

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E803951

LARRY DALTON SQUIRES,
EMPLOYEE

CLAIMANT

EXCELSIOR HOTEL,
EMPLOYER

RESPONDENT

TWIN CITY FIRE INS. CO.,
INSURANCE CARRIER

RESPONDENT

OPINION FILED DECEMBER 14, 2004

Upon review before the FULL COMMISSION in Little Rock,
Pulaski County, Arkansas.

Claimant represented by HONORABLE ROBERT R. CORTINEZ, SR.,
Attorney at Law, Little Rock, Arkansas.

Respondents represented by HONORABLE A. GENE WILLIAMS,
Attorney at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Affirmed.

OPINION AND ORDER

The Arkansas Court of Appeals has remanded the
above-styled case to the Full Commission for further
findings of fact. See, Excelsior Hotel v. Squires, CA03-116
(Ark. App. 9-3-2003), 115 S.W.3d 823 (2003). The
respondents appeal an administrative law judge's opinion
filed February 21, 2002. The administrative law judge
found, "The preponderance of the evidence shows that as a
result of his compensable injuries, the claimant has
sustained permanent anatomical impairment of 30% to the body
as a whole, consistent with the opinion of Dr. Griebel, for

which he is entitled to benefits, payable by the respondents." After reviewing the entire record *de novo*, the Full Commission affirms the opinion of the administrative law judge.

I. HISTORY

The parties stipulated that the claimant, age 49, sustained compensable injuries to his ribs and left shoulder on March 25, 1998. Dr. Wendell L. Pahls dictated on March 25, 1998, "Larry is a 42-year-old gentleman that fell about three feet off a ladder and struck his left flank on the edge of a bucket. He complains of severe left rib pain." Dr. Pahls noted "a large abrasion around the sixth or seventh rib on the left. Is exquisitely tender in that region." Dr. Pahls noted that x-rays showed "non-displaced fractures of the sixth and seventh rib with some questionable fracture of the eighth rib as well. No hemo or pneumothorax is appreciated."

Dr. Pahls referred the claimant to Dr. Thomas Hart, who reported on March 30, 1998:

Mr. Squires is a 42 year old male who claims that he has been healthy most of his life. He was working at the Excelsior Hotel he said when he was on a ladder about three to four feet off the ground. He said he had not eaten earlier and when he made a position change he was somewhat light headed and unfortunately fell, landing on a five

gallon bucket on the left side of his body. He had the immediate onset of severe rib pain, chest pain, and lower flank and some minimal back complaint. He immediately had a large ecchymotic area. He was taken to the emergency room at Baptist Medical Center on 3-25-98. At that time he was evaluated by Dr. Pahls. Imaging studies did indicate some fractured ribs. No pneumothorax or hemopneumothorax was identified and he was placed on some po (sic) pain medication. Apparently on his follow up today he is still having some very significant severe pain on the left side of his chest which is now causing some pulmonary complications in that he is having congestion and difficulty breathing because of splinting secondary to severe pain. He is referred today for possible nerve block/injections. Again, he had a very thorough trauma evaluation by Dr. Pahls and there does not appear to be any other significant neurological deficits or traumatic areas other than those described above and his lower back complaint....

Dr. Hart noted on physical examination, "You could hear audible congestion in his lungs." Dr. Hart placed in the claimant "a low thoracic epidural catheter."

The claimant continued to follow up with Dr. Hart, who noted "markedly decreased" pain on April 3, 1998. Dr. Hart also noted that the claimant was "down to 2 cigarettes a day." Dr. Hart noted on April 14, 1998:

His last presentation was a few days ago. As I mentioned before, in short summary, he has multiple broken ribs after a fall on-the-job injury. We had an epidural catheter with a continuous infusion of Fentanyl and Marcaine which significantly reduced his rib pain complaints allowing him deep breathing and pulmonary

functions to reduce any pulmonary compromise, i.e., pneumonia, etc....

As we discussed before, usually rib fractures are most painful over the first two to four weeks. Hopefully we have gotten him over the hump. I think it is appropriate now to go ahead and discontinue the epidural catheter....He is to continue his pulmonary toilet as well as his walking program, and hopefully within a short period of time, may be able to return to his active employment....

The claimant received emergency treatment on April 20, 1998, at which time Dr. Pahls noted, "Examination shows tenderness along the posterior aspect of the chest wall but his bruising and ecchymosis is healing. He still had some inspiratory crackles in his left base and the rest of the examination is unremarkable....I spent quite a bit of time with him this morning discussing his various complaints, most of which revolve around his narcotic withdrawal and nicotine withdrawal. I have suggested that he only withdraw from one agent at a time and have recommended that he continue smoking a few cigarettes a day for the next couple of weeks until he is over the narcotic withdrawal."

