Issue Date: 27 January 2005U.S. Department of Labor Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

In the Matter of:
CALVIN B. LAWSON
Claimant
vs. Case No. 2004-BLA-05271

WESTMORELAND COAL COMPANY
Employer
and

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

Before: Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER - DENYING CLAIM[1]

Jurisdiction and Claim History

This case comes on a request for a hearing pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§ 901 *et seq*. (the Act) (DXs 28, 29, 35)[2] dated August 13, 15 and September 5, 2003.[3]

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[1] 20 C.F.R. § 725.477, 5 C.F.R. § 554-7 (Administrative Procedure Act), and also 20 C.F.R. § 725.479 Finality of decisions and orders.
(a) A decision and order shall become effective when filed in the office of the deputy commissioner (see § 725.478), and unless proceedings for suspension or setting aside of such order are instituted within 30 days of such filing, the order shall become final at the expiration of the 30th day after such filing (see § 725.481).
(b) Any party may, within 30 days after the filing of a decision and order under § 725.478, request a reconsideration of such decision and order by the administrative law judge. The procedures to be followed in the reconsideration of a decision and order shall be determined by the administrative law judge.
(c) The time for appeal to the Benefits Review Board shall be suspended during the consideration of a request for reconsideration. After the administrative law judge has issued and filed a denial of the request for reconsideration, or a revised decision and order in accordance with this part, any dissatisfied party shall have 30 days within which to institute proceedings to set aside the new decision and order or affirmance of the original decision and order.

[2] References to "ALJX", "CX", "DX" and "EX" refer to the exhibits of the Administrative Law Judge, Claimant, Director and the Employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

[3] And the regulations at 20 C.F.R. Ch. VI, Subchap. B (the Regulations).

A hearing was held on May 12, 2004, in Bristol, Virginia. The Claimant is represented by Joseph Wolfe, Esq., Wolfe, Williams & Rutherford, Norton, Virginia. Westmoreland Coal Company (hereinafter "Employer") is represented by Douglas A. Smoot, Esq., Jackson Kelly, PLLC, Charleston, West Virginia. An appearance was entered for the Director, OWCP, who was not represented at the hearing. The Claimant appeared at the hearing and testified. Forty-three (43) Director's exhibits, DX 1 through DX 43,[4] four (4) Claimant's exhibits, CX 1 through CX 4,[5] fifteen (15) Employer's exhibits, EX 1 through EX 15,[6] and two Administrative Law Judge's exhibits, ALJX 1 and 2,[7] were received into the record for identification. The record remained opened following the close of the formal hearing. Subsequent to the hearing, the Employer submitted the rereading of the April 12, 2004 x-ray. (EX 16). Further, the parties have submitted post-hearing memoranda. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing, and the arguments of the parties.

Because this subsequent claim was filed after January 20, 2001, evidence is limited subject to 20 C.F.R. § 725.414(a)(2)(2004). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations have undergone extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 *et seq*. (2000). *See also* 68 Fed. Reg. 69930-69935 (2003). The Department of Labor has taken the position that, as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 C.F.R. § 718.101(b) (2004). The United States District Court for the District of Columbia upheld the validity of the new regulations in ***National Mining Association v. Chao***, 160 F.Supp. 2d 47 (D.D.C. 2001). However, the district court's decision was affirmed in part, reversed in part, and the case remanded on appeal to the United States Court of Appeals for the District of Columbia Circuit. ***National Mining Association v. Department of Labor***, 292 F.3d 849 (D.C.Cir. 2002) (upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a Claimant to an Employer exceeded the authority of the Department of Labor). Recently, the Benefits Review Board has upheld the evidence development provisions of 20 C.F.R. § 725.414 (2004). ***Dempsey v. Sewell Coal Co.***, 23 B.L.R. ___, BRB Nos. 03-0615 BLA/A (June 28, 2004) (*en banc*).

