

IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
May 20, 2013 Session

GARRY HALL v. NESCO, INC. ET AL.

**Appeal from the Chancery Court for Putnam County
No. 2011-34 Ronald Thurman, Chancellor**

**No. M2012-02368-WC-R3-WC - Mailed July 3, 2013
FILED JULY 7, 2013**

An employee was hospitalized with severe respiratory problems after spending about four days over the course of two weeks power-washing the roof of a commercial building his employer owned. The employee's treating physician ordered numerous tests, none of which revealed definitively the cause of his condition. Based on the employee's response to steroid medication and the fact that medical testing revealed no infection or other condition, the treating physician opined that the employee had developed interstitial lung disease from his exposure to a combination of toxic substances while washing the roof. In contrast, the employer's consulting physician opined that the employee was not exposed to toxic substances in sufficient concentrations while washing the roof to cause interstitial lung disease and that the employee's condition had been caused by infectious pneumonia, which was not detected by testing during the employee's hospitalization because the testing was conducted too soon after the infection developed. The employer denied the employee's workers' compensation claim, and the employee filed suit in the Chancery Court for Putnam County. The trial court found for the employee and awarded 92.5% permanent partial disability. The employer has appealed, arguing that the proof preponderates against the trial court's finding of causation and award of 92.5%. The appeal has been referred to this Special Workers' Compensation Appeals Panel for a hearing and a report of findings of fact and conclusions of law pursuant to Tennessee Supreme Court Rule 51. We affirm the trial court's judgment.

**Tenn. Code Ann. § 50-6-225(e) (2008 & Supp. 2012) Appeal as of Right; Judgment
of the Chancery Court Reversed**

E. RILEY ANDERSON, SP. J., delivered the opinion of the Court, in which CORNELIA A. CLARK, J., and BEN H. CANTRELL, SR. J., joined.

Heather H. Douglas, Nashville, Tennessee, for the appellants, Nesco, Inc. and Accident Fund Insurance Company of America.

Laura B. Baker, Brentwood, Tennessee, for the appellee, Garry Hall.

OPINION

Factual and Procedural Background

Garry Hall (“Employee”) began working for Nesco, Inc. (“Employer”) in 2000. Employee’s work consisted primarily of building and repairing motorcycle transmissions, but he also performed other tasks as needed, such as machine work or building maintenance. In April 2010, Employee and a co-worker were assigned to clean the roof of a commercial building owned by Employer and prepare it for waterproof coating. The building housed International Specialty Supply (“ISS”), a company that grows green sprouts and bean sprouts, manufactures commercial sprout equipment, and sells the products necessary to operate a commercial sprout business.

In his deposition testimony, Bob Rust, the CEO of ISS, stated that ISS uses in its operations chlorine, ammonia, and various cleaners and other chemicals, all of which pose a risk of injury if inhaled. Mr. Rust described the process used to grow sprouts. The first phase of this process consists of sanitizing the seeds with chlorine. The use of chlorine to sanitize the seed is recommended by the federal Food and Drug Administration. ISS workers inside the building use no protective gear or special precautions, and the ISS CEO testified that chlorine exposure had “never bothered anybody.” Seeds are placed in separate quadrants of a rotary drum; a cup of dry chlorine is added to each quadrant; and water is then used to dilute the chlorine and clean the seed. This process lasts about thirty minutes. The chlorinated water drains from each rotary drum into a “catch tray,” from which it flows directly into the city sewer system. The air from the room is vented through a downward facing vent on the side of the building near the roof. Any fumes or mists or gases from the cleaners ISS uses in the building also vent through the vent on the side of the building. The roof of the ISS building where Employee worked is a large, flat, open-air space. A number of air vents throughout the building open onto the roof, but these vents contain no fans forcing air out from inside the building, and they were not connected to the rooms in which the chlorine was used.

