IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT JACKSON
March 22, 2005 Session

BERTHA PAULETE BROGDEN MORROW v. DANA CORPORATION, ET AL.

Direct Appeal from the Circuit Court for Shelby County
No. 303866 T.D. Kay S. Robilio, Circuit Judge

No. W2004-01670-WC-R3-CV - Mailed July 18, 2005; Filed August 17, 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 the employee suffered no permanent impairment and no vocational disability as the result of an injury sustained during the course of her employment with Dana Corporation. We conclude that the evidence presented supports the findings of the trial judge and, in accordance with Tennessee Code Annotated §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 JANICE M. HOLDER, J., and JAMES L. WEATHERFORD, SRJ., joined.

Jack V. Delaney, Memphis, Tennessee, for the appellant, Bertha Paulette Brogden Morrow.

Christopher Hale Crain, Memphis, Tennessee, for the appellees, Dana Corporation and ITT Hartford Specialty Risk Services.

MEMORANDUM OPINION

I. FACTUAL BACKGROUND.

Paulette Morrow began working for Dana Corporation in Newbern, Tennessee, on March 10, 1997, providing janitorial services. As a part of her duties she disposed of waste rubber. Waste rubber was weighed before it was discarded by pulling the container of rubber onto a scale. On September 4, 1997, while pulling a container of rubber scrap weighing 220 pounds onto the scale, she heard a pop. Her back hurt on the left side but her leg hurt on the right side and became numb.

She reported the accident to her supervisor who sent her to the emergency room, and the next day an appointment was made for her with Dr. Daniel Green. Dr. Green took x-rays, recommended physical therapy, and released her to return to work after two weeks.

Upon returning to work, Mrs. Morrow felt her supervisors began "picking" on her. She was accused of sexual harassment. When her supervisors refused to reveal the identity of the person making the complaint, she quit her job. Since she was no longer an employee, she did not know she could return to Dr. Green and went to see Dr. Steve Bell, who she described as her family physician. Dr. Bell ordered a CT scan that indicated a ruptured disc on the left side. Dr. Bell prescribed pain medication and muscle relaxers. Dr. Bell is now deceased but had an associate by the name of Dr. William Joseph Oswald whom Mrs. Morrow continued to see.

In September of 1998, Mrs. Morrow hired an attorney. Shortly thereafter, the workers' compensation insurance carrier was contacted, and she was given a list of three physicians. She chose Dr. John Brophy. Dr. Brophy examined her, sent her to Dr. Phillip Green in Memphis for a nerve block and to Work Solutions, a work hardening program, for physical therapy. At Work Solutions she was given a weight lifting program which Mrs. Morrow testified she could not do because of the pain.

After she was released by Dr. Brophy, Mrs. Morrow returned to Dr. Oswald. Because he did not treat patients with back problems, he sent her to various other doctors including Dr. Allen Sills who performed surgery on March 21, 2002. Mrs. Morrow testified she has had pain constantly since September 1997. The surgery eased the pain a little but it has since gotten worse. She has not worked since her surgery. She testified she is unable to do her housework or even walk any significant distance.

II. MEDICAL EVIDENCE.

Dr. William Joseph Oswald, who testified by deposition, has been a family practitioner in Memphis since 1954. He and his associate, Dr. Steve Bell, had been seeing Mrs. Morrow for thirty-five to forty years. Mrs. Morrow initially was seen with regard to her back by Dr. Bell.[1] Mrs. Morrow reported she had been working at Dana Corporation and, in that job, was required to move large barrels of waste rubber. During that activity, she suffered an injury to her lower back in September 1997. She first saw Dr. Bell about her injury on October 23, 1997, complaining of pain in the low back and pain in the left para-spinal muscles. Dr. Bell prescribed muscle relaxers, a nonsteroidal anti-inflammatory medication and back exercises. She was next seen in Dr. Oswald's office on January 27, 1998. The left side of her low back was hurting. She was continued on conservative treatment with muscle relaxers, analgesics, physical therapy and hot compresses.

