THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
May 18, 2015 Session

HAROLD GAMBLE v. MID-STATE INDUSTRIAL SUPPLY, INC.

Appeal from the Chancery Court for Dickson County
No. 2011-CV-80 Robert E. Burch, Circuit Judge sitting as Chancellor

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No. M2014-01043-SC-R3-WC – Mailed August 3, 2015
Filed September 3, 2015

Employee filed this workers' compensation action alleging that he suffered two low back injuries while working as a truck driver for Employer. The trial court held that Employee was not a credible witness and that Employee's alleged workplace injuries did not occur within the course and scope of his employment. Employee has appealed the trial court's decision. Pursuant to Tennessee Supreme Court Rule 51, the appeal has been referred to the Special Workers' Compensation Appeals Panel for hearing and a report of findings of fact and conclusions of law. We affirm the judgment of the trial court.

Tenn. Code Ann. § 50-6-225(e) (2008 & Supp. 2013) Appeal as of Right;
Judgment of the Chancery Court Affirmed

PAUL G. SUMMERS, SR. J., delivered the opinion of the Court, in which CORNELIA A. CLARK, J. and JON KERRY BLACKWOOD, SR. J., joined.

David M. Rich, Nashville, Tennessee, for the appellant, Harold Gamble.

Blakeley D. Matthews and Pele I. Godkin, Nashville, Tennessee, for the appellee, Mid-State Industrial Supply Inc.

OPINION

Factual and Procedural Background

The plaintiff, Harold Gamble ("Employee"), began working for the defendant, Mid-State Industrial Supply Inc. ("Employer") as a fuel truck driver in 2006. He alleged that he suffered two separate low back injuries in 2009. The first injury occurred on April 28, 2009, when a pressurized fuel line that he was working with detached from a fuel truck striking him on the wrist and throwing him to the ground. He was approved for treatment for this claim over several months and was placed on light duty work. The second event occurred on October 2, 2009, when he felt an intense pain in his lower back while shoveling gravel and muck outside his employer's office.

Following the April 28, 2009 injury, Employee sought workers' compensation benefits which were originally provided by the workers' compensation carrier. However, an Employer investigation revealed that Employee failed to disclose his history of significant low back problems in a taped conversation with a workers' compensation claims representative or to his treating physicians. His claim was then denied. Employee did not return to work after the second injury.

Following the denial of his claim, Employee filed a workers' compensation claim in the Chancery Court for Dickson County on February 22, 2011. A bench trial was held on July 11, 2012 before the Honorable Robert E. Burch.

Employee, fifty-eight years old at the time of trial, testified that he "quit" school after eleventh grade but had no trouble reading and writing. He had never attempted to finish school or get his G.E.D. and had worked most of his life driving a semi-truck but had also done various types of construction work. His last job was with Employer, and he was hired as a driver for Employer in 2006 and continued in that position through October 2009.

Employee testified that prior to the April 28, 2009 incident he suffered from "mild back pain that would come and go" as well as "just body pain." He admitted to taking narcotic pain medications prior to the April 2009 incident but denied ever taking them while on the job. Employee testified that as he was unlocking a pressurized diesel fuel line from his truck on April 28, 2009, "it took off." He then "grabbed the back of [the fuel line]" in an attempt to secure it and prevent injury to other employees nearby. When he grabbed the line, it "snatched [him] off the ground," and "the loading head hit the palm of [his] hand and [his] wrist." Following this incident, Employee told his coworkers that he was injured and was advised by these coworkers to report the injury to his supervisor, Ben Head.

After reporting the injury to his supervisor, Employee participated in a conference call with representatives from Employer's workers' compensation insurance carrier. He testified that he described the injuries to both his back and wrist and was sent to an urgent care clinic. The clinic released him back to work with light duty restrictions of no repetitive bending, no stooping or twisting, and no lifting or carrying more than ten pounds. Employee testified that he was routinely assigned work that exceeded his restrictions, including painting fuel tanks and cleaning out "fuel diapers" that were used to catch excess fuel from around the fuel tanks.

Employee testified that on October 2, 2009, although he was still under light duty work restrictions, he was assigned to shovel muck outside Employer's office. He described the material that he was shovelling as weighing fifteen or twenty pounds per shovel load. After working for several hours, Employee "felt [his] back go out," and "just came undone." He described the pain as excruciating and equivalent to the pain "which women describe as having a baby." Eventually, at Employer's insistence, he was taken to the hospital by ambulance, where he was given a shot of morphine for the pain but no other treatment.

