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Issue Date: 09 January 2004

In the Matter of

MRS. JUANITA BROCK, on behalf of,
MR. WHITT BROCK
Claimant

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Case No.: 1999 BLA 1144

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS ON REMAND FROM THE BENEFITS REVIEW BOARD

This matter involves a claim filed by Mr. Whitt Brock, now represented by Mrs. Juanita Brock, for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("Act").[1] Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis.[2] Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

On May 29, 2003, the Benefits Review Board remanded this case to the Office of Administrative Law Judges ("OALJ") for further adjudication by Administrative Law Judge John Holmes. On September 16, 2003, Associate Chief Administrative Law Judge Thomas Burke attempted to notify all parties[3] that since Judge Holmes was no longer with OALJ, he intended to assign the case to another administrative law judge. *See Strantz v. Director, OWCP*, 3 BLR 1-431 (1981). Judge Burke gave the parties 30 days to submit an objection and briefs on the remanded issues. I received the case file on November 9, 2003 for consideration. No

[1]After Mr. Brock filed his second claim in 1997, the U.S. Department of Labor ("DOL") issued new regulations concerning black lung claims, with an effective date of January 19, 2001. Portions of both the new and former regulations apply to Mr. Brock's present case. The former regulations are identified by the following citation modifier, "(2000)."

[2]On April 23, 2002, the Benefits Review Board affirmed the denial of Mrs. Juanita Brock's survivor claim (1999 BLA 1143) since the evidence failed to establish that Mr. Brock died due to coal workers' pneumoconiosis.

[3]Unfortunately, the notice sent to Mrs. Brock's last known address was returned due to an insufficient address.

objection or briefs were attached. My decision in this case will be based on the testimony presented at the hearings and all the evidence in the record, DX 1 to DX 37 and CX 1 and CX 2 (which were admitted in the April 2001 hearing).[4]

Background and Case History

Mr. Whitt Brock's First Claim
(DX 22)

On January 26, 1975, Mr. Brock filed his first claim for benefits. The claim was denied on May 29, 1980 for failure to prove pneumoconiosis and total disability. Mr. Brock appealed the denial on June 9, 1980. Eventually, at a hearing in May 1984, Administrative Law Judge Reid C. Tait remanded the case for review of additional medical evidence provided by Mr. Brock. On September 10, 1984, after considering the additional evidence, the District Director again denied the claim. Mr. Brock again appealed the adverse decision.

On December 12, 1986, Administrative Law Judge V. M. McElroy conducted a second hearing in Mr. Brock's case. On September 22, 1987, Judge McElroy issued his decision concerning Mr. Brock's claim. After noting that Mr. Brock's self-employed coal hauling from the tipple to home consumers did not qualify as coal mine employment under the Act, Judge McElroy credited Mr. Brock with six years and eight months of coal mine employment based on his reported earnings from coal companies. Next, based on the date Mr. Brock filed his claim and since he had less than 10 years of coal mine employment, Judge McElroy adjudicated the claim under Part 410, which required an affirmative showing by Mr. Brock that he had coal workers' pneumoconiosis and was totally disabled by the disease. Finding the preponderance of the chest x-rays did not establish pneumoconiosis, Judge McElroy evaluated the pulmonary testing and medical opinion to determine whether Mr. Brock had a totally disabling chronic lung disease. He concluded the more probative evidence did not establish total disability. As a result, Judge McElroy denied Mr. Brock's disability claim.

In early December 1987, Mr. Brock requested a modification due to a mistake of fact. The District Director denied the modification request and Mr. Brock requested another hearing. As a result, the case was forwarded to OALJ in the spring of 1988. On October 19, 1988, Administrative Law Judge Giles J. McCarthy conducted a third hearing. On July 10, 1989, Judge McCarthy again determined that since Mr. Brock had six years and eight months of coal mine employment, his claim should be adjudicated under Part 410. Under those provisions, Mr. Brock failed to establish his entitlement because the preponderance of the most recent chest x-ray evidence was negative and he was not totally disabled. Accordingly, Judge McCarthy denied Mr. Brock's claim. Mr. Brock asked for reconsideration and Judge Giles denied the reconsideration request on August 4, 1989. On August 14, 1989, Mr. Brock appealed the decision to the Benefits Review Board ("BRB" or "Board"). On March 18, 1993, the BRB affirmed Judge McCarthy's determination that the preponderance of the more probative chest x-

[4]In its most recent decision, based on a concession by the District Director, the BRB concluded Mr. Brock had established a material change in conditions in his second claim. As a result, under 20 C.F.R. § 725.309 (2000), I must consider the entire record, including the evidence in DX 22 from Mr. Brock's first claim, to address the issues presented to me on this remand.

ray interpretations failed to establish the presence of pneumoconiosis. In footnote 2, the Board also affirmed Judge McCarthy's finding concerning the length of Mr. Brock's coal mine employment. However, based on a motion by the District Director and due to a new court decision, the BRB remanded Mr. Brock's claim to Judge McCarthy for adjudication of the claim under Part 718.

Since Judge McCarthy was no longer with the U.S. Department of Labor ("DOL"), Administrative Law Judge Samuel J. Smith adjudicated Mr. Brock's claim under Part 718 on August 31, 1994. After attributing diminished probative value to the x-ray interpretations of physicians affiliated with the parties, Judge Smith concluded the remaining, non-affiliated x-ray interpretations by Dr. Jones, Dr. Penman, and Dr. Becknell established the presence of pneumoconiosis.