This case has an extensive procedural history, involving the filing of four (4) claims in all. The Claimant filed his initial claim for benefits under the Act on February 20, 1987. (DX 1-

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[4] At Tr. 5.

[5] At Tr. 11.

[6] At. Tr. 24.

[7] At. Tr. 34.

1).[8] On June 4, 1987, this claim was initially denied by an OWCP claims examiner, who determined that the Claimant failed to establish any element of entitlement. (DX 1-11). At the Claimant's request, this matter was referred to the Office of Administrative Law Judges for a formal hearing. (DX 1-19). This hearing was conducted on September 20, 1988, before Administrative Law Judge John J. Forbes, Jr. On November 22, 1988, the administrative law judge issued a decision and order denying the claim. The administrative law judge found that the Claimant had established the existence of pneumoconiosis, but also found that total respiratory disability was not established. The Claimant appealed to the Benefits Review Board ("the Board"), which affirmed in a decision dated August 22, 1991. *Lawson v. Westmoreland Coal Co.*, BRB No. 88-4139 BLA (Aug. 22, 1991) (unpub.). On further appeal, the United States Court of Appeals for the Fourth Circuit vacated the Board's Decision and Order, and remanded the case to the Board for further proceedings. *Lawson v. Westmoreland Coal Co.*, No 91-1243 (4th Cir. Sept. 29, 1992). By Order dated February 3, 1993, the Board in turn forwarded the case to the Office of Administrative Law Judges for further proceedings. On December 15, 1993, a Decision and Order on Remand – Denying Benefits, was filed. The Claimant took a second appeal to the Benefits Review Board, which affirmed the finding that the Claimant was not totally disabled, and upheld the denial of benefits in a Decision and Order, dated November 16, 1994. *Lawson v. Westmoreland Coal Co.*, BRB No. 94-0633 BLA (Nov. 16, 1994). No further action was taken on this first claim.

The Claimant filed his second claim for benefits under the Act on April 26, 1996. (DX 2-1). This claim was denied by the District Director, who found that the Claimant failed to establish total respiratory disability or a material change in conditions. (DX 2-21). On March 18, 1997, the District Director issued a *Proposed Decision and Order – Memorandum of Conference*, in which it was found that there was insufficient evidence to establish pneumoconiosis or total respiratory disability. (DX 2-33). This claim was referred on June 5, 1997, for a formal hearing. (DX 2-38). That hearing was conducted on December 4, 1997, before Administrative Law Judge Fletcher Campbell, Jr. On April 27, 1998, Judge Campbell filed a Decision and Order denying the claim. (DX 2). The Claimant took no further action on this claim.

Mr. Lawson filed his third claim for benefits on November 1, 2000. (DX 3). This claim was initially denied on January 11, 2001, with the District Director finding that the Claimant failed to establish any element of entitlement. (DX 3). Mr. Lawson submitted additional evidence in support of the claim, and the District Director on August 16, 2001 issued a *Proposed Decision and Order Denying Request for Modification*, again finding that the Claimant failed to establish any element of entitlement.[9] (DX 3). The Claimant did not pursue this claim, and had

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[8] Director's Exhibits 1 through 3 contains all of the evidence filed with the Claimant's first three (3) claims.

[9] I find that this subsequent claim is timely. The effect of the District Director's 2001 finding that Mr. Lawson failed to establish entitlement "repudiates any earlier medical determination [that the Claimant is totally disabled due to pneumoconiosis] and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations [of 20 C.F.R. § 725.308]." ***Westmoreland Coal Company v. Amick***, No. 04-1147, slip op. 8 (4th Cir. Dec. 6, 2004) (unpub.) (quoting ***Wyoming Fuel Company v. Director, OWCP*, [*Brandolino*],** 90 F.3d 1502, 1507,

taken no further action to secure benefits until filing the instant subsequent claim.

