U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 June 2004

In the Matter of:

THURMAN E. PROFFITT,
Claimant

Case No.: 2003-BLA-6135

v.

DOMINION COAL CORP.,
Employer

and

SUN COAL COMPANY, INC.,
Carrier

and

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

Appearances:

Joseph Wolfe, Esq.
Wolfe, Williams and Rutherford
Norton, Virginia
For the Claimant

Joseph W. Bowman, Esq.
Street Law Firm
Grundy, Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits filed under the Black Lung Benefits Act, 30 U.S.C. § 901 et. seq. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725,

and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2003). In this case, the Claimant, Thurman Proffitt, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this case on November 5, 2003 in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18 (2003). At the hearing, Director's Exhibits ("DX") 1-36, Claimant's Exhibits ("CX") 1-2, and Employer's Exhibits ("EX") 1-4[1] were admitted into evidence without objection, except as to Claimant's objections to the qualifications of the person who administered pulmonary function and blood gas tests in DX 35. The record was held open to allow briefing on this issue, and for the Claimant to submit impeachment evidence on Dr. Fino's qualifications. Transcript ("Tr.") at 7-9, 10, 14. The Claimant did not submit any post-hearing brief or evidence, obviating the need for responsive briefing by the Employer. DX 35 was provisionally admitted at hearing; absent any further evidence or argument, its admission into evidence is confirmed. The record is now closed.

I have reviewed and considered the entire record in reaching my decision.

PROCEDURAL HISTORY

The Claimant filed an initial claim on December 20, 1979. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on May 15, 1980, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, nor that it was caused by coal mine work, nor that the Claimant was totally disabled. The Claimant did not appeal that determination. DX 34.

More than one year later, on March 21, 1995, the Claimant filed a duplicate claim. The duplicate claim was denied by the District Director, OWCP on June 19, 1996 on the grounds that the evidence did not show that the Claimant had pneumoconiosis, nor that it was caused by coal mine work, nor that the Claimant was totally disabled. The District Director also found that the Claimant did not establish a material change in condition. The Claimant did not appeal that determination. DX 35.

The Claimant filed his current claim on October 11, 2001. DX 1. The District Director issued an award of benefits in a Proposed Decision and Order issued on March 6, 2003. DX 28. The Employer requested a hearing on March 19, 2003. DX 30. The claim was referred to the Office of Administrative Law Judges on June 12, 2003. DX 36.

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[1] The transcript of Dr. Castle's deposition, EX 4, was not available at the time of the hearing, but Claimant did not object to its admission when available. It was submitted after the hearing.

ISSUES

The issues contested by the Employer are:

1. How long Mr. Proffitt worked as a miner.

2. Whether he has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

5. Whether his total disability is due to pneumoconiosis.

6. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2003).

Tr. 5, DX 36.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on October 11, 2001. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2003), as amended at 68 Fed. Reg. 69935 (2003). Pursuant to 20 C.F.R. § 725.309(d) (2003), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 C.F.R. § 718.1, 718.202, 718.203 and 718.204 (2003). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); *Labelle Processing Company v. Swarrow*, 72 F.3d 308 (3rd Cir. 1996). As will be discussed in detail below, the recent pulmonary function tests and exercise arterial blood gas studies, in combination with the majority of current medical opinions, establish that the Claimant now has a total pulmonary disability. This constitutes a change in an applicable condition of entitlement pursuant to Section 725.309(d). Therefore, I have considered all of the evidence in the record in reaching my decision that Mr. Proffitt is entitled to benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background

Mr. Proffitt testified only briefly at the hearing. Mr. Proffitt was born in 1940. DX 1. He has been married to his wife, Wanda, since 1965. DX 6; Tr. 16. The evidence in the record consistently indicates that Mr. Proffitt began smoking when he was fifteen (1955) and that he has smoked approximately one pack a day since that time.

Mr. Proffitt testified that he worked in coal mine employment until 1994 and that he has performed no work in any capacity since that time. Tr. 16. On his work history form, Mr. Proffitt reported that while he was employed in coal mines, he repaired track, hung vent curtains, cut coal, and he shoveled and cleaned belts. DX 3.

Mr. Proffitt's last coal mine employment took place in Virginia. DX 4. Therefore, the law of the Fourth Circuit governs this claim. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Length of Coal Mine Employment

Mr. Proffitt alleged 30 years of coal mine employment. The District Director, OWCP found that he had established 20.42 years of coal mine employment. DX 28. Counsel for the Employer stipulated that he worked for Dominion Coal for over 10 years. Tr. 5. Based on Social Security and other employment records in evidence, I find that the Claimant worked for at least 20 years in coal mine employment. DX 2, DX 4, DX 34, DX 35.