Next, Judge Smith evaluated the diverse medical opinion. He discounted Dr. Dahhan's conclusion that Mr. Brock did not have pneumoconiosis because "he was of the mistaken belief that the x-ray evidence was negative for coal worker's pneumoconiosis." Judge Smith concluded the opinion of Dr. Baker, who considered the chest x-ray evidence as negative, was equivocal. Then after noting Dr. Williams found no pulmonary disease, Judge Smith stated the opinions of Dr. Becknell, Dr. Clarke, Dr. Penman, and Dr. Schaeffer, who each found evidence of pneumoconiosis through chest x-rays, were the "better reasoned medical opinions." Judge Smith also highlighted Dr. Schaeffer's status as a treating physician. Accordingly, Judge Smith found Mr. Brock proved the presence of pneumoconiosis through medical opinion under 20 C.F.R. § 718.202 (a) (4).

Turning to the issue of total disability, Judge Smith concluded that none of the medical tests and medical opinion sufficiently established that Mr. Brock was indeed disabled from coal mine employment. Accordingly, although Mr. Brock had established the presence of pneumoconiosis, Judge Smith nevertheless denied his claim because he failed to prove total disability. On September 9, 1994, Mr. Brock appealed the adverse decision.

On July 31, 1995, the BRB denied Mr. Brock's claim. The Board noted that since it had already affirmed the finding that the chest x-ray evidence was negative, Judge Smith was not permitted to re-evaluate that evidence and reach a different conclusion. Thus, the Board vacated Judge Smith's finding on chest x-rays and restated the radiographic evidence was insufficient to establish the presence of pneumoconiosis. Notably, in footnote three of its decision, the Board highlighted that since Mr. Brock had less than ten years of coal mine employment, even if he established the presence of pneumoconiosis, he would still have to prove that his pneumoconiosis was caused by his coal mine employment. The BRB believed that might be a significant issue because some of Mr. Brock's coal exposure occurred when he was trucking coal from the tipple to coal consumers, which did <u>not</u> qualify as coal mine employment under the Act. In an additional footnote, number four, the BRB also stated that in the absence of an objection, it affirmed Judge Smith's findings under 20 C.F.R. § 718.202 (a) (2) to (4). That last cited subparagraph, (a) (4) permits a claimant to establish the presence of pneumoconiosis through medical opinion. Thus, the BRB affirmed Judge Smith's finding that Mr. Brock proved the

presence of pneumoconiosis through medical opinion.[5] Finally the BRB affirmed Judge Smith's conclusion that the medical evidence did not establish total disability. Mr. Brock did not appeal the BRB's denial of his claim.

Second, and Present Claim

On February 18, 1997, Mr. Brock filed his second claim for black lung disability benefits (DX 2). While determining Mr. Brock had pneumoconiosis on the basis of medical opinion, the District Director denied Mr. Brock's claim on April 7, 1998 for failure to prove total disability (DX 20). After Mr. Brock appealed (DX 21), the District Director forwarded the case to OALJ on May 20, 1998 (DX 23) and a hearing was scheduled for October 7, 1998 (DX 24). Prior to the hearing, a continuance was granted to permit Mr. Brock additional time to prepare his case. Unfortunately, prior to the next scheduled hearing, Mr. Brock passed away in January 1999 (DX 26 and DX 28). Based on the joint motion of the parties' representatives, Administrative Law Judge Mollie W. Neal remanded Mr. Brock's case back to the District Director for consideration of both autopsy evidence and Mrs. Brock's separate survivor claim (DX 27).[6] After consideration of the autopsy findings, the District Director reversed his previous finding on pneumoconiosis and denied the claim for failure to prove the presence of pneumoconiosis (DX 29). Mr. Brock's representative appealed the denial on July 12, 1999 (DX 30) and the case was forwarded to OALJ on July 21, 1999 (DX 37).

After two continuances, a hearing was finally conducted by Administrative Law Judge John C. Holmes on April 24, 2001. On June 13, 2001, Judge Holmes issued a Decision and Order denying Mr. Brock's claim due to failure to establish the presence of pneumoconiosis. Judge Holmes also adopted the previous finding of 6 years and 9 months of coal mine employment for Mr. Brock. Mr. Brock's representative appealed the decision on June 22, 2001.

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[5]Directly in footnote 4, and indirectly in footnote 10, of a subsequent April 2001 decision, the BRB reiterated this affirmation. The BRB stated, "The Board affirmed Judge Smith's finding that the medical opinion evidence was sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202 (a) (4) (2000) as unchallenged on appeal." That finding is somewhat troubling. Judge Smith based his decision on the medical opinion after giving greater probative weight to the medical opinions of the physicians who believed the chest x-rays were positive for pneumoconiosis, which was consistent with his conclusion that the chest x-ray evidence established the presence of pneumoconiosis. However, while affirming Judge Smith's finding on medical opinion, the Board at the same time vacated his finding that the chest x-ray evidence was positive for pneumoconiosis. Since it had previously affirmed Judge McCarthy's finding that the radiographic evidence was negative for black lung disease, the Board concluded Judge Smith had no authority to reopen that issue. In other words, even though Judge Smith relied on positive chest x-rays to evaluate the medical opinions and the BRB vacated his chest x-ray determination, thereby reinstating Judge McCarthy's findings that the chest x-rays were negative, the Board still upheld Judge Smith's conclusion that the more probative medical opinion established the presence of pneumoconiosis.

[6]Mrs. Juanita Brock filed her survivor claim on April 15, 1999 (DX 31). The District Director denied the claim on July 17, 1999 because she failed to prove her husband's death was due to pneumoconiosis (DX 35). Mrs. Brock appealed (DX 36) and the case was forwarded to OALJ in July 1999 (DX 37). Following his April 24, 2001 hearing, Administrative Law Judge John C. Holmes denied Mrs. Brock's survivor claim on June 13, 2001 because the medical evidence failed to establish that Mr. Brock died due to pneumoconiosis. Mrs. Brock appealed. On April 23, 2002, affirming Judge Holmes' findings in regard to death due to pneumoconiosis, the BRB upheld the denial of Mrs. Brock's survivor claim.

