IN THE SUPREME COURT OF TENNESSEE
AT NASHVILLE

JOHN O. PEOPLES, PLAINTIFF/APPELLEE, v. A & M EXPRESS, INC. and LUMBERMEN'S UNDERWRITING ALLIANCE, DEFENDANTS/APPELLANTS.	)	BEDFORD CHANCERY NO. 19750 Hon. Tyrus H. Cobb, Chancellor S. CT. NO. 01S01-9801-CH-00007 AFFIRMED

JUDGMENT

This case is before the Court upon motion for review pursuant to Tenn. Code Ann. § 50-6-225(e)(5)(B), 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 motion for review is not well taken and should be denied; 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 evenly by the parties, for which execution may issue if necessary.

IT IS SO ORDERED.

PER CURIAM

BARKER, J. NOT PARTICIPATING

IN THE SUPREME COURT OF TENNESSEE

SPECIAL WORKERS' COMPENSATION APPEALS PANEL

AT NASHVILLE, DECEMBER 1998 SESSION

JOHN O. PEOPLES, Plaintiff/Appellee v. A & M EXPRESS, INC. and LUMBERMEN'S UNDERWRITING ALLIANCE, Defendants/Appellants	)	BEDFORD CHANCERY NO. 01S01-9801-CH-00007 HON. TYRUS H. COBB, CHANCELLOR

For the Appellant:	**For the Appellee:**
William L. Abernathy, Jr. Leitner, Williams, Dooley and Napolitan, PLLC 2300 First American Center Nashville, TN 37238-2300	John H. Norton, III One on the Square P. O. Drawer 37 Shelbyville, TN 37162 Thomas F. Bloom 500 Church Street, 5th Flr. Nashville, TN 37219

M E M O R A N D U M O P I N I O N

Members of Panel:

Justice William M. Barker
Senior Judge William H. Inman
Special Judge Joe C. Loser, Jr.

MODIFIED

INMAN, Senior Judge

This workers' compensation appeal has been referred to the Special Workers' Compensation Appeals Panel of the Supreme Court in accordance with Tenn. Code Ann. § 50-6-225(e)(3) for hearing and reporting to the Supreme Court of findings of fact and conclusions of law.

The plaintiff is 46 years old. He has an eighth grade education, with no specialized training. His work history is principally that of a truck driver. On September 12, 1994, he was injured when he crashed into highway equipment near Glasgow, Kentucky, and he filed this action on January 24, 1995 seeking workers' compensation benefits for the injuries sustained in the job-related accident.

The plaintiff had suffered a compensable back injury in 1983 for which he had undergone two lumbar laminectomies, performed by Dr. Ray Hester, a Nashville neurosurgeon, in 1983 and 1984. His claim for workers' compensation benefits was settled on the basis of a 40 percent permanent, partial disability.

He testified at the trial of the case which is the subject of this litigation, that he had fully recovered from all effects of his 1983 accident, and he does not claim an aggravation of a previously existing injury.

Immediately following the accident of September 12, 1994, he was taken to a hospital in Glasgow, where he was treated and released. He had sustained no fractures, lacerations or other indicia of trauma. He returned to Tennessee and contacted Anna Clevenger, the person in charge of workers' compensation matters for his employer, A & M Express, and requested permission to see Dr. Hester (who had treated him for the 1983 injuries). After some equivocation, the plaintiff was informed that he would have to see one of the employer's physicians, Dr. Gary Daniels.

The claim was received by Lumbermen's on September 15, 1994. Gloria Wenk, a Senior Claims Adjuster, informed the plaintiff that he would have to see approved physicians, one of whom was Dr. Daniels.

The plaintiff first saw Dr. Daniels that day, and two or three times thereafter. According to the plaintiff, Dr. Daniels performed no diagnostic tests, and his condition did not improve. The plaintiff testified that prior to the collision he was pain free and felt normal but after the collision he continued to have pain and tingling in his arm, hands and legs and pain in his neck and back.

When Dr. Daniels' medication provided no relief, the plaintiff called either Gloria Wenk at Lumbermen's or Anna Clevenger at A&M Express, who told him that he could see another physician. Dr. Daniels thereupon referred him to Dr. R. Manuel Weiss, a board-certified neurosurgeon in Nashville.