Medical Evidence

Chest X-rays

Chest X-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest X-rays and their interpretations are found at 20 C.F.R. § 718.102 (2003) and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b) (2003). All such readings are therefore included in the "negative" column. X-ray interpretations that make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physician qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).[2] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A = NIOSH certified A-reader; B = NIOSH certified B-reader; BCR = Board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12/12/78	DX 34 Sutherland (A[3]) ILO Classification: 1/1		
12/22/79	DX 34 Sutherland (A) ILO Classification: 1/1		
04/14/80		DX 34 Eryilmaz (BCR, B) ILO Classification: 0 Smith (BCR, B) ILO Classification: 0/0	
07/25/84			DX 15 Cunningham Negative for acute abnormality.
04/27/94	DX 35 Bassali (BCR, B) ILO Classification: 1/1		
03/31/95		DX 35 Forehand (B) Gaziano (B) Shipley (B) Spitz (BCR, B) Wiot (BCR, B)	
03/13/96		DX 35 Castle (B) ILO Classification: 0/1	

[2]NIOSH is the federal government agency which certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as A-readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as B-readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

[3] Dr. Sutherland was an A-reader from September 12, 1970, to December 13, 1996. U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004 (visited June 18, 2004), http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
03/14/97			DX 14 Kennedy Chronic obstructive pulmonary disease
08/04/00			DX 14 Coburn Chronic interstitial changes
11/12/01			DX 14 Coburn Chronic interstitial changes
01/31/02	DX 12 Patel (BCR, B) ILO Classification: 1/0	EX 1 Wheeler (BCR, B)	DX 13 Navani (BCR, B) Film quality 1
06/26/02		DX 27 Castle (B) ILO Classification: 0/1	
12/26/02	CX 1 Robinette (B) ILO Classification: 1/1		
05/29/03	CX 2 Patel (BCR, B) ILO Classification: 1/0		
09/26/03		EX 2 Fino (B) ILO Classification: 0/0	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in connection with this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.203(b)(2)(i) (2003).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 34 04/14/80 Peralta	39 63”	2.5	2.9	86	91	No[4]	---
DX 35 03/31/95 Iosif	54 62”[5]	2.61 2.66	4.61 4.86	56.7 54.7	--- ---	No No	Mild obstruction. Significant improvement after bronchodilator.
DX 35 03/13/96 Castle	55 62”	2.30 2.47	3.47 3.74	66 66	88 109	No No	The pre-bronchodilator spirometry does not meet reproducibility standards. The post-bronchodilator spirometry is valid. Mild obstructive airway disease. No restriction.
DX 7 01/31/02 Rasmussen	61 63”	1.38 1.57	3.25 3.04	42 52	57 68	Yes No	Moderate, partially reversible obstructive ventilatory impairment. Per Dr. Michos, DX 8, valid study.
DX 27 Castle 06/26/02	62 63”	1.10 1.24	2.74 3.19	40 39	48 ---	Yes Yes	Moderately severe airway obstruction with a slight response to bronchodilators.

[4] Because the initial claim was filed before March 31, 1980, the regulations at 20 CFR Part 727 applied, rather than those at 20 CFR Part 718.

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 62” to 63”, I have taken the mid-point (62.5”) in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
CX 1 12/26/02 Robinette	62 62”	.90 1.03	1.78 2.10	50 49	--- ---	Yes Yes	Severe obstructive lung disease with response to bronchodilator therapy.
CX 2 05/29/03 Rasmussen	62 63”	1.09 1.17	2.05 2.35	53 50	44 52	Yes Yes	Severe, slightly reversible obstructive ventilatory impairment.
EX 2 09/26/03 Fino	63 62.5”	1.08	2.75	39	---	Yes	Severe obstruction.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial blood oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in this case. A “qualifying” arterial gas study yields values, which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2003).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify	Physician Impression
DX 34	04/14/80	Peralta	36 32	75 98	No[6] No	--- ---
DX 35	03/31/95	Iosif	36.7	73.1	No	---
DX 35	03/13/96	Castle	36.8	78	No	Normal