On April 23, 2002, the BRB remanded the case to Judge Holmes. Although Judge Holmes had correctly determined Mr. Brock could not establish the presence of pneumoconiosis under 20 C.F.R. §§ 718.202 (a) (1) to (3), the Board vacated his finding concerning the newly submitted medical opinion under 20 C.F.R. § 718.202 (a) (4) because he incorrectly concluded that neither Dr. Hudson nor Dr. Smith had diagnosed pneumoconiosis. In its remand order, the BRB directed Judge Holmes to take three actions. First, he had to assess whether the newly submitted medical opinion established the presence of pneumoconiosis. Second, if pneumoconiosis was established by medical opinion, Judge Holmes was directed to determine whether Mr. Brock could establish total disability under 20 C.F.R. § 718.204 (b) (2) (iii), which provides that absent countervailing evidence, a miner with pneumoconiosis and cor pulmonale with right sided congestive heart failure is considered totally disabled. Third, if Mr. Brock's case met the requirements of 20 C.F.R. § 718 (b) (2) (iii), thereby establishing total disability and correspondingly a material change in condition under 20 C.F.R. 725.309, Judge Holmes had to consider the entire record to determine whether Mr. Brock was entitled to benefits under Part 718.

On July 11, 2002, Judge Holmes issued his second decision, again denying Mr. Brock's claim for benefits. Judge Holmes concluded Dr. Hudson's findings were minimally credible and overcome by the negative radiographic evidence in the record. Judge Holmes concluded that Doctor's Smith's conclusion was negative for pneumoconiosis. He also observed that the best evidence in the record, the autopsy report, established that Mr. Brock did not have pneumoconiosis. Consequently, Mr. Brock did not establish a material change in conditions. Mr. Brock's representative again appealed Judge Holmes' denial of benefits.

Finally, the procedural history of this case comes to a close on May 29, 2003, with the BRB's decision to once again remand this case to Judge Holmes. At that time, the BRB observed that the Director conceded Mr. Brock had established total disability under 20 C.F.R. § 718.204 (b) (2) (iii) based on the autopsy finding of cor pulmonale and Judge Smith's finding of legal pneumoconiosis.[7] Collaterally, the Director also conceded Mr. Brock had established a material change in condition under 20 C.F.R. § 725.309. In light of these concessions, the BRB concluded the case needed to be remanded because Judge Holmes had not considered the entire record on the merits. Additionally, the BRB noted that Dr. Hudson's opinion was sufficient to support a finding of legal pneumoconiosis. Also, since the claim arose within the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit, the Board observed that section 718.202 (a) provided alternative means for proving pneumoconiosis.[8] As a result, even though the radiographic evidence was negative and Mr. Brock could not establish pneumoconiosis under section 718.202 (a) (1), he might still prevail on the issue through medical opinion, 20 C.F.R. § 718.202 (a) (4). Consequently, the BRB vacated Judge Holmes' findings under 20 C.F.R.§ 718.202 (a) (4) and directed Judge Holmes to consider "all the medical opinion under that

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[7]In its September 9, 2002 Response Brief, pages 10 and 11, the Director stated, "we concede that the autopsy evidence of cor pulmonale (right heart failure) demonstrates a 'material change in conditions' under section 725.309 (d) because it establishes total disability under section 718.204 (b) (2) (iii), [fn] assuming that the miner suffered from "legal" pneumoconiosis under section 718.202 (a) (4) as found by ALJ Smith in the prior claim" (emphasis added). That underlying assumption is at best questionable, *see* footnote 5.

[8]*Cornett v. Benham Coal, Inc.,* 227 F.3d 569 (6th Cir. 2000). For a contrary position in a different circuit, *see Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

section." In turn, if Mr. Brock proved the presence of pneumoconiosis under that section, Judge Holmes was also required to "consider whether the claimant has established the other elements of entitlement in the miner's claim."

ISSUES ON REMAND

1. Whether the medical opinion evidence in the record establishes the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (4).

2. If the presence of pneumoconiosis is established, whether Mr. Brock is entitled to black lung disability benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on March 22, 1924, Mr. Brock married Mrs. Juanita Brock on December 31, 1945 (DX 2 and DX 8). Between 1947 and 1972, Mr. Brock worked about a year mining coal underground and then started driving a truck carrying coal. Initially, for a few years, he hauled coal for the coal mining companies. Later, he became self-employed as a coal truck driver.

During his truck driving period, covering just under 15 years, Mr. Brock essentially engaged in two types of coal deliveries. Initially, he drove coal from the coal mine site to the tipple. Later, Mr. Brock added deliveries from the coal mine company tipple to coal consumers. In the presentation of his claims, Mr. Brock claimed both types of work as coal mine employment, seeking credit for about 15 years of coal mine employment. However, as previously explained by Judge McElroy, only the deliveries from the coal mine to the tipple qualify as coal mine employment under the Act.[9] Mr. Brock's other deliveries to consumers do not qualify for coal mine employment since Mr. Brock was delivering processed coal. Recognizing this regulatory distinction and sorting through the conflicting and less than clear evidence concerning the extent of Mr. Brock's consumer delivery activities, Judge McElroy and Judge McCarty concluded Mr. Brock could be credited with six years and eight months of qualified coal mine employment. The BRB subsequently affirmed that determination in its March 1993 decision (DX 22). Later, when Judge Holmes reviewed the issue, he similarly concluded Mr. Brock had six years and nine months of coal mine employment. Having reviewed the record and considering the BRB's affirmation of Judge McCarthy's determination, I also conclude that Mr. Brock accumulated just less than seven years of qualified coal mine employment.

Issue #1 – Presence of Pneumoconiosis

In its latest remand order, the BRB concluded Mr. Brock has established a material change in conditions under 20 C.F.R. § 725.309 (d) (2000) since the denial of his first claim.

[99] *See* 20 C.F.R. § 725.202 (b) ("A transportation worker shall be considered a miner to the extent that his or her work is integral to the extraction and preparation of coal.")