On September 23, 1994, Nelda Peoples, plaintiff's wife, called Gloria Wenk to say that Dr. Daniels had referred her husband to Dr. Weiss. She asked if he could see Dr. Ray Hester, who had performed Mr.. Peoples' previous surgeries. Ms. Wenk advised Ms. Peoples that Dr. Daniels had made the September 28 appointment with Dr. Weiss and that although she would inquire if Dr. Hester could be one of the three approved neurosurgeons, she did not believe that he would be approved.

Ms. Wenk testified that on September 27, 1994, she called Nelda Peoples and offered a panel of three neurosurgeons (Drs. Weiss, Allen and McPherson). She also told Mrs. Peoples that Mr. Peoples could keep his September 28 appointment with Dr. Weiss and then decide which of the three he preferred. The plaintiff agreed that he was offered a choice of three neurosurgeons, Dr. Weiss, Dr. Allen and Dr. McPherson, all board-certified.

Significantly, on September 27, Ms. Wenk also advised Nelda Peoples that Dr. Hester and his group, Neurosurgical Associates, were not approved, because of bad experiences with Neurosurgical Associates, which had too many unsuccessful surgeries and procedures.

On September 27 and September 29, 1994, the plaintiff saw Dr. Weiss, with complaints of pain in his arms, legs, neck and chest. Dr. Weiss noted complaints of tingling fingers and a weak grip, left more than right, but found no evidence of objective neurologic disease and no

evidence of a neurologic syndrome. There were no symptoms suggestive of a disc rupture or some other form of a neural impingement.

Dr. Weiss described a litany of wide-ranging complaints which he said were so disseminated, diffuse, vague and ill-defined that he did not suspect a surgically remedial lesion. Because the plaintiff said he had total body pain radiating in all directions, Dr. Weiss believed that, even if Mr. Peoples had a herniated disc, surgery would not be an effective treatment for him. He testified that people with symptoms to that extent generally have musculo-ligamentous phenomena in the absence of fractures or dislocations or some other structural substrate and are best left alone without surgery, perhaps doing a regular exercise program or using over the counter anti-inflammatory agents. In his judgment, the plaintiff was not a candidate for surgery.

The plaintiff was irate with Dr. Weiss about his medical advice. After seeing Dr. Weiss only twice, the plaintiff believed that he was "getting the run-around" from Lumbermen's, and thereupon contacted Dr. William R. Schooley, an associate of Dr. Hester.

On September 30, Lumbermen's offered another choice of neurosurgeons from the original panel. The plaintiff again asked to see Dr. Hester, and Gloria Wenk again denied that request. After being denied Dr. Hester, the plaintiff chose Dr. McPherson, an approved board-certified neurosurgeon.

On October 3, 1994, plaintiff's counsel contacted Gloria Wenk to ask whether his client could see Dr. Ray Hester instead of the panel doctors. Ms. Wenk told him that she could not allow the plaintiff to see Dr. Hester, and that the plaintiff's appointment with Dr. McPherson should be kept.

By this time, either the plaintiff, his or his counsel had been told five (5) times that Dr. Hester and his group were not authorized to treat Mr.. Peoples.

Nevertheless, on October 4 and again on October 11, 1994, the plaintiff saw Dr. Schooley, a member of Dr. Hester's group, Neurosurgical Associates.

Parenthetically, Gloria Wenk testified that, if the plaintiff had exhausted the panel or was dissatisfied with the panel, Lumbermen's was prepared to offer a fourth neurosurgeon, viz., Dr. Harold Smith, Dr. Cushman or Dr. Zellen, but the plaintiff or his wife or attorney always requested Dr. Hester or "his partner" (Dr. Schooley) by name.

On October 24, the plaintiff saw Dr. McPherson, who noted pain in the low back and both hips, some pain in the right leg and some neck pain, and no persistent weakness. The CT scan of the cervical spine showed some degeneration but nothing that appeared to pinch a nerve.