The Claimant filed the instant subsequent claim on August 30, 2002. (DX 5). After review by the District Director, a *Schedule for the Submission of Additional Evidence* was issued on April 8, 2003. (DX 21). The District Director indicated that the Claimant would be entitled to benefits if a decision were issued at that time. On July 16, 2003, the District Director issued a *Proposed Decision and Order – Award of Benefits – Responsible Operator*. (DX 25). At the request of the Employer, this matter was referred on November 20, 2003, to the Office of Administrative Law Judges for a formal hearing. (DX 56).

Because Mr. Lawson's most recent coal mine employment occurred at a mine located in the Commonwealth of Virginia (DX 6), the rulings of the United States Court of Appeals for the Fourth Circuit control in the adjudication of this case. ***Danko v. Director, OWCP***, 846 F.2d 366, 368, 11 B.L.R. 2-157 (6th Cir. 1988). *See* ***Broyles v. Director, OWCP***, 143 F.3d 1348, 1349, 21 B.L.R. 2-369 (10th Cir. 1998); ***Kopp v. Director, OWCP***, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); ***Shupe v. Director, OWCP***, 12 B.L.R. 1-200 (1989) (*en banc*).

Mr. Lawson testified at the hearing. (Tr. 16-23). He started working in the mines when he was eighteen years old, when he was occupied in drilling and shooting the coal. (Tr. 17-19). The Claimant left the mines in 1986. (Tr. 20). He recounted that his breathing has become progressively worse, especially during the past five (5) or six (6) years. (Tr. 20). He also testified that he had to be hospitalized for his breathing. (*Id.*). Mr. Lawson claims that he is now limited in his activities as a result of his breathing. He can no longer walk as he used to. (Tr. 21). He started smoking "just once in awhile" when he was a teenager, when he quit for a time at about age eighteen (18), because he didn't smoke in the mines. (Tr. 21). He resumed this habit, and says that he quit altogether in 1967 or 68. (*Id.*). He insisted that when he smoked, it would not even be a half a pack per day. (Tr. 22). He is married, and continues to live with his wife, Wilma.[10]

Issues

A miner must prove whether: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. ***Gee v. W. G. Moore and Sons***, 9 B.L.R. 1-4 (1986) (en banc); ***Baumgartner v. Director, OWCP,*** 9 B.L.R. 1-65 (1986) (en banc). *See* ***Mullins Coal Co., Inc. of Virginia v. Director, OWCP***, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987); ***Island Creek Coal Co. v. Compton***, 211 F.3d 203, 207, 22 B.L.R. 2-162 (4th Cir. 2000). The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc.***, 12 B.L.R. 1-111 (1989); ***Perry v. Director, OWCP***, 9 B.L.R. 1-1 (1986) (*en banc*).

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20 B.L.R. 2-302 (10th Cir. 1996)). The prescriptive periods of the Act, 30 U.S.C. § 932(a) and 20 C.F.R. §725.308 would not have begun to run until after that point. This claim, filed within three years of the prior denial, is thus timely.

[10] I find that Wilma Lawson is the Claimant's dependent for purposes of augmentation of benefits.

The specific issues for adjudication in this case are:

1. Whether the evidence establishes a change in an applicable condition of entitlement since the final denial of his previous claim;
2. Whether the medical evidence establishes that the Claimant suffers from pneumoconiosis;
3. If so, whether the Claimant's pneumoconiosis arose at least in part out of his coal mine employment;
4. Whether the Claimant suffers from a totally disabling pulmonary or respiratory impairment; and
5. Whether any total respiratory disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(c).

Stipulation/Withdrawal of Issues

At the hearing, the Claimant's counsel accepted the District Director's finding of 23.84 years of coal mine employment, and the parties so stipulated. (Tr. 7). I find this stipulation is supported by substantial evidence. Employer's counsel withdrew the issues of whether the Claimant's spouse qualifies as a dependent for purposes of augmentation of benefits. (Tr. 8).[11]

Burden of Proof

"Burden of proof," as used in the this setting and under the Administrative Procedure Act ("APA")[12] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[13] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [***Ondecko***], 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[14]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The

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[11] In order to preserve the issue for appeal, the Employer has also contested the validity of the Secretary's regulations, as amended. (Tr. 8-9).