Consequently, the entire record from both his first and second claims must be examined to determine whether Mr. Brock had pneumoconiosis. Although the BRB has directed my attention to medical opinion under 20 C.F.R. § 718.202 (a) (4), I will address all four means available under 20 C.F.R. § 718.202 (a) to establish pneumoconiosis.

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[10] The regulatory definitions include both clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[11] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[12] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Brock had complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3) is not applicable. As a result, the presence of pneumoconiosis must be demonstrated through chest x-ray, autopsy evidence, or medical opinion.

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[10]20 C.F.R. § 718.201 (a).

[11]20 C.F.R. § 718.201 (a)(1) and (2).

[12]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-Rays[13]

The following table summarizes all chest x-ray interpretations admitted into evidence:

Date of x-ray	Exhibit	Physician	Interpretation
Dec. 30, 1975	DX 22	Dr. Clarke, A[14]	Positive for pneumoconiosis, profusion 1/2,[15] type p/q opacities[16]
Apr. 12, 1976	DX 22	Dr. Sargent, B, BCR	Completely negative
Apr. 23, 1976	DX 22	Dr. Jones	Positive for pneumoconiosis, profusion 1, type p opacities
Apr. 26, 1976	DX 22	Dr. Wells	Negative for pneumoconiosis
Jan. 22, 1981	DX 22	Dr. Cole, BCR, B	Completely negative
(same)	DX 22	Dr. Becknell	Positive for pneumoconiosis, profusion 1/2, type p opacities
May 10, 1984	DX 22	Dr. Elmer, B, BCR	Completely negative
(same)	DX 22	Dr. Cole, B, BCR	Calcified granulomas; negative for pneumoconiosis
(same)	DX 22	Dr. Baker	Negative for pneumoconiosis
Jun. 20, 1984	DX 22	Dr. Cole, B, BCR	Completely negative

[13]In his 1998 medical opinion (DX 19), Dr. Smith references a 1994 chest x-ray taken at the Claiborne County Hospital when Mr. Brock was treated for chest pains which showed "some calcified areas." I have not included that interpretation because the chest x-ray is not in the record.

[14]The following designations apply: A – A reader; B – B reader; and, BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. An "A Reader" has either attended a chest x-ray classification class or submitted six chest x-ray interpretations for evaluation. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[15]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[16]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

Nov. 5, 1986	DX 22	Dr. Elmer, B, BCR	Calcified granulomas; negative for pneumoconiosis
(same)	DX 22	Dr. Cole, B, BCR	Calcified granulomas; negative for pneumoconiosis
(same)	DX 22	Dr. Williams	Completely negative
Nov. 10, 1986	DX 22	Dr. Halbert, B, BCR	Completely negative
(same)	DX 22	Dr. Clarke, A	Positive for pneumoconiosis, profusion 1, type p/q opacities
(same)	DX 22	Dr. Marshall, B, BCR	Positive for pneumoconiosis, profusion 1/0, type p/q opacities
(same)	DX 22	Dr. Cole, B, BCR	Unreadable
Nov. 20, 1987	DX 22	Dr. Mathur, B, BCR	Positive for pneumoconiosis, profusion 1/2, type p/s opacities
(same)	DX 22	Dr. Penman	Positive for pneumoconiosis, profusion 1, type p opacities
(same)	DX 22	Dr. Poulos, BCR, B	Completely negative
(same)	DX 22	Dr. Sargent, BCR, B	Calcified granulomas; negative for pneumoconiosis
May 28, 1997	DX 12	Dr. Sargent, BCR, B	Calcified granulomas; negative for pneumoconiosis
(same)	DX 13	Dr. Hudson	Calcified granulomas; negative for pneumoconiosis
Sep. 12, 1997	DX 18	Dr. Norris	Calcified granulomas; no active infiltrates

Of the 12 chest x-rays that span 22 years, the physicians who evaluated nine films had no dispute over the interpretation. Based on that consensus, I find the December 30, 1975 and April 23, 1976 chest x-rays are positive for pneumoconiosis. In a similar manner, the following seven films are negative for pneumoconiosis: April 12, 1976; April 26, 1976; May 10, 1984; June 20, 1984; November 5, 1986; May 28, 1997; and, September 12, 1997.

The three remaining chest x-rays generated a professional dispute. Dr. Becknell found evidence of pneumoconiosis in the January 22, 1981 x-ray; Dr. Cole disagreed. Since Dr. Cole is a dual qualified radiologist, I give his assessment greater probative weight and conclude the January 22, 1981 chest x-ray is negative for pneumoconiosis. Both Dr. Clarke and Dr. Marshall saw pneumoconiosis in Mr. Brock's November 10, 1986 chest x-ray. Dr. Halbert concluded the same film was completely negative. Both Dr. Marshall and Dr. Halbert are similarly dual qualified radiologists. The standoff between these two experts is broken by Dr. Clarke. As a result, I find the November 10, 1986 film is positive for pneumoconiosis. The last disputed x-ray was taken on November 20, 1987. Dr. Mathur and Dr. Penman determined the study was positive for pneumoconiosis. Dr. Poulos and Dr. Sargent disagreed. Dr. Penman had no specialized training in chest x-ray interpretation. As result, Dr. Mathur's well qualified interpretation is overcome by the opposite conclusion of two dual qualified physicians. Consequently, the November 20, 1987 film is negative for pneumoconiosis.

In summary, three of the twelve chest x-rays (December 30, 1975, April 23, 1976, and November 10, 1986) are positive for pneumoconiosis. On the other hand, nine films (April 12, 1976; April 26, 1976; January 22, 1981; May 10, 1984; June 20, 1984; November 5, 1986;

November 20, 1987; May 28, 1997; and, September 12, 1997) are negative for pneumoconiosis. Since the preponderance of the chest x-rays, nine out of twelve, are negative, I conclude the radiographic evidence in the entire record fails to establish the presence of pneumoconiosis under 20 C.F.R. § 718.202 (a) (1).