Employee and another individual spent approximately four days over the course of two weeks using a chemical cleaning solution and a power washer to clean bird droppings, black mold, and “black stuff” from the ISS roof. Employee and his co-worker performed the work by pouring an odorous, unidentified cleaning solution onto the roof, scrubbing the roof

with brooms, and rinsing the scrubbed area with a power washer. Employee had previously used the unidentified cleaning solution to wash concrete sinks inside Employer's facility. Employee and his co-worker did not wear protective gear or masks, and mist from the power washer and cleaning solution blew on them. By the end of each day, their clothing was "soaking wet." While working, Employee smelled the cleaning solution as well as "a little bit" of ammonia, which he believed was coming from inside the building, but he did not smell chlorine. Employee experienced no eye or nose irritation while working. Employee went inside the ISS building to use the restroom. During the last two days of the project, Employee, then forty-five years of age, experienced shortness of breath and weakness. Employee also coughed while working on the roof. Employee's symptoms worsened on Sunday, April 25, 2010, so he consulted a physician at a walk-in clinic, who directed him to a local emergency room. Employee told the intake nurse at the emergency room that he had been in contact with sick friends who were suffering from a respiratory problem. Employee did not mention any chemical exposure at that time. Employee was diagnosed with pneumonia and admitted for inpatient treatment. Employee remained hospitalized until May 8, 2010.

Dr. David Henson, a board certified pulmonary critical care doctor with thirty years' experience treating patients, treated Employee during his hospitalization. Dr. Henson, testifying by deposition, stated that he obtained a history from Employee that included Employee's report of developing shortness of breath and flu-like symptoms shortly after he began cleaning the ISS roof. Dr. Henson's initial impression was that Employee had "some kind of pulmonary infection," so he started Employee on wide spectrum antibiotic therapy for a community-acquired infection, as well as medication for Employee's underlying smoking-related chronic obstructive pulmonary disease ("COPD"). Employee had started smoking at age thirteen and had smoked two packs of cigarettes per day for more than thirty years at the time of his hospitalization.

Dr. Henson ordered numerous tests to determine the cause of Employee's respiratory problems, including an echo cardiogram, blood, sputum, and urine cultures. He also tested Employee for HIV, Legionnaire's disease, and hypersensitivity to various yeast and fungal agents, including bird droppings. Employee also underwent tests for mycoplasma, a type of bacteria that can cause pneumonia, particularly in persons in Employee's age group. Because mycoplasma bacteria are difficult to grow in a culture, mycoplasma pneumonia is typically diagnosed by testing a patient's blood for antibodies produced by the human body to fight the infection. Employee tested negative for mycoplasma antibodies. Employee also tested negative for other types of bacterial pneumonia. Employee also underwent a more invasive bronchoscopy, which involves passing a flexible tube through a patient's nose, between the vocal cords, and into the lungs while the patient is sedated, to retrieve secretions and sputum from the lower lungs to test for cancer, bacteria, and tuberculosis. These tests also were

negative. Several chest x-rays were taken during Employee's hospitalization as well, all of which showed a pattern consistent with pneumonia and infiltrates in his lungs. These x-rays also revealed that the pneumonia and infiltrates were not responding to the antibiotics Dr. Henson had prescribed. The x-rays were not otherwise diagnostic of the cause of Employee's condition.

A high resolution CT scan performed on April 29, 2010, showed a pattern, referred to as "ground glass opacities," in both lungs.¹ This pattern indicated an inflammation of the air exchange portion of the lungs, ordinarily caused by interstitial lung disease, a non-infectious process, and not ordinarily caused by an infectious process such as bacterial pneumonia. The results of this CT led Dr. Henson to conclude that Employee was suffering from something other than community-acquired bacterial pneumonia. As a result, Dr. Henson initiated a course of steroid treatment, but he also continued the antibiotic regimen because the possibility of an infection could not be ruled out entirely. Dr. Henson explained that steroids suppress inflammation and improve interstitial lung disease but are not ordinarily used to treat infections because they interfere with the inflammatory process the human body uses to fight infections. On the other hand, antibiotics are used to treat infections but do not affect an interstitial lung disease one way or the other. Thus, steroids are prescribed for interstitial lung disease but are not ordinarily prescribed for community-acquired bacterial pneumonia.