[1]During his deposition, Dr. Oswald was reading from Mrs. Morrow's medical records, and it is sometimes difficult to determine whether the office notes are based upon Dr. Oswald's or Dr. Bell's observations.

On May 21, 1998, she had a flare up of her low back pain. The office note indicated, "Back sore, onset two weeks ago. No trauma." At that time, Dr. Bell reviewed x-rays that had been taken October 11, 1997, and noted no gross abnormalities. Dr. Bell ordered a CT scan of Mrs. Morrow's lumbar and thoracic spine. This examination was performed by Dr. Ronnie M. Warner on August 14, 1998, and revealed a disc protrusion at L4/L5 on the left side extending into the intervertebral foramen. Dr. Bell felt she had a ruptured disc at L4/L5 and sent her to see Dr. Allen Nadel, a neurologist. A report from Dr. Nadel, dated August 31, 1998, indicated he reviewed the CT scan which showed a probable herniated disc at L4/L5 on the left when her pain had always been on the right. Dr. Nadel performed an electro-myelogram (EMG) nerve conduction study. He indicated her exam was normal, stated that he could not relate the present symptoms to the injury which occurred at work, and recommended continuing conservative treatment.

On October 8, 1998, Mrs. Morrow began seeing Dr. Brophy. On November 11, 1999, she was seen at Dr. Oswald's office, apparently for her back problem, but was not seen again until August 4, 2000, when Dr. Bell noted she had a ruptured disc and should be seen by a neurosurgeon. She was referred to Dr. John Houser for an evaluation, but it is unclear whether she saw him.

On June 8, 2001, she was seen for a variety of complaints and was referred to a neurosurgeon, Dr. John Lindermuth. Dr. Lindermuth ordered an MRI and a myelogram. The MRI revealed prominent changes of the L4/L5 disc to the left. The myelogram did not show a problem on the right side which was the symptomatic side. Dr. Lindermuth offered an epidural block, but when Mrs. Morrow said she would have to consult with her attorney, Dr. Lindermuth told her he was unwilling to proceed with treatment based upon an attorney's recommendation and referred her back to Dr. Oswald. Dr. Oswald admitted that an MRI will show an old injury as such. The MRI should have shown some scarring and so forth if it was an old injury, but it did not.

On October 15, 2001, Mrs. Morrow was seen by Dr. Robert Segal, a neurologist, on referral from Dr. Bell. He reviewed her films and did not see a "compressive radiculopathy on the right."

On March 1, 2002, she was sent to see Dr. Sills, a neurosurgeon. He performed a right L4/L5 lumbar diskectomy. She had a postoperative MRI which showed a para-central and lateral recess soft tissue encroachment consistent with shallow disc herniation. Dr. Oswald felt Mrs. Morrow to be impaired to such an extent that she will probably not be able to have any gainful employment. According to Dr. Oswald, she will be very limited on any kind of lifting, motion or movement and cannot stand or sit for any significant period of time. Dr. Oswald thinks her condition is permanent. He believes the injury she sustained on September 4, 1997, is the primary cause of the problems she has had with her back. Dr. Oswald further stated that she probably will have to have further surgery.

Dr. Allen K. Sills, a neurosurgeon, testified by deposition. He is licensed to practice medicine in Tennessee and Mississippi and is board certified by the American Board of Neurological Surgery. He is an assistant professor in the Department of Neurosurgery at the University of Tennessee College of Medicine and director of resident training in the Department of Neurosurgery at Methodist University Hospital at the University of Tennessee, Memphis. Dr. Sills first saw