Autopsy Evidence

(Note: the following summary, and other remaining portions of this decision, contain information obtained from the autopsy of Mr. Brock, submitted by Mrs. Brock. While respecting the dignity and privacy of the deceased, I must engage in some discussion of the detailed observations since this medical information is relevant on determining whether Mr. Brock had pneumoconiosis.)

Prior to reviewing the autopsy report, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on a biopsy or autopsy is helpful. The regulation defines "clinical" pneumoconiosis as a condition "characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment.," 20 C.F.R. § 718.201 (a). As a result, an autopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202 (a) (2).

Dr. C. Blake
(CX 1)

On January 23, 1999, the day Mr. Brock died, Dr. Blake, a forensic pathologist, conducted a post-mortem chest examination of Mr. Brock. As background information, Dr. Blake noted that Mr. Brock had been exposed to coal dust through coal mining and truck hauling. After an extended illness, Mr. Brock was admitted to the hospital on January 17, 1999 and placed on oxygen support. He passed away several days later.

Upon gross examination of the lungs, Dr. Blake observed a pinkish gray tint and some suggestion of mild pan-lobular emphysema. The secondary bronchial passages were filled with heavy mucus. Dr. Blake also found mucopurulent bronchitis and moderate pulmonary edema. Some pulmonary nodes had grayish to grayish-black pigmentation. Additionally, Dr. Blake commented, "of significance is the grossly absent evidence of any nodular excrescences or evidence of true coal miner's pneumoconiosis (black lung disease)."

When Dr. Blake examined the heart, he noted mild atherosclerotic changes in the coronary arteries. The wall of the right ventricle appeared thickened, indicative of cor pulmonale.

Dr. Blake's microscopic examination of the lung tissue disclosed evidence of: mild pan-lobular emphysema, minimal focal fibrosis, and extreme mucus plugging of the bronchial passages mixed with inflammatory cells. The physician found "no suggestion of microscopic criteria of Black Lung changes."

Based on his autopsy examination, Dr. Blake concluded Mr. Brock had: mild to moderate pulmonary edema; mild, diffuse pan-lobular interstitial fibrosis and emphysema; cor pulmonale (right heart failure); severe bronchial mucus plugging; mild, acute bronchitis; and, mild to moderate arteriosclerosis. Concerning the manner of death, Dr. Blake explained that in the last period of his life, Mr. Brock "accumulated progressively massive mucus plugging of his bronchial passages, leading to cerebral hypoxia and slow heart death." Mr. Brock's mild pulmonary fibrosis and emphysema contributed to his cor pulmonale. On the issue of pneumoconiosis, Dr. Blake stated neither gross nor microscopic examination of the lungs provided "criteria of Coal Miner's Pneumoconiosis." He found no evidence of any significant contribution of silicon particles or miconodular fibrosis associated with coal workers' pneumoconiosis. According to Dr. Blake, Mr. Brock apparently "simply did not have enough prolonged exposure in the underground coal mine environment to acquire changes qualifying for Pneumoconiosis."

Based both on Dr. Blake's specific findings and his conclusions, the presence of pneumoconiosis can not be established by autopsy evidence under 20 C.F.R. § 718.202 (a) (2) in Mr. Brock's case.

Medical Opinion

Even though neither the preponderance of the radiographic evidence nor autopsy findings demonstrate that Mr. Brock had black lung disease, the presence of pneumoconiosis in his lungs may still be established through reasoned medical opinion, based on objective medical tests, including blood gas studies, pulmonary function tests, physical examinations and medical and work histories, under 20 C.F.R. § 718.202 (a) (4). At the same time, the existence of pneumoconiosis "shall not be made solely on the basis of a living miner's statements or testimony," 20 C.F.R. § 718.202 (c).

Preliminarily, to help place some of the diverse medical opinions into perspective, I note that none of the five arterial blood gas studies administered between 1976 and 1997 produced results that qualified for total disability under the regulations.[17] Mr. Brock also underwent six pulmonary function tests during the same period of time.[18] A couple of those tests produced results near qualifying for total disability.[19] However, questions arose concerning their acceptability due to the absence of tracings or patient cooperation. Of the last four pulmonary examinations, including the most recent, three of the tests showed near normal pulmonary functions.[20]

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[17]April 26, 1976 (DX 22); May 10, 1984 (DX 22); November 5, 1986 (DX 22); November 20, 1987 (DX 22); and, May 28, 1997 (DX 11).

[18]December 30, 1975 (DX 22); April 23, 1976 (DX 22); May 10, 1984 (DX 22); November 5, 1986 (DX 22); November 11, 1986 (DX 22); and, May 28, 1997 (DX 9).

[19]Pulmonary function test of December 30, 1975 and November 11, 1986.

[20]May 10, 1984; November 5, 1986; and, May 28, 1997.

Dr. Boyce E. Jones
(DX 22)

On April 23, 1976, Dr. Jones examined Mr. Brock, who claimed 25 years as a coal miner and struggled with shortness of breath upon exertion. He conducted a pulmonary function test and interpreted a chest x-ray positive for pneumoconiosis. Dr. Jones concluded Mr. Brock had pneumoconiosis and should avoid exposure to any additional dust.

Dr. Abdul Dahhan
(DX 22)

On April 26, 1976, Dr. Dahhan also examined Mr. Brock. Mr. Brock had mined coal for 12 years and had shortness of breath upon exertion. Dr. Dahhan was unable to obtain a satisfactory pulmonary function test and the blood gas study did not exceed the total disability threshold. The physical examination of the chest was normal and the chest x-ray was negative for pneumoconiosis. The physician also found no signs of cardiomegally. Dr. Dahhan diagnosed chronic bronchitis and premature heart contraction.

