatment with Dr. Peek and disclosed how he had injured himself, as noted by the language, "acute March 31 when UAMS climbing." As he had to go to the emergency room after his day at work, it is only logical that his increase in pain was due to climbing down the pole at work.

The Majority asserts that the claimant did not disclose his injury to Dr. Peek until October. This is an error of fact and is patently wrong as evidenced by the notation indicating the claimant had acute pain from climbing. Furthermore, I note that the claimant is not required to give the "gory details" of his injury to his physician. See, Siders v. Southern Mattress Co., 240 Ark.

267, 398 S.W. 2d 901 (1966). Furthermore, Dr. Peek credibly testified the claimant did disclose the reasons for his injuries, but that he did not document it thoroughly in his reports because it did not have any relevance to the claimant's treatment. Additionally, as previously mentioned, the claimant, on April 5, 2004, reported he had been to the emergency room on March 31 and that he had an increase in symptoms with activity and due to climbing, which is consistent with both the claimant's and Dr. Peek's testimony.

With respect to the August incident, Dr. Peek also testified that the claimant contacted his nurse the day of the accident and that the claimant said he injured himself at work. As a result of that call, the claimant was ordered steroids and asked to return for an MRI. There is absolutely no evidence in the record to refute that testimony. Additionally, I found the claimant's testimony regarding his reporting the August incident to be more credible than the witnesses presented by the respondents' witnesses.

The Majority essentially rejected the testimony of the claimant and Dr. Peek for the testimony of the respondents' witnesses. I find this to be curious. This is particularly true since it is apparent that Mitchell said he believed the claimant had injured himself climbing down a pole the day before. Furthermore, it is simply not logical that he would contact the workers' compensation coordinator if the claimant had not sustained a work-related injury. Finally, I find it extremely suspicious that the respondents would not have listed notice as an issue if the claimant had not reported his injuries were work-related from the beginning. (I note that the respondents raise the issue of notice in their appeal brief, however, there is no indication that this issue was properly raised prior to the first hearing as required by Ark. Code Ann. §11-9-701.)

Certainly, the respondents' witnesses and even the claimant would have a vested interest in the outcome of this case. However, Dr. Peek would not. As such, I am simply baffled by the Majority's refusal to give any weight to the

testimony of Dr. Peek. Perhaps even more disconcerting is their blatant failure to acknowledge or consider the claimant's report of an injury due to climbing as reflected by the April 5, 2004, note. The testimony of Dr. Peek was virtually identical to that of the claimant with regard to how the injuries occurred and when they were reported. When questioned about why he did not have more detailed notes regarding the occurrence of the claimant's injuries in his notes, Dr. Peek gave a plausible explanation, testifying that unless it had bearing on treatment, he did not record it. He went on to indicate that he usually did not handle workers' compensation cases and expressed a displeasure for most workers' compensation patients. Certainly Dr. Peek's explanation provides a rational basis for why his reports do not go into detail regarding the claimant's injury.

Additionally, it is apparent that Dr. Peek does not like most workers' compensation patients, which makes it quite peculiar that he would then somehow be inclined to lie on behalf of this one claimant. Furthermore, the Majority

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fails to provide any explanation as to why Dr. Peek would provide false testimony. In sum, I find that the Majority fails to consider the true facts of the case and find it is simply deplorable to reject the opinion of Dr. Peek when he has no reason to lie on behalf of the claimant.

Therefore, I must respectfully concur in part and dissent in part.

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PHILIP A. HOOD, Commissioner