[6] Because the initial claim was filed before March 31, 1980, the regulations at 20 CFR Part 727 applied, rather than those at 20 CFR Part 718.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify	Physician Impression
DX 7, DX 11	01/31/02	Rasmussen	37 35	64 55	No Yes	Marked impairment in oxygen transfer. Per Dr. Michos, DX 8, acceptable study.
DX 27	06/26/02	Castle	38.3	71.2	No	Normal
CX 1	12/26/02	Robinette	39	66	No	Normal pCO_2, decreased pO_2.
CX 2	05/29/03	Rasmussen	39 38	62 50	No Yes	Minimal resting hypoxia. Markedly hypoxic with exercise.
EX 2	09/26/03	Fino	45.5	78.6	No	Normal

Medical Opinions

Medical opinions are relevant to the issues of whether a miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a)(4) (2003). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2003). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.202(b)(2)(iv) (2003). With certain specified exceptions which do

not apply here, the cause or causes of total disability must also be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2003). Quality standards for reports of physical examinations performed before January 19, 2001, are found at 20 C.F.R. § 718.104 (2000). The record contains the following medical opinions submitted in connection with the current claim.

Treatment Records

Records from the Clinch Valley Medical Center indicate that Mr. Proffitt was hospitalized in July 1984 for back pain, weakness, and shortness of breath and weight loss. He was diagnosed as having osteoarthritis and glycid intolerance. DX 15.

Mr. Proffitt was hospitalized again in July 1988 for acute lumbar radicular syndrome. DX 15.

Mr. Proffitt was again hospitalized at Clinch Valley Medical Center in March 1999 for shortness of breath and cough. Mr. Proffitt was diagnosed as having viral influenza, acute bronchitis with exacerbation of chronic obstructive pulmonary disease, hypertension, and hyperlipidemia at that time. DX 15.

The record contains Dr. Dwight Bailey's office records from February 1997 to April 2002. DX 14. Dr. Bailey is board-certified in Family Practice. DX 26. The notes indicate that Mr. Proffitt saw Dr. Bailey every one to three months during that period. Dr. Bailey's assessments consistently list a diagnosis of chronic obstructive pulmonary disease. Other recurrent diagnoses include degenerative disk disease with many references to low back pain, arthritis, hypertension and hyperlipidemia. In early visits his lungs were clear. As time went on, the records referenced occasions of acute exacerbation of his COPD, decreased breath sounds, inspiratory and expiratory wheezes, and note that Mr. Proffitt's subjective complaints included shortness of breath, increasing cough, and congestion. DX 14.

In a letter dated August 26, 2002, Dr. Bailey wrote a letter on Mr. Proffitt's behalf in which he stated:

> Mr. Thurman Proffitt is a 60-year-old white male who worked in the mines approximately twenty-eight years. He has a history of progressive shortness of breath requiring oxygen at night. He has dyspnea on exertion.
>
> His chest x-ray shows chronic interstitial changes consistent with black lung disease and pneumoconiosis. He has had oximetry at night at three hours and 12.7 minutes with an oxygen saturation less than 90% which is 30.s% of the time monitored. He had a pulmonary function test which showed moderate obstruction consistent with his pneumoconiosis.
>
> I feel that the patient does have significant pneumoconiosis at this time.

DX 26.

Opinions Given in Connection with Black Lung Claims

Dr. A. M. Peralta examined Mr. Proffitt on behalf of the Department of Labor on April 14, 1980, in connection with his first claim. In his conclusion Dr. Peralta wrote that there was "no evidence of CHF (congestive heart failure) or cor pulmonale at time of exam." In response to whether Mr. Proffitt had a condition related to coal dust exposure, Dr. Peralta wrote "not definitely known." DX 34.

Dr. German Iosif examined Mr. Proffitt on behalf of the Department of Labor on March 31, 1995, in connection with his second claim. DX 35. He is board-certified in Internal Medicine and Pulmonary Disease. He took occupational, medical, and social histories, and administered chest x-ray, arterial blood gas, and pulmonary function testing. He also recorded Claimant's subjective complaints and reviewed medical records. Dr. Iosif reported that Mr. Proffitt worked in coal mine employment for over 20 years. He also recorded that Mr. Proffitt had smoked one pack of cigarettes a day for approximately 35 years. Dr. Iosif concluded that Mr. Proffitt had COPD/chronic bronchitis, and that there was no evidence of pneumoconiosis. He attributed the COPD/chronic bronchitis to cigarette smoking. He also opined that the degree of ventilatory impairment was "mild" and was due to "years of cigarette smoking." DX 35.