Dr. James L. Becknell
(DX 22)

On January 22, 1981, Dr. Becknell examined Mr. Brock who had suffered a chronic cough for 10 to 12 years. Dr. Becknell noted bilateral rales upon examination and interpreted a chest x-ray positive for pneumoconiosis. The doctor diagnosed mild to moderate pneumoconiosis and concluded Mr. Brock was severely impaired due to a heart condition being treated at a Veterans Administration hospital.

Dr. E.W. Schaeffer
(DX 22)

In March 1984, Dr. Schaeffer indicated that he had treated Mr. Brock since 1961, mostly for chronic coughs and colds. Mr. Brock was an ex-miner and presented with shortness of breath complaints. Although Dr. Schaeffer did not hear wheezing in his office, he noted Mr. Brock typically experienced that symptom at night. Dr. Schaeffer believed Mr. Brock had pneumoconiosis. While he didn't have a chest x-ray to support his diagnosis, Dr. Schaeffer based his opinion on hospitalization records. Dr. Schaeffer diagnosed chronic obstructive pulmonary disease due to pneumoconiosis.

Dr. Glenn R. Baker, Jr.
(DX 22)

On May 10, 1984, Dr. Baker, board certified in pulmonary disease, conducted a pulmonary examination. Mr. Brock reported periodic coal mine employment over the course of 20 years. During that period, he spent about 4 years underground and another 7 to 8 years, near coal mines and tipples. His total exposure to coal dust was 12 years. Mr. Brock complained about chronic shortness of breath. The physical exam and pulmonary function test was normal.

The chest x-ray was negative for pneumoconiosis. The blood gas test showed mild resting hypoxemia. Dr. Baker diagnosed a chronic non-specific pulmonary disorder with shortness of breath. He later added that Mr. Brock has a history suggestive of asthma. At the same time, coal dust may have contributed to his symptoms of bronchitis and asthma.

Dr. Cordell H. Williams
(DX 22)

Dr. Cordell Williams evaluated Mr. Brock on November 5, 1986. Mr. Brock had 13 years of coal mine employment and struggled with a chronic cough and possible asthma. He was a non-smoker. Upon examination, the lungs were clear and the chest x-ray was negative for pneumoconiosis. The blood gas study was normal and the pulmonary function test produced a suboptimal MVV. Dr. Williams concluded Mr. Brock did not have an occupational lung disease associated with his coal mine employment. While he might have bronchial asthma, Dr. Williams also indicated Mr. Brock retained the respiratory capacity for coal mine employment.

Dr. W.F. Clarke
(DX 22)

Dr. Clarke examined Mr. Brock on November 10, 1986. Mr. Brock had worked in coal mining about 12 years and experienced shortness of breath. He was a non-smoker. Upon physical examination, Dr. Clarke heard rales and rhonchi. The chest x-ray was positive for pneumoconiosis. The pulmonary function test showed a mild restriction and a moderate chronic obstruction defect. Noting no other cause for Mr. Brock's breathing problems, Dr. Clarke concluded Mr. Brock was totally disabled due to his coal mine employment.

Dr. Robert W. Penman
(DX 22)

On November 20, 1987, Dr. Penman evaluated Mr. Brock's pulmonary condition. Mr. Brock reported 12 years of coal mine employment and shortness of breath for 15 years. Dr. Penman heard some bilateral rales and the chest x-ray was positive for pneumoconiosis. At the same time, the blood gas study was normal. In light of Mr. Brock's history of coal mine employment and the positive chest x-ray, Dr. Penman diagnosed coal workers' pneumoconiosis. Dr. Penman also concluded Mr. Brock did not have a lung impairment.

Dr. A. R. Hudson
(DX 10)

On May 28, 1997, Dr. Hudson examined Mr. Brock. Mr. Brock had 15 years of coal mine employment, including one year underground. He was a non-smoker who suffered with a chronic cough and wheezing. Upon examination, Dr. Hudson heard rare crackles. The chest x-ray was negative for pneumoconiosis. Neither the pulmonary function test nor the arterial blood gas studies demonstrated a total disability. Dr. Hudson diagnosed chronic bronchitis and cardiac arrhythmia. Since Mr. Brock never smoked and in the absence of any other factor to explain his persistent cough, Dr. Hudson believed the chronic bronchitis was due to coal mine employment.

That is, because Mr. Brock's cough was "unexplained by other factors," Dr. Hudson believed Mr. Brock had an occupational lung disease related to his exposure to coal dust. At the same time, Mr. Brock did not have a respiratory impairment. Mr. Brock did have disability associated with his spinal surgery that caused muscle atrophy in his hands.

Dr. William N. Smith
(DX 19)

On January 23, 1998, Dr. Smith evaluated Mr. Brock for severe shortness of breath. Mr. Brock reported that he had worked around coal mines for about 10 years. He was a non-smoker who at that time was struggling with severe shortness of breath. He also was undergoing chemotherapy for recently diagnosed bone cancer. Upon physical examination, Dr. Smith observed that Mr. Brock's right hand, arm and shoulder had atrophied. According to Mr. Brock, after a mouth infection spread to his spine, he had neck surgery in the 1970s. About eight years later, Mr. Brock developed his right hand problem. Dr. Smith reported that Mr. Brock's right chest wall muscle had also atrophied. Mr. Brock struggled for breath, had expiratory rales, and coughed frequently. A chest x-ray had previously disclosed small calcified areas in the right lung. Dr. Smith diagnosed chronic obstructive pulmonary disease, "possible pneumoconiosis," arteriosclerotic heart disease, bone cancer, and atrophied right side muscle, including the chest wall due to a spinal cord injury.

Dr. C. Blake
(CX 1)

As previously summarized, based on his macro and micro examination of Mr. Brock's lungs and associated tissue, and absent any evidence of coal workers' pneumoconiosis, Dr. Blake concluded Mr. Brock did not have pneumoconiosis.