[12] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[13] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [***Sainz***], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[14] Also known as the risk of nonpersuasion, *see* 9 J. Wigmore, **Evidence** § 2486 (J. Chadbourn rev. 1981).

Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

Length of Coal Mine Employment and Responsible Operator

The length of the Claimant's qualifying coal mine employment is no longer contested as an issue, with the parties stipulating to 23.84 years in the mines. I find that this stipulation is supported by the record, and therefore credit Mr. Lawson with 23.84 years of coal mine employment. Mr. Lawson has claimed that he was last employed in mining with Westmoreland Coal Company. *See* (DX 6). I thus find that Westmoreland Coal Company is the responsible operator liable for the payment of benefits.

Evidence Limitations

The Employer has contested the limitations on the submission of evidence as set forth in the Secretary's regulations, as amended. I duly note, yet find to be without merit, the Employer's challenge to the regulations.

At the formal hearing, all of the exhibits were introduced and marked for identification. (Tr. 24-34). I hereby admit into evidence the Administrative Law Judge exhibits, ALJXs 1-2, and the Director's exhibits in their entirety. (DXs 1-43). Having considered the Claimant's evidence in view of the limitations set forth in 20 C.F.R. Part 725, I admit the Claimant's exhibits in their entirety as well. (CXs 1-4).

The following exhibits introduced by the employer are admitted into evidence:

Initial Evidence (20 C.F.R. § 725.414(a)(3)(i)):
Readings of October 13, 2003 and December 3, 2003 x-rays by Drs. Hippensteel and Castle. (EXs 4, 3). The pulmonary function studies, dated October 13 and December 3, 2003, from Drs. Hippensteel and Castle. (EXs 4, 3). The arterial blood gas studies, dated October 13, 2003 and December 3, 2003, administered by Drs. Hippensteel and Castle. (EXs 4, 3). The medical reports, dated October 13 and December 3, 2003, by Drs. Hippensteel and Castle. (EXs 4, 3).

Rebuttal Evidence (20 C.F.R. § 725.414(a)(3)(ii)):
The rereading of the June 26, 2003, chest x-ray by Dr. Wiot. (EX 12). The rereading of the October 17, 2002, chest x-ray by Dr. Spitz. (EX 5). The rereading of the April 12, 2004 x-ray by Dr. Wheeler, which will be admitted as Employer's Exhibit 16. (EX 16). Those portions of Dr. Branscomb's report submitted in rebuttal to the clinical tests introduced by the Director and the Claimant.

Deposition Testimony (20 C.F.R. § 725.414(c)):
The deposition testimony of Drs. Castle and Hippensteel. (EXs 11, 14).

For purposes of appeal, particularly a challenge to the Secretary's regulations, all of the

exhibits marked for identification as well as those admitted into evidence shall remain with the record. With respect to the exhibits not admitted into evidence, I find that "good cause" has not been shown to support their admission.[15]

Subsequent Claim Medical Evidence

The following medical evidence admitted for this subsequent claim is set forth as follows:

X-Ray Interpretations

X-RAY DATE	***READING DATE***	***EXH.***	***PHYSICIAN/ QUALIFICATIONS***	***INTERPRETATION***
10-17-2002	10-17-2002	DX 12	M. Ranavaya, B[16]	1/0, p/q, Quality (Q.) 1
10-17-2002	01-10-2003	DX 13	P. Barrett, B/BCR	Quality (Q.) 1
10-17-2002	04-23-2004	CX 3	DePonte, B/BCR	1/1, s/s, Q. 1
10-17-2002	09-18-2003	EX 5	Spitz, B/BCR[17]	Q. 1, no pneumoconiosis