Dr. James R. Castle examined Mr. Proffitt on behalf of the Employer on March 13, 1996, also in connection with the second claim. Dr. Castle is board-certified in Internal Medicine and Pulmonary Disease, and a B-reader. In a report dated May 2, 1996, he noted Mr. Proffitt's occupational, medical, and social histories and he administered chest x-ray, arterial blood gas, and pulmonary function testing. He also recorded Claimant's subjective complaints and reviewed medical records. Dr. Castle concluded that there was no evidence of coal workers' pneumoconiosis, but that Mr. Proffitt had chronic bronchitis by history, due to tobacco use. Dr. Castle also found a "mild obstructive airways disease secondary to tobacco use." Dr. Castle also noted that Mr. Proffitt had an elevated carboxyhemoglobin level "indicating recent exposure to products of combustion such as tobacco smoke." After reviewing additional medical records, Dr. Castle opined again that Mr. Proffitt has no "physiologic abnormalities related to coal mining employment or coal dust exposure." He wrote that even if it were determined that Mr. Proffitt had pneumoconiosis, it was not disabling and that his physiologic function "is well above disability standards and would afford him the capability of performing his usual coal mining employment duties." DX 35.

In connection with the current claim, Dr. D. L. Rasmussen examined Mr. Proffitt on January 31, 2002, on behalf of the Department of Labor. Dr. Rasmussen is board-certified in Internal Medicine and Forensic Medicine, and a B-reader. CX 2. Dr. Rasmussen took occupational, medical, and social histories and administered chest x-ray, arterial blood gas and pulmonary function testing. He also recorded Claimant's subjective complaints. He recorded Mr. Proffitt's coal mine employment history as totaling approximately 28 years. Dr. Rasmussen also noted that Mr. Proffitt smoked cigarettes since he was 15 years old, smoking one pack a day. On physical examination, Dr. Rasmussen said the chest expansion seemed reduced; breath sounds were moderately to markedly reduced; there were scattered, bilateral rhonchi; and prolonged expiratory phase. Dr. Rasmussen wrote that the chest x-ray interpreted by Dr. Patel

showed pneumoconiosis (1/0), that the pulmonary function study showed a "moderate, partially reversible obstructive ventilatory impairment," and the arterial blood gas studies showed a "marked impairment in oxygen transfer during very light exercise." He concluded that Mr. Proffitt had coal workers' pneumoconiosis based on his 28 years of coal mine employment and his chest x-ray results. Dr. Rasmussen determined that the pneumoconiosis was due to coal mine dust exposure. He also concluded that Mr. Proffitt had a "marked loss of lung function" and that he "does not retain the pulmonary capacity to perform his last regular coal mine job." Dr. Rasmussen opined that both Mr. Proffitt's cigarette smoking and his coal mine dust exposure contribute to the impairment, but that the coal mine dust exposure "significantly contributes to his pulmonary impairment." DX 10, DX 11.

Dr. Castle examined Mr. Proffitt on behalf of the Employer for the second time on June 26, 2002. He took occupational, medical, and social histories, and administered chest x-ray, arterial blood gas, and pulmonary function testing. He also recorded Claimant's subjective complaints and reviewed medical records. Dr. Castle recorded that Mr. Proffitt was employed in coal mines for 26–28 years. He also recorded that Mr. Proffitt smoked one pack of cigarettes a day since he was 15 years old. His chest examination was normal except for a prolonged expiratory phase and bilateral wheezing. Chest x-ray showed a few s/s type opacities which he classified as 0/1, stating they were not consistent with pneumoconiosis. Valid spirometry showed moderately severe obstruction with slight response to bronchodilators, with no restriction. There was evidence of hyperinflation, gas trapping, and mildly reduced diffusion. Resting arterial blood gas was normal. He did not perform an exercise study because of Mr. Proffitt's back troubles. Dr. Castle concluded that there was no evidence of coal workers' pneumoconiosis, but that Mr. Proffitt had pulmonary emphysema due to tobacco abuse. He also diagnosed a "moderately severe airway obstruction with hyperinflation and diffusion reduction due to his pulmonary emphysema." Dr. Castle also noted that Mr. Proffitt was a current smoker and that he showed an elevated carboxyhemoglobin level. He also concluded that Mr. Proffitt had a total pulmonary disability due to tobacco smoke induced chronic obstructive pulmonary disease. He elaborated:

> Even if one were to conclude that Mr. Proffitt does have radiographic evidence of simple coal workers' pneumoconiosis, my opinion concerning his lack of disability due to that process would remain unchanged. My opinion is not predicated upon his having a normal or negative x-ray. It is, however, contingent upon his not having the physiologic changes indicating disability due to coal workers' pneumoconiosis.

DX 27.