The plaintiff was scheduled to see Dr. McPherson again on November 7, 1994. Before this visit, he obtained his imaging studies from Dr. Schooley's office, whose records note that on November 7, 1994, "patient had to pick up films and go for SO (second opinion) with workmen's comp dr. [sic] *but wants only Dr. Hester for a doctor."*

Upon seeing Dr. McPherson again on November 7, 1994, the plaintiff described some "pressure" in his neck but had good range of motion in his neck. He described no arm pain. He felt some numbness in his arms and some pain between his shoulder blades. He also complained of tingling in both feet and low back and right leg pain. Both straight leg raising test and MRI confirmed no nerve root entrapment in the lumbar spine. According to Dr. McPherson, muscular soft-tissue pain, likely caused by the accident, was the source of discomfort in the low back. He advised the plaintiff to exercise, but the advice was ignored or unacceptable.

By both history and physical examination, according to Dr. McPherson, there was no evidence of any nerve root entrapment of the cervical spine. The plaintiff had no arm pain with the motions expected if he had cervical nerve root entrapment, and Dr. McPherson believed that, if the accident had caused a cervical disc to herniate or bulge, it would have become symptomatic within five or six weeks after the accident.

For further study, Dr. McPherson referred the plaintiff to Dr. Rubinowicz, a neurologist certified by the American Academy of Psychiatry and Neurology with twelve years' experience.

On November 16, 1994, Dr. Rubinowicz examined the plaintiff, who gave a history of bilateral burning hip discomfort and right leg tingling, intermittent foot numbness associated with shooting pain in both lower extremities which was greater on the right side. He also described mid-back pain which occasionally radiated into his hands and arms and was associated with numbness. His wife also told Dr. Rubinowicz of the plaintiff's frequently dropping things.

Dr. Rubinowicz' examination, which included the neck, revealed no motor deficits in his arms or legs. Sensory testing revealed no focal areas of abnormality, and his reflexes were sound. Straight leg raising was negative, and there was only a mild decrease in range of motion of the neck.

The plaintiff testified that Dr. Rubinowicz was the only one of the three company doctors who really had an accurate idea, who was "clued in" with what was going on with his neck, back and arms. but Dr. Rubinowicz found no objective signs of nerve root entrapment of the cervical spine and focused on the lumbar spine because "that is where he described most of his symptoms being a problem." He believed that the plaintiff had symptoms *consistent with a muscular strain.* Dr. Rubinowicz saw no reason to evaluate the cervical spine, because the only suggested area of nerve entrapment was to the lumbar spine. He thereupon ordered EMG nerve conduction studies for both legs. Those tests were performed on November 23, 1994 and revealed no focal abnormalities and no evidence for nerve or muscle disease. He found no evidence of nerve entrapment syndrome or a peripheral neuropathy of the lumbar spine and felt that conservative treatment should be continued.

Dr. Rubinowicz opined that a bulging disk can be treated conservatively by medication, therapy, exercise, or splints or braces. In the event of a bulging disk with no other evidence of focal neurologic findings and a normal EMG, he would anticipate some improvement in a three

to six month period. By the time the plaintiff saw Dr. Rubinowicz, he was only two and one-half months post-accident.

If an MRI revealed a bulging disc but there was some question of nerve impingement, an accepted course would be to perform another diagnostic study to rule in or rule out nerve entrapment, and that study would be an EMG. He testified that an osteophyte, or bone spur, can cause nerve entrapment or impingement.

After seeing Dr. Rubinowicz, the plaintiff never again asked for another doctor from the panel of neurosurgeons. Instead, he made an appointment to see Dr. Hester.

On December 1, 1994, the plaintiff saw Dr. Ray Hester, who noted pain in the neck and low back, and numbness in both hands, mainly when lying down, with pain in both legs at times, with right a little worse then the left.

According to his notes, Dr. Hester felt that Mr.. Peoples had a "significant cervical and lumbar strain that is slowly improving [and . . .] would continue *to slowly improve with time." He felt that Mr.. Peoples needed to do some therapy, particularly at home, and that it would be another two or three months before he recovered sufficiently to return to work with some restrictions.*

On December 22, 1994, the plaintiff returned to Neurosurgical Associates but saw *Dr. Schooley* instead of Dr. Hester, possibly because Dr. Schooley was a 'new' physician and did 'not have as many patients as Dr. Hester.' He was aware of Dr. Hester's opinion.

Dr. Schooley ordered an MRI, which he said showed a "moderate degree of encroachment on the left neural foramen at C6-7" and the "C7-T1 level demonstrates what appears to be a mild degree of lateral disc bulge possibly representing early herniation intruding on the left lateral recess and neural foramen." Dr. Schooley interpreted that study to show a disc at C6-7 that was herniated or bulging enough to push on the nerve root to give him pain. He opined that the only anatomic change was the C6-7 disc which moved from its normal position and pushed on the nerve as it exited the foramen, but he conceded that *never was there a herniated disc,* just a bulging one. He also thought that an osteophyte at C6-7 could cause

symptoms, and that the osteophytes predated the accident. He felt that the radiculopathy was caused by a mixture of the bulging disc and foraminal stenosis at C6-7.

Because of the MRI and the plaintiff's complaints of pain, *and notwithstanding there were no objective signs of herniation noted by the MRI radiologist or any prior treating or consulting physician,* Dr. Schooley performed *the first of three surgeries,* an anterior cervical diskectomy and fusion.

Upon learning from the employer of the scheduled surgery, Gloria Wenk called the plaintiff's counsel on December 30, 1994 to advise him that the surgery was not authorized and would not be paid by Lumbermen's. Counsel told Ms. Wenk that Dr. Rubinowicz' opinion was all right, but those of the other two panel doctors were not and that "*this is an issue we'll obviously deal with in litigation.*"

The first surgery gave only temporary relief. After a month or so, the pain "just came back," to the same level as before the surgery, with no apparent cause.

Dr. Schooley repeated the same surgery (anterior cervical diskectomy and fusion) at the same level, C6-7, on May 21, 1995, "to take out a little more bone" because "the relief of his symptoms was insufficient and . . . *these osteophytes . . . might be causing enough trouble that it was worth taking them out.*"

The pain "just came back" after the second surgery.

On September 15, 1995, Dr. Schooley performed a *third* cervical spine surgery, a foraminotomy at two levels, C6-7 and C7-T1, *to takeout yet more bone.* Operative notes on that date do not mention the removal of any soft discal herniation.

The pain returned after the third surgery.

Dr. Schooley assigned a DRE Category III impairment of 15 percent to the whole body for the plaintiff's cervical spine condition. According to Dr. Schooley, the Combined Value Table of the *AMA Guides, 4th Ed.* gives a 36 percent whole body rating when combining the 15 percent new impairment with the pre-existing 25 percent whole body medical impairment.

The Medical Proof

Dr. M. Robert Weiss, a board-certified neurological surgeon, testified that he saw the claimant in September, 1994, on a referral from Dr. Gary Daniels. The claimant had no fractures, lacerations or other signs of trauma, but was having neck and back pain, radiating to his right leg. Examination revealed no neurological deficit. Claimant walked normally, with an unrestricted waist range of motion. He had no muscle spasm, and neck range of motion was unrestricted. Reflexes were normal. X-rays had previously been taken, but Dr. Weiss ordered a bone scan to ensure that the x-ray films had missed nothing. Dr. Weiss found no evidence of objective neurologic disease and released the claimant to return to work. He assessed zero percent impairment. With respect to a herniated disc, Dr. Weiss was of the opinion that the likelihood of it was remove based on his clinical tests and did not order the traditional myelogram or MRI.

Dr. Warren E. McPherson is a board-certified neurosurgeon. He first saw the claimant on October 20, 1994, who had a history of two lumbar laminectomies in 1983 and 1984. Dr. McPherson testified that the claimant complained of pain in his low back and hips, and numbness in both feet together with neck pain. An MRI taken on October 25, 1994 revealed no ruptured disc. On his third visit to Dr. McPherson, no pathology could be found to explain the pain the plaintiff complained of, and to quote Dr. McPherson,"I was wondering about whether there was anything else going on."

Dr. McPherson then referred the plaintiff to a medical neurologist, Dr. Rubinowicz, who conducted a nerve conduction study of the plaintiff's legs and found them normal. Dr. McPherson opined that the plaintiff had "some type of muscular soft tissue pain." He opined that the plaintiff, if he was truly asymptomatic before the accident, would "get another 2%" based on his subjective complaints.

Dr. Richard Rubinowicz is a board-certified neurologist. He initially saw the claimant on November 16, 1994, for purposes of evaluation. After describing the plaintiff's symptoms and complaints, it was his impression that the symptoms were consistent with a muscular strain.

He found no objective signs of any nerve root entrapment of the cervical spine. He saw the claimant again on November 23, 1994 and performed an EMG to evaluate his legs. The studies revealed no nerve or muscle disease or any focal abnormalities. He testified that a bulging disc and a herniated disc were entirely different, and that a bulging disc can be treated conservatively. He was not questioned about impairment and expressed no opinion.

Dr. William R. Schooley is a neurosurgeon who is not board-certified. He saw the claimant in December 1994, who had been treated conservatively "by the time he got here to me." Dr. Schooley described the plaintiff's symptoms as being consistent with his nerve roots being pinched by a disc in his neck "so I took the disk out of his neck and did a bone fusion."

The result was unsatisfactory and Dr. Schooley said, "I had to go back in his neck in the *front* and take out a little more bone."

The result was again unsatisfactory, and "we eventually went back for a third operation and took out some bone in the *back."*

Based on the *AMA Guidelines to the Evaluation* of Permanent Impairment, 4th Ed., for a DRE cervicothoracic Category III impairment. Dr. Schooley rated the plaintiff's impairment at 15 percent.

On cross-examination, he conceded that his partner, Dr. Hester, had examined and treated the plaintiff. Dr. Hester's notes revealed, *"I anticipate it will be another two or three months before he's recovered sufficiently to return to work."* Dr. Schooley acknowledged that the plaintiff was Dr. Hester's patient, and did not know what directed the plaintiff "to me" unless Dr. Hester was busy and "I was the new physician here at that time and I didn't have as many patients as Ray [Dr. Hester] did and that may be why I got him."

The Findings of the Trial Court

The Chancellor found that the plaintiff was justified in going to Dr. Schooley because he was not getting relief from his persistent pain, and that the services of Dr. Schooley were reasonable and necessary since he was the only physician who ordered an MRI, the most effective diagnostic tool. Based on Dr. Schooley's opinion of 15 percent impairment, the

Chancellor found that the plaintiff had a 35 percent permanent partial vocational impairment to his whole body for which benefits were awarded. The medical expenses of Dr. Schooley "and those provided at his behest" were approved. Whether the multipliers were properly applied is not an issue.

We note that the Chancellor did not comment on the fact that the three surgeries failed to alleviate the pain, according to the testimony of the plaintiff.

The Issues

I. Whether the employer is liable for the unauthorized expenses incurred by the plaintiff and whether the unauthorized medical treatment was reasonable and necessary.

II. Whether the claimant is entitled to a 15 percent whole body medical rating.

The Issue of Unauthorized Medical Treatment

T.C.A. § 50-6-204 requires the employer to furnish free of charge to the employee all medical expenses as may be reasonably required and that:

> (4) The injured employee shall accept the medical benefits afforded hereunder; provided, that the employer shall designate a group of three (3) or more reputable physicians or surgeons . . . from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician . . .

Subsection (d)(6) provides that:

> If the injured employee refuses . . . to accept the medical or specialized medical services which the employer is required to furnish under the provisions of this law, his right to compensation shall be suspended and no compensation shall be due and payable while he continues such refusal.

Discussion

These statutory mandates are clearly expressed. The issue of unauthorized or unapproved medical services usually arises in instances wherein the employer has failed to furnish a panel of physicians in conformity with the statute, and the employee has chosen a physician unilaterally. *See, e.g., Rice Bottling Co. v. Humphreys*, 372 S.W.2d 170 (Tenn. 1963). But even in such cases, the Supreme Court has refused to hold that in every instance the failure of the employer to furnish a panel of three physicians renders the employer liable for the expenses of physicians chosen by the employee. *See, e.g., Employers Insurance of*

Wausau v. Carter, 572 S.W.2d 174 (Tenn. 1975). When the employer has complied with the statute and furnished the employee with a panel of physicians, as is the case here, the employee has a rather heavy burden of demonstrating why he disdained the services of the panel of physicians. *Baggett v. Jay Garment Co.,* 826 S.W.2d 437 (Tenn. 1992). The plaintiff argues that he was justified in seeking the surgical services of Dr. Schooley because the panel physicians afforded him no relief and refused to perform surgery. The Chancellor agreed that since none of the panel physicians ordered an MRI, as did Dr. Schooley, the plaintiff was justified in seeking Dr. Schooley's services. We do not agree, because case law does not support the rather flagrant deviation from the statute evident in this case.

Parenthetically, at the outset, we note that it was *Dr. Hester* whose services were so aggressively sought by the plaintiff, *and not those of Dr. Schooley*. We also note that Dr. Hester told the plaintiff that, after conservative treatment, *he could return to work,* and declined to perform surgery. The plaintiff then sought the services of Dr. Schooley, who was "new" to the practice, and who proceeded to perform three, repeat three, surgeries on the plaintiff, which were not successful. The argument of the employer that these surgeries were unnecessary focuses attention, because (1) Dr. Schooley was aware of the opinion of his experienced partner that three months of conservative treatment was indicated, and (2) he nevertheless performed three (3) unsuccessful surgeries. It is reasonable to conclude that in no small measure the importunation of the plaintiff for immediate relief of his pain was a factor in these repeated procedures. We also note that the experienced plaintiff was fully aware of the workers' compensation law's requirements, and that he was informed no less than *five (5) times* that Dr. Hester - or his group - was not approved owing to a history of unsuccessful surgeries. Be that as it may, the employer was under no duty to explain the reasons for the disapprobation of Drs. Hester and Schooley; it complied with its statutory duty, and, significantly, even *offered to arrange for the services of other board-certified neurosurgeons,* disdained by the plaintiff.

The plaintiff argues that he gave notice to the employer of his intention to seek the services of Dr. Schooley, and was justified in doing so because only Dr. Schooley correctly

diagnosed his condition. The fallacy of this argument is to be found in the fact that (*1) the statute would thereby be rendered meaningless, and (2) the record does not reflect that Dr. Schooley's diagnosis or treatment was correct. The thrust of all the cases dealing with the issue of unauthorized medical treatment is that an employee may not act on his own initiative under all circumstances, *Pickett v. Chatt. Conv. & Nursing Home, Inc.*, 627 S.W.2d 941 (Tenn. 1982), and cases cited, and that the refusal of an employee to accept the services of panel physicians, on the one hand, or to seek additional medical treatment, on the other, must be resolved on a case by case basis. *Rice Brothers, supra.* The holding in *Con. Coal Co. v. Pride,* 452 S.W.2d 349 (Tenn. 1970), quoted with approval in *Buchanan, supra,* is clear on the point. Under the clear facts of this case we hold that the evidence preponderates against the Chancellor's findings (1) that the plaintiff was justified in seeking the services of Dr. Schooley, and that (2) the employer is liable for the payment of his and Dr. Hester's fees and related charges. The decretal provision respecting such charges - $58,917.98 - is vacated.

The Issue of 15 Percent Medical Rating

The employer argues that the medical rating of fifteen percent is against the weight of the medical proof, and is not supported by Dr. Schooley's testimony.[1]

Dr. McPherson assessed a two percent rating; the remaining physicians found no impairment.

Dr. Schooley's rating was based on the DRE Category III, which requires a patient to have significant signs of radiculopathy such as loss of reflexes or unilateral atrophy with greater than a 2 cm. decrease in circumference compared with the unaffected side. We reproduce Dr. Schooley's testimony:

Q: The permanent impairment that you've assigned, it's DRE Category III; tell me the basis of that opinion, please.

A: It's defined as radiculopathy in his arm. And in the book, if you look it up, it says radiculopathy, and my opinion is that's what he had from that nerve being injured, and that's why he gets that rating, in my opinion.

[1]The multiplier statute, T.C.A. § 50-6-241, was not referenced by the Chancellor, nor by the parties on appeal.

Q: O.K. Do you have a DRE handy?
A: It's based on this. [the referenced book]

Mr.. Abernathy: I'd like to attach a copy of that page as an exhibit.

Q: *Did he have loss of reflexes?*

A: *No.*

Q: *Did he have unilateral atrophy?*

A: *No.*

We find Dr. Schooley's opinion of 15 percent whole person impairment to be less credible than the impairment rating of Dr. McPherson, who opined that the plaintiff had an impairment rating of two percent. Considering the record as a whole, we conclude that the plaintiff has a whole body disability of ten percent and the judgment will be modified accordingly. Costs are assessed to the parties evenly.

_____
William H. Inman, Senior Judge

CONCUR:

_____
William M. Barker, Justice

_____
Joe C. Loser, Jr., Special Judge