[15] These exhibits are **not** introduced into evidence, because they exceed the limitations set forth in Section 725.414(a)(3), but shall remain marked for identification only: Dr. Jerome Wiot's interpretation of the October 17, 2002, chest x-ray. (EX 1). The November 4, 2001, medical report, and associated readings of a November 12, 2001, chest x-ray, by Drs. McSharry, Wheeler and Scott. (EX 2). The rereading by Dr. Meyer of the October 17, 2002, chest x-ray. (EX 5). The interpretation of a December 3, 2003, chest x-ray by Dr. Meyer. (EX 6). The interpretations of the October 13 and December 3, 2003 chest x-rays by Dr. Wiot. (EX 8). The rereading of the October 13, 2003 film by Dr. Meyer. (EX 9). The rereadings of the October 13 and December 3, 2003 x-rays by Dr. Spitz. (EX 13, 10). The rereading of the June 26, 2003 x-ray by Dr. Meyer. (EX 15).

The medical report prepared by Dr. Ben Branscomb, dated March 28, 2004, shall be admitted in its entirety, but limited solely to rebuttal of pulmonary function and arterial blood gas studies submitted by the Director and the Claimant. 20 C.F.R. § 725.414(a)(3)(ii). (EX 7). I emphasize that, on its face, the regulation limits such rebuttal to an assessment of the opposing party's tests. Dr. Branscomb's comprehensive report goes beyond the allowable rebuttal evidence.

[16] The credentials of interpreters of the x-rays are signified as "A" for an A-reader of x-rays, "B" for a B-reader, "BCR" for a board-certified radiologist, and "B/BCR" for a radiologist who possesses dual qualifications. A physician who is "board-certified" has received certification in radiology by the American Board of Radiology or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(1)(ii)(C). *See* ***Staton v. Norfolk & Western Railway Co.***, 65 F.3d 55, 57, 19 B.L.R. 2-271 (6th Cir. 1995).

A "B reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Occupational Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to x-ray readings performed by "B-readers" over interpretations by physicians who possess no radiological qualification. *See* ***LaBelle Processing Company v. Swarrow***, 72 F.3d 308, 20 B.L.R. 2-76 (3d Cir. 1995).

An administrative law judge may properly defer to the readings of the physicians who are both B-readers and Board-certified radiologists. ***Roberts v. Bethlehem Mines Corp.***, 8 B.L.R. 1-211 (1985). *See* ***Zeigler Coal Co. v. Director, OWCP [Hawker]***, 326 F.3d 894, 899, __ B.L.R. 2-___ (7th Cir. 2003). Finally, a radiologist's academic teaching credentials in the field of radiology are relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See* ***Worhach v. Director, OWCP***, 17 B.L.R. 1-105 (1993).

06-26-2003	04-23-2004	CX 2	DePonte, B/BCR	1/1, s/s Q. 1
06-26-2003	04-22-2004	EX 12	Wiot, B/BCR[18]	Q. 1, no pneumoconiosis
10-13-2003	10-13-2003	EX 4	Hippensteel, B	Q. 2, no pneumoconiosis
12-03-2003	12-19-2003	EX 3	Castle, B	Q. 2, no pneumoconiosis
04-12-2004	04-23-2004	CX 1	DePonte, B/BCR	1/1, s/s Q. 1
04-12-2004	05-25-2004	EX 16	Wheeler, B/BCR[19]	Q. 1, no pneumoconiosis

Pulmonary Function Studies

Pulmonary function studies may provide some of the acceptable documentation for a reasoned medical opinion diagnosis of pneumoconiosis at 20 C.F.R. § 718.202(a)(4). Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R. § 718.103 (2004) and require, in relevant part, that (1) each study be accompanied by three tracings, ***Estes v. Director, OWCP***, 7 B.L.R. 1-414 (1984); (2) the reported FEV1 and FVC or MVV values constitute the best efforts of three trials; and (3) for claims filed after January 19, 2001, a flow-volume loop must be provided.