Dr. Castle also testified in a deposition taken on November 4, 2003. EX 4. In this deposition, Dr. Castle reiterated his earlier findings that Mr. Proffitt had tobacco smoke-induced pulmonary emphysema. He also testified that Mr. Proffitt does not have any coal mine dust-related lung disease. EX 4, p.27. Dr. Castle also emphasized that at the time of his examination and testing of Mr. Proffitt, his carboxyhemoglobin level was 6.6, consistent with someone smoking a pack or more of cigarettes a day. EX 4, p.17. He also testified that Mr. Proffitt's pulmonary function studies, specifically showed hyperinflation and gas trapping "which would

be consistent with an emphysematous process." EX 4, p.21. Dr. Castle agreed that coal mine dust exposure can cause emphysema, but he stated specifically:

> [Coal mine dust exposure] causes what is known as focal emphysema. Focal emphysema is part of the diagnostic criteria for the pathologic diagnosis of coal workers' pneumoconiosis. Focal emphysema that is seen there is a dilated area around the coal macule, and in that sense, it does cause emphysema. In terms of whether or not it causes bullous emphysema or this type of emphysema that we see here, it does not typically do that.

EX 4, p.31. He also testified that Mr. Proffitt had a reduction in diffusion capacity, "which is also not typical of coal mine dust exposure." EX 4, p.32. Dr. Castle also testified that Mr. Proffitt had "marked hyperinflation" and "gas trapping" which are "hallmarks of tobacco smoke-induced pulmonary emphysema. EX 4, p.32. He said the decline in Mr. Proffitt's pulmonary function testing results was "accelerated even for cigarette smoking" which indicated to him "that this is an individual very highly susceptible to the effects of tobacco smoking." EX 4, p. 33. He again concluded that Mr. Proffitt did not have the "pulmonary ability to return to coal mining." EX 4, p.50.

Dr. Emory H. Robinette examined Mr. Proffitt on December 26, 2002, at the request of his counsel, and submitted a report dated February 3, 2003. Dr. Robinette is board-certified in Internal Medicine and Pulmonary Disease, and a B-reader. He took occupational, medical, and social histories and administered chest x-ray, arterial blood gas and pulmonary function testing. He also recorded Claimant's subjective complaints, which included profound shortness of breath on exertional activity, two pillow orthopnea, chronic cough and congestion, and paroxysmal wheezing and nocturnal dyspnea. Dr. Robinette reported Mr. Proffitt's coal mine employment history as totaling 28 years. He also reported that Mr. Proffitt smoked cigarettes from the time he was 15 years old, smoking one pack of cigarettes per day on a regular basis. Physical examination disclosed an increased AP diameter, diminished breath sounds, bilateral expiratory wheezes, marked prolongation of the expiratory phase and rhonchi. Dr. Robinette concluded that the physical assessment showed "marked emphysema," and that the chest X-ray showed evidence of pneumoconiosis 1/1 with mild interstitial pulmonary fibrosis and emphysema. Opacities were scattered in all lung zones. Pulmonary function studies showed decreased flow rates. Lung volume studies showed evidence of elevated total lung capacity and residual volume. Diffusion capacity was reduced. Resting arterial blood gas studies revealed mild resting hypoxemia and elevated carboxyhemoglobin. He concluded that Mr. Proffitt had simple coal workers' pneumoconiosis, very severe obstructive lung disease with intercurrent hypoxemia, mild hyperglycemia, hypertensive cardiovascular disease, and degenerative arthritis with apparent failed back syndrome. He further concluded:

> … Functionally, Mr. Proffitt has severe airflow obstruction … Obviously, Mr. Proffitt's pulmonary disease is so severe that he would be unable to work as an underground coal miner. His pulmonary disease is at least partially related to his coal mining employment but it is acknowledged that he has continued to smoke cigarettes and there is an elevation of the patient's carboxyhemoglobin level. These factors are contributing to his worsening airflow obstruction. This condition is chronic and irreversible. …

CX 1.

Dr. D.L. Rasmussen examined Mr. Proffitt a second time on May 29, 2003, at the request of his counsel. He again recorded Mr. Proffitt's occupational, medical, and social histories and administered chest x-ray, arterial blood gas and pulmonary function testing. He also recorded Claimant's subjective complaints, noting that Mr. Proffitt denied nocturnal dyspnea since he was placed on oxygen therapy. Chest expansion was essentially normal. Breath sounds were moderately to markedly reduced. There were no rales, rhonchi or wheezed. There was prolonged expiratory phase with forced respirations. Dr. Rasmussen wrote that the chest x-ray interpreted by Dr. Patel showed pneumoconiosis (1/0) in all lung zones, that the pulmonary function study showed a "severe, slightly reversible obstructive ventilatory impairment." Maximum breathing capacity was reduced, improving with bronchodilator therapy. There was minimal resting hypoxia; on exercise he was markedly hypoxic. The studies indicated very marked loss of lung function. He concluded that Mr. Proffitt had pneumoconiosis based on his years of coal mine employment and his chest x-ray. He determined that the pneumoconiosis was due to coal mine dust exposure. Dr. Rasmussen also concluded that Mr. Proffitt "does not retain the pulmonary capacity to perform his last regular coal mine job." He opined that:

> The two risk factors for this patient's disabling lung disease are his cigarette smoking and his coal mine dust exposure. Both contribute since both cause the same type of lung tissue destruction. They even share some cellular and biochemical mechanisms causing lung tissue damage. The patient exhibits a rather profound impairment in gas exchange as well, perhaps out of proportion to his ventilatory impairment. This clearly indicates that his coal mine dust exposure is a major contributing factor.

CX 2.

Dr. Gregory J. Fino examined Claimant on September 26, 2003, on behalf of the Employer, and submitted a report dated October 16, 2003. Dr. Fino is board-certified in Internal Medicine and Pulmonary Disease. He took occupational, medical and social histories, and administered chest x-ray, arterial blood gas, and pulmonary function testing. He also recorded Claimant's subjective complaints and reviewed medical records back to the 1978 chest x-ray. Dr. Fino reported that Mr. Proffitt's coal mine employment totaled 28 years. He also reported that Mr. Proffitt smoked one pack of cigarettes a day from 1955 to June 2003. On physical examination, he reported decreased breath sounds. He found no pleural or parenchymal abnormalities consistent with pneumoconiosis on the chest x-ray, and classified it as 0/0. Spirometry showed severe obstruction. Lung volumes were elevated, and air trapping was present. Diffusing capacity was reduced. Oxygen saturation, carboxyhemoglobin and resting arterial blood gas were normal. Dr. Fino concluded that Mr. Proffitt had "severe pulmonary emphysema secondary to cigarette smoking," and that Mr. Proffitt "has a totally disabling respiratory impairment due to pulmonary emphysema that would prevent him from returning to his last mining job that would require similar effort." Thus he agreed that Mr. Proffitt was disabled, but attributed the disability solely to cigarette smoking. Dr. Fino went on to state:

> … Assuming that coal mine dust played some role in the obstructive lung disease, it was clinically insignificant. The extent of the obstruction that may have been caused by coal mine dust had been demonstrated in the pulmonary function studies from 1995 and 1996. There was not enough obstruction to cause a reduction in the FEV1.
>
> This is not to say that coal mine dust cannot progress or cause an obstructive ventilatory abnormality. However, the pattern of abnormality over time is clearly consistent with cigarette smoking. …
>
> The Department of Labor examination performed on 1/31/02 demonstrated a reduction in the diffusing capacity which is reflected by the drop in the pO2 value. A reduction in the diffusing capacity can also be seen in the examination by Dr. Rasmussen on 5/29/03. The drop in the pO2 is consistent with pulmonary emphysema.

Dr. Fino concluded that there was insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis; that there was a disabling respiratory impairment; and that even were he to assume the presence of pneumoconiosis, it did not contribute to the disability. EX 2.

In a deposition taken on November 3, 2003, Dr. Fino essentially reiterated these findings and his conclusion that Mr. Proffitt has "cigarette smoking-induced severe pulmonary emphysema." EX 3, p.28. He also testified that Mr. Proffitt did not have any coal mine dust-related lung disease. EX 3, p.27. Of note, Dr. Fino discussed how in reviewing other medical records, there was evidence that Claimant's carboxyhemoglobin levels were abnormally high, indicating that Mr. Proffitt's cigarette smoking had not ceased. EX 3, p.11–15. He also opined that the "marked acceleration in FEV-1 loss between 1995 and the present time" is more consistent with ongoing cigarette smoking than coal-dust related disease. EX 3, p.30.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921 (c)(3), 20 C.F.R. § 718.304 (2003), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c) (2003). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion, and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d) (2003). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2003); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

Except for one post-bronchodilator study in January 2002, all of the recent pulmonary function tests meet the regulatory requirements to show total disability, as do both exercise blood gas studies. Moreover, all of the doctors who examined Mr. Proffitt since January 2002 agree that his pulmonary or respiratory impairment would prevent him from performing his last regular coal mine job. Accordingly, I find that the Claimant has established this element of entitlement and in so doing, also established a change in a condition of entitlement pursuant to § 725.309(d).

