IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT JACKSON
August 22, 2011 Session

GEORGE McGOWAN v. STATE OF TENNESSEE

Appeal from the Tennessee Claims Commission
No. 20060655705 Nancy C. Miller-Herron, Commissioner

No. W2011-00869-SC-WCM-WC - Mailed November 16, 2011;
Filed February 15, 2012

An employee was exposed to smoke as a result of a fire at his workplace. Testing revealed the presence of bullous emphysema, a dangerous condition caused by cigarette smoking. Surgery was required to treat that condition. The Claims Commission ruled that the smoke exposure at work had aggravated and advanced his preexisting lung disease and awarded permanent total disability benefits. The employer has appealed,[1] contending that the evidence preponderates against the Commissioner's finding of causation. We agree and reverse the judgment.

Tenn. Code Ann. § 50-6-225(e) (2008) Appeal as of Right;
Judgment of the Claims Commission Reversed

TONY A. CHILDRESS, SP. J., delivered the opinion of the Court, in which JANICE HOLDER, J. and WALTER C. KURTZ, SR. J., joined.

Robert E. Cooper, Jr., Attorney General & Reporter; Martha A. Campbell, Associate Deputy Attorney General, for the appellant, State of Tennessee.

Andrew L. Wener, Memphis, Tennessee, for the appellee, George McGowan.

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[1] Pursuant to Tennessee Supreme Court Rule 51, this workers' compensation appeal has been referred to the Special Workers' Compensation Appeals Panel for a hearing and a report of findings of fact and conclusions of law.

MEMORANDUM OPINION

Factual and Procedural Background

George McGowan ("Employee") was employed as a Sergeant at the Wilder Youth Development Center ("Wilder")[2] in Somerville, Tennessee. Employee had worked at Wilder for twenty-one years at the time his alleged injury occurred on June 27, 2006. On that date, Employee was working third shift when a fire alarm went off in the "school area" of the facility. Employee responded to the alarm and went into the building to "investigate what was going on and see was it safe for anyone to enter the building." While attempting to determine where the fire was located within the building, Employee was exposed to smoke, which he described as "electrical smoke." Employee did not know how long he was in the building. Eventually, the local fire department was summoned to the scene, and Employee finished his shift. After finishing his shift, Employee attended a class concerning the use of physical restraints. Employee went home after this class.

Employee's head and chest were "hurting" after his exposure to the smoke from the June 27 fire and he slept poorly during the next day. Employee felt even worse when he reported to work the following night. Employee informed his supervisor that he was going to the local emergency room "to find out what was wrong." Employee was examined at the emergency room, received a prescription for pain medication, and was released to return home. Later that morning, Employee received a call from the hospital requesting that he return to the emergency room. Employee was advised that x-rays taken earlier had revealed the presence of bullous emphysema in both lungs. Employee was admitted to the emergency room for smoke inhalation and was subsequently transferred to St. Francis Hospital in Memphis, where he came under the treatment of Dr. Syed Shirazee. Dr. Shirazee, a pulmonary physician, ordered additional testing that confirmed the presence of large bullae in the upper parts of both lungs. Surgery was recommended, and Dr. James Johnson, a thoracic surgeon, removed the bullae on June 30, 2006. A second surgical procedure was performed on July 3 to control post-surgical bleeding.

Employee did not return to work after recovering from the surgeries and applied for and received social security disability benefits. On March 12, 2007, Employee filed a complaint for workers' compensation benefits with the Tennessee Claims Commission. During the hearing the Claims Commission held on October 13, 2010, Employer asserted that Employee's disability was caused by Employee's pre-existing emphysema and denied that

[2] Wilder is operated by the Department of Children's Services to house juveniles who have been adjudicated to be delinquents.

Employee's exposure to smoke on June 27, 2006, accelerated this condition or caused any permanent disability.

Three physicians testified concerning causation: Dr. Shirazee, Dr. Johnson, and Dr. James Talmage, an occupational health and emergency medicine specialist who reviewed Employee's medical records at the request of Employer. All three testified by deposition.

Dr. Shirazee testified that he first saw Employee on June 28, 2006, and followed him until September 2008. Dr. Shirazee testified that Employee's smoke exposure on June 27, 2006, contributed to and aggravated his "pulmonary condition." Dr. Shirazee described bullous emphysema as "a disease process. The basic diagnosis is emphysema, and you have bullous emphysema which is a variant of emphysema that causes part of the lung to form large sacks of air due to lung destruction that takes place." Dr. Shirazee testified that this disease was most often found in patients who had smoked a pack or more of cigarettes per day for twenty years.[3] Dr. Shirazee opined that Employee's bullous emphysema had developed prior to June 27, 2006, and stated that Employee "probably had a flareup of his condition" as a result of the June 27 incident. Dr. Shirazee further testified concerning the relationship between the pre-existing condition and the June 27 incident:

> Q: [A]ssuming [Employee] had never suffered the smoke inhalation that he did at work, do you have an opinion whether he would have ever required the treatment that he has received from you and Dr. Johnson related to his condition of massive bullous emboli and COPD?
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> . . .
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> Q: Do you have an opinion as to whether he would have needed this treatment anyway?
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> A: I have no way of knowing, you know, unless he had a flareup or if he had, you know, a precipitating event that brought him to us.
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> . . . .
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> Q: Was [Employee's] massive bullous emboli a pretty advanced condition when you saw him on the 28th of June, 2006?
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> A: Yes.
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> Q: It was a pretty serious condition, wasn't it?
>
> A: Yes.
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> . . . .
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> Q: . . . . Do people with his condition ultimately require medical treatment, generally speaking?

[3] Employee testified that he had smoked at least a pack of cigarettes per day for twenty years, but had quit smoking in approximately 1999.

A: They do if they come to the attention of the physicians. Some of them can live their entire life and never come to see a physician.

Dr. Shirazee testified that the surgery performed by Dr. Johnson was not treatment for smoke inhalation. Instead, Dr. Shirazee testified that the surgery was treatment for the bullae in Employee's lungs.

Dr. Johnson testified that bullae were "areas of destroyed lung tissue that are essentially like large balloons on the lung[s]." Dr. Johnson testified that there were several dangers associated with this condition, including rupture, which could cause a potentially fatal condition called pneumothorax, infections, and hemorrhaging. Dr. Johnson testified that another common problem associated with bullae was that, "as they enlarge, they compress the adjacent functioning lung tissue so that a patient with emphysema breathes even less well than normally because of the mechanical effect of compressing his adjacent lung." Dr. Johnson testified that Employee's bullous emphysema and chronic obstructive pulmonary disease ("COPD") were caused by years of smoking. Dr. Johnson also testified that Employee's bullous emphysema and COPD preexisted the incident that occurred on June 27, 2006. Dr. Johnson was asked if smoke inhalation could cause an aggravation of bullous emphysema. Dr. Johnson responded to this question by describing three types of injury caused by smoke inhalation: carbon monoxide poisoning, acute thermal injury, and exposure to a toxic substance, such as hydrogen cyanide, contained in the smoke. Dr. Johnson then stated that, unlike smoke inhalation, bullous emphysema was a chronic process most often caused by cigarette smoking. Dr. Johnson stated that what he "found in [Employee's] lungs was totally consistent with somebody who had emphysema from years of cigarette smoking. This is not something that happens in two days." Dr. Johnson went on to state, "[T]here's no question that anybody with underlying chronic lung disease is more vulnerable to any acute insult, whether it's influenza or smoke inhalation." The following question and answer then occurred:

Q: Okay. And assuming that those are what occurred in this particular instance, would that still have — would those symptoms still have required your surgery?

A: Well, the — again, the indication for this surgery was giant bullae within the lungs. And the primary purpose of resecting the bullae is to allow the residual lung tissue to expand and to feel better with air to ventilate better so that you can improve the patient's ventilation and oxygenation and hopefully the symptoms of dyspnea. It can occasionally, be difficult [to] tell which patient is going to improve and which is not.

. . . .

Q: And — you needed to remove that on the date that you removed it because of?

A: Well, [Employee] was severely — he was severely dyspneic. And again, the idea was to improve his oxygenation by removing this large bullae, as well as to prevent him from having further complications down the road.

Dr. Talmage testified that, although he was not a pulmonary specialist, his work as an emergency medicine specialist, as an occupational health specialist for the Cookeville Fire Department, and from involvement with a federal government program to compensate employees injured by radiation and heavy metal exposure at Oak Ridge, gave him familiarity with emphysema and the effects of smoke inhalation. Dr. Talmage reviewed medical records provided to him by counsel for Employer. The records Dr. Talmage reviewed included those of Drs. Shirazee and Johnson, the Fayette Methodist hospital emergency room, and St. Francis Hospital. Dr. Talmage also reviewed the records of Dr. Karl Rhea, Employee's primary care physician. Dr. Talmage did not examine Employee and testified that he did not believe an examination occurring four years after the event would provide useful information concerning the causation issue.

Dr. Talmage testified that the expected symptoms of acute smoke inhalation injury included chest pain, nausea, and vomiting and that the record of Employee's June 28, 2006 emergency room visit did not refer to any of those symptoms. Dr. Talmage further testified that the symptoms of smoke inhalation typically were most severe about twenty-four hours after the exposure. Dr. Talmage testified that a chest x-ray of someone suffering from an acute smoke inhalation would show "infiltrate, [a] pneumonia-like pattern," and that Employee's June 28 x-ray did not show the presence of this pneumonia like pattern. Dr. Talmage also noted that the record of Employee's physical examination set out in the June 28 emergency room record showed a pulse rate of sixty-two, a normal respiratory rate of twenty, normal blood pressure, and a normal oxygen saturation rate. Dr. Talmage also noted, however, that Employee had "recorded symptoms of some chest discomfort and cough, which could be symptoms of smoke inhalation or emphysema."

Dr. Talmage testified that the initial record of June 28, 2006, from St. Francis hospital described Employee's condition as "stable" and that:

> The typical thing with smoke inhalation is about a five-day stay in the ICU of the hospital where for that many days you're seriously ill with elevated pulse or elevated respiratory rate, low blood oxygen level, need for artificial respirations through a respirator, things like that. The people who are sick from smoke inhalation typically aren't stable the next day so the people that have a trivial exposure are currently stable.

Dr. Talmage observed that Dr. Shirazee testified that the June 28 event aggravated Employee's pre-existing condition but that Dr. Shirazee did not "clearly distinguish between a temporary exacerbation of symptoms and a permanent aggravation or change in an underlying illness." Dr. Talmage opined that Employee "had temporary symptoms from his smoke inhalation exposure at work, but there is no objective medical evidence that I can find that says he had a significant or permanent change in his anatomy or physiology other than he had surgery that changed his anatomy and physiology."

During cross examination, Dr. Talmage conceded that he did not know if the records he reviewed, which he received from Employer's attorney, were complete. Dr. Talmage also agreed that an emergency room patient with symptoms of smoke inhalation would likely be referred to a pulmonologist, such as Dr. Shirazee. Dr. Talmage disagreed with the opinions of Dr. Shirazee and Dr. Johnson that the June 27 incident did or could have aggravated Employee's pre-existing emphysema. Dr. Talmage opined that "[t]he smoke inhalation didn't have a thing to do with [Employee's] need for lung surgery."

Dr. David Strausser, a vocational evaluator, testified concerning his evaluation of Employee. Because the extent of disability is not contested on appeal, Dr. Strausser's testimony will not be summarized. The Commissioner took the case under advisement, and issued a written decision wherein she found that Employee's "pre-existing bullae emphysema was aggravated and advanced by smoke inhalation from the fire at the John Wilder Youth Development Center on June 27, 2006." The Commissioner awarded permanent total disability benefits. On appeal Employer contends that the evidence preponderates against the Commissioner's finding that the smoke inhalation from the June 27, 2006 fire aggravated and advanced Employee's pre-existing bullae emphysema.

Standard of Review

The standard of review of findings of fact in a workers' compensation case is "de novo upon the record of the trial court, accompanied by a presumption of correctness of the finding, unless the preponderance of evidence is otherwise." Tenn. Code Ann. § 50-6-225(e)(2) (2008). When credibility and weight to be given testimony are involved, considerable deference is given to the trial court when the trial judge had the opportunity to observe the witnesses' demeanor and to hear in-court testimony. Madden v. Holland Grp. of Tenn., Inc., 277 S.W.3d 896, 900 (Tenn. 2009). "When 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." Foreman v. Automatic Sys., Inc., 272 S.W.3d 560, 571 (Tenn. 2008). A trial court's conclusions of law are reviewed de novo upon the record with no presumption of correctness. Seiber v. Reeves Logging, 284 S.W.3d 294, 298 (Tenn. 2009).

Analysis

It is undisputed that Employee is permanently and totally disabled and that the cause of his disability is his diminished ability to breathe. Employee's diminished breathing ability was caused by the removal of substantial portions of both lungs to treat his bullous emphysema. Employee's bullous emphysema was caused by cigarette smoking, and it existed prior to June 27, 2006. There is no contention, nor evidence to support such a contention, that Employee's present breathing limitations are the direct result of damage to his remaining lung tissue caused by smoke he inhaled on June 27, 2006. Therefore, as we perceive it, the question presented is whether there is a nexus between the June 27, 2006 incident and Employee's subsequent need for surgery. For instance, if the smoke inhalation advanced the severity of Employee's emphysema thereby making the surgery necessary, then Employer is liable for all the consequences of that incident. On the other hand, if the smoke inhalation merely led to testing which revealed Employee's preexisting emphysema, then Employer is not liable.

The commissioner found that Employee's pre-existing condition was "aggravated and advanced" by the smoke inhalation, and a pre-existing condition does not necessarily preclude recovery in a workers' compensation case. See Trosper v. Armstrong Wood Prods., Inc., 273 S.W.3d 598, 604 (Tenn. 2008). In fact, in Trosper our Supreme Court considered the claim of an employee who alleged that certain repetitive work activities had aggravated his underlying osteoarthritis. 273 S.W.3d at 600. After reviewing the case law concerning pre-existing conditions, the Trosper Court held "if the work injury advances the severity of the pre-existing condition, or if, as a result of the pre-existing condition, the employee suffers a new, distinct injury other than increased pain, then the work injury is compensable." 273 S.W.3d at 607.

Employer asserts that Dr. Shirazee's testimony that the June 27 incident "caused, contributed to or aggravated [Employee's] 'pulmonary condition,'" and Dr. Johnson's testimony that persons with chronic lung diseases are "more vulnerable" than those who do not have such conditions, do not satisfy the standard set out in Trosper and earlier cases. Employer points out that neither doctor gave any specific description of the effect of the June 27 incident on Employee's lungs or his preexisting emphysema. Employer further asserts that neither doctor stated that the incident caused an anatomical change or an actual progression of the underlying disease.

Employee's disability was caused by the removal of a portion of his lungs, and Dr. Johnson made statements which implied that the surgical removal of the bullae from Employee's lungs was necessary because of the presence of the bullae themselves, rather than any physiological effect of smoke inhalation. In particular, Dr. Johnson stated, "the indication for this surgery was giant bullae within the lungs. And the primary purpose of

resecting the bullae is to allow the residual lung tissue to expand and to feel better with air to ventilate better so that you can improve the patient's ventilation and oxygenation." The plain meaning of this testimony is that the surgery was performed to treat the bullous emphysema and not the smoke inhalation. This conclusion is consistent with the testimony of Dr. Shirazee. Specifically, when was asked if the surgery performed by Dr. Johnson was treatment for "[Employee's] massive bullous emboli, or was it because of smoke inhalation?," Dr. Shirazee answered, "[t]hat was for the bullae that [Employee] had." Dr. Shirazee also stated that the surgery performed by Dr. Johnson was not a reasonable or necessary treatment for Employee's smoke inhalation. Finally, although Dr. Shirazee stated that the smoke inhalation contributed to and aggravated Employee's emphysema, he did not state that the smoke inhalation itself advanced the severity of Employee's preexisting condition or cause a new distinct injury.

Although absolute certainty with respect to causation is not required in workers' compensation cases and reasonable doubt must be construed in favor of the employee, Fritts v. Safety Nat'l Cas. Corp., 163 S.W.3d 673, 678 (Tenn. 2005), proof of a causal connection may not be speculative or conjectural. Clark v. Nashville Mach. Elevator Co., 129 S.W. 3d 42, 47 (Tenn. 2004). Dr. Shirazee's testimony certainly supports the Commissioner's finding that the smoke inhalation aggravated Employee's pre-existing bulla emphysema. Not all aggravations of pre-existing conditions, however, are compensable. See, e.g., Smith v. Smith's Transfer Corp., 735 S.W.2d 221, 225-26 (Tenn. 1987). In order for an aggravation of a pre-existing condition to be compensable the aggravation must advance the severity of the pre-existing condition or cause an employee to suffer a new, distinct injury. Trosper, 273 S.W.3d at 607. Neither Dr. Shirazee or Dr. Johnson testified that the smoke inhalation advanced the severity of Employee's pre-existing emphysema, and the Commissioner did not base its award upon a finding that the smoke inhalation caused Employee to suffer a new, distinct injury. After reviewing the record, we conclude that the evidence preponderates against the Claims Commission's finding that the smoke inhalation advanced Employee's pre-existing bulla emphysema.

Conclusion

The judgment of the Claims Commission that Employee sustained a compensable injury is reversed, and the claim is dismissed. Costs are taxed to George McGowan, for which execution may issue, if necessary.

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TONY A. CHILDRESS, JUDGE

IN THE SUPREME COURT OF TENNESSEE
AT JACKSON

GEORGE MCGOWAN v. STATE OF TENNESSEE

Tennessee Claims Commission
No. 20060655705

No. W2011-00869-SC-WCM-WC - Filed February 15, 2012

JUDGMENT ORDER

This case is before the Court upon the motion for review filed by George McGowan pursuant to Tenn. Code Ann. § 50-6-225(e)(5)(A)(ii), 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.

It appears to the Court that the motion for review is not well-taken and is therefore denied. The Panel's findings of fact and conclusions of law, which are incorporated by reference, are adopted and affirmed. The decision of the Panel is made the judgment of the Court.

Costs are assessed to George McGowan, for which execution may issue if necessary.

It is so ORDERED.

PER CURIAM

HOLDER, JANICE M., J., NOT PARTICIPATING