Death Certificate
(CX 2)

On February 1, 1999, a physician (signature illegible) certified that Mr. Brock died on January 23, 1999 due to multiple myelomas associated with bone metasis and renal failure.

Discussion

The majority of physicians to consider Mr. Brock's pulmonary condition (Dr. Jones (1976), Dr. Becknell (1981), Dr. Schaeffer (1984), Dr. Clarke (1986), Dr. Penman (1987), Dr. Hudson (1997), and possibly Dr. Baker (1984) and Dr. Smith (1998)), for diverse reasons, concluded Mr. Brock had, or possibly had, pneumoconiosis. However, a few doctors (Dr. Dahhan (1976), Dr. Williams (1986) and Dr. Blake (1999)) disagreed. At first pass, the consensus of the majority would seem to prevail; however, in light of the conflicting opinions, I must assess the relative probative value of each respective opinion and then determine the pneumoconiosis issue on the basis of the more probative assessments.

To assess relative probative value, I principally consider the following two factors: a) documentation, and b) reasoning. As I begin this evaluation, I again emphasize that the regulations have established two types of pneumoconiosis: clinical (medical) and legal. In sorting through the various opinions, I will highlight where appropriate which type of pneumoconiosis the respective doctor considered.

As to the first probative value factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co*., 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91 (1988).

Without much hesitation, I initially find the death certificate to have little probative value on the issue of pneumoconiosis. Not only is the physician's identity indecipherable, the record contains no indication of the documentation the physician may have relied on for his or her conclusion.

Next, with all due respect to Judge Smith, I conclude that the opinions of Dr. Jones, Dr. Becknell, and Dr. Penman have <u>diminished</u> probative value because they essentially based their diagnosis of pneumoconiosis on <u>positive</u> chest x-ray interpretations. Reliance on that type of evidence is misplaced since I (and previously the BRB) have determined that the preponderance of the radiographic evidence is <u>negative</u>, rather than positive, for pneumoconiosis. Once the positive chest x-ray interpretations are removed from their documentation, their respective diagnoses fail.

In Dr. Jones' exam, the other pulmonary medical evidence consisted of a normal pulmonary function test and normal physical chest exam. Dr. Jones also reported an incorrect history of coal mine employment of "25 years." Thus, his diagnosis was solely based on the incorrect chest x-ray reading.

Likewise, other than chest sounds consisting of rales, the only other objective medical evidence of a pulmonary abnormality identified by Dr. Becknell in his terse pulmonary report diagnosing clinical pneumoconiosis was his positive chest x-ray interpretation. Absent any

specific explanation on the pulmonary report form for his diagnosis, I conclude Dr. Becknell based his pneumoconiosis finding on incorrect radiographic documentation.

Other than a few noted rales, and a positive chest x-ray, Dr. Penman identified no other abnormality to support his clinical pneumoconiosis diagnosis and a contemporaneous blood gas study was normal. Dr. Penman also specifically stated the medical test supporting his diagnosis was the positive chest x-ray. That documentation is inconsistent with my finding about the chest x-ray evidence.

Both Dr. Dahhan and Dr. Williams presented findings that are consistent with the negative chest x-ray evidence. In that regard, on the issue of whether Mr. Brock had clinical pneumoconiosis, their opinions are documented and well reasoned. However, their assessments still have diminished probative value for two reasons. First, since they conducted their pulmonary exams in 1976 and 1986, respectively, their assessments do not address whether Mr. Brock may have developed pneumoconiosis later in life. Second, neither doctor addressed the issue of legal pneumoconiosis. After diagnosing chronic bronchitis, Dr. Dahhan did not discuss its etiology. Similarly, Dr. Williams apparently did not consider whether coal dust exposure may have been a factor in the development of Mr. Brock's diagnosed bronchial asthma.

Dr. Baker's opinion has diminished probative value due to equivocal and insufficient reasoning. Initially, after the chest x-ray failed to establish the presence of pneumoconiosis and both the pulmonary function test and blood gas study were normal, Dr. Baker diagnosed a "nonspecific" pulmonary disorder with associated shortness of breath and cough. In other words, Dr. Baker did not believe Mr. Brock had clinical pneumoconiosis. Later, Dr. Baker was asked whether coal dust more likely than not caused Mr. Brock's lung problem. Raising the possibility of legal pneumoconiosis, Dr. Baker replied that coal dust "may have contributed to his bronchitis or asthma." Notably absent in that equivocal conclusion is any explanation for his causation determination or reference to any objective medical evidence from the essentially normal pulmonary examination to support his stated possibility.

In a slightly similar manner, Dr. Smith's diagnosis loses probative value due to documentation and reasoning shortfalls. After a physical examination and noting a four year old chest x-ray had shown the presence of "some calcified areas," Dr. Smith included "possible pneumoconiosis" in his diagnosis. Dr. Smith also identified chronic obstructive pulmonary disease, but he did not identify an etiology. In terms of documentation, Dr. Smith rendered his assessment without any pulmonary or blood gas testing. Further, the chest x-ray Dr. Smith references is not in the record. In the area of reasoning, Dr. Smith did not explain how he developed the "possibility" of pneumoconiosis. In fact, his opinion is unclear on whether the possibility relates to clinical, legal, or both types of, pneumoconiosis. More significantly, "possible" pneumoconiosis is an equivocal medical opinion.