Paulette Morrow on February 7, 2002. She reported a full-length tightening sensation in her low back radiating into her right buttock and down the posterior aspect of her leg toward the knee. She said she had a few symptoms on the left but the majority of her symptoms had been on the right. She indicated the symptoms had gotten worse in the two months prior to her visit with him. She had what he described as an essentially normal neurologic exam. She did have a lumbar CT myelogram study done in August 2001 that suggested a left-side disc lesion at the L4/L5 level with some mild spinal stenosis or narrowing around the nerves resulting in a smaller than normal opening through which the nerve could exit. Dr. Sills recommended some updated imaging studies since she had new symptoms that had developed since her previous x-rays,

The new MRI of the lumbar spine showed degenerative changes at the L4/L5 disc with a bulge or possibly a small fragment of a disc that was in the center and slightly to the left side at the L4/L5 level. It did appear to possibly contact the left side at the L5 nerve root, but there was no contact with the right side.

Dr. Sills entertained the possibility of fibromyalgia, which he described as a poorly understood musculoskeletal condition where people complain of pain in various joints and muscle groups that can be variable in presentation, onset, and location. The pain is thought to relate to inflammation in different parts of the body rather than to actual compression of a nerve. That was discussed with Ms. Morrow along with the possibility of surgery and other options such as pain treatment and a spinal rehabilitation program. Following that discussion, Mrs. Morrow opted for the surgery.

Dr. Sills performed a right-side L4/L5 lumbar diskectomy with a foraminotomy over the right L5 root. The latter procedure involves going down to the area where the nerve is located and creating an enlarged space around the nerve to relieve the pressure upon it. After surgery, Mrs. Morrow was next seen on April 23, 2002. She indicated she was doing better but was still having pain in her right leg. Dr. Sills thought she was making satisfactory progress and recommended continuing her muscle relaxer, progressively increasing her activities, and trying to discontinue her narcotic pain medications. He saw her on June 4, 2002, when she reported that she was still having some pain in her low back and into both legs. She had contacted the doctor's office several times requesting different pain medications. He performed an exam which was normal. He had another MRI done that revealed that she continued to have a small disc abnormality on the left side but he did not recommend further surgery.

Dr. Sills did not believe Mrs. Morrow had sustained a permanent impairment or was under any physical limitations. He did indicate that when he did the surgery he found centrally located disc fragments that may have caused some stenosis on the right side. He said that the time gap between the 1997 injury and the surgery was too great to give an opinion as to whether they were related events. While Dr. Sills admitted that it was possible the condition he observed could have been caused by the 1997 injury, it is clear he considered that connection to have been speculative. Dr. Sills also noted in his medical history that Mrs. Morrow reported having back problems for two or

three years. Since he first saw her on February 7, 2002, her reported history would have placed the onset of her back problems in 1999.[2]

Dr. John D. Brophy, certified by the American Board of Neurological Surgery, testified by deposition. He first saw Paulette Morrow on October 8, 1998. She reported that on September 4, 1997, she was lifting waste rubber onto a scale at work and felt a pop in her back. Her greatest pain was localized in the right superior lumbar para-spinal muscles. She also had intermittent pain extending from the sacrum to the right buttock associated with paresthesias of the right lateral thigh to the knee. He reviewed a CT scan dated August 14, 1998, demonstrating a left L4/L5 herniated disc with no evidence of nerve root compression on the right. His impression was that she had myofascial pain syndrome associated with a left L4/L5 herniated disc contra lateral to her pain. There was no clinical evidence of radiculopathy. Myofascial pain syndrome is pain related to the soft tissues, muscles, tendons and ligaments. It is usually self-limited and improves over time and with exercise. Dr. Brophy indicated there was potentially pressure on the nerve on the left but that she had no symptoms on the left.

He next saw Ms. Morrow on October 26, 1998. She was referred to Work Solutions for a work conditioning program. Her participation was characterized by marginal attendance and inconsistent efforts. She reported that her back pain increased in severity during the exercise program. His impression on that visit was myofascial pain syndrome and sacroiliitis.[3] He recommended that she proceed with a serious endurance exercise program of two miles a day, seven days a week and continue treatment with anti-inflammatories. She was cleared to return to work on full duty on November 2, 1998. He believed she had reached maximum medical improvement on November 2, 1998, with no permanent impairment.