I may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. ***Houchin v. Old Ben Coal Co.***, 6 B.L.R. 1-1141 (1984); ***Runco v. Director, OWCP***, 6 B.L.R. 1-945 (1984). To be qualifying, the regulations provide that the FEV1 and either the MVV or FVC values must be equal to or fall below those values listed at Appendix B for a miner of similar gender, age, and height, or the ratio of the FEV1/FVC equals 55% or less. Assessment of the pulmonary function study results is dependent on the miner's height, which has been recorded most recently between 68 to 70 inches. I therefore find that the Claimant's height is 69 inches for purposes of evaluating the pulmonary function studies. ***Protopappas v. Director, OWCP***, 6 B.L.R. 1-221 (1983). *See Toler v. Eastern Associated Coal Corp.*, 43 F.3d 109, 114, 19 B.L.R. 2-70 (4th Cir. 1995).

The following pulmonary function studies are in the subsequent claim record:

DATE	***EXH.***	***PHYSICIAN***	***FEV1***	***FVC***	***%***	***MVV***	***QUALIFY***	***HT/AGE***
10-17-2002	DX 12	Ranavaya	1.39	2.25			Yes	69"/71
	(bronchodilator)		1.37	2.30			Yes	

Dr. Ranavaya observed "fair" cooperation and "good" comprehension in the performance of this test. Tracings are attached. Nevertheless, Dr. Michos initially considered this test

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[17] Dr. Spitz has been a Professor of Radiology at the University of Cincinnati since 1971. (EX 5).

[18] Dr. Wiot has been Professor Emeritus of Radiology, University of Cincinnati, since 1998. Before that time, he has served at the University of Cincinnati as a Professor of Radiology from 1966 until 1998, Associate Professor of Radiology from 1962 until 1966, and Assistant Professor of Radiology from 1962 until 1966. (EX 1).

[19] Dr. Wheeler has also held various academic positions in the Department of Radiology at the Johns Hopkins School of Medicine. Most recently, Dr. Wheeler has been an Associate Professor of Radiology since 1974, and prior to that an assistant professor of radiology since 1969. (EX 16).

unacceptable because of the lack of tracings, and specifically because he was "unable to hand calculate values from tracings provided." (DX 12). After further review, Dr. Michos deemed this test acceptable. (*Id.*).

06-26-2003	CX 4	Rasmussen	1.42	2.69	53%	42	Yes	68"/72
		(bronchodilator)	1.38	2.86	48%		No	

Tracings are attached. Dr. Rasmussen interpreted the results as showing a "severe, irreversible restrictive and obstructive ventilatory impairment. Maximum breathing capacity is markedly reduced. ... Total lung capacity is minimally reduced. Residual volume is normal. Single breath carbon monoxide diffusing capacity is moderately reduced." Dr. Ben Branscomb reviewed this test. In a March 28, 2004 report, Dr. Branscomb opined that the "MVV is submaximal [and that a] plateau is not reached." (EX 7). He nevertheless concluded that the tracings indicated a "moderate obstructive impairment." (EX 7).

12-03-2003	EX 3	Castle	1.57	2.70	58%	43	Yes	70"/72
		(bronchodilator)	1.56	2.65	59%		No	

Tracings are attached. Dr. Castle interpreted these studies as valid, and opined that this test "shows mild decrease in FVC and moderate decrease in FEV1 with mild to moderate obstruction." He also concluded that the test demonstrated "normal" lung volumes. (EX 3).

10-13-2003	EX 4	Hippensteel	1.42	2.29	62%	49	Yes	69"/72
		(bronchodilator)	1.37	2.57	53%		No	

Dr. Hippensteel noted moderate airflow obstruction, a severely reduced MVV, and concluded that the "lung volumes show some air trapping but no restriction." The "diffusion is normal." (EX 4). Tracings are attached.

Arterial Blood Gas Studies

Arterial blood gas studies may provide some of the acceptable documentation for a reasoned medical opinion diagnosis of pneumoconiosis at 20 C.F.R. § 718.202(a)(4). Total disability may also be established by qualifying blood gas studies under 20 C.F.R. § 718.204(b)(2)(ii) (2004). In order to be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found at the table at Appendix C.

The following blood gas studies are in the subsequent claim record:

DATE	***EXH***	***PHYSICIAN***	***PCO2***	***PO2***	***QUALIFY***
10-17-2002	DX 12	Ranavaya	*34*	*70*	*No*

The Claimant's physician advised that an exercise protocol would be contraindicated.

06-26-2003	CX 4	Rasmussen	36	73	No
12-03-2003	EX 3	Castle	42.7	82.6	No

Dr. Castle viewed the results of this study as "normal," and likewise opined that the carboxyhemoglobin level as "normal." (EX 3).

10-13-2003	EX 4	Hippensteel	39.6	76.9	No

Dr. Hippensteel observed "normal gas exchange at rest" and "normal carboxyhemoglobin level."

Medical Opinions and Reports

The regulations provide that a medical report is "[a] physician's written assessment of the miner's respiratory or pulmonary condition. A medical report may be prepared by the physician who examined the miner and/or reviewed the available admissible evidence." 20 C.F.R. § 725.414(a)(1). Medical opinions may demonstrate the presence of pneumoconiosis, total respiratory disability and disability causation at Sections 718.202(a)(4), 718.204(b)(2)(iv) and 718.204(c).

Dr. Mohammed I. Ranavaya. Dr. Ranavaya examined the Claimant on October 17, 2002 at the request of the Department of Labor. He issued his report that date. (DX 12). Mr. Lawson's medical history was positive for pneumonia, attacks of wheezing, arthritis, heart disease and high blood pressure. The Claimant has suffered broken ribs, a work-related injury, and a ruptured esophagus in 1988 which required hospitalization.

Mr. Lawson told Dr. Ranavaya that he had smoked from 1946 until 1968 at 1/2 pack per day. His current complaints included a daily dry cough, wheezing and dyspnea and paroxysmal nocturnal dyspnea. The latter condition has been relieved by sitting up in bed and using an inhaler. He has experienced sputum production that has occurred for the last four to five years. The wheezing has been present after exertion, when laying down. Mr. Lawson has felt this symptom since the 1980's. Dr. Ranavaya noted that the Claimant also complains of shortness of breath upon mild to moderate exertion – walking about 200 feet on level ground, about ten to fifteen (10 to 15) feet up a gentle incline or on climbing five to six (5 to 6) steps.

During the physical examination, Dr. Ranavaya detected a "well healed left Thoracotomy scar from esophogeal surgery." There were no abnormalities on palpation and percussion. Auscultation of the chest revealed "minimally prolonged expiratory phase w/scattered few expiratory wheeze." The extremities were negative or within normal limits.

Dr. Ranavaya reviewed a chest x-ray, and conducted clinical testing – an arterial blood gas test, ventilatory study and an EKG. Based on this testing and his history and physical examination, Dr. Ranavaya diagnosed pneumoconiosis, hypertension and chronic bronchitis.

He explained the diagnosis of pneumoconiosis based on the Claimant's 23 years of coal mine work and the positive x-ray (0/0). He also said that the "diagnosis of chronic bronchitis – Chronic Obstructive Pulmonary Disease in my opinion is unrelated to occupational exposure to dust in coal mining and could be related to a 10+ pack year history of cigarette smoking." Turning to the disability finding, the doctor opined that the "[m]ild pulmonary impairment which in and of itself would not prevent this gentleman from performing his usual or last coal mine employment." Dr. Ranavaya is board certified in occupational medicine and is a B-reader. (DX 12).