As Mr. Brock's treating physician, Dr. Schaeffer was in a position to present a well documented and probative medical opinion. However, due to the manner in which he presented his opinion, a poor documentary foundation, and inconsistent subsequent medical evidence, I give diminished probative value to his finding of legal pneumoconiosis. Initially, Dr. Schaefer presented his treating physician opinion by recalling Mr. Brock's breathing complaints and

stating, "Diagnosis: pneumoconiosis." When subsequently asked to provided the underlying objective medical evidence for his diagnosis, he acknowledged that he did not have any chest x-ray evidence of pneumoconiosis. While unable to diagnose clinical pneumoconiosis, Dr. Schaeffer nevertheless found Mr. Brock had legal pneumoconiosis because his chronic obstructive impairment, as demonstrated by his complaints of shortness of breath and wheezing, was caused by pneumoconiosis. Dr. Schaeffer reached that conclusion even though he also readily acknowledged that he had never actually heard Mr. Brock's wheezing (since it apparently only happened at night). In other words, other than his physician-patient relationship and Mr. Brock's breathing complaints, Dr. Schaeffer provides no objective medical evidence for his opinion. This dearth of medical evidence is significant since subsequent pulmonary function tests and blood gas studies showed Mr. Brock had essentially normal pulmonary and respiratory functions. Additionally, Dr. Schaeffer's diagnosis of a pneumoconiosis-related obstructive breathing impairment is further undone by the autopsy findings of emphysema and bronchitis, without any sign, neither pigmentation nor fibrotic reaction, of coal dust involvement.

Because Dr. Clarke's clinic pneumoconiosis diagnosis was based on a positive chest x-ray, that portion of his assessment has diminished probative value for the reasons previously discussed concerning the diagnoses of Dr. Jones, Dr. Becknell, and Dr. Penman. Dr. Clarke also diagnosed legal pneumoconiosis by concluding Mr. Brock's shortness of breath was due to his coal mine employment. The physician highlighted two factors that lead to his conclusion: a) Mr. Brock had engaged in coal mine employment; and, b) the pulmonary examination provided no other cause for his shortness of breath. While questions have arisen about the validity of Dr. Clarke's pulmonary function test which showed a pulmonary impairment, his legal pneumoconiosis diagnosis principally has diminished probative value because in 1986, he obviously did not have access to the results of the 1999 autopsy.

Rather than identifying any medical evidence or test that supported his legal pneumoconiosis diagnosis, Dr. Clarke simply relied on the absence of any other viable cause. That is, through a process of elimination, he concluded that coal dust must be the cause of Mr. Brock's pulmonary problems. However, while not specifically identifying the etiology of Mr. Brock's pulmonary difficulties, the 1999 autopsy report nevertheless also eliminates coal dust exposure as a cause. Specifically, Dr. Blake reported no signs of coal dust-related lung damage during both his gross and microscopic examination of Mr. Brock's lungs. Though he confirmed the presence of both emphysema and bronchitis, which are consistent with Mr. Brock's breathing complaints, Dr. Blake found neither coal dust pigmentation nor fibrotic reactions to coal dust exposure. Consequently, the autopsy provides strong evidence that coal dust exposure may also be eliminated as a cause of Mr. Brock's pulmonary difficulties. Since Dr. Clarke rendered his opinion on legal pneumoconiosis without the important autopsy information, his opinion became much less probative when Dr. Blake published his findings.

For the same reasons noted above, Dr. Hudson's diagnosis of chronic bronchitis due to coal mine employment, or legal pneumoconiosis, loses probative value in light of the 1999 autopsy findings. In his examination of Mr. Brock, essentially none of the medical tests suggested the cause for Mr. Brock's bronchitis. As a result, since Mr. Brock was also a non-smoker, and his symptoms were "unexplained by other factors," Dr. Hudson concluded Mr. Brock's pulmonary condition developed due to his coal mine employment. Although the cause

of Mr. Brock's breathing problems remains a mystery after the 1999 autopsy, the absence of any post-mortem evidence of coal dust involvement in Mr. Brock's lungs severs the connection between his coal mine employment and pulmonary condition.

At the conclusion of this relative probative value evaluation, only Dr. Blake remains and I find his conclusion that Mr. Brock does not have coal workers' pneumoconiosis to be documented, well reasoned and the most probative medical opinion. At this point, since the medical record clearly does not support a finding of clinical pneumoconiosis, only legal pneumoconiosis remains a possibility. On that issue, though Dr. Blake speaks in terms of clinical pneumoconiosis, his actual gross examination and microscopic lung tissue findings are exceptionally probative on the issue of legal pneumoconiosis because he recorded no evidence of coal dust involvement with Mr. Brock's lungs or lung tissue. Although Dr. Blake did not have Mr. Brock's medical record before him, he did know Mr. Brock had been a coal miner and the purpose of his autopsy examination was to determine whether Mr. Brock had coal workers' pneumoconiosis. Dr. Blake discovered that Mr. Brock did not have black lung disease. Based on his exceptionally probative observations and findings, I conclude Mr. Brock did not have either clinical or legal pneumoconiosis.

CONCLUSION

As directed by the Benefits Review Board, I have considered all the medical opinion evidence to determine whether Mr. Brock had pneumoconiosis. The medical opinion does not support a finding that Mr. Brock had clinical pneumoconiosis. Likewise, although at least two physicians presented a diagnosis of legal pneumoconiosis, neither doctor was aware of the 1999 autopsy findings which demonstrated that Mr. Brock's lung had not reacted to his coal dust exposure. The one physician who was aware of the autopsy findings, Dr. Blake, presented the most probative medical opinion, in which he concluded that Mr. Brock did not have coal workers' pneumoconiosis. Consequently, the preponderance of the more probative medical opinion does not support a finding of pneumoconiosis under 20 C.F.R. § 718.202 (a) (4). Additionally, the preponderance of the radiographic films and definitive autopsy evidence preclude a finding of pneumoconiosis under 20 C.F.R. §§ 718.202 (a) (1) and (2). Further, the regulatory presumptions of pneumoconiosis under 20 C.F.R. § 718.202 (a) (3) are inapplicable. As a result, a critical element of entitlement, the presence of pneumoconiosis, has not been proven. Accordingly, Mr. Brock's claim for benefits under the Act must be denied.

ORDER

The claim of MR. WHITT BROCK for benefits under the Act is **DENIED**.

SO ORDERED:

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RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: January 9, 2004
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2001), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 (2001) and § 725.479 (2001). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances