IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
March 24, 2005, Session

GLORIA JEAN SMITH v. V.F. IMAGEWEAR (WEST), INC.

Direct Appeal from the Chancery Court for Davidson County
No. 01-4041-III Richard Dinkins, Chancellor

No. M2004-00947-WC-R3-CV - Mailed - July 14, 2005
Filed - August 15, 2005

This workers' compensation appeal has been referred to the Special Workers' Compensation Appeals Panel in accordance with Tennessee Code Annotated section 50-6-225(e)(3) for hearing and reporting to the Supreme Court of findings of fact and conclusions of law. In this appeal, the employee asserts that the trial court erred in finding that she failed to prove by a preponderance of the evidence that she sustained a work-related injury during the course of her employment with V.F. ImageWear (West), Inc., that would entitle her to benefits under the workers' compensation laws. We conclude that the evidence presented supports the findings of the trial judge and, in accordance with Tennessee Code Annotated section 50-6-225(e)(2), affirm the judgment of the trial court.

Tenn. Code Ann. § 50-6-225(e) (1999) Appeal as of Right; Judgment of the Trial Court Affirmed.

DONALD P. HARRIS, SR. J., delivered the opinion of the court, in which ADOLPHO A. BIRCH, J., and ROBERT E. CORLEW, III, SP. J., joined.

Aubrey T. Givens, Nashville, Tennessee, for the appellant, Gloria Jean Smith.

Bree A. Taylor, Nashville, Tennessee, for the appellee, V.F. ImageWear (West) Inc.

MEMORANDUM OPINION

I. FACTUAL BACKGROUND.

Gloria Smith, a resident of Springfield, Tennessee, was forty-one old at the time of the trial. She was employed by V.F. Imagewear sewing trim and emblems onto uniforms. She now is the primary caregiver for her two-year-old child.

Mrs. Smith strained her back in October 1999. The injury was reported to her supervisor, but no written report was made. Mrs. Smith acknowledged that when she was examined in the emergency room at NorthCrest Medical Center on October 17,1999, she stated that she had experienced lower back pain off and on for more than a year. She was examined by Dr. Ferland on October 20, 1999, and she told him she had experienced back pain three years previously. Mrs. Smith testified that after October 1999, she experienced back pain continuously, took over-the-counter medications and occasionally missed work. She asserts the pain she experienced following the October 1999 strain was not anything like it became in June 2001.

On June 26, 2001, Mrs. Smith testified she was at work lifting a forty to fifty pound box when she felt a pop and a very sharp pain in her back. She reported the incident but was not provided a panel of doctors by her employer. She went to Dr. Robert Ferland, her personal physician, who referred her to Dr. Douglas Matthews. Dr. Matthews advised surgery. She did not immediately have the operation because V.F. Imagewear fired her in October 2001, and she lost her medical insurance. After she was approved for TennCare, she had the surgery in December 2002. Dr. Matthews took bone from her left hip, fused it into her back and installed six screws, three on each side of her spine. Following surgery, she went through physical therapy. She last saw Dr. Matthews in June 2003.

Since the surgery, her life has changed drastically. She is no longer able to play with her children, clean, bend, walk or even lie down. She has pain every day. There is tingling and numbness down her right leg into the bottom of her foot. She can only sit, stand or walk for short periods of time. She has difficulty lying down in that she has to lay in certain positions in order to be comfortable. Sometimes the pain wakes her at night. She does not believe she could work at V.F. Imagewear within the restrictions placed upon her by Dr. Gaw and other physicians.

When she saw Dr. Ferland on June 27, 2001, she did not relate the popping incident that had occurred at work but merely told him she was experiencing back pain. She testified that after October 1999, on a scale of one to ten, her back pain was a seven. When she reported the current injury, she listed the date of the accident as October 1999 to June 26, 2001. When she filled out her short term disability application she also indicated that she had injured herself in October 1999. It says "October 1999, slipped disc pressed against nerve." The date of the application was July 11, 2001.

Richie Marie Ross, supervisor over the special sewing and alteration area, testified for the defendant, V.F. Imagewear. She held that position in October 1999. According to Ross, Mrs. Smith did not report an injury to her back in October 1999, nor did she ask for medical treatment as a result of a work-related injury. During the year 2000, Mrs. Smith's attendance at work was poor. Frequently, she was absent, tardy or left work early. In March 2001, Mrs. Smith was absent without giving advance notice. Ms. Ross spoke with her about the absences and was told by Mrs. Smith that they were due to problems with her back, including the absences occurring on March 26-28, 2001. She also missed June 13, 2001 and June 27, 2001 due to her back.