Dr. Frank H. Ma reported on April 23, 1998 that a chest x-ray demonstrated "multiple rib fractures and large pleural effusion on the left side without any evidence of pleural effusion."

Dr. Jack A. Griebel, Jr., a pulmonary disease specialist, provided a consultation on April 23, 1998 and reported, "Chest x-ray shows a large pleural effusion filling approximately one-third of the left chest." Dr. Griebel's impression was "Post-trauma with multiple rib fractures. Left-sided pleural effusion, probably secondary to slight hemorrhagic bleeding from rib fractures and now oncotic associated pleural effusion. Dyspnea on exertion, associated with number two." Dr. Griebel planned a "thoracentesis for alleviation of symptoms." The impression from a subsequent radiological examination was "Post-thoracentesis with decreased size of the left pleural effusion. Small left pleural effusion remains with parenchymal change in the left lung base. Differential includes atelectasis or pneumonia. No pneumothorax."

Dr. Pahls reported on April 23, 1998:

His rib fracture has continued to give him trouble, and he still cannot breathe adequately. He states that his breathing seems to be even worse than it was when he was seen in the clinic, and today he simply could not tolerate it any longer so he decided to seek medical attention in the work injury clinic....

Have consulted with Dr. Jack Griebel who is kind enough to see the patient here in the emergency department and perform thoracentesis. A large amount of hemorrhagic effusion was extracted. Arrangements are being made for the patient to be

followed in Dr. Griebel's office for his pulmonary complaints with repeat chest x-ray in about a week....

Dr. Griebel's impression on April 27, 1998 was "Abnormal chest x-ray with persisting left pleural effusion." Dr. Griebel gave the following impression on May 8, 1998:

Trauma, left rib fractures. Hemorrhagic pleural effusion with associated dyspnea, slowly improving following evacuation. As it now seems to be resolving I have recommended not re-invading the space to remove more fluid but to continuing the current regimen and observation. We will plan to see him back in two weeks with follow-up chest x-ray.

The impression from a radiological examination taken May 12, 1998 was "Multiple mildly displaced rib fractures on the left with little interval healing since the prior studies. Persistent moderate left pleural effusion. Little change seen from the study of 04/23/98."

Dr. Griebel wrote on June 5, 1998:

I have been assisting in Mr. Squires' care, along with Dr. Wendell Pahls, since I first evaluated the patient on 4/23/98.

Mr. Squires suffered a fall on 3/25/98, sustaining multiple left rib fractures and he has had problems with recurring left pleural effusions, requiring multiple drainage procedures. This has resulted in extensive musculoskeletal injury and spasm, as well as a great deal of pain in the region, causing extensive disability with dyspnea.

Mr. Squires is slowly improving from this. I think he should be able to try to return to work on June 15, 1998, to limited work duties....

He is also currently being treated for an asthma condition that has resolved from this. However, I think this is currently stable and should allow him to return to work on the above date....

Dr. Griebel's impression on June 30, 1998 was "Hemorrhagic left pleural effusion, improving, now with symptomatic limitation of range of motion and problems with the left shoulder. I think an orthopedic consultation would be appropriate at this time to rule out any secondary injury from the severe fall that he experienced in March." Dr. Earl Peeples subsequently assessed "Shoulder bursitis and left rib fractures with left chest wall contusion." Dr. Peeples began treating the claimant's shoulder.

Dr. Griebel reported the following laboratory and x-ray findings on January 13, 1999:

Pulmonary function testing today reveals a forced vital capacity that is slightly decreased but within normal limits. FEV-1 is mildly decreased at 2.48, 61% of predicted. Airway mechanics show mild obstructive pulmonary physiology.

Dr. Griebel's impression was "Abnormal pulmonary function testing with mild obstructive airway defect." Dr. Griebel's further impression was "Chronic bronchitis. History of cigarette abuse. History of significant trauma

with multiple left rib fractures complicated by hemorrhagic pleural effusion evacuated." Dr. Griebel's treatment plan for the claimant was "continuing intermittent use of Albuterol. I have discussed with him extensively smoking cessation therapy and have recommended him to the smoking cessation clinic at Baptist Medical Center."

Dr. Griebel's impression on May 12, 1999 was "1. Reactive airway disease syndrome, asthma secondary to pulmonary contusion syndrome as suffered from fall with multiple rib fractures on 3/25/98. 2. Acute bronchitis exacerbating number 1 with asthma flair, resolving. 3. Chronic pain/musculoskeletal from scapular and rib fracture injury - chronic."

Dr. Griebel wrote on January 8, 2001:

I have been asked to write a letter summarizing Mr. Larry Squires' health condition and my care of him.

Mr. Squires first began seeing me in consultation from Dr. Wendall Pauls (sic) in April of 1998 when Dr. Pauls had begun following Mr. Squires for a rib fracture and severe injury sustained in a fall at work. The patient was treated over time and noted to develop a left pleural effusion which I was asked to assist in evaluation and this effusion was drained....Since that time, I have followed Mr. Squires for a prolonged period of time. He has continued to manifest significant shortness of breath and had a reactive airway, almost asthma-like, condition since his fall....

Mr. Squires has significant obstructive airway defect abnormalities on his pulmonary function testing as documented on the values of November 18, 1999 with an FEV1 of 2.13, 53% of predicted. He continues to require regular use of inhaled bronchodilator therapy and, I think, has some limitation of his lung capacity secondary to pleural thickening and scarring from the severe rib fractures. How much of Mr. Squires' current lung impairment, reactive airway disease, and chronic obstructive pulmonary disease is secondary to the trauma is unclear. He certainly, however, was relatively asymptomatic from a pulmonary standpoint prior to the injury and has been quite symptomatic since the injury. How long his problem with dyspnea will persist into the future is unclear. It depends on how much of this is chronic obstructive pulmonary disease versus how much is reactive airway disease and the course of reactive airway disease can be quite variable. Certainly, at this point in time, it has been quite some time and he has shown no evidence of reversal at this point. I suspect he will have some problem requiring medication and treatment of this for a prolonged period of time. The patient's FEV1 would suggest marked abnormality at 53% of normal capacity suggesting by AMA criteria permanent impairment of 30% by AMA criteria.

The parties deposed Dr. Griebel on September 18, 2001. Dr. Griebel testified that the purpose of the thoracentesis procedure he had performed was "to remove fluid that has built up between the lung and the chest wall to open that space so that the lung can more fully expand and allow normal respiration." The respondents' attorney examined Dr. Griebel:

Q. What kind of smoking history did he have?

A. I didn't document that in that note, I don't think. The only documentation I have of that is of long-term tobacco user on his initial consultation note of April the 23rd, 1998.

Q. Is smoking a kind of practice that can cause obstructive lung disease?

A. Yes, it is.

Q. Is that something which tends to progress and get worse over time?

A. Very slowly over time....

Q. In the examination part of your January 1999 note it says, "He had mild expiratory wheezes with maximal expiratory effort not at rest." Describe what you're saying to us there.

A. If one were to auscultate him sitting as we are right now with just asking him to take a regular breath in and out, one would not hear wheezes, but if one asked him to take a really deep breath and then to let it out rapidly, one can hear wheezes in that situation.

Q. Are those wheezes a sign of obstructive lung disease?

A. Yes.

Q. The kind of thing you would get from smoking or if you had emphysema?

A. Yes.

Q. Okay. When you treated him earlier for removing the fluid from his lungs, is there any kind of sequela that can come from having fluid in your lungs?

A. He had a - well, he didn't really have fluid in his lung. He had fluid outside of the lung....Whether or not he had fluid in his lung, I

don't truly know. It'd be very difficult to document something as that. He had a - he had such a strong blow at that time to the chest to cause that sort of hemorrhagic - that blood fluid to build up out there that it would certainly be possible to have what we call contused lung, which is basically a very bruised sort of lung. That's not necessarily caused by the fluid. It's concomitant to occur with the fluid....He does have chronic scarring in that lung base now.

Q. On the left side over there. Okay. If you have scarring, would that cause what's known as restrictive lung disease?

A. It could. It doesn't necessarily always cause restrictive lung disease.

Q. Okay. If it caused restrictive lung disease, you would expect to see a decrease in the forced vital capacity on pulmonary functions?

A. Yes. Although there are other things that could cause a decrease to the forced vital capacity too....

Q. I have a January 8, 2001, letter here from you, "To whom it may concern," kind of summarizing your care. I wanted to ask you about the pulmonary function testing from November of '99 which referred to a FEV1 of 2.13 liters....do you have any way of knowing whether that obstruction is due to underlying chronic obstructive pulmonary disease or some kind of reactive process which is going on at the time of the test?

A. It's a isolated event with this test. No, I have no way of knowing which of those two.

Q. Okay. And let me ask you some technical questions about the studies themselves. I understand, at least according to the AMA guidelines, if you're going to do FEV1 testing, there needs to be a standardization or calibration

of the equipment according to a certain standard. Do you know if that equipment had been calibrated?

A. I believe our equipment is calibrated every day.

Q. Do you know what standard they use?

A. No. I'm sorry. I don't have that information.

Q. And I understand that in a pulmonary function test, the patient blows into the device through a tube. Is that right?

A. That is correct.

Q. And to make sure the patient is giving full effort, you want at least three attempts at the test?

A. That is correct.

Q. Okay. And those should be within a few percent of each other as far as the results?

A. That is correct.

Q. Do you know if three attempts were made in the test that you refer to?

A. In the November '99 test, I believe there are three attempts....

Q. Finally, if a person has chronic obstructive pulmonary disease due to smoking, you would expect a measurement of the FEV1 to be rather consistent over time and trail off eventually?

A. Yes.

Q. Okay. If he had a reactive component at the time he was being tested, his FEV1 the following day might be much better or much worse, depending on how he was doing?

A. That's correct....

The claimant's attorney questioned Dr. Griebel:

Q. What was your disability rating based on?

A. Can I go back to my letter?

Q. Yes, sir.

A. Yeah. In my letter of January the 8th of 2001 this year, I based it on his standard FEV1 abnormality and - which at that time, I said was 53 percent capacity. Let's see if I got that. Yeah. That's based on the November 1999 pulmonary function testing....

Q. Now, you did state that the reactive airway disease was secondary to his injury.

A. I think so.

Q. What - why is it difficult to say that all of this condition is related to the injury or 75 percent is related to the injury? Why is it difficult to say that?

A. Because I can't really tell the difference between his chronic obstructive component and his reactive component. I can't tell how much the reactive component is laying on top of the chronic obstructive component.

Q. All right, sir. So we have two factors that are included. Two conditions that are included in the impairment rating. Now, the next question is: Is the chronic obstructive pulmonary disease - and which you gone on to say is secondary to the trauma is unclear - so is - was that secondary to the trauma or what makes it unclear?

A. The part that I mean is unclear is what I was talking about with regards to how much of his current problem is reactive airway disease syndrome and how much is COPD, chronic obstructive

pulmonary disease. The chronic obstructive pulmonary disease is not likely to be due to the trauma. The reactive airway disease component overlying it could well be all due to the trauma.

Q. So is it a fair statement to say that you believe that he has a permanent impairment due to the reactive airway disease that is due to his injury, but you cannot place a percentage on that impairment?

A. That would be correct. That's very difficult for me.

Q. Because it overlays with the chronic obstructive pulmonary disease?

A. That is correct.

Q. So whenever you determined the 30 percent, did you factor in both conditions or just one condition?

A. In my mind, I looked at how much I had to treat Larry over the years for this and then - which I felt like was relatively significant - and then looked at the FEV1 criteria from the AMA guidelines.

Q. All right. So did you treat him more for the reactive airway disease or more for the chronic obstructive pulmonary disease?

A. I felt like I was primarily looking at the reactive airway disease.

Q. Do you believe that the chronic obstructive pulmonary disease was aggravated by this injury that he received?

A. I think that's certainly a possibility.

Q. And if he had no symptoms prior to this injury and had symptoms subsequent to the injury, with

that scenario would you believe that there was an aggravation of this?

A. That would seem a logical conclusion to me.

Q. And would that be your opinion?

A. Yes.

Q. So, Doctor, if there was an aggravation of this pre-existing condition combined with the reactive airway disease that was secondary to the injury, could you now state a permanent impairment rating that's a fixed rating rather than just looking at the reactive airway disease condition?

A. I think - in my mind, I would sort of stick to what I had - and I may be thinking incorrectly on this, but I think I would stick to the rating that I set here on January the 8th with that, in that I feel like that degree of airway obstruction represents the worst his reactive airway disease is at any one time. The worst combined impairment.

Q. Which would be 30 percent?

A. Right.

Q. So are you saying that a 30 percent impairment rating to the body as a whole is a result of the injury he sustained while working for Excelsior?

MR. WILLIAMS: Object to form.

Q. Just go ahead and answer.

A. I guess. Yes. Yes.

A pre-hearing order was filed on November 5, 2001. The claimant contended that, as a result of his compensable injuries, he had sustained "permanent anatomical impairment

to his lung," which Dr. Griebel had properly rated as 30%. The respondents contended that the claimant's pulmonary condition was not a proper basis for an award of anatomical impairment pursuant to Act 796 of 1993. The respondents contended that the pulmonary impairment was "related to the claimant's pre-existing chronic obstructive pulmonary disease and intermittent flare-ups of asthma, and was not caused by the claimant's compensable injuries to his ribs and left shoulder." The respondents further contended that the condition of the claimant's lungs could not be "the basis of a compensable anatomical impairment, pursuant to the 4th Edition of the AMA Guides, as required by the Act."

The parties agreed to litigate the issue, "anatomical impairment rating."

The administrative law judge filed an opinion on February 21, 2002. The ALJ found, "The preponderance of the evidence shows that as a result of his compensable injuries, the claimant has sustained permanent anatomical impairment of 30% to the body as a whole, consistent with the opinion of Dr. Griebel, for which he is entitled to benefits, payable by the respondents."

The respondents appealed to the Full Commission. In an opinion filed December 10, 2002, the Full Commission

affirmed and adopted the administrative law judge's decision. The respondents appealed to the Arkansas Court of Appeals, which has reversed and remanded to the Full Commission.

II. ADJUDICATION

An injured worker must prove by a preponderance of the evidence that he is entitled to an award for a permanent physical impairment. Weber v. Best Western of Arkadelphia, Workers' Compensation Commission F100472 (Nov. 20, 2003). Ark. Code Ann. §11-9-102(4)(F)(ii)(a) provides, "Permanent benefits shall be awarded only upon a determination that the compensable injury was the major cause of the disability or impairment." "Major cause" means "more than fifty percent (50%) of the cause," and a finding of major cause "shall be established according to the preponderance of the evidence." Ark. Code Ann. §11-9-102(14). Any determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings. Ark. Code Ann. §11-9-704(c)(1)(B). "Objective findings" are those findings which cannot come under the voluntary control of the patient. Ark. Code Ann. §11-9-102(16)(A)(i).

Ark. Code Ann. §11-9-522(g) directed the Commission to adopt an impairment rating guide to be used in assessing anatomical impairment. The Commission therefore established Rule 34, which adopted the Guides to the Evaluation of Permanent Impairment (4th ed. 1993) published by the American Medical Association. To the extent that the Guides allow subjective criteria for establishing an impairment rating, the Guides must yield to the statutory definition of anatomical impairment as defined by the Arkansas General Assembly. Rizzi v. Sam's Wholesale Club, Workers' Compensation Commission E515370 & E112991 (April 1, 1999).

As we understand the Court of Appeals' opinion, it has remanded for further findings of fact on the following issues: (1) Whether the claimant sustained a compensable lung injury; (2) Whether the compensable injury the major cause of the claimant's impairment; (3) Whether the assessment of 30% impairment conformed with the *Guides*; and (4) Whether the impairment was based on objective findings.

(1) Whether the claimant sustained a compensable lung injury.

Based on our *de novo* review of the entire record, the preponderance of evidence shows that the claimant sustained a compensable lung injury. The parties stipulated that the

claimant sustained a compensable injury to his ribs in March 1998. Dr. Pahls reported that the claimant fell off a ladder, and that the claimant complained of severe left rib pain. X-rays showed non-displaced fractures of the sixth, seventh, and possibly the eighth rib. Only five days after the compensable injury, on March 30, 1998, Dr. Hart reported "pulmonary complications." By April 1998, Dr. Griebel reported "a large pleural effusion filling approximately one-third of the left chest." Dorland's Illustrated Medical Dictionary, 28th Ed., generally defines "effusion" as "escape of fluid into part or tissue." The earliest impression of Dr. Griebel, a pulmonary disease specialist, was "Left-sided pleural effusion, probably secondary to slight hemorrhagic bleeding from rib fractures and now oncotic associated pleural effusion."

Dr. Griebel's impression in May 1998 was "Hemorrhagic pleural effusion with associated dyspnea, slowly improving following evacuation. As it now seems to be resolving I have recommended not re-invading the space to remove more fluid but to continuing the current regimen and observation." Dr. Griebel's subsequent impression in May 1998 was "Persistent moderate left pleural effusion." Dr. Griebel's impression in June 1998 was still "hemorrhagic

left pleural effusion." Dr. Griebel's impression in May 1999 was "reactive airway disease syndrome, asthma secondary to pulmonary contusion syndrome as suffered from fall with multiple rib fractures on 3/25/98."

The preponderance of evidence in this matter manifestly indicates that the claimant sustained a compensable lung injury as a result of the compensable injury occurring March 25, 1998. The evidence does not show that the claimant's post-injury hemorrhagic effusion in his left lung was the result of cigarette smoking, asthma, or any other non-work related condition.

(2) Whether the claimant's compensable injury was the major cause of the anatomical impairment.

The preponderance of evidence shows that the compensable injury was the major cause of the claimant's anatomical impairment. Based on the record before us in the instant matter, any implication that cigarette smoking is the major cause of the claimant's impairment is based on conjecture and speculation. Conjecture and speculation cannot be permitted to supply the place of proof. Dena Construction Co. v. Herndon, 264 Ark. 791, 575 S.W.2d 155 (1979). The Full Commission recognizes that there are some references to nicotine use on the claimant's part, but the

claimant never required any treatment of record for his left lung until after the March 1998 compensable injury. Nor do the findings and testimony of Dr. Griebel indicate that the impairment rating was based on cigarette smoking. Based on the record before us, the Commission can find no other cause for the claimant's anatomical impairment other than the compensable injury.

(3) Whether the assessment of 30% impairment conformed with the *Guides*.

Chapter 5 of the Guides to the Evaluation of Permanent Impairment, 4th Edition, deals with "The Respiratory System." Section 5.1 of Chapter 5 states:

Assessment of the respiratory system should begin with the patient's description of the specific complaints related to respiration. Then a review should follow of personal habits and workplace exposures to potentially toxic substances that might explain or contribute to the existence of the symptoms. During the physical examination, the physician evaluates structural or movement abnormalities of the chest and its contents. Radiologic techniques provide visual evidence of internal anatomic abnormalities that are not apparent by external inspection of the chest wall or auditory assessment of the lungs, heart, and pleural space. While each of the techniques mentioned above provides a certain amount of information about the severity of any respiratory abnormality, their main objectives are diagnostic and qualitative rather than quantitative. Pulmonary function testing, on the other hand, provides an objective assessment of the severity of respiratory abnormality but only a small amount

of diagnostic information. The appropriate techniques are discussed below, the major emphasis being on the quantitation of abnormalities in terms of pulmonary function testing.

In the present matter, the preponderance of evidence demonstrates that Dr. Griebel's assessment of anatomical impairment complied with the provisions found in the Guides. In January 1999, Dr. Griebel described abnormal pulmonary function testing. Dr. Griebel implicitly assigned a Class 2 impairment, pursuant to Table 8, p. 5/162, Classes of Respiratory Impairment. Dr. Griebel noted a history of cigarette abuse, but he also noted the trauma to the claimant's ribs and ensuing "hemorrhagic pleural effusion."

In January 2001, Dr. Griebel wrote, "Mr. Squires has significant obstructive airway defect abnormalities on his pulmonary function testing as documented on the values of November 18, 1999 with an FEV1 of 2.13, 53% of predicted. He continues to require regular use of inhaled bronchodilator therapy and, I think, has some limitation of his lung capacity secondary to pleural thickening and scarring from the severe rib fractures....The patient's FEV1 would suggest marked abnormality at 53% of normal capacity suggesting by AMA criteria permanent impairment of 30% by AMA criteria." Dr. Griebel's assessment of 30% permanent

impairment can be found in Table 8, Class 3, p. 5/162 of the Guides.

Based on our review of the record, the Full Commission finds that Dr. Griebel's assessment of 30% anatomical impairment conformed with the provisions of the Guides to the Evaluation of Permanent Impairment.

(4) Whether the claimant's anatomical impairment was based on objective findings.

Finally, the Full Commission finds that Dr. Griebel's assessment of 30% anatomical impairment was based on objective findings resulting from the pulmonary function testing performed on the claimant. The record does not show that these findings were in any way "within the claimant's voluntary control." The Court of Appeals in the instant matter cites Emerson Elec. v. Gaston, 75 Ark. App. 232, 58 S.W.3d 848 (2001). In Gaston, the Court affirmed the Commission's award of anatomical impairment for a respiratory condition. That case discussed whether "pulmonary function testing" used in assessing impairment was within the claimant's voluntary control. The Commission and Court concluded that the testing was objective and not within the claimant's control. In the present matter, the record similarly shows that the claimant was not able to

manipulate his breathing, during the pulmonary function testing administered by Dr. Griebel, in order to achieve a certain level of impairment. The record shows that the anatomical impairment of the claimant assessed by Dr. Griebel was based on objective and measurable physical findings, pursuant to Ark. Code Ann. §11-9-704(c)(1)(B).

Based on our *de novo* review of the entire record, the Full Commission affirms the administrative law judge's finding that the claimant sustained a compensable anatomical impairment in the amount of 30%. The Full Commission finds that the claimant sustained a compensable lung injury as a result of his March 25, 1998 compensable injuries. We find that the compensable injury was the major cause of the claimant's anatomical impairment, that Dr. Griebel's assessment of 30% impairment conformed with the provisions of the Guides to the Evaluation of Permanent Impairment, 4th Ed., and that the claimant's anatomical impairment was based on objective and measurable physical findings. The claimant's attorney is entitled to a fee for legal services pursuant to Ark. Code Ann. §11-9-715(Repl. 1996). For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to an additional fee of two-hundred

fifty dollars (\$250). See, Ark. Code Ann. §11-9-715(b) (2) (Repl. 1996).

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I respectfully dissent from the majority opinion finding that the claimant was entitled to permanent impairment in the amount of 30% to the body as a whole. In my opinion, the claimant has failed to prove by a preponderance of the evidence that he sustained an injury to his lungs as a result of his compensable injury.

In my opinion, the record is void of any evidence demonstrating that the claimant's COPD is due to his rib fractures. The claimant, a lifelong smoker, has been diagnosed with mild chronic obstructive pulmonary disease, COPD, and RADS. Dr. Griebel testified COPD can be caused by smoking, and is progressive over time.

Dr. Griebel apparently made the diagnosis of COPD solely on the basis of mild expiratory wheezes, which he

first noted on January 19, 1999. However, wheezes are also a characteristic of cigarette-induced bronchitis.

Symptomatic triggers of wheezing, such as exposures to allergens, chemicals, cigarette smoke, and strong odors, and seasonal occurrence of distress are highly suggestive of asthma. Wheezing that following (sic) several minutes of exercise indicates a diagnosis of exercise-induced asthma, while wheezing that usually accompanies respiratory tract infections is classified as asthmatic bronchitis.