In the opinion of Dr. Brophy, evaluation of Mrs. Morrow's August 1998 CT scan demonstrated no structural abnormalities that would account for her right-side tenderness. Dr. Brophy testified there was a herniated disc on the left but nothing in her history would indicate her symptoms were related to that herniated disc. Any subsequent condition would not be causally related to the 1997 injury. Dr. Brophy testified Mrs. Morrow had a soft tissue injury in 1997 and had the potential to significantly improve if she had been compliant with the treatment plan but she was not. A report from David Brick at the work hardening program indicated that he had discussed with Ms. Morrow the fact that she had only exerted minimal to no effort at their facility. According to the report, Mrs. Morrow contacted her attorney and was told that she did not have to continue the work hardening program.

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[2]Dr. Sills also noted that on April 23, 2002, Mrs. Morrow, following surgery, had an extensive conversation with Dr. Sills about his records stating she had not reported the injury to her supervisors and the circumstances surrounding that. She asked him to change the medical record to reflect she had reported the injury, but Dr. Sills was unwilling to comply with her request.

[3]According to Dr. Brophy, sacroiliitis is S-1 joint pain thought to be originating from the joint between the sacrum and the iliac bone. It is treated with time, anti-inflammatories, and an exercise program. Sometimes physical therapy and steroid injections in the joint are helpful.

III. RULING OF THE TRIAL COURT.

The trial court found that Mrs. Morrow sustained a soft tissue injury at work on September 4, 1997, that did not result in permanent impairment. The court further found that she did not in good faith follow the treatment recommendations of Dr. Brophy in that she failed to complete the work hardening program.

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.

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 690,692 (Tenn. 1997). Although causation cannot be based upon merely speculative or conjectural proof, absolute certainty is not required. Any reasonable doubt in this regard is to be construed in favor of the employee. 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 his or her case by a preponderance of the evidence. ***Elmore v. Travelers Ins. Co.***, 824 S.W.2d 541, 543 (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.

Since the expert medical testimony was presented by deposition, this panel is in as good a position as the trial court to evaluate that testimony and draw its own conclusions. Both Dr. Allen K. Sills and Dr. John D. Brophy are certified as neurological surgeons by the American Board of Neurological Surgery. Both doctors actually treated Mrs. Morrow, Dr. Brophy as the result of Mrs. Morrow's selection from a panel submitted by the employer, and Dr. Sills as the result of a referral from Mrs. Morrow's personal physician. Both doctors were of the opinion that Mrs. Morrow suffered no permanent impairment as a result of her 1997 injury. Their opinions have reasonable bases.

Neither Dr. William Joseph Oswald nor Dr. Steve Bell normally treats patients with orthopaedic or neurological problems. To the extent Mrs. Morrow was seen in their clinic for her back problems, she was primarily under the care of Dr. Bell from the time of her injury through at least October 15, 2001, when he referred her to Dr. Robert Segal. There is no evidence that Dr. Oswald personally examined Mrs. Morrow with regard to this condition until four years after the injury had occurred. None of the many doctors to whom Mrs. Morrow was referred by Dr. Oswald or Dr. Bell for evaluation related her symptoms to the injury she sustained at work in 1997. Dr. Oswald's opinion that her reported symptoms were caused by this incident is simply without foundation and contrary to the clear weight of the evidence.

VI. CONCLUSION.

Because we find the trial court's determination to be clearly supported by a preponderance of the evidence, we affirm the trial court's judgment and tax the costs of this appeal to the appellant, Bertha Paulette Brogden Morrow.

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DONALD P. HARRIS, SENIOR JUDGE

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JUDGMENT ORDER

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 appears 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 on appeal are taxed to the Appellant, Bertha Paulette Brogden Morrow, for which execution may issue if necessary.

IT IS SO ORDERED.

PER CURIAM