Employee's condition began to improve after Dr. Henson administered steroids. Employee's lack of response to antibiotics and his improvement after receiving steroids further supported Dr. Henson's conclusion that Employee was suffering from interstitial lung disease rather than bacterial pneumonia.

Employee also underwent pulmonary function testing while hospitalized to determine whether his illness was due to COPD or interstitial lung disease. This testing showed Employee had restricted breathing capacity and no significant obstructive lung disease, which meant Employee was having difficulty inhaling air into his lungs. As Dr. Henson explained, "[r]estrictive lung disease is when we have more difficulty getting air into our lungs, so we take a breath in and if we just can't fill our lungs up with air, then that's restrictive lung disease." Dr. Henson stated that any condition that causes the lungs to fill with fluid, including an inflammatory process such as interstitial lung disease, will produce a restrictive result on a pulmonary function test.

¹This term refers to the appearance of the CT scan and should not be understood literally as meaning the presence of ground glass in the lungs.

Dr. Henson acknowledged that Employee also suffered from COPD. Unlike restrictive lung disease, COPD impairs a person's ability to exhale air from the lungs. As Dr. Henson explained:

[A]n obstructive lung disease is where we have more difficulty getting air out of our lungs, so a person would take a deep breath in and blow out hard and if it takes him longer than a second or two to get air out of his lungs, then that is airway obstruction.

Employee's April and May 2010 pulmonary function tests revealed a very strong restrictive lung disease, but his COPD—Employee's inability to exhale—was not detected. According to Dr. Henson, these results ruled out COPD as a major factor in Employee's shortness of breath and respiratory failure.

Because Employee's illness responded to steroids, Dr. Henson believed it was not likely to have been caused by an infection. Although Dr. Henson acknowledged that interstitial lung disease has many causes, he testified as follows concerning the causation of Employee's condition:

In my opinion, it is most consistent with the exposure on the roof both because we know that he was exposed at that time to not just chlorine gas or ammonia gas but also to cleaning agents as well as the bird excrement and probably other factors on the roof that we don't know about all at the same time. It seemed that, temporally speaking, shortly after this exposure is when he became acutely ill.

Later in the deposition, Dr. Henson reiterated his opinion that Employee's exposure to a variety of substances caused Employee's condition:

[W]e know that under such exposures you have other symptoms such as burning of your eyes or throat with chlorine gas; however, during [Employee's] exposure, he was also exposed to many other things such as cleaning solution, organic chemicals and bird excrement on top of the roof which I think together with the exposures of chlorine gas and ammonia that we know were being vented from that building, that all of that together produced his symptoms and not just the chlorine gas itself.

So because this is an unusual exposure in that regard, I think this, with the exposures to even levels of chlorine or ammonia that might not alone produce significant pulmonary reaction, can when combined with all these other exposures.

Dr. Henson testified that Employee had been hospitalized with lung problems again in June and November 2011. Dr. Henson attributed these relapses to the cessation of steroids. Dr. Henson testified that these additional hospitalizations support his opinion that Employee has interstitial lung disease because the inflammatory process it causes is known to recur after cessation of steroids, whereas lung infections are not. Dr. Henson explained that Employee's interstitial lung condition is an acute condition that comes and goes. As such, the inflammation may not show up on chest x-rays or CT scans unless Employee is experiencing an acute episode. Dr. Henson also described it as "farfetched" that someone, like Employee, who had been fairly healthy and able to work for many years without significant pulmonary difficulties, would experience three life-threatening illnesses from an infection in a span of a year and a half.