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those disease recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a 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.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2003). In this case, the Claimant has been diagnosed with "chronic obstructive pulmonary disease," which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 C.F.R. § 718.202(a) (2003) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in § 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), § 718.305 (not applicable to claims filed after January 1, 1982) or § 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314–315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987); *Eastern Associated Coal. Corp. v. Director*, 220 F.3d 250, 258–259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148, 1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the 15 available x-rays in this case, six x-rays have been read by some or all reviewers to be positive for pneumoconiosis, and six have been read as negative by some or all readers. Four x-rays are silent as to the existence of pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. 718.202(a)(1) (2003); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213, n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually-qualified physicians. *Scheckler v. Clinchfield*

Coal Co., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *Adkins*, 958 F.2d at 52.

The x-rays submitted in conjunction with Mr. Proffitt's first claim include two reports from December 12, 1978, and December 22, 1979, both from Dr. Sutherland, who was an A-reader. These were read as positive. There is also an x-ray from April 14, 1980 which was read as negative by two dually-qualified radiologists.

The x-rays submitted in conjunction with Mr. Proffitt's second claim included an x-ray taken on April 27, 1994. This was read as positive (1/1) by a dually-qualified radiologist. There are no others readings of this x-ray. An x-ray taken almost a year later on March 31, 1995 was read as negative by five B-readers, two of whom are dually-qualified. Finally, an x-ray dated March 13, 1996 was also read as negative by a B-reader.

Interpretations of x-rays taken in connection with medical treatment include the one taken in 1984, which noted no acute abnormality, and those taken in 1997, 2000, and 2001, which mention chronic obstructive pulmonary disease or chronic interstitial changes, but do not mention pneumoconiosis. Whether an x-ray interpretation which is silent as to pneumoconiosis should be interpreted as negative for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co*., 6 B.L.R. 1-930 (1984). I find that the 1984 x-ray is negative, but the more recent x-rays are neither positive nor negative.

Of the recent x-rays of record, the x-ray dated January 31, 2002 was read as positive by a dually-qualified radiologist and as negative by a similarly-qualified radiologist. The next x-ray dated June 26, 2002 was read as negative by a B-reader. There are no others readings of this x-ray. The next x-ray report dated December 26, 2002 was read as positive by a B-reader. There are no others readings of this x-ray. The next x-ray report dated May 29, 2003 was read as positive by a dually-qualified radiologist. There are no others readings of this x-ray. The most recent x-ray, taken on September 26, 2003, was read as negative by a B-reader. There are no others readings of this x-ray.

I find that the evidence submitted with the previous claims does not support a positive finding of pneumoconiosis by x-ray. However, in reviewing the more current X-rays, which were taken approximately six years later than the last x-ray associated with the second claim, I find that these reports support a positive finding of pneumoconiosis. First, I note that these x-rays are more probative since they are significantly more recent. In addition, the current evidence contains five x-rays, one of which was read twice. There are three positive readings—two performed by dually-qualified physicians, and three negative readings—only one of which was performed by a dually-qualified physician. Therefore, although there are an even number of negative and positive x-ray interpretations within the current x-ray evidence, there are more dually-qualified physicians who found the presence of pneumoconiosis on x-ray. For this reason, I find that the x-ray evidence supports a positive finding of pneumoconiosis.

I must next address the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Whether a medical report is sufficiently documented and reasoned is for the judge to decide as finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186–187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. O*nderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration…weighing…the medical evidence." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 C.F.R. § 718.104(d) (2003).

In reviewing the medical opinions, I note that Drs. Rasmussen, Robinette, and Bailey all found positive evidence of pneumoconiosis. Drs. Castle, Fino, Iosif, and Peralta did not. In assessing these opinions I discount Dr. Peralta's because his conclusion—that it was not "definitely known" whether or not Mr. Proffitt has pneumoconiosis—was equivocal, and remote in time.

The remaining conflicting medical opinions must be weighed to resolve the contrary conclusions. I find that all of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions, and the smoking and coal mine employment histories assumed were all consistent

and fairly accurate. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions.

In considering the negative findings of Dr. Castle, Fino, and Iosif, however, I note that each of these physicians relied on negative x-rays for their conclusion that Mr. Proffitt did not have pneumoconiosis, whereas I have found the greater weight of recent x-ray evidence to be positive for pneumoconiosis.[7] This diminishes the weight to be given their respective opinions. In addition, Dr. Iosif's opinion is based on medical information and data that is more than seven years older than that reviewed by other physicians. For this reason, I find that his opinion is also less probative.

