

2024 IL App (5th) 220606WC-U
No. 5-22-0606WC
Order filed June 7, 2024

NOTICE: This order was filed under Supreme Court Rule 23(b) and is not precedent except in the limited circumstances allowed under Rule 23(e)(1).

IN THE
APPELLATE COURT OF ILLINOIS
FIFTH DISTRICT
WORKERS' COMPENSATION COMMISSION DIVISION

AMEREN ILLINOIS,)	Appeal from the Circuit Court
)	of St. Clair County.
Appellant,)	
)	
v.)	No. 22MR80
)	
THE ILLINOIS)	
WORKERS' COMPENSATION)	Honorable
COMMISSION <i>et al.</i>)	Julie K. Katz,
(Ricky A. Duncan, Appellee).)	Judge Presiding.

JUSTICE CAVANAGH delivered the judgment of the court.
Presiding Justice Holdridge and Justices Hoffman, Mullen, and Barberis concurred in the judgment.

ORDER

¶ 1 *Held:* The Illinois Workers' Compensation Commission's original decision was not against the manifest weight of the evidence when it found that the employee had failed to carry his burden of proving irritant-induced bronchial reactivity or a permanent exacerbation of preexisting asthma from his exposures to chemical fumes in the workplace.

¶ 2 Petitioner, Ricky A. Duncan, sought workers' compensation benefits from respondent, Ameren Illinois (Ameren), for an alleged permanent and irreversible condition of irritant-induced bronchial reactivity. Duncan claimed that he contracted this condition by inhaling

chemical fumes on September 4, 2013, and October 8, 2014, while he was on duty as a gas journeyman. Arbitrator Edward Lee found that although the two exposures had temporarily exacerbated Duncan’s preexisting asthma, Duncan had failed to prove any permanent ill effects from the two exposures. (Ameren already had paid for medical treatment and other workers’ compensation benefits for the temporary exacerbations.) As the arbitrator put it, Duncan had “fail[ed] to meet his burden of proof as to any indication of permanent aggravation or permanent partial disability relating thereto in terms of the underlying asthma—rather, that any perceived progression of symptoms would be compatible with his ten plus year history of symptoms compatible with asthma.” Thus, the arbitrator denied Duncan’s claim for permanent total disability benefits, additional temporary total disability benefits, and additional medical benefits. On June 26, 2019, the Illinois Workers’ Compensation Commission (Commission) adopted the arbitrator’s decision.

¶ 3 Duncan appealed to the St. Clair County circuit court. On October 8, 2020, concluding that the Commission’s decision was against the manifest weight of the evidence, the court set aside the decision and remanded the case to the Commission.

¶ 4 On April 12, 2022, on remand, the Commission issued a new decision, this one in Duncan’s favor, awarding him medical payments, temporary total disability benefits, and permanent and total disability benefits.

¶ 5 On September 13, 2022, the circuit court confirmed the Commission’s remand decision.

¶ 6 Ameren now appeals the circuit court’s interlocutory order of October 8, 2020, and final judgment of September 13, 2022.

¶ 7 Because we are unconvinced that the Commission’s original decision (issued on June 26, 2019) was against the manifest weight of the evidence, we reverse the circuit court’s orders of October 8, 2020, and September 13, 2022, vacate the decision the Commission issued on remand (on April 12, 2022), and reinstate the Commission’s original decision.

¶ 8 I. BACKGROUND

¶ 9 Duncan worked for Ameren as a gas journeyman lead man. His job was to repair and replace natural gas lines. It was heavy outdoor work in which he frequently was exposed to heat, cold, fumes, gases, and solvents.

¶ 10 On September 4, 2013, Duncan and a coworker, Al Hoernis, went to a job site to check on a gas line because Ameren wanted to install a utility pole nearby. He and Hoernis dug a ditch, and about three feet down, they came upon a four-inch cast-iron line, which was marked as a gas line. Their task was to determine whether the line was alive or dead, that is, whether it still contained gas. To do so, they had to rupture the line and see if gas came out. Duncan went down into the ditch and sawed into the cast iron with a hacksaw. What looked like water spouted out, causing him and Hoernis to wonder if, instead of a gas line, it was a water line. The liquid running out of the line turned red and foamy as it pooled in the bottom of the ditch. From his experience as a gas journeyman, Duncan knew that gas lines, especially old ones, commonly were cleaned with benzene.

¶ 11 Duncan went to the truck and radioed one of his supervisors, reporting what he and Hoernis had found. Duncan also told his supervisor that he, “had a tight chest”; that he was having difficulty breathing; and that there was a rusty taste in his mouth. He had been exposed to the liquid in the ditch for about 20 minutes. Hoernis, who had gone down into the ditch and collected a sample of the liquid, likewise had a rusty taste in his mouth. A supervisor came to the

job site, and Duncan described his symptoms to him. The supervisor took Duncan to the hospital.

¶ 12 Duncan arrived at St. Elizabeth's Hospital in Belleville, Illinois, at 11:38 a.m. on September 4, 2013. He reported to the medical personnel that after inhaling an unknown toxic gas, he began coughing and having chest pain and shortness of breath. He mentioned he had "worked in the gas utility field for 20+ years" (to quote from the emergency-room report). A pulse oximetry test revealed that his oxygen saturation levels were between 97% and 100%, a normal reading. Nevertheless, the partial pressure of oxygen in his arterial blood gas was 71 millimeters of mercury (mm Hg), which was low, the normal range being 75 to 100 mm Hg. This result of 71 mm Hg was in line, however, with a result of 68 mm Hg obtained 14 years earlier, on July 28, 1999, when Duncan went to a pulmonologist, Dr. David S. West, because of "shortness of breath on exertion."

¶ 13 At the time of this visit to the emergency room of St. Elizabeth's Hospital on September 4, 2013, Duncan's breath sounds were clear in both the right and left lungs, and his respiratory pattern was regular, although Duncan complained of dyspnea (shortness of breath) on exertion. He was diagnosed with a "respiratory problem" as the primary impression and bronchitis and chemical exposure as additional impressions. At 4:56 p.m. on September 4, 2013, when he was discharged from the hospital, his condition was "improved and stable." Dr. Hayden Smith prescribed albuterol, methylprednisolone, and azithromycin; told him to follow up with his personal physician in three days; and released him to light duty.

¶ 14 Duncan testified he was taken off work for two days after the initial exposure but that he then returned to field work as a gas journeyman and continued full-time for nine months, until May 12, 2014. He testified, however, that his supervisor accommodated him by not assigning him to gas leaks. Whenever a gas leak had to be repaired, Duncan waited in the truck.

¶ 15 On September 9, 2013, as Dr. Smith had directed, Duncan followed up with Dr. Adele Roth of Illini Family Medicine, who had been his primary physician since 1999. He complained to her of having, for the past five days, a persistent cough. In her physical examination of Duncan, Dr. Roth found that he had a “normal respiratory rate and pattern with no distress” but that he had “diffuse inspiratory wheezes” and “diffuse expiratory wheezes” (“diffuse” in the sense that the airway obstruction did not sound localized). She diagnosed “acute bronchitis” and told him to continue using an albuterol inhaler, which she first prescribed for him in 2002.

¶ 16 On September 19, 2013, Duncan returned to Dr. Roth. He still complained of a cough. In addition, he complained of congestion and tightness in his chest and pain and pressure in his sinuses. Dr. Roth wrote, “His primary symptoms include cough, ear complaints, facial pressure, fever, headache, nasal congestion, and rhinorr[h]ea” (a runny nose). She noted that Duncan had a history of “allergies and frequent sinusitis.” The respiratory examination that day revealed a “normal respiratory rate and pattern with no distress” and “normal breath sounds with no rales, rhonchi, wheezes[,] or rubs.” Dr. Roth diagnosed acute sinusitis and instructed Duncan to “continue [his] inhaler on a regular basis.” Also, she referred him to a pulmonologist, Dr. Peter Tuteur, at Washington University.

¶ 17 Duncan first saw Dr. Tuteur on November 6, 2013. He recounted to Dr. Tuteur that after inhaling the fumes from the reddish foam in the ditch, he experienced a tightness in his chest, breathlessness, coughing, and a “ ‘rusty sewer fluid’ ” taste in his mouth, to quote from the report that Dr. Tuteur wrote that day. Duncan’s “only coworker,” Dr. Tuteur continued, “also experienced the taste but felt that he did not wish to seek additional medical attention and after several days no longer had anything but transient respiratory symptoms.” Duncan, however, had

sought treatment in the emergency room of St. Elizabeth's Hospital. He told Dr. Tuteur that, ever since the exposure in the ditch, he "felt severely impaired." To quote further from Dr. Tuteur's report:

"In contrast to his former ability to shovel continually to develop a 3 x 3 x 3 foot hole in less than an hour he had to stop shoveling after 5 minutes. His 'buddies helped.' Currently he has reached a plateau where he is able to shovel for 10 sometimes 15 minutes. With this exercise chest tightness pressure, and soreness would develop as well as breathlessness and increasing cough ***.

Currently though breathless with minimal exercise at baseline, symptoms worsen in response to a wide variety of triggers including increasing exercise, cold air, smells like products of fossil fuel combustion or natural, barbecue smoke, cleaning solutions, and other irritants. When this develops, he takes albuterol meter dose inhalers which produces some partial relief within a half hour, but takes more than an hour and a half to return to baseline."

¶ 18 "Of import," Dr. Tuteur remarked, is that Duncan "had no chronic childhood illnesses such as *** asthma," and "there is no personal *** history of allergies or asthma." By Dr. Tuteur's understanding at the time of his report, Duncan was "without a [] prior pulmonary history or symptomatology." Being previously free of any breathing difficulties (Dr. Tuteur thought), Duncan was exposed to a liquid that, according to subsequent chemical analysis, "included excessive concentrations of lead, benzine, ethyl benzine, to[yl]ene, and methyl mercaptan." This exposure "result[ed] in severe limitation of exercise," and Duncan's condition was "still exacerbated when [he was] exposed to triggers."

¶ 19 Laboratory data, Dr. Tuteur noted, tended to corroborate Duncan's complaints of

respiratory limitation. A pulmonary function study dated November 6, 2013, revealed a “minimal obstructive abnormality manifested by reduced flow at low lung volumes.” Duncan had a reduced forced expiratory volume at one second and also a reduced forced vital capacity (which was the amount of air he could forcefully and quickly exhale after taking a deep breath). In addition, “[a] methacholine challenge test [was] positive for the presence of bronchial reactivity.”

¶ 20 Dr. Tuteur concluded in his report, “This clinical picture is quintessentially consistent with the diagnosis of irritant induced bronchial reactivity.” He regarded “[t]his underlying clinical state” as “objectively confirmed by the positive methacholine challenge test.”

¶ 21 On November 14, 2013, Duncan returned to Dr. Roth. He told Dr. Roth he had a “recent cough and dyspnea.” A respiratory examination again revealed (to quote Dr. Roth’s report) a “normal respiratory rate and pattern with no distress” and “normal breath sounds with no rales, rhonchi, wheezes[,] or rubs.” Dr. Roth diagnosed “reactive airway disease.” She noted, “[Duncan] has asthma which was first diagnosed in adulthood. The current exacerbation began 6 weeks ago.”

¶ 22 On May 1, 2014, Duncan went to Dr. Roth’s office for an annual examination. Duncan complained he was still short of breath. A respiratory examination revealed, again, as Dr. Roth put it in her report, a “normal respiratory rate and pattern with no distress” but “coarse breath sounds throughout.”

¶ 23 On May 9, 2014, Duncan returned to Dr. Tuteur for further evaluation and continued care. Duncan told Dr. Tuteur that, since his last visit, he had attempted to continue working but that he had “encountered serious pulmonary problems.” Specifically, Dr. Tuteur noted the following description of symptoms he had received from Duncan:

“Recurrent triggers are found in the environment of the parking lot as he enters the workplace secondary to vehicular exhaust. Furthermore as he travels through the mechanic shop as well as other areas where natural gas odor is present. Chest tightness, shortness of breath and discomfort develop[]. Seeking relief in the offices produced response to different triggers such as toner, magic marker and perfumes and colognes worn by personnel. Job site triggers also exist and most prominently cold ambient air. The environment in which he has the least amount of symptoms is of course his home. Even going into restaurants or commercial venues from time to time exposures initiate an exacerbation sufficient to cause severe symptoms require rescue inhaler and delayed response develops.”

¶ 24 Dr. Tuteur reviewed a pulmonary function study dated May 9, 2014, which, he noted, revealed “a moderate obstructive ventilatory defect at baseline conducted 5 hours after Advair and albuterol that improves significantly and substantially (32%) following the administration of 3 puffs of albuterol.” To Dr. Tuteur, “[t]his demonstrate[d] marked reversibility (bronchial reactivity).” He further concluded, “[C]ompared to previous studies[,] the baseline values reflect a more severe obstruction leading to concern for the initiation of bronchial remodeling,” or scarring of the bronchial passages.

¶ 25 Dr. Tuteur diagnosed “severe irritant induced workplace associated bronchial reactivity,” a “permanent and irreversible” condition. He advised:

“It is medically indicated for [Duncan] to maintain environmental control in the home through the use of [high efficiency particulate air] filters placed in rooms where he spends most of his time, and eliminate known triggers such as cooking fumes, cleaning solutions, perfumes, colognes, hairspray, ambient tobacco smoke,

etc. It is medically contraindicated for him to return to the workplace.”

¶ 26 From May 12 to September 21, 2014, in accordance with Dr. Tuteur’s recommendation, Duncan was off work, on disability.

¶ 27 On August 30, 2014, while Duncan was on disability leave from Ameren, private investigators hired by Ameren videotaped him attending an outdoor barbecue at the Elks Lodge in Fairview Heights, Illinois. In the video, Duncan stood next to a smoking grill, wrapped hot dogs and hamburgers, and placed them on trays. The barbecue smoke did not appear to cause him any respiratory distress. He unloaded children’s bicycles from a pickup truck and jumped down from the bed of the truck. He walked around on the grounds. He stood in a group of people, one of whom was smoking cigarettes. The tobacco smoke did not appear to bother Duncan. On August 31, 2014, at the Elks Lodge, he was videotaped moving picnic tables.

¶ 28 In the arbitration hearing, Duncan explained that on August 30, 2014, at the Elks Lodge, the wind was blowing hard and he was upwind of the barbecue smoke and cigarette smoke.

¶ 29 On September 9, 2014, pursuant to section 12 of the Workers’ Compensation Act (820 ILCS 305/12 (West 2014)), Duncan submitted to an independent examination by Dr. Thomas M. Hyers, a pulmonologist at C.A.R.E. Clinical Research in St. Louis, Missouri. Dr. Hyers found Duncan’s respiration to be, as Dr. Hyers wrote in his report, “unlabored,” with a respiratory rate of 19 at rest. Duncan was “able to speak easily in complete sentences without stopping for breath.” Dr. Hyers repeatedly attempted a spirometry only to obtain “uninterpretable” results: “non-reproducible expiratory curves after multiple attempts.” According to Dr. Hyers, the reason why the spirometry was unrevealing was a lack of effort by Duncan.

¶ 30 Even so, Dr. Hyers did not doubt that Duncan had preexisting asthma. As Dr. Hyers noted in his report, “Mr. Duncan has asthma clearly documented in the medical record prior to the workplace exposure in September of 2013.” Because Duncan had a prior medical history of asthma flareups, Dr. Hyers opined that

“[Dr. Tuteur’s] diagnosis of irritant-induced asthma is incorrect, *i.e.*, the workplace exposure did not cause his asthma. Any exacerbation of his asthma symptoms by the workplace exposure had resolved by the time of his follow-up visit with Illini Family Medicine on 09-19-2013 when his chest exam was normal. He has incurred no permanent partial disability as a result of his workplace exposure. His work capability returned on 09-19-2013 to his work capability prior to the exposure incident. He will require ongoing medical care and medication for his pre-existing asthma, which is not a work-related condition.”

¶ 31 On September 22, 2014, Duncan returned to work, full-time, as a gas journeyman at Ameren.

¶ 32 The second work-related exposure was on October 8, 2014. Duncan was sitting in a crew room at Ameren. A valve on a pipe was being repaired, and Duncan smelled mercaptan, the odorant added to natural gas. At the same time, in an adjacent storeroom, propane-fueled forklifts were in use. Duncan testified that there were “extremely high levels of fumes in there” without any ventilation. He recounted that his chest tightened up and that he could hardly breathe. His vocal cords began swelling shut. He went outside to try to escape the fumes, but diesel trucks were lined up outside, idling, as crews were getting ready to go out on jobs. He went back inside the building and, leaning against a wall, retreated into the lunchroom. Someone noticed his labored breathing and called an ambulance, which took him to St. Elizabeth’s

Hospital.

¶ 33 Dr. Roth examined Duncan in the hospital. A report she signed on October 8, 2014, reads as follows under “PHYSICAL EXAMINATION”: “When saw the patient he looks pretty comfortable in no distress. Family at the bedside. Respirations are nonlabored. Good air entry bilaterally. No rales, rhonchi, or wheezing could be appreciated.” Even though Dr. Roth observed no objective symptoms of respiratory distress or discomfort, she decided to keep Duncan in the hospital overnight.

¶ 34 Duncan was discharged from St. Elizabeth’s Hospital the next day, on October 9, 2014. The discharge summary, signed by Dr. Pankaj Kaul, noted the following under “HOSPITAL COURSE”: “Patient admitted with shortness of breath, chest tightness, started yesterday after being exposed to fumes at work. *** Overnight his symptoms actually did better and he did not have any further more [sic] complaints.” Dr. Kaul continued, under “PHYSICAL EXAMINATION,” “When saw him, he looks pretty comfortable in no distress. Respirations are nonlabored. Good air entry bilaterally. No rales, rhonchi, or wheezing appreciated.”

¶ 35 When Dr. Tuteur examined Duncan on October 17, 2014, he found his oxygen saturation to be “96% sitting while breathing room air.” Examination of the chest revealed “full, equal, and synchronous expansion.” Breath sounds were normal.

¶ 36 On March 30, 2015, Dr. Anne-Marie M. Puricelli performed an independent medical examination of Duncan in connection with a claim by him for disability insurance benefits. In a report she wrote that day to Lauren N. Barginear, Ameren’s senior employee benefits clerk, Dr. Puricelli recounted what history she had been able to obtain from Duncan. (Dr. Puricelli remarked, in her report, that he “was not very interested in giving a full history.”) He told Dr. Puricelli that “his bouts of asthma started in September 2013,” when some chemicals

spilled out of a gas line, and that on October 8, 2014, while in the workplace, he was exposed to fumes a second time. He “denie[d] any prior history of asthma.” After summarizing the records from Dr. Tuteur’s office, including the pulmonary function report of October 17, 2014, Dr. Puricelli noted what she had found in her physical examination of Duncan. He appeared to be “in no acute distress.” His pulse oximeter was 94%. She noted the following from her examination of his lungs: “Initial scant wheeze in the right anterior lung field. Otherwise, he has good air movement throughout. No other wheezing and normal inspiratory and expiratory phases. He coughed for much of the examination.” She diagnosed “[h]istory of reactive airway dysfunction syndrome or reactive airway disease.” She opined that, at the time, he was “not capable of performing his normal duties as Gas Journeyman Leadman.”

¶ 37 On April 18, 2017, at Ameren’s request, Dr. Puricelli examined Duncan a second time. In the report she wrote that day to Kelly A. Powell-Rogers, Ameren’s retirement and insurance clerk, Dr. Puricelli noted the following about Duncan’s lungs: “Initially, there was some fine rhonchi in the bases that cleared with coughing. He was[,] otherwise, clear with good air movement, no wheezes.” At first, with two liters per minute of oxygen flowing into his nostrils, Duncan’s oxygen saturation level was 96%. After he was off oxygen for five minutes, his oxygen saturation level dropped to 91%. Dr. Puricelli’s diagnosis was “[h]istory of reactive airways disease.” In her opinion, “after examining *** Duncan and reviewing the available records,” he was “currently disabled for all occupations.”

¶ 38 II. ANALYSIS

¶ 39 Duncan writes in his brief, “The Circuit Court concluded that the Commission’s April 12, 2022, decisions finding causation were not against the manifest weight of the evidence. This Court should review the same Commission decision, *and only that decision*, and reach the

same conclusion.” (Emphasis added.) In other words, Duncan contends that we should disregard the Commission’s original decision and address only the question of whether the decision the Commission issued on remand is against the manifest weight of the evidence. In support of that contention, he quotes *Freeman United Coal Mining Co. v. Industrial Comm’n*, 188 Ill. 2d 243, 248 (1999): “Where the Commission has had the opportunity to review the evidence in a proceeding for a second time, it is the Commission’s ultimate determination that should be accorded deference, not the determination it made initially.”

¶ 40 In *Freeman*, however, the supreme court held that because the Commission made a legal error in its initial decision, “the circuit court *properly* reversed that decision and remanded the cause to the Commission for further consideration.” (Emphasis added.) *Id.* Thus, Duncan’s quotation from *Freeman* would be apposite only if, in the present case (as in *Freeman*), it was “proper[]” of the circuit court to reverse the Commission’s initial decision and to remand the case to the Commission. *Id.*

¶ 41 If the circuit court sets aside the Commission’s original decision and, on remand from the circuit court, the Commission issues a new decision, the initial question for us is whether the circuit court erred by setting aside the original decision. *Vogel v. Industrial Comm’n*, 354 Ill. App. 3d 780, 785-86 (2005). If the court was correct to set aside the Commission’s original decision, we give deference to the factual findings the Commission made in the decision it issued on remand—that is, we defer to those findings unless they are against the manifest weight of the evidence. See *Inter-City Products Corp. v. Industrial Comm’n*, 326 Ill. App. 3d 185, 196 (2001). On the other hand, if the court erred by setting aside the Commission’s original decision, we reverse the court’s judgment, vacate the decision the Commission issued on remand, and reinstate the Commission’s original decision. *Id.*

¶ 42 In setting aside the Commission’s original decision in this case, the circuit court held as follows: by finding that Duncan failed to prove he suffered a permanent increase in bronchial reactivity because of the two workplace exposures, the Commission made a finding that was against the manifest weight of the evidence. The threshold question on appeal is whether that holding is erroneous.

¶ 43 To answer that question, we begin by discussing what it means for a factual finding to be against the manifest weight of the evidence. “For a finding of fact to be contrary to the manifest weight of the evidence, an opposite conclusion must be clearly apparent.” *Shafer v. Illinois Workers’ Compensation Comm’n*, 2011 IL App (4th) 100505WC, ¶ 35. Thus, a finding that a claimant failed to prove causation is against the manifest weight of the evidence only if it is *clearly* apparent—not just *arguably* apparent—that the claimant proved causation. Case law further describes this deferential standard of review by saying that a factual finding is against the manifest weight of the evidence only if “*no* reasonable person” would agree with the finding. (Emphasis added.) *Pacernick v. Board of Education of the Waukegan Community Unit School District No. 60*, 2020 IL App (2d) 190959, ¶ 103.

¶ 44 So, even if we disagreed with a finding of fact by the Commission, disbelieved witnesses whom the Commission believed, and believed witnesses whom the Commission disbelieved, it would not necessarily follow that the Commission’s factual finding is against the manifest weight of the evidence. See *Hosteny v. Illinois Workers’ Compensation Comm’n*, 397 Ill. App. 3d 665, 674 (2009); *East St. Louis Police Department v. Illinois Workers’ Compensation Comm’n*, 2023 IL App (5th) 220536WC-U, ¶ 41. Rather, the Commission’s finding is against the manifest weight of the evidence only if the finding is outside the range of reasonableness. *East St. Louis Police*, 2023 IL App (5th) 220536WC-U, ¶ 41. If reasonable minds could disagree on the

question of causation, our duty is to defer to the Commission’s finding on causation. See *id.* “The Commission’s finding of causation is a factual finding, to which we owe great deference, especially in view of the Commission’s long-recognized expertise in medical matters.” (Internal quotation marks omitted.) *Id.*

¶ 45 Duncan had the burden of proving that his 20-minute exposure to fumes of mercury, benzene, and mercaptan on September 4, 2013, and his exposure to mercaptan fumes and propane and diesel fumes on October 8, 2014, caused him to suffer a permanent injury. See *Parro v. Industrial Comm’n*, 167 Ill. 2d 385, 393 (1995). On this question of causation, Ameren argues it was reasonable of the Commission to believe Dr. Hyers, who, after examining Duncan and reviewing his medical records, opined that the two exposures only temporarily exacerbated Duncan’s preexisting asthma without permanently changing his pulmonary condition.

¶ 46 Ameren points out that Duncan’s preexisting lung problems would invalidate a chain-of-events theory of causation. “A chain of events which demonstrates *a previous condition of good health*, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee’s injury.” (Emphasis added.) *International Harvester v. Industrial Comm’n*, 93 Ill. 2d 59, 63-64 (1982). Ameren contends that, before the exposure on September 4, 2013, Duncan’s pulmonary health was not good. Citing medical records, Ameren notes that, “[b]etween 1999 and August[] 2013, [Duncan] suffered from asthma, bronchospasms, bronchitis, pneumonia, and shortness of breath.” According to Ameren, the Commission did not *have* to find that Duncan had proved a causal connection between the two exposures and a permanent aggravation of his preexisting asthma. The Commission was entitled to find, alternatively, that “any perceived progression of symptoms

would be compatible with [Duncan's] ten plus year history of symptoms compatible with asthma” (to quote the arbitration decision).

¶ 47 In Duncan's view, this alternative finding is unreasonable for two reasons. First, in the opinions of at least three doctors, namely, Dr. Anderson, Dr. Tuteur, and Dr. Puricelli, Duncan was unable to work after the two exposures because of difficulty breathing. Before the exposures, though, he worked without accommodation. Second, before the exposures, he “did not require *** significant medical intervention in order to breathe as he did after the exposures.” Now he requires the “chronic use of steroids and other medications, emergency inhalers[,] [and] a constant supply of oxygen,” together with “strict environmental controls.” Duncan argues, therefore, that “the best medical and scientific explanation for [his] condition” is the explanation that Dr. Tuteur gave. In his deposition, Dr. Tuteur testified:

“One would say that with reasonable medical certainty, that the asthma that [Duncan] experienced prior to September 2013 was severely exacerbated and worsened by this exposure, and this was an irreversible phenomenon, and that this exposure initiated a clinical state that rendered him totally and permanently disabled to continue the work that he did because of the inevitable exposure to triggers which would exacerbate his condition and chronically worsen airway obstruction.”

Duncan contends, “There is no evidence in the record that explains how or why [his] pre-2013 medical condition would or could progress completely independent of the exposures, yet coincidental in time with them, to the point the condition prevented [him] from working.”

¶ 48 This contention seems to assume that asthma can never worsen on its own as a person grows older. The record appears to contain no medical opinion, however, that, in its natural

course, asthma is incapable of becoming more reactive over time. That the two exposures *caused* Duncan to become more “bronchially reactive” is not the only reasonable inference. An alternative reasonable inference is that his asthma attacks from the two exposures were *symptomatic* of, or indicative of, naturally worsening asthma.

¶ 49 Dr. Tuteur rejected the natural progression theory. Instead, he opined that the two exposures altered Duncan’s bronchial tubes, making Duncan hypersusceptible to environmental irritants. As Dr. Tuteur put it in his deposition, “every time [that Duncan] has an exacerbation, he is subjected to what is called remodeling of the airways.” Remodeling, Dr. Tuteur explained, was a “scarring of the airways, producing narrowing that is irreversible,” with the result that “the best pulmonary function he can achieve is continually reduced because of the remodeling.” The exposure to chemicals in September 2013, Dr. Tuteur opined, inflicted an acute injury to Duncan’s airways, with inflammation and “the subsequent development of serious bronchial reactivity,” and more proneness to shortness of breath.

¶ 50 On cross-examination, Dr. Tuteur was asked if there were any objective way to determine whether an exposure had scarred bronchial tubes:

“Q. Do you have any way to go in with a tube or some kind of diagnostic test to determine whether there is, in fact, scar formation within the bronchial areas?”

A. Well, this concept was and is documented by research that is done by serial bronchial biopsies, via bronchoscope, mostly done in France.

Q. But with regard to Mr. Duncan, has it been objectively—

A. No. Because there is no therapeutic reason to do that. There is no—
there would be no change in the therapeutic response. And there is a finite risk for

bronchoscopy, with one in 1,000, one in 5,000 deaths.”

Thus, Dr. Tuteur could be understood as admitting the only way to objectively prove his theory of remodeling was a series of biopsies by bronchoscope: a biopsy before the exposure and, for comparison, another biopsy after the exposure. Such bronchoscopic biopsies had not been performed on Duncan, and hence the postulated remodeling had not been empirically observed.

¶ 51 Though agreeing that, theoretically, remodeling of bronchial tubes could happen, Dr. Hyers regarded such remodeling as unsubstantiated in Duncan’s case. On cross-examination, Duncan’s attorney asked Dr. Hyers:

“Q. Do you agree with Dr. Tuteur’s opinion that exacerbations of Mr. Duncan’s condition can lead to remodeling of his airways?

A. Exacerbations of asthma can lead to remodeling in general. I can’t tell you what has happened with Mr. Duncan’s airways and neither can Dr. Tuteur.”

¶ 52 The Commission surely had the right to believe Dr. Hyers’s testimony that, theoretically, remodeling of the bronchial tubes through scarring could occur but that such remodeling was, in Duncan’s case, unproven. That testimony by Dr. Hyers was not inherently unbelievable. After all, Dr. Tuteur could be understood as conceding (in so many words) that, without before-and-after bronchial biopsies, his theory that the two workplace exposures had remodeled Duncan’s bronchial tubes was empirically unsubstantiated.

¶ 53 Nevertheless, Duncan blatantly urges us to believe Dr. Tuteur over Dr. Hyers. See *Compass Group v. Illinois Workers’ Compensation Comm’n*, 2014 IL App (2d) 121283WC, ¶ 19. “Of course, this is not our role. We will not merely reevaluate the credibility of these witnesses and substitute our judgment for that of the Commission.” *Id.* The Commission was entitled to believe Dr. Hyers. He is board-certified in internal medicine and pulmonary medicine. He not only

examined Duncan but reviewed medical records that Dr. Tuteur initially did not review before Dr. Tuteur arrived at his own opinion on causation. When Dr. Tuteur first asserted causation, he was not yet accurately informed on Duncan's prior history of pulmonary symptoms (although Dr. Tuteur afterward was provided the medical records—and nevertheless adhered to his causation opinion).

¶ 54 Dr. Hyers opined that Duncan had preexisting asthma and that the two workplace incidents triggered asthma attacks without significantly changing Duncan's preexisting asthma. One incident was in 2013, and the other was in 2014. In Dr. Hyers's view, those two asthma attacks were consistent with (1) the asthma attacks that Duncan had been having once a year, on average, from 2009 to 2013 and (2) the dyspnea and bronchospasms that he had been experiencing for more than a decade. Duncan's medical records for the period of May 1999 to August 2013 reveal that on 15 or 16 separate occasions, he complained of pulmonary symptoms, including shortness of breath, coughing, tightness in his chest, and wheezing, and that he used an albuterol inhaler. Therefore, it would be within the range of reasonableness for a trier of fact to believe Dr. Hyers over Dr. Tuteur. We cannot say it is clearly evident that Dr. Tuteur is more credible than Dr. Hyers. Presented with these conflicting medical opinions on causation, we decline to choose one opinion over the other but, instead, defer to the Commission's determination of credibility. See *Max Shepard, Inc. v. Industrial Comm'n*, 348 Ill. App. 3d 893, 901 (2004).

¶ 55 As Ameren points out, the chain-of-events method of proving causation is inapplicable because, in this case, there was no previous condition of good pulmonary health. See *International Harvester*, 93 Ill. 2d at 63-64 ("A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's

¶ 59 Circuit court judgments reversed; Commission's original decision reinstated;
Commission's decision on remand vacated.