Dr. Henson opined to a reasonable degree of medical certainty that Employee's April 2010 condition more likely than not resulted from interstitial lung disease rather than a bacterial pneumonia. Dr. Henson explained that interstitial lung disease can result from exposure to chlorine and ammonia gases, any kind of pulmonary toxin, such as fire, smoke in fire, acid, or other pulmonary irritants. Dr. Henson opined that the diagnosis of interstitial lung disease was most consistent with Employee's work-related inhalation exposure in April 2010 to chlorine and ammonia gases, cleaning agents, bird excrement, and other unknown factors while working on the roof, resulting in permanent injuries to Employee's lungs. Dr. Henson also found that Employee's exposure to various oils and cleaning agents throughout his employment possibly contributed over time to priming his lungs to becoming more irritated when exposed to the various toxins on the roof. Pursuant to the Sixth Edition of the AMA Guidelines ("AMA Guides"), Dr. Henson assigned Employee a permanent anatomical impairment of 55% to the body as a whole as a result of his April 2010 work accident. This impairment does not include Employee's smoking-related COPD. Dr. Henson recommended that Employee work only where he is not exposed to any kind of environmental toxins, such as chemicals or smoke, and recommended that Employee not work as a mechanic, where he would be exposed to oil, fumes, and organic chemicals. He also recommended that Employee avoid exertion, significant exposure to any pulmonary toxin, of humidity and heat.

During cross-examination, Dr. Henson agreed that Employee had COPD, a condition caused by Employee's more than thirty-year history of smoking and unrelated to his employment. Dr. Henson also agreed that COPD causes an inflammatory process and that steroids are used to treat COPD. Dr. Henson further acknowledged that Employee did not

report to him smelling chlorine or ammonia while working on the roof and did not report watery eyes or nasal irritation. Dr. Henson agreed that he had never been to the roof where Employee worked in April 2010. Dr. Henson was unaware whether ammonia or chlorine were actually vented to the roof where Employee had been working. Dr. Henson agreed that his understanding of the substances to which Employee had been exposed was based on Employee's statements. He also agreed that Employee suffered from both diabetes and anemia, each of which diminishes lung function.

At Employer's request, Dr. Jonas Kalnas, a physician at Vanderbilt University Medical Center who is board certified in occupational and environmental medicine, examined Employee on August 5, 2011. Dr. Kalnas earned his undergraduate degree in chemical engineering, earned a medical degree from Harvard School of Public Health, and later obtained a Master's Degree in Environmental Health Sciences, with majors in industrial hygiene and air pollution control. After receiving this training, Dr. Kalnas spent a year at the Mayo Clinic in Rochester, Minnesota, where he participated in a research fellowship in pulmonary physiology and lung disease. Dr. Kalnas works primarily as a consultant performing "causation analysis." Dr. Kalnas is not a pulmonologist, and he does not treat patients, except to refer them to other practitioners when his evaluations indicate additional treatment may be needed.

Dr. Kalnas reviewed Employee's medical records, examined Employee for three and a half hours on August 5, 2011, and ordered additional testing, including a high resolution CT scan and a pulmonary function test. Dr. Kalnas testified that the CT scan showed no evidence of interstitial lung disease, and the pulmonary function test showed COPD, but no restrictive lung disease, such as interstitial lung disease. Dr. Kalnas opined that Employee's April 2010 lung illness and hospitalization likely resulted from Employee having acquired a respiratory infection from contact with sick friends during the weeks prior to his work on the roof. Dr. Kalnas also opined that Employee's ongoing symptoms, which are consistent with COPD, are likely attributable to "emphysema which is caused by cigarette smoking." Dr. Kalnas further opined that Employee's diabetes and anemia also likely contribute to his small lung volume and decreased diffusing capacity.