The most common cause of self-inflicted respiratory impairment is cigarette smoking. . . . The examining physician should standardize data collection regarding dose by inquiring about the age when the patient started smoking, age at quitting or current age if the smoking continues, and the average number of packs smoked per day. . . . Cigarette smoking is the most significant causative factor in the development of chronic bronchitis, emphysema, and lung cancer.

Guides, at p. 154-155.

Despite his acknowledgment that cigarette smoking is a known cause of COPD, Dr. Griebel never obtained a detailed history of the claimant's tobacco use as required by the Guides. Dr. Griebel failed to explore why the claimant first exhibited respiratory wheezes over six months after he returned to work, when two prior examinations had shown no wheezes. The Guides indicate that the wheezing when the

claimant was diagnosed with bronchitis was more likely than not due to the cigarette smoking.

Dr. Griebel did not attribute the COPD to the claimant's work injuries.

Q. Are you saying that [COPD] has any connection or any cause from the rib fractures this man got in 1998?

A. I don't know.

Q. Okay.

A. He has obstructive physiology now. Whether he had that prior to the rib fractures or not, I don't know.

A. ...The chronic obstructive pulmonary disease is not likely to be due to the trauma.

Dr. Griebel could only speculate about a causal connection of RADS to the injury. Dr. Griebel believed the claimant developed RADS, an asthma-like condition, as a consequence of a lung contusion, but could not confirm a contusion actually occurred or explain how a contusion would cause RADS.

Q. ...What would be the mechanism for this type of syndrome with a person who has had pleural effusion?

A. The pleural effusion, I don't know a particular reason why it would be associated with reactive airway disease syndrome. I think reactive airway disease syndrome could

be generated from a pulmonary contusion, a blow to the lung that was occurring at the time of the trauma.

Q. Okay. Any way to determine whether or not he, in fact had a pulmonary contusion?

A. No. The pleural fluid would have been hiding it at the time.

Q. Well, once the pleural fluid is gone and the contusion clears up, what would cause the lung airways to respond in a reactive fashion?

A. Processes can be started that cause inflammation to generate and cause an asthma-like condition to be set off. I don't think anybody really knows the exact answer to your question as far as mechanistically. Other non-specific things can do that also. Sometimes people can have reactive airway disease syndrome after a viral infection. The most common thing is a noxious gas inhalant irritant.

Dr. Griebel never ruled out "other non-specific things" causing inflammation as potential causes of RADS in the claimant.

Dr. Griebel repeatedly noted that he did not know whether the RADS was permanent. On March 22, 1999, he wrote:

In some patients this can improve to the point where they do not need the medications in as short a period of six months to one year. Reactive airway disease syndrome has been reported to go on in many patients for periods lasting five to ten years, however.

On September 3, 2000, Dr. Griebel again wrote, "How long this will continue into the future is unknown." On January 8, 2001, Dr. Griebel wrote:

How long his problem with dyspnea will persist into the future is unclear. It depends on how much of this is chronic obstructive pulmonary disease versus how much is reactive airway disease and the course of reactive airway disease can be quite variable.

It is inconsistent for Dr. Griebel to issue a permanent impairment rating for a condition which he has repeatedly admitted may not be permanent. The Guides require a rating report to include an explanation for concluding that a pulmonary condition "is stable and unlikely to change." Dr. Griebel was unable to conclude that the claimant's condition was stable.

Dr. Griebel also never determined the frequency of attacks. Dr. Griebel issued an opinion that pulmonary function tests showed a permanent obstructive defect; however, he conceded that limitations from RADS are episodic.

Q. But a person with a reactive or intermittent obstruction could function perfectly normal in between attacks then?

A. Yes.

Q. And the real limiting factor would be how often the attacks occurred and how severe they were?

A. Yes, with one caveat and to my knowledge - I don't have documentation of this, but someone with reactive disease or asthma, in general, could be limited to the environments they could work in because of something irritating it and triggering a reaction.

Dr. Griebel went on to state:

Q. I am looking at my November [1999] note, and in here I mention that the patient has intermittent good and bad times since his last visit. But I have not documented any number - certain number of events. . . .

Q. Okay. It looks like he next saw you in August of 2000. Do you have any kind of information to show how many times he would have had a reactive attack between November of 1999 and August 2000?

A. I don't have a specific number set there.

A. He was still noticing some mild limitation with shortness of breath with exertion [in February 2001]. He was still continuing to use - required to continue to use his inhalers.

Q. Did he tell you how often he was using those?

A. I have not documented that.

Q. Okay. Did he tell you how often or if he had additional attacks of shortness of breath?

A. I have not documented it. . . .

Dr. Griebel nonetheless assigned a rating purportedly based on the Guides. However, in my opinion, this rating does not comply with the Guides, which state:

Asthma presents a difficult problem in impairment evaluation because results of pulmonary function studies may be normal or near normal between attacks. Despite the intermittent nature of the disease, severe impairment may be diagnosed when the individual is receiving optimum medical therapy and has physiologic test results in the severely impaired range on three successive tests performed at least one week apart. The frequency of attacks also should be taken in consideration when deciding on the level of impairment.

As the Guides further explain, an asthmatic condition may limit an individual only from a particular occupational setting and "does not necessarily indicate that the individual has permanent pulmonary impairment in occupational settings other than those causing the abnormality."

The essential data needed for a determination of permanent impairment due to RADS is suspiciously missing from Dr. Griebel's records and his testimony. Nearly three years after the event which he believed gave rise to the

condition, Dr. Griebel did not know whether the condition might further improve. He never documented the frequency and severity of attacks, performed no analysis of the "impact of medical condition on life activities", and did not perform testing "on three successive tests... at least one week apart." The test results showed only a mild defect, not "the severely impaired range" required by the Guides.

The pulmonary functions do not comply with the Guides. Dr. Griebel offered a rating based on tests done on a single occasion and which are typically used to measure limitation due to obstructive lung disease rather than reactive lung disease. The Guides describe requirements for valid pulmonary function testing:

The testing and spirometry must be performed on standardized equipment calibrated according to, and using techniques described in, the 1987 ATS Statement on Standardization of Spirometry.

Measurements are made from at least three acceptable spirometric tracings of forced expiration: forced vital capacity (FVC), forced expiratory volume in the first second (FEV), and the ratio of these measurements (FEV/FVC). The maneuvers should be performed at least three times, and results of the two best FVC efforts should be within 5% of each other. The tracing with the highest FVC and the tracing with the highest FEV should be used to calculate the FEV/FVC

ratio, even if these measurements occur on different expiratory efforts.

If wheezing is heard on chest examination... spirometry should be repeated after the administration of an inhaled bronchodilator. The spirogram indicating the best effort, either before or after administration of the bronchodilator, should be used to determine FVC and FEV and the presence of permanent impairment.

There are no spirometric tracings from the November 1999 pulmonary function tests on which the rating is based, only an interpretation of the January 13, 1999, tests stating, "abnormal pulmonary function testing with mild obstructive airway defect." There is no documentation in the record to establish either the January or November tests were repeated after the use of a bronchodilator. The record also lacks the requisite documentation of the calibration standard for the equipment, although Dr. Griebel "believed" it was calibrated by some unspecified method.

Dr. Griebel also did not know whether RADS was the major cause of the limitations purportedly shown by the pulmonary tests. Nor did Dr. Griebel know if the tests showed obstruction due to underlying COPD or some kind of reactive process.

A. It's a isolated event with this test. No, I have no way of knowing which of those two.

Q. ... In other words, you observed he has some limitations now, but you can't tell where those came from?

A. That's correct.

A. Because I can't really tell the difference between his chronic obstruction component and his reactive component. I can't tell how much the reactive component is lying on top of the chronic obstructive component.

Q. So it's a fair statement to say that you believe he has a permanent impairment due to the reactive airway disease that is due to his injury, but you cannot place a percentage on this impairment?

A. That would be correct. That's very difficult for me.

Q. And in this case, you can't tell whether that decrease is due to the reactive disease or some unrelated chronic obstructive disease?

A. That is correct.

Dr. Griebel's inability to differentiate between the claimant's COPD and RADS is, in my opinion, fatal to the claim. Especially since Dr. Griebel conceded it was unlikely that the COPD was due to the accident. Even if the frequency

and severity of the attacks had been documented, that information would not constitute objective findings for purposes of an impairment rating. Before an impairment rating can be assigned for a pulmonary condition, the Guides require clear documentation of the nature of the pulmonary condition and stringent pulmonary testing procedures. The reasons are obvious:

Dyspnea is the most common presenting symptom in patients with any type of pulmonary impairment. Its importance is matched only by its nonspecificity and resistance to quantification. Dyspnea can be caused by diseases of cardiac, hematologic, metabolic or neurologic origin; anxiety can also play a major role in its genesis.

In this case, the claimant has a years-long history of cigarette use, and diagnoses of COPD, bronchitis, and RADS. The wheezing which lead to the pulmonary function tests was only diagnosed in January, 1999, when the claimant was first diagnosed with bronchitis, which was six months after the claimant's injury. As the Guides note, "cigarette smoking is the most significant causative factor in the development of chronic bronchitis, emphysema, ... The claimant's doctor admitted he did not know if the asthmatic condition was permanent, never documented the frequency of

attacks of shortness of breath, and admitted he did not know the source of the impairment. In my opinion, the claimant has not met his burden of proof.

Therefore, for all the reasons set forth herein, I must respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, Commissioner