Employee testified that following this incident he saw Dr. Stahlman, an orthopedic surgeon, and was subsequently referred to Dr. Clendenin, a physiatrist. He testified that he discussed his prior back problems with Dr. Clendenin. Employee said that Dr. Clendenin eventually told him that he could no longer treat him because "he wasn't a medical doctor to operate on a patient." Dr. Clendenin ordered a Functional Capacity Evaluation ("F.C.E."), but Employee had trouble completing the exam because of his severe pain.

Employee testified that at the time of trial he was still in a lot of pain and that even walking to his mailbox at the end of his driveway caused him significant pain. He testified that he had not applied for any jobs since stopping work with Employer in October 2009 and that he does not feel that he can work anymore.

On cross-examination, Employee admitted that he did not "quit" school in eleventh grade but rather that he was expelled after a physical altercation with his principal. He further admitted to providing an untruthful answer in his discovery deposition regarding past military service. He claimed that he previously stated that he had no prior military service because his service record was "classified" and he "really didn't want to discuss it." However, he admitted to telling other coworkers that he was part of an elite special operations squad in Vietnam.

Employee initially testified that the first time he had any back trouble was after a workplace injury that occurred with a prior employer in early 2006. However, on further

questioning, he admitted that he had been taking narcotic pain medication prescribed by his primary care physician, Dr. Margaret Stolz, beginning in 2005 or earlier. He further admitted to stating in his discovery deposition that he did not have any back problems from the time he began working for Employer in mid-2006 until April 28, 2009. However, he acknowledged that during this time period his medical records indicated that he had multiple appointments with Dr. Coker, an orthopedic surgeon, who was treating him for low back pain. While working for Employer, but prior to the April 2009 incident, Employee underwent a number of diagnostic tests ordered by Dr. Coker, including a myelogram of his back and a CT scan. He was also given a series of spinal injections aimed at relieving his low back pain. When questioned about the discrepancies in his earlier deposition testimony, Employee stated that he "had forgotten about that."

Employee also admitted to treating with Dr. Cochran, a pain management specialist, for low back pain during the time period that he worked for Employer. Dr. Cochran prescribed Lortab, a narcotic pain medication, to Employee to treat his low back pain. Beginning in September 2008, Dr. Cochran increased Employee's dosage of Lortab and instructed him to take the medication four times a day. However, Employee denied following these instructions and maintained that he only took the medication at night and only after he was no longer working.

Employee recalled participating in a recorded phone conversation with a claims representative for the workers' compensation insurance carrier in May 2009. Employee admitted stating during this conversation that he had been treated for low back problems in the past, but at the time of his April 28, 2009 injury, he was not treating with any doctors for back pain. He further stated that the last time he was treated for any kind of back problems was "probably a year or so ago, maybe a little longer." He denied having chronic back pain and stated that before he had this injury "[his] back was doing pretty good." That said, Employee also listed Lortab as one of his regular medications. Employee testified that after his April 28, 2009 injury, in addition to the claims representative, he remembered speaking with doctors from a walk-in clinic, Dr. Stahlman and Dr. Clendenin. When asked if he told every one of these doctors that his back was fine before the April 28, 2009 incident, Employee responded, "Yes, sir. . . . As far as I can remember." Employee explained that he did not tell the claims representative about his treatment with Dr. Cochran because "he's a pain medication doctor." When asked if he had a pending appointment with Dr. Cochran in May 2009 when he gave his statement to the claims representative, Employee stated, "I could have. . . . I don't remember."

On re-direct examination Employee testified that he had completed a Department of Transportation medical examination in November 2008. During this examination, he disclosed that he had a preexisting back problem and also that he was taking Lortab. A copy of the report of this examination was provided to Employer.

Employee's next witness was Gary Gossett, Chief Financial Officer for Employer. Mr. Gossett, who was charged with maintaining Employee's personnel file, identified four notes from that file which documented Employee's visits to an urgent care clinic. The notes dated May 1, 2009, May 5, 2009, and May 14, 2009, all had a check mark in a box entitled "pre-existing condition," however, Mr. Gossett testified that he was unable to read the medical short-hand that identified what Employee told his urgent care physicians was his pre-existing condition. The fourth note, dated May 27, 2009, contained a notation that indicated that Employee suffered from "back pain" from an "injury of '05." Mr. Gossett further testified that Employee's 2008 Department of Transportation medical examination report was part of his personnel file and confirmed that Employee checked a box entitled "chronic low back pain" on this document. Mr. Gossett described Employee as a good worker prior to the April 2009 incident but stated that he sometimes "butted heads" with his supervisor Ben Head.

On cross-examination Mr. Gossett stated that he does not review the Department of Transportation physicals for content but rather simply looks to see whether an employee has passed the physical and can work as a driver. He further testified that even though Employee disclosed some information about his low back problems in this physical, he did not list Dr. Cochran or Dr. Coker as treating physicians, despite the fact that he was in active treatment with these doctors at the time of the physical. Mr. Gossett further testified that he was unaware that Employee had been prescribed Lortab four times a day during the time he was driving for Employer and stated that, had he known, he would not have allowed Employee to work as a driver due to safety concerns. Mr. Gossett confirmed that Employee did not tell him that he had any serious back problems prior to the April 28, 2009 incident. Mr. Gossett denied any assertions that Employer required Employee to exceed his work restrictions when he returned to light duty work following the April 28, 2009 incident. Mr. Gossett testified that Employee stopped coming to work in October 2009, despite being released to return to work without any restrictions, and that Employee was eventually fired due to his failure to show up for work.

Employee presented the deposition testimony of Dr. Melvin Law. Dr. Law is an orthopedic surgeon who examined Employee on March 24, 2010, based on a referral from Dr. Coker. Dr. Law stated that Dr. Coker was formerly a partner in his practice but had retired. Dr. Law reviewed Dr. Coker's records in assessing Employee in order to render a second opinion on whether Employee was a candidate for back surgery. He took a history from Employee, performed a physical evaluation, and ordered diagnostic imaging of Employee's back. Employee told Dr. Law that he had two on-the-job injuries to his back in 2009, and that, as a result, he had been off work since October 2009. Employee reported increased pain with activity as well as a weakness in his right leg. Dr. Law's physical exam revealed tenderness and severe difficulty with Employee's gait, as well as

"some subjective weakness in the right lower extremity." X-rays revealed scoliosis and degenerative changes in Employee's spine. Dr. Law also reviewed a myelogram CT that had been ordered by Dr. Coker, which showed multilevel degenerative changes in Employee's spine and some facet joint arthritic changes. From these imaging studies, Dr. Law also diagnosed Employee with osteoporosis. Dr. Law testified that these findings could lead to Employee's being more susceptible to injuring his lower back than an average person. Dr. Law also testified that an acute injury could cause an onset of pain or an exacerbation of problems in someone with a degenerative spine. Dr. Law concluded, based upon the history Employee provided, that Employee had suffered a work-related injury. Employee had reported to Dr. Law that the pain he experienced after the work-related injury was "disabling"; Dr. Law determined that the pain Employee suffered after the injury was greater than his pre-injury pain. Dr. Law assigned Employee a nineteen percent permanent impairment rating.

On cross-examination, Dr. Law admitted that his only interaction with Employee was on March 24, 2010 and that this visit was solely for purposes of providing a second opinion regarding Employee's surgical prospects. Dr. Law testified that he ultimately recommended a nonsurgical course of treatment for Employee. Dr. Law testified that, putting aside the history provided by Employee, the only clinical findings that the March 24, 2010 visit revealed were that Employee had longstanding degenerative disc disease with no evidence of an acute injury. He further testified that his findings regarding Employee's level of disability were based on Employee's statements about his subjective levels of pain, which Dr. Law accepted as true. Finally, Dr. Law testified that he is not credentialed to perform impairment evaluations under the Medical Impairment Registry ("MIR") program.

Dr. Coker's treatment records were admitted into evidence as an exhibit to Dr. Law's deposition. The records revealed that Employee presented to Dr. Coker on July 26, 2007, complaining of chronic back pain. Dr. Coker ordered X-rays and an MRI, which showed right lumbar scoliosis, facet disc disease, and degenerative disc disease at L5-S1. Dr. Coker ordered further imaging studies and prescribed a course of steroid injections. A treatment note from August 2007 revealed that the steroid injections only provided Employee with temporary relief and that Dr. Coker diagnosed Employee with a multilevel symptomatic degenerative disc problem. Dr. Coker continued to see Employee regularly throughout 2008 and continued to attempt to relieve Employee's low back pain through conservative non-surgical treatments, including steroid injections, physical therapy, and narcotic pain medication. Dr. Coker also ordered a myelogram CT scan in February of 2008 which showed multilevel degenerative disc disease.

A note in Dr. Coker's file from August 20, 2008, documented a phone conversation between a member of Dr. Coker's staff and Employee's son that revealed Employee was receiving narcotic pain medications from his primary care doctor, Dr.

Stolz, as well as from Dr. Coker. Dr. Coker's note further stated that Employee was told that this was a violation of policy and that he would not be given any more narcotic pain medication until the situation was resolved. Dr. Coker then referred Employee to Dr. Cochran for pain management and compliance issues.

When Employee next presented to Dr. Coker in January 2010, Employee rated his pain as 10 out of 10 and described a work-related injury he had suffered while shoveling gravel. Dr. Coker ordered X-rays of Employee's lumbar spine and a thoracic myelogram CT scan. These imaging studies again confirmed that Employee suffered from a multilevel degenerative disc disease but showed no indication of any acute injuries. Based on Employee's complaints of pain, Dr. Coker referred Employee to Dr. Law for a surgical consultation.

Following Dr. Law's deposition being admitted into evidence, Employee rested his case. Employer presented testimony from one live witness, Ben Head, Employee's direct supervisor at the time of Employee's alleged work related injuries. Mr. Head stated that Employee would sometimes tell stories that Mr. Head deemed to be of "questionable" veracity. Mr. Head confirmed that Employee told him that he was part of a Special Forces squadron in Vietnam named the "black widows." Mr. Head denied having any knowledge that Employee was taking narcotic pain medication while working for Employer. Mr. Head stated that he was in charge of finding tasks within Employee's work restrictions following the April 28, 2009 injury. Mr. Head denied ever requiring Employee to exceed his work restrictions. Mr. Head assigned Employee to paint fuel tanks but provided him with an extension device for his paint roller to prevent him from having to bend or stoop. However, Mr. Head observed Employee removing the extension device himself and bending down to paint. Mr. Head also assigned Employee to clean out fuel diapers around the fuel tank but testified that the maximum weight of these diapers when fully soaked with fuel was around two pounds. Finally, Mr. Head admitted assigning Employee to shovel muck outside Employer's office on October 2, 2009, but stated that he first weighed the shovel and a scoop of the grime to ensure that Employee was working within his restrictions. According to Mr. Head, the shovel weighed four pounds and a scoop of the grime weighed approximately three and-a-half pounds.

Employer also presented the deposition testimony of Dr. Clendenin. Dr. Clendenin stated that he specializes in physiatry, which he defined as "nonsurgical treatment of musculoskelatal pain." Dr. Clendenin first saw Employee on August 4, 2009, as a referral from his partner, Dr. Stahlman. Dr. Clendenin testified that when asked to provide a history, Employee related the events surrounding the April 28, 2009 incident and told Dr. Clendenin that he was in severe pain in his lower back, made worse by any activity. Employee admitted to taking Lortab, but he did not disclose the reason he was taking this medication; and Dr. Clendenin did not ask. Employee did not disclose

that he had been in active treatment for degenerative disc disease with Dr. Coker for several years prior to the April 28, 2009 incident and did not disclose that he was treating with Dr. Cochran for pain management at the time of the April 2009 incident. Dr. Clendenin made a notation that Employee's back problems began "in April" and that the portion of Employee's intake questionnaire asking how long he had suffered from these back problems was left blank. Dr. Clendenin testified that getting an accurate history from a patient is key to making an assessment of the patient's condition, as well as to making an effective treatment plan.

Dr. Clendenin's initial physical examination revealed some tenderness over Employee's sacroiliac joint on the right, but no tenderness over the lumbar spine itself. In this initial visit, Employee showed no symptoms of pain magnification and displayed good effort on reflex testing. Dr. Clendenin's initial impression was a sprained right sacroiliac joint, and he recommended light duty work restrictions as well as steroid injections. Employee underwent one steroid injection, but obtained no significant relief. Employee continued to present to Dr. Clendenin with no subjective long term improvement and increased complaints of pain down both legs and in his back. Dr. Clendenin conducted an examination on September 30, 2009, which revealed a normal straight leg raising test and normal strength in both legs. Dr. Clendenin also determined that Employee's back was "painful to superficial touch," a finding that indicated symptom magnification or inconsistency. Following the September 30, 2009 visit, Dr. Clendenin determined that Employee was nearing maximum medical improvement ("MMI") and ordered an F.C.E. to determine Employee's work restrictions going forward.

On October 13, 2009, Employee presented to Dr. Clendenin for an unscheduled visit. Employee claimed that he had injured his back doing some lifting on October 2, 2009, and had been transported to the hospital by ambulance. Dr. Clendenin's physical examination revealed that Employee was amplifying his pain and "was grimacing and moving around like he was in terrible pain and couldn't move." He also had some pain on an axial rotation maneuver intended to test for symptom magnification. Employee requested a second opinion at this visit, and Dr. Clendenin complied by delaying the F.C.E. and sending Employee to see Dr. Klekamp, an orthopedic surgeon. Dr. Clendenin received a report from Dr. Klekamp, which he reviewed as part of Employee's continuing care. Dr. Klekamp opined that Employee was not a candidate for surgical intervention and was "hypersensitive to light touch across the lumbar spine." Dr. Clendenin interpreted these findings as additional signs of possible symptom magnification. Following Dr. Klekamp's report, Dr. Clendenin again ordered that Employee undergo a F.C.E. The F.C.E. revealed a consistency percentage of fifty-five percent, suggesting poor effort. Dr. Clendenin determined that Employee had many subjective complaints but few physical findings. He also had some inconsistencies that were further validated by his F.C.E performance. Dr. Clendenin released Employee to return to work with no restrictions in October 2009, opining that Employee did not have a permanent impairment

and that there was no objective reason that he could not return to work. Dr. Clendenin confirmed that he was certified under the MIR program to perform impairment evaluations.

Employee underwent an independent MIR evaluation by Dr. David West on January 28, 2011. Dr. West's findings were introduced into evidence by Employer. Dr. West determined that Employee suffered from a "lumbar sprain/strain to the low back with preexisting history of degenerative disc and joint disease to the lumbar spine" and assigned Employee a three percent impairment rating to the body as a whole.

Finally, the records of Dr. Cochran were entered into evidence by Employer. These records largely consist of illegible hand-written notes. However, within those notes is a typed letter from Dr. Cochran to Dr. Coker, dated September 2, 2008. In the letter, Dr. Cochran confirmed that Employee was referred to him by Dr. Coker based on medicine compliance issues. Dr. Cochran further confirmed that he was upping Employee's dosage of Lortab to "7.5 QID" (four times per day) based on his subjective complaints of continued back pain.

Following the conclusion of proof on July 11, 2012, the trial court took the case under advisement. On April 30, 2014, the trial judge entered a memorandum opinion finding that Employee had failed to establish that he was injured in the scope of his employment. The trial court found that "[Employee] is not to [be] believed on this oath, and while he undoubtedly has pain in his spine, he is exaggerating the severity and chronology thereof." The trial court determined that there were no physical changes from before and after Employee's alleged injury. Thus, the only way to determine if Employee's pre-existing condition was exacerbated by his job injuries would be to determine if his pain increased. Because Employee was found not to be credible, the trial court found that there was no proof of increased pain.

Employee has appealed, alleging that the trial court erred by finding him not to be credible, and consequently, finding that he did not suffer a compensable injury. Employee also asserts, for the first time on appeal, that Employer is estopped from claiming a lack of knowledge of Employee's preexisting back problems because of his disclosures on the 2008 Department of Transportation physical that was part of Employee's personnel file. Finally, Employee claims that he was prejudiced by the nearly two year delay between the conclusion of trial and the issuance of the trial court's memorandum opinion.

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. 2013), 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). 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

Credibility

Employee first asserts that the trial court erred by finding him not credible and consequently finding that there was no exacerbation of his preexisting back injury. As stated above, we give "considerable deference" to a trial court's findings of credibility and assessment of the weight to be given to live in-court testimony. Tryon, 254 S.W.3d at 327. However, despite a deferential standard of review for live testimony, this Panel must still assess independently where the preponderance of the evidence lies. See Tenn. Code Ann. § 50-6-225(e)(2) (2008 & Supp. 2013); see also Orman v. Williams Sonoma, Inc., 803 S.W.2d 672, 675 (Tenn. 1991).

After independently reviewing the record under the appropriate standards, we conclude that the evidence does not preponderate against the trial court's findings on Employee's credibility. As the trial court pointed out in its memorandum opinion, Employee's testimony is rife with contradictions and inconsistencies. Employee admitted at trial that, as far as he could remember, he told every doctor or claims representative that he talked to in 2009, the year of his alleged injuries, that he had no significant back problems prior to the April 28, 2009 incident. He further admitted to providing similar testimony in his discovery deposition in this case. Contrary to these assertions, the treatment records from Dr. Coker and Dr. Cochran indicate that Employee was undergoing regular treatment for chronic low back problems for several years prior to this alleged injury. Dr. Coker first saw Employee in 2007 and conducted multiple

physical examinations. These included a variety of radiographic imaging studies, steroid injections on Employee's lower back, and narcotic pain medication to alleviate Employee's lower back pain. Dr. Cochran first saw Employee in 2008, the year before the alleged work-related injury, following a referral from Dr. Coker who had discovered that Employee was receiving narcotic pain medication from multiple sources. Dr. Cochran continued providing Employee narcotic pain medication to treat his chronic low back pain through the time of his alleged workplace injury. In September 2008, roughly seven months before Employee's first alleged workplace injury, Dr. Cochran increased Employee's dosage of Lortab and instructed him to take the medication four times a day. The combination of extensive diagnostic testing and continued high dosages of narcotic pain medication that Employee was prescribed in the months and years prior to his alleged workplace injury belie Employee's assertions that his back was in "pretty good" shape and that he had no significant back problems prior to the April 28, 2009 incident.

Additionally, multiple physicians found signs of symptom magnification or malingering. Dr. Clendenin testified that, while Employee originally did not have any indications of symptom magnification, as his treatment continued, Employee became hypersensitive to even a light touch. He also recalled an unscheduled visit shortly after Employee's second alleged injury in October 2009, where Employee clearly displayed amplified pain symptoms and "was grimacing and moving around like he was in terrible pain and couldn't move." Dr. Klekamp, who evaluated Employee at Employee's own request for a second opinion, similarly found that Employee showed signs of symptom magnification. Additionally, Dr. Stahlman's treatment notes indicated some inconsistent findings. Finally, Employee underwent a F.C.E., which revealed poor consistency of effort. Based upon the above evidence, the trial court properly found that Employee was not a credible witness.

Causation

Employee next asserts that the trial court erred in finding that his injury was not suffered in the scope or course of his employment. In order to prove causation, a plaintiff in a workers' compensation case must establish "the causal relationship between the alleged injury and the claimant's employment activity." Excel Polymers, LLC v. Broyles, 302 S.W.3d 268, 274-75 (Tenn. 2009). Proof of causation, in all but the most obvious cases, requires expert medical proof. Cloyd v. Hartco Flooring Co., 274 S.W.3d 638, 643 (Tenn. 2008). Where expert medical testimony is presented by deposition at trial, an appellate court may independently assess where the preponderance of the evidence lies. Thomas v. Aetna Life & Cas. Co., 812 S.W.2d 278, 283 (Tenn. 1991). This does not mean, however, that "the deposition testimony of experts should be read and evaluated in a vacuum." Id. Rather, "[w]hile causation and permanency of an injury must be proved by expert medical testimony, such testimony must be considered in conjunction with the lay testimony of the employee as to how the injury occurred and the

employee's subsequent condition." Id.

After a de novo review of the expert medical testimony in this case, we are unable to determine that the evidence preponderates against the trial court's finding that Employee did not suffer a compensable injury. Consistent with the trial court's findings, we conclude that there is no objective or diagnostic evidence that Employee suffered an acute injury on either April 28, 2009, or October 2, 2009, that aggravated or exacerbated his preexisting degenerative disc disease. Dr. Law, who assigned Employee a nineteen percent permanent impairment rating, testified repeatedly that he was basing his opinion on Employee's subjective complaints of pain and a history of events provided by Employee. Dr. Law confirmed that, after reviewing Dr. Coker's treatment notes, and based upon his own examination of Employee, there was no difference in the physical examination and diagnostic testing done in 2008 and the physical examination and diagnostic testing done in 2010 after Employee's alleged injuries. On both occasions, the testing indicated Employee's longstanding degenerative disc disease. Consequently, Dr. Law could not point out any diagnostic evidence of an acute injury suffered by Employee around the time of his alleged workplace injuries. The only indication of an advancement of Employee's pre-existing condition was Employee's increased complaints of pain.

Despite not having a full and accurate history from Employee, Dr. Clendenin testified that Employee had few objective findings and many subjective findings compounded by a F.C.E. that showed a low consistency of effort. Based on this assessment, Dr. Clendenin assigned Employee no permanent impairment rating and released Employee back to work with no restrictions. Dr. West, the MIR physician, assigned Employee a three percent permanent impairment rating. However, Dr. West noted that this rating was based, in part, on Employee's documented history of non-verifiable radicular complaints.

This expert medical testimony viewed in combination with Employee's non-credible live testimony, supports the trial court's conclusion that Employee did not suffer an injury to his lower back in the course or scope of his employment.

Estoppel and Undue Delay

Having determined that Employee was not a credible witness and did not suffer a compensable work related injury, we briefly address Employee's remaining contentions. Employee asserts that under the doctrine of estoppel, Employer is estopped from claiming a lack of knowledge of Employee's preexisting back problems because Employee disclosed some information about his prior back problems during a 2008 Department of Transportation medical examination, a report of which was provided to Employer. Employee further asserts that under federal transportation law, Employer is precluded from denying a commercial driver compensation for a work injury on the basis that the

injury is due to a preexisting medical condition if that work injury terminates the driver's ability to maintain his or her commercial driver's license and the employer has previously enjoyed the benefits of that commercial licensure. After a thorough review of the record, as well as the trial court's memorandum opinion, we find no reference to federal transportation law or estoppel in the trial court proceedings. As the Tennessee Supreme Court has stated on numerous occasions, "[i]t is axiomatic that parties will not be permitted to raise issues on appeal that they did not first raise in the trial court." Powell v. Cmty. Health Sys., Inc., 312 S.W.3d 496, 511 (Tenn. 2010) (citing Barnes v. Barnes, 193 S.W.3d 495, 501 (Tenn.2006)). Thus, we refrain from addressing these contentions as they have not been properly preserved for review on appeal.

Finally, Employee asserts that he was prejudiced by the delay between the trial in this matter, which occurred and concluded on July 11, 2012, and the filing of the trial court's memorandum opinion on April 30, 2014. Employee asserts that this delay compromised the ability of the trial court to remember the events at trial and led to trial exhibit 9, Dr. Cochran's records, being lost.

The delay in the trial judge's rendering of a decision is not itself grounds for reversal. See Schaeffer v. Richard, 306 S.W.2d 340, 343 (Tenn. 1956) (finding that "if the Legislature had intended for the judgment to be void when rendered by a [t]rial [j]udge more than sixty days after the hearing of the cause without a jury it would have said so in specific words"). Moreover, although Employee alleges prejudice from the loss of a trial exhibit, the record does not support this allegation. First, nothing in the record suggests that the trial court's recollection of the trial proceedings was faulty. Second, as Employer points out, the trial exhibit in question was in fact not lost, but rather was inadvertently made a part of the technical record instead of included with the other trial exhibits. The exhibit was available to the trial judge; and we have examined it in our review of this case, along with the transcript and the entire record. Under all these circumstances, Employee's assertion of prejudice resulting from the delay is wholly without merit.[1]

[1] In so holding we do not approve of the delay that occurred here and remind trial courts of the statutory directive to render decision within sixty days from the completion of the trial. See Tenn. Code Ann. § 20-9-506 (2009). We note that, if a trial court fails to render a decision timely, a party may file a Motion to Render Decision. See Tenn. Sup. Ct. R. 11(III)(c). The record does not reflect the filing of any such motion in this case.

Conclusion

The trial court's judgment is affirmed. Costs of this appeal are taxed against Mr. Gamble, and his surety, for which execution shall issue if necessary.

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PAUL G. SUMMERS, SENIOR JUDGE

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

HAROLD GAMBLE v. MID-STATE INDUSTRIAL SUPPLY, INC.

Chancery Court for Dickson County
No. 2011-CV-80

No. M2014-01043-SC-R3-WC – Filed September 3, 2015

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 Mr. Gamble, and his surety, for which execution may issue if necessary.

PER CURIAM