In analyzing causation in this case, Dr. Kalnas placed particular emphasis on the information Employee provided. First, Dr. Kalnas noted that Employee reported his symptoms beginning approximately a week before the day he was hospitalized, which Dr. Kalnas believed was before Employee began working on the roof. Dr. Kalnas pointed out that upon arriving at the emergency room, Employee reported having contact with sick friends a few days before the onset of his illness. Dr. Kalnas also emphasized that Employee did not report smelling chlorine or having eye or nasal irritation while working on the roof. Dr. Kalnas opined that chlorine and ammonia exposure would cause eye and nasal irritation

at concentrations much lower than the concentrations necessary to cause harm to the lungs. Based on the foregoing, Dr. Kalnas opined that Employee had suffered a severe episode of mycoplasma pneumonia in April 2010. Dr. Kalnas acknowledged that tests performed during Employee's hospitalization were negative for that disease, but he testified that the antibodies these tests are designed to detect do not develop until two weeks after the onset of the infection. Thus, Dr. Kalnas opined, the tests performed during Employee's hospitalization were premature.

Dr. Kalnas located ten cases in the medical literature in which mycoplasma pneumonia had advanced to acute respiratory distress syndrome, like that Employee developed. Dr. Kalnas agreed, generally, with Dr. Henson that steroids are not ordinarily used to treat infections, but he opined that severe infections sometimes require steroid treatment to calm the body's inflammatory process, as in Employee's case.

Dr. Kalnas emphasized that pulmonary function testing performed in August 2011 showed no evidence of interstitial lung disease, but was consistent with COPD. He also pointed out that, unlike the CT scan obtained during Employee's hospitalization, the 2011 CT scan showed COPD, but no signs of "ground glass opacities," or any other evidence of interstitial lung disease. Dr. Kalnas stated that the inflammatory patterns seen on the 2010 CT scan were likely caused by the mycoplasma pneumonia. Although Dr. Kalnas opined that Employee has a 45% anatomical impairment to the body as a whole, he attributed the entirety of the impairment to Employee's smoking, COPD, diabetes, and anemia, and none to any work-related accident.

During cross-examination, Dr. Kalnas agreed that he does not ordinarily treat patients, that he is not a lung specialist, and that the focus of his practice is consulting to determine the cause of various alleged occupational disorders. Dr. Kalnas also agreed that the record reflects that none of Employee's sick friends were diagnosed with pneumonia and that their respiratory symptoms resolved. Dr. Kalnas further acknowledged that the April 2010 pulmonary function test was positive for restrictive lung disease, but he pointed out that pneumonia, although unrelated to interstitial lung disease, also has the effect of restricting airflow into the lungs. He reiterated that the 2011 CT scan ordered as part of his evaluation showed no scarring of the lungs or interstitial lung disease. Finally, while Dr. Kalnas agreed that exposure to chlorine or ammonia gas in sufficient concentrations can cause interstitial lung disease, he stated that such exposure would first cause eye and nose irritation, neither of which Employee reported experiencing. Dr. Kalnas stated that repeated low-level exposures to chlorine or ammonia were not known to cause chronic interstitial lung disease, although a single, intense exposure might have this effect. Dr. Kalnas reiterated his opinion that a combination of antibiotics and steroids is the most effective treatment for rare cases of severe mycoplasma pneumonia. Dr. Kalnas conceded that Employee had tested negative

for mycoplasma infection during his hospitalization, but he repeated his opinion that the test had been administered too early to detect the mycoplasma antibodies. Dr. Kalnas conceded that mycoplasma infections rarely cause acute respiratory distress syndrome like that Employee suffered. Finally, he opined that chronic interstitial lung disease usually develops over a long period of time rather than as a result of an acute exposure to an airborne toxin.

The trial court ruled from the bench, finding Dr. Henson's deposition testimony on the issue of causation more credible than that of Dr. Kalnas because Dr. Henson was Employee's treating physician. The trial court also felt Dr. Kalnas was more of an advocate than an independent witness. The trial court found that Employee had suffered a compensable injury while washing the roof at ISS and adopted Dr. Henson's anatomical impairment rating of 55% to the body as a whole. The trial court awarded Employee 92.5% permanent partial disability benefits. Employer has appealed, contending that the evidence preponderates against the trial court's finding of causation. In the alternative, Employer argues that the award is excessive and also asks that its liability for future medical expenses be limited to that reasonably necessary to treat the Employee's work-related injury.

Standard of Review

Appellate review of decisions in workers' compensation cases is governed by Tennessee Code Annotated section 50-6-225(e)(2) (2008 & Supp. 2012), which provides that appellate courts must "[r]eview . . . the trial court's findings of fact . . . de novo upon the record of the trial court, accompanied by a presumption of the correctness of the finding, unless the preponderance of the evidence is otherwise." As the Supreme Court has observed many times, reviewing courts must conduct an in-depth examination of the trial court's factual findings and conclusions. *Wilhelm v. Krogers*, 235 S.W.3d 122, 126 (Tenn. 2007). The extent of an injured worker's disability is a question of fact. *Lang v. Nissan North Am.*, 170 S.W.3d 564, 569 (Tenn. 2005). When the trial court has seen and heard the witnesses, considerable deference must be afforded the trial court's factual findings. *Tryon v. Saturn Corp.*, 254 S.W.3d 321, 327 (Tenn. 2008). No similar deference need be afforded the trial court's findings based upon documentary evidence, such as depositions. *Glisson v. Mohon Int'l, Inc./Campbell Ray*, 185 S.W.3d 348, 353 (Tenn. 2006). Similarly, reviewing courts afford no presumption of correctness to a trial court's conclusions of law. *Seiber v. Reeves Logging*, 284 S.W.3d 294, 298 (Tenn. 2009).

Analysis

Causation

“Except in the most obvious, simple and routine cases,” a claimant in a workers’ compensation case must establish a causal relationship between the claimed injury and the employment activity by a preponderance of the expert medical testimony, as supplemented by the lay evidence. *Orman v. Williams Sonoma, Inc.*, 803 S.W.2d 672, 676 (Tenn. 1991). While causation must be proven by medical evidence and cannot be based upon speculative or conjectural proof, absolute certainty is not required. *Clark v. Nashville Mach. Elevator Co.*, 129 S.W.3d 42, 47 (Tenn. 2004); *see also Glisson*, 185 S.W.3d at 354. “Benefits may properly be awarded upon medical testimony that shows the employment ‘could or might have been the cause’ of the employee’s injury when there is lay testimony from which causation reasonably can be inferred.” *Fritts v. Saftey Nat’l Cas. Corp.*, 163 S.W.3d 673, 678 (Tenn. 2005) (quoting *Clark*, 129 S.W.3d at 47). Any reasonable doubt “concerning the cause of the injury should be resolved in favor of the employee.” *Whirlpool Corp. v. Nakhoneinh*, 69 S.W.3d 164, 168 (Tenn. 2002).

Furthermore, the trial court has the discretion to accept the opinion of one medical expert over that of another medical expert. *Cloyd v. Hartco Flooring Co.*, 274 S.W.3d 638, 644 (Tenn. 2008) (quoting *Orman*, 803 S.W.2d at 676). When making this determination, a trial court may consider, among other things, the qualifications of the experts, the circumstances of their examination, the information available to them, and the evaluation of the importance of that information by other experts. *Id.* Where, as here, the medical proof relevant to causation is presented by deposition, a reviewing court may draw its own conclusions about the weight and credibility that should be afforded the evidence. *Glisson*, 185 S.W.3d at 353. Applying these standards we conclude that the evidence does not preponderate against the trial court’s finding that Employee’s April 2010 lung injury was causally related to his work for Employer.

Both experts are well-qualified. Dr. Henson is a board certified pulmonary critical care doctor with thirty years’ experience treating patients. Dr. Kalnas is board certified in occupational and environmental medicine with expertise in determining causation, but he does not treat patients and is not a pulmonologist. Dr. Henson treated Employee during his April 2010 hospitalization and thereafter. In contrast, Dr. Kalnas examined Employee on a single occasion, for three and a half hours, more than a year after Employee’s hospitalization. It is undisputed that a 2010 CT scan ordered during Employee’s hospitalization revealed an inflammatory process in Employee’s lungs that restricted his ability to take in air. Dr. Kalnas explained that this CT scan demonstrated that Employee was suffering from mycoplasma pneumonia, although Dr. Kalnas acknowledged that numerous tests ordered

during Employee's hospitalizations were negative for infections, including mycoplasma pneumonia. Dr. Henson attributed the 2010 CT scan results to Employee's exposure to toxins while cleaning the roof. It is undisputed that exposure to chlorine, ammonia, and other toxins can cause an inflammation of the lungs. The record demonstrates that air from inside the ISS building passed out through a vent on the side of the building near the roof and through open-air vents on the roof. The record also demonstrates that the air vented from the building to which Employee was exposed contained some level of chlorine and ammonia gases, as well as any other chemical or cleaner used inside the ISS building, although the record does not reflect the concentrations of these substances.

Although Employee did not smell chlorine while cleaning the roof, he smelled ammonia, as well as the odor of the unidentified cleaning solution poured on the roof. The record also demonstrates that Employee was exposed to bird droppings, black mold, and unidentified "black stuff" while cleaning the roof and that the power washer actually produced a mist, which soaked Employee's clothing each day as he worked.

Dr. Kalnas testified that Employee was not exposed to sufficient concentrations of ammonia and chlorine gas to injure his lungs. Although Dr. Henson agreed that the concentrations of ammonia and chlorine to which Employee was exposed may not have been sufficient to cause Employee's lung injury, Dr. Henson opined that Employee's combined exposure to the various substances—bird droppings, mold, ammonia, chlorine, the unidentified cleaner, and other substances that may have been present on the roof—was the most likely cause of the lung condition that resulted in Employee's April 2010 hospitalization. Dr. Henson's opinion was based primarily on two facts: (1) all medical tests, including those for infections such as mycoplasma pneumonia, were negative; and (2) Employee's condition did not respond to antibiotics, the normal treatment for infections, but responded favorably to steroids, the typical treatment for inflammatory lung disorders, like interstitial lung disease. In contrast, Dr. Kalnas testified that the test results for mycoplasma pneumonia were negative because the tests were conducted prematurely, and he opined that severe infections respond favorably to a combination of antibiotics and steroids, like those prescribed for Employee.

Dr. Henson pointed out that Employee had worked for years prior to the April 2010 incident without any pulmonary problems and that Employee's symptoms began while he was working on the roof. Dr. Henson noted as well that Employee had been hospitalized for respiratory problems in June and November 2011, when steroid treatment ceased, suggesting that the pulmonary difficulties stemmed from interstitial lung disease, not an infection. In contrast, Dr. Kalnas opined that Employee's recurring pulmonary difficulties were more likely attributable to smoking-related emphysema and COPD. Dr. Kalnas pointed to the 2011 CT scan that showed COPD but did not show interstitial lung disease. Dr. Henson testified

that Employee's interstitial lung condition is an acute condition that comes and goes. As such, the inflammation may not show up on chest x-rays or CT scans unless Employee is experiencing an acute episode.

The medical testimony concerning causation is not overwhelming, but it also is not speculative or conjectural. Causation need not be proven to an absolute certainty. Here, Dr. Henson, Employee's treating physician, opined that Employee's employment was the most likely cause of the injury. Employee testified that his symptoms began shortly after he began working on the roof. Despite Dr. Kalnas's testimony to the contrary, the evidence does not preponderate against the trial court's finding that Employee's lung injury is causally related to his employment.

Disability Award

Employer also contends that the award of 92.5% permanent partial disability to the body as a whole is excessive. In determining an award of vocational disability, a trial court must "consider all pertinent factors, including lay and expert testimony, the employee's age, education, skills and training, local job opportunities, and capacity to work at types of employment available in [Employee's] disabled condition." Tenn. Code Ann. § 50-6-241(d)(2)(A) (2008 & Supp. 2012); *see also Orman*, 803 S.W.2d at 676. The claimant's own assessment of his physical condition and resulting disabilities cannot be disregarded. *Walker v. Saturn Corp.*, 986 S.W.2d 204, 208 (Tenn. 1998). It is not the role of this court "to simply substitute its judgment for that of the trial court in a[ss]essing the employee's vocational disability." *Howell v. Nissan N. Am., Inc.*, 346 S.W.3d 467, 474 (Tenn. 2011). Applying these standards, we conclude that the evidence does not preponderate against the award of 92.5% permanent partial disability.

Employee was forty-seven years old at the time of trial and had lived and worked in Putnam County his entire life. Employee has an eighth grade education. He had twice attempted the GED examination but without success. He has not received any vocational training other than on-the-job training. Employee has previously worked as a farm hand, a dishwasher at Shoney's, an assembly line worker building transmissions, and a general laborer loading and unloading trucks. Employee worked ten years for Employer repairing and building motorcycle transmissions and performing general maintenance work before his April 2010 injury. Employee has not worked at all since that time.

Dr. Henson assessed Employee's anatomical impairment as a result of the April 2010 injury at 55%. Additionally, Dr. Henson imposed permanent restrictions that include avoiding environmental toxins (such as chemicals, smoke, oil, fumes), physical exertion, pulmonary toxins, and heat and humidity. These restrictions essentially prevent Employee

from working at any of the jobs he has previously held. Although Dr. Kalnas attributed Employee's anatomical impairment to non-work-related causes, he expressed reservations about Employee's ability to work with his pulmonary impairment.

Employee testified about the limitations he now experiences as a result of the injury to his lungs, explaining that he cannot overexert himself, must frequently take breaks, quickly runs out of breath when walking, and has difficulty breathing in humid and hot environments. Despite these limitations, Employee candidly admitted that he probably can do some work, although he does not know how to do any job other than those he held prior to the injury. The evidence fully supports and does not preponderate against the trial court's judgment awarding Employee 92.5% permanent partial disability benefits to the body as a whole.

Future Medical Treatment

Employer finally contends that it should only be liable for future medical expenses causally related to Employee's work-related injury and not for future medical expenses related to any and all respiratory illness. Employer also raises its "concern regarding the difficulty of determining what future symptoms will be deemed related" to Employee's work-related respiratory injury. Tennessee law already provides Employer the relief it requests. By statute, employers are only liable for future medical treatment "made reasonably necessary" by work-related injuries. Tenn. Code Ann. § 50-6-204 (a)(1) (2008 & Supp. 2012). Employer's concern regarding the difficulty of determining what medical treatment is made reasonably necessary by the work injury is not ripe for consideration in this appeal. Employer may raise this concern when and if a dispute arises concerning Employee's future medical treatment.

Conclusion

The trial court's judgment awarding Employee 92.5% permanent partial disability to the body as a whole is affirmed in all respects. Costs are taxed to Nesco, Incorporated and Accident Fund Insurance Company of America, and their sureties, for which execution may issue if necessary.

E. RILEY ANDERSON, SPECIAL JUDGE

IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE

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**Chancery Court for Putnam County
No. 2011-34**

No. M2012-02368-WC-R3-WC - FILED JULY 7, 2013

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 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 will be paid by Nesco, Incorporated and Accident Fund Insurance Company of America, and their sureties, for which execution may issue if necessary.

PER CURIAM