In assessing the three positive physician opinions, significant weight must be given to the opinion of Dr. Bailey as he is Mr. Proffitt's treating physician. It appears that Dr. Bailey has treated Mr. Proffitt quite frequently over the course of at least five years (1997–2002), seeing him as often as every other month. Dr. Bailey has also specifically treated Mr. Proffitt's respiratory condition. I find that he has obtained superior and relevant information regarding Mr. Proffitt's condition and I give his opinion much weight.

In sum, with the exception of Dr. Peralta's opinion, I do not wholly discredit any of the medical opinions of record. In resolving the conflict presented by the physicians of record, however, I find the opinions of Drs. Bailey, Rasmussen, and Robinette merit greater probative weight. This is especially true in light of the fact that both Dr. Rasmussen and Dr. Robinette are both board-certified pulmonologists and that Dr. Bailey has been Mr. Proffitt's treating physician for a significant amount of time. These credible and well-reasoned medical opinions are convincing for purposes of establishing that Mr. Proffitt has pneumoconiosis. This evidence outweighs the contrary conclusions provided by Drs. Fino, Castle, and Iosif who relied on negative x-ray evidence to support their findings. I conclude, therefore, that the weight of the medical opinions of record establishes that the Claimant has pneumoconiosis as the Act requires for entitlement to benefits.

In light of the x-ray evidence that I have found to be generally positive, in combination with the physician opinion evidence, I find that the Claimant has established that he has pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. 921 (c)(1); 20 C.F.R. 718.203(b) (2003). As Claimant has established at least 20 years of coal mine employment, he is entitled to the presumption. I find that there is no evidence to contradict such a finding, and conclude that the Claimant has established this element of entitlement.

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[7] In addition, Dr. Fino relied on multiple negative readings of the x-rays taken January 31, 2002, and June 26, 2002, which are not admissible under the current rules. *See* EX 2; 20 CFR § 725.414(a)(3)(i) (2003).

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to the Claimant's disability. A "substantially contributing cause" is one which has a material adverse effect on the Claimant's respiratory or pulmonary condition, on one which materially worsens another respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 C.F.R. § 718.204(c) (2003); *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3rd Cir. 1989).

The Benefits Review Board has held that § 718.204 places the burden on the Claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates that it has not changed. See 65 *Fed. Reg*. 79923 (2000). ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment…"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 791–792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109 (4th Cir. 1995) the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the Claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the Claimant did not have pneumoconiosis. The Court noted that there was no case law directly on point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However, the Court did hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

Toler, 43 F.3d at 116. *See also Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

In weighing the various physician opinions regarding causation of total disability in the present case, I find that there are two positive findings: Dr. Rasmussen and Dr. Robinette. Dr. Bailey gave no opinion on causation of total disability. Dr. Castle, Dr. Fino and Dr. Iosif found that Mr. Proffitt's total disability was due to cigarette smoking only. Dr. Peralta's opinion from 1980 is of no weight as he made no findings regarding presence of disease or disability.

Similarly, Dr. Iosif's opinion, given when Mr. Proffitt had only a "mild" impairment, is due little weight. In any event, under *Toler* and *Scott*, I find no persuasive reasons to rely on the opinions of Drs. Castle, Fino and Iosif, which were premised on the absence of pneumoconiosis. In addition, Dr. Rasmussen and Dr. Robinette do not dispute that tobacco abuse plays a role in the Claimant's total disability, they merely find that both cigarette abuse and pneumoconiosis contribute to that disability. I find that the well-reasoned and documented opinions of Dr. Rasmussen and Dr. Robinette establish that Mr. Proffitt's total disability is due to pneumoconiosis within the meaning of the statute and regulations. Thus the Claimant has also established this element of entitlement.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 C.F.R. 725.503(b) (2003). The Claimant filed his claim in October 2001. When he was examined by Dr. Rasmussen in January 2002, he was already totally disabled. I therefore find that the Claimant is entitled to benefits from October 2001, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden of establishing that he has pneumoconiosis, that it arose out of his coal mine employment, that he has a total respiratory disability, and that the total respiratory disability arises from his pneumoconiosis. In doing so, the Claimant has also shown a change in condition pursuant to § 725.309(d).

ATTORNEY FEES

The Regulations address attorney's fees at 20 C.F.R. §§ 725.362, 725.365 and 725.366 (2003). Claimant's attorney has not yet filed an application for attorney's fees. Claimant's attorney is hereby allowed thirty (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits, filed by Thurman E. Proffitt on October 11, 2001, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHT: Pursuant to 20 C.F.R. § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order by filing notice of appeal with the Benefits Review Board, at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.