Stephanie Williams in Human Resources at V.F. Imagewear testified that Mrs. Smith initially came to her office on July 5, 2002, to request information concerning application for a medical leave. At that time, she did not report an incident or injury that occurred at work. Later, on July 25, 2001, Mrs. Smith made an Accident/Incident Report, but Ms. Williams understood that Mrs. Smith was referring to an occurrence in October 1999. The report read, "Gloria claimed that 10/99 this incident happened before the line received the carts to put the work on. She said they used to lift the boxes and put them on the line and work out of the boxes. She worked two years with her back hurting off and on, she said."

II. MEDICAL EVIDENCE.

Dr. David W. Gaw, a board certified orthopaedic surgeon, performed an independent medical examination of Mrs. Smith on September 3, 2003. According to Dr. Gaw, Mrs. Smith related the onset of her problems to June 27, 2001. She stated that she was lifting boxes at work weighing approximately forty to fifty pounds when she felt sudden pain in her back. The pain gradually increased over the next few days and soon began to radiate down the right lower extremity. Subsequently, she saw Dr. Matthews, a neurosurgeon, and had various imaging studies done, including an MRI, myelogram and post-myelographic CT scan. She underwent surgery on December 5, 2002, that consisted of a multi-level decompression diskectomy and fusion. Following surgery, her leg pain significantly improved. According to Mrs. Smith, the right leg pain was at least 80-90% better and her back pain was about 60-70% better. She had not returned to work at the time of the examination. Mrs. Smith reported that she continued to have a lot of soreness and aching in her back and difficulty with repetitive activities. She also reported difficulty with performing her household chores.

Dr. Gaw performed a physical examination and described Mrs. Smith as being 5'8", weighing 228 pounds. He observed a long scar down the mid-line of the lower back consistent with her surgery. She reported a lot of soreness and tenderness across the lower back but no muscle spasm was noted. She had thirty degrees of true lumbar flexion, the normal being sixty degrees. She had normal hip or sacral movement. She had fifteen degrees of true lumbar extension, the normal being twenty-five degrees. Right lateral flexion averaged fifteen. To the left she had twenty-five degrees. Straight leg-raising hurt at seventy degrees. Dr. Gaw noted no weakness or atrophy of the muscle groups of the lower extremities. He noted there were good pulses, good coordination, and good movement of the joints of the lower extremities.

Dr. Gaw diagnosed Mrs. Smith as having degenerative lumbar disc disease and noted that she had undergone surgery consisting of a multi-level decompression and fusion from L2 to L5 with internal fixation and bone grafting. Based upon the patient's history, Dr. Gaw felt the incident at work in June 2001 was most likely the cause of her injury. Dr. Gaw believed she has sustained a permanent injury as a result of the incident and, according to the AMA Guidelines, 5th Edition, she sustained a 15% impairment due to the multi-level surgery and a 9% impairment as a result of the loss of range of motion, for a combined 23% whole person impairment. Dr. Gaw imposed restrictions of lifting no more than thirty to thirty-five pounds occasionally or ten pounds frequently,

avoiding frequent twisting, bending or standing in awkward positions and being able to alternate sitting and standing as needed.

Dr. Gaw acknowledged other factors such as weight, age and pre-existing injuries could affect range of motion. Mrs. Smith related to Dr. Gaw a prior minor back injury, but she did not report pain radiating into her lower extremity nor did she relate that she experienced numbness and tingling in her lower extremities. Additionally, she did not relate that she had missed work because of back pain nor that she had back pain for about four to five years prior to the date of injury. According to Dr. Gaw, there is no clinical significance to a popping in the back because a disc is soft tissue and would not pop or produce any sound.

Dr. John Keith Nichols testified for the defendant. He performed an independent medical evaluation of Mrs. Smith. Prior to the medical evaluation, he had reviewed the medical records of Dr. David Gaw, Dr. Douglas Matthews and Dr. Ferland. He reported that Mrs. Smith was not extremely cooperative and was a poor historian. Mrs. Smith taped the interview and physical examination and terminated the evaluation before clarification of specific issues could be obtained. According to his report, Dr. Nichols said Mrs. Smith denied having the same symptoms prior to June 2001. She reported straining her back at Day Trek but denied it was the same problem. Mrs. Smith reported injuring herself on June 27, 2001, when she felt a pop in her back while lifting boxes weighing twenty to fifty pounds. She went to her family physician, Dr. Ferland, who referred her to Dr. Matthews. Mrs. Smith stated she told a nurse practitioner that she had injured herself at work but the medical records do not reflect this statement. She reported that she had pain but not as bad as prior to surgery. She states that it is six or seven on a scale of one to ten after surgery, that her leg is 30% better after surgery and her back is 30% better. She describes her pain as being in her lower back and sometimes it radiates into the right leg to the bottom of her foot. She states there is tingling in the bottom of her foot and pins and needles or tingling along the posterior leg. She reports her pain as being worse when sitting, standing, lifting, bending and walking and better when lying down.

A review of the medical records of Dr. Ferland indicate that the patient was seen on October 20, 1999, with complaints of low back pain for one month. She reported having been seen in the emergency room on October 17, 1999, and was told she had a slipped disc. The medical records state "Today continued pain in the lower back, pain radiating into knees, right greater than left, positive numbness/tingling." The report further indicates that she had picked up heavy boxes at work one month prior to her visit and had a positive history of back pain three years ago with the same symptoms. She was at the time given a diagnosis of sciatica as well as degenerative disc disease. She was referred to physical therapy and given medications.

Mrs. Smith was seen in Dr. Ferland's office on June 27, 2001. At that time, she reported that her pain was a five on a scale of one to ten and had been present for two years. She complained of sharp pain to the right buttock and down the leg. An MRI was ordered of the lumbar spine. Mrs. Smith was seen by Dr. Guy Ferland on June 28, 2001, complaining of pain in the right lower extremity on straight leg-raising on the right side. She was diagnosed as having back pain with lumbar radiculopathy, right side. She was seen on July 5, 2001, complaining of low back pain

radiating into the right leg and foot. The patient reported an injury in 1999, growing worse on and off since. The MRI was obtained on July 16, 2001, revealing left lateral disc herniation and protrusion at L2/3 causing foraminal stenosis, lateral recess, spinal stenosis, bilaterally at multiple levels, worse on the left at L2/3 and on the right at L3/4. Dr. Ferland saw her again for follow-up on July 19, 2001, and referred her to a neurosurgeon.

Dr. Matthews initially evaluated the patient on August 21, 2001. According to Dr. Matthews, the patient reported developing back pain about October 1999, that Mrs. Smith says stayed with her pretty much every day. She has had recurrent episodes. By January 2000, she developed some right lower extremity radicular pain. Dr. Matthews performed a physical examination and diagnosed her with degenerative disc disease at L3/4, disc bulges, herniation on the right and in the right foramina at L3 and a possibly mild symptomatic disc protrusion at L2/3. She underwent surgery on December 5, 2002.

Dr. Nichols diagnosed Mrs. Smith as having chronic low back and right lower extremity pain, status post-microscopic decompressive lumbar laminectomy left L2, bilateral L3, 4 and 5 with diskectomy on the left at L2/3 and total radical disketomy bilateral L3/4 and L4/5 with iliac crest bone graft harvest, posterior lumbar interbody fusion L3/4 and L4/5 with machine arthrodesis and segmental pedicel screw fixation at L4/5.

In the opinion of Dr. Nichols, based upon the available information, there was not a probable causal relationship between the patient's current complaint and a specific occupational injury. A review of the medical records revealed that she reported being seen in the emergency room in October 1999, for a slipped disc. She was then seen in Dr. Ferland's office for lower back pain radiating into the bilateral extremities, right greater than left associated with numbness and tingling. This record would indicate that Mrs. Smith had significant lower extremity pain well prior to June 2001. Additionally, at the initial evaluation on June 27, 2001, Mrs. Smith reported pain for two years radiating to the right buttock and leg. There were no report of a specific work-related incident occurring on that date. Likewise, there was not a report of a specific work-related injury occurring during her appointment with Dr. Ferland on June 28, 2001. The first mention of a work-related injury is on July 5, 2001, when the patient was having low back pain radiating into the right leg and foot with a questionable work injury from lifting boxes in 1999 worse on and off since. Furthermore, in Dr. Matthews' initial evaluation on August 21, 2001, Mrs. Smith reported that she began having pain in October 1999, and the pain had stayed with her pretty much every day. She reported to Dr. Matthews that by January 2000 she had developed some right lower extremity radicular pain. She also reported some left hip radicular pain, but 99% of it was in her right leg with chronic pain. Thus, she had pre-existing back problems in 2001, with no reported back injury on June 27, 2001, to any of her initial evaluating physicians or nurse practitioners. In fact, she herself reported to these health care providers that this was a long standing chronic problem.

III. RULING OF THE TRIAL COURT.

The trial court found that Mrs. Smith failed to prove by a preponderance of the evidence that she

sustained an injury at work on June 26, 2001, that caused the condition for which she sought treatment on June 27, 2001, and the subsequent treatment for which she sought to recover under the workers' compensation laws. Accordingly, Mrs. Smith was denied workers' compensation benefits.

IV. STANDARD OF REVIEW.

The standard of review of issues of fact is *de novo* upon the record of the trial court accompanied by a presumption of correctness of the findings, unless the preponderance of evidence is otherwise. Lollar v. Wal-Mart Stores, Inc., 767 S.W.2d 143, 149 (Tenn. 1989); Tenn. Code Ann. § 50-6-225(e)(2). Where the trial judge has seen and heard the witnesses especially if issues of credibility and weight to be given oral testimony are involved, considerable deference must be afforded those circumstances on review since the trial court had the opportunity to observe the witnesses' demeanor and to hear the in-court testimony. Long v. Tri-Con Industries, Ltd., 996 S.W.2d 173, 178 (Tenn. 1999). Where the issues involve expert medical testimony that is contained in the record by deposition, determination of the weight and credibility of the evidence necessarily must be drawn from the contents of the depositions and the reviewing court may draw its own conclusions with regard to those issues. Orman v. Williams Sonoma, Inc., 803 S.W.2d 672 at 676 (Tenn. 1991).

V. ANALYSIS.

The sole issue presented on this appeal is whether the trial court erred in finding that the employee, Mrs. Smith, failed to carry her burden of proof that she had sustained a work-related, compensable injury. In order to be eligible for workers compensation benefits, an employee must suffer "an injury by accident arising out of and in the course of employment which causes either disablement or death." Tenn. Code Ann. §50-6-102(12). The phrase "arising out of" refers to causation. The causation requirement is satisfied if the injury has a rational, causal connection to the work. Reeser v. Yellow Freight Systems, Inc., 938 S.W.2d 690 (Tenn. 1997). Although causation cannot be based upon merely speculative or conjectural proof, absolute certainty is not required. Id. at 692. Any reasonable doubt in this regard is to be construed in favor of the employee. Id. We have thus consistently held that an award may properly be based upon medical testimony to the effect that a given incident "could be" the cause of the employee's injury, when there is also lay testimony from which it reasonably may be inferred that the incident was in fact the cause of the injury. Id.

It is well settled in this state that a plaintiff in a workers' compensation case has the burden of proving every element of this case by a preponderance of the evidence. Elmore v. Travelers Ins. Co., 824 S.W.2d 541 (Tenn. 1992) . Medical causation and permanency of an injury must be established in most cases by expert medical testimony. See, e.g., Thomas v. Aetna Life & Cas. Co., 812 S.W.2d 278, 283 (Tenn. 1991). With these principles in mind, we review the record to determine whether the evidence preponderates against the findings of the trial court.

We have carefully reviewed the medical evidence produced at trial and the testimony of the witnesses appearing before the court. We are satisfied that if a work-related injury occurred, it

occurred in October 1999. This suit was filed December 31, 2001, more than two years after that time. Tennessee Code Annotated section 50-6-203 provides that actions for workers' compensation benefits are forever barred unless within one year from the termination of medical treatment or cessation of benefits a claim is filed in the appropriate court. No claim for this injury was filed. The trial court found Mrs. Smith's testimony was not credible. We must give that finding considerable deference. Accordingly, we must rely solely upon the medical evidence as to the issue of causation. Based on the medical evidence outlined above, we agree with the trial court that the employee, Mrs. Smith, failed to prove by a preponderance of the evidence that she sustained a work-related injury on June 26, 2001, that resulted in her undergoing the medical treatment she has experienced and her current physical disability.

VI. CONCLUSION.

Because we do not find the evidence preponderates against the trial judge's findings, the judgment of the trial court is affirmed. The costs of this cause are taxed to the appellant, Gloria Jean Smith.

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DONALD P. HARRIS, SR. J.

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JUDGMENT

This case is before the Court upon the entire record, including the order of referral to the Special Workers' Compensation Appeals Panel, and the Panel's Memorandum Opinion setting forth its findings of fact and conclusions of law, which are incorporated herein by reference.

Whereupon, it appeals to the Court that the Memorandum Opinion of the Panel should be accepted and approved; and

It is, therefore, ordered that the Panel's findings of fact and conclusions of law are adopted and affirmed, and the decision of the Panel is made the judgment of the Court.

Costs will be paid by the Appellant, Gloria Jean Smith, for which execution may issue if necessary.

IT IS SO ORDERED.

PER CURIAM