Dr. Donald L. Rasmussen. Dr. Rasmussen examined the Claimant on June 26, 2003, and dictated his report that day. (CX 4). Dr. Rasmussen recorded complaints of shortness of breath on exertion, a condition of four to five (4 to 5) year duration. Mr. Lawson told him that he couldn't walk more than three to four (3 to 4) steps on a stairway, and that he suffers from a minimal morning productive cough. The Claimant said that he wheezes mostly in the mornings, does not have orthnopnea, but that he does occasionally awaken at night because of shortness of breath. Mr. Lawson denied ankle swelling, but complained of an occasional "chest heaviness"

with coughing. He told Dr. Rasmussen that an earlier report that he had an enlarged heart was related to lung disease. He also said that he has had hypertension, but denied any other cardiovascular or other pulmonary disease. The past medical history included an esophageal rupture in 1988. The Claimant said that he had smoked from 1947 at age 16 until 1968 at the rate of 1/2 pack per day.

Dr. Rasmussen recorded a coal mine work history of 23 years and four months in the mines. The Claimant told the doctor that his last mine work was as a section foreman, which required not only walking, but also operating equipment, lifting 50 pound rock dust bags and unloading supplies.

On conducting the physical examination, Dr. Rasmussen observed on examination of the chest "breath sounds [that were] moderately to markedly reduced but tubular in quality [with] no rales, rhonchi or wheezes." He observed no edema or clubbing. Dr. Rasmussen referred to the chest x-ray interpretation of 1/1 by Dr. Manu Patel. He also conducted pulmonary function and arterial blood gas testing.

Dr. Rasmussen concluded:

> This patient has marked loss of lung function. He does not retain the pulmonary capacity to perform his last regular coal mine job.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has coalworkers' pneumoconiosis which arose out of his coal mine employment.
>
> The two risk factors for this patient's disabling lung disease are his cigarette smoking and his coal mine dust exposure. Both contributed. Both cause lung tissue damage resulting in chronic obstructive pulmonary disease including chronic bronchitis and emphysema. They, in fact, use some of the same cellular and biochemical mechanisms in causing lung damage.

(CX 4 at 3-4). Dr. Rasmussen also cited epidemiologic studies as support for his conclusions. He is board certified in internal medicine, forensic medicine and is a B-reader. He was a visiting Assistant Professor of Internal Medicine, Meharry-Medical College, Clinical Assistant Professor of Medicine, Marshall University School of Medicine from 1978 to 1988, a Consultant in Occupational Disease at the West Virginia School of Osteopathic Medicine, and has been an Adjunct Clinical Instructor in Respiratory Therapy at the College of West Virginia since 1987. (CX 4).

Dr. Kirk E. Hippensteel. Dr. Hippensteel examined the Claimant on October 13, 2003, and on March 8, 2004, issued his report of this examination and of his extensive review of other records. (EX 4). The doctor recorded a coal mine employment history of 23 years and four months. Mr. Lawson retired in 1987 on January 1, 1987 from the position of section foreman. Mr. Lawson told Dr. Hippensteel that his last work as a foreman required him to walk during the entire shift, and to be available to assist other miners in tasks that sometime entailed lifting upwards of 94 pounds. Dr. Hippensteel characterized this as "intermittent manual labor."

Mr. Lawson said that he had experienced trouble with his breathing since before he left the mines. He complained that he could walk only 1/2 block or ascend one flight of stairs before

becoming short of breath. Mr. Lawson also said that he coughs up gray sputum. He has no history of asthma or TB. The Claimant gets occasional chest pain, but denied any heart attack or angina. He told Dr. Hippensteel that he had been told about an enlarged heart. After taking a bicycle exercise test, the Claimant said that he felt the effects of that procedure for months. He also told Dr. Hippensteel that he has been taking several breathing medications, including nebulizer treatments and an inhaler, and has used antibiotics on occasion. The Claimant admitted to smoking less than 1/2 pack of cigarettes per day "off and on" from age 18 to age 37. He represented that he has not smoked since age 37.

Dr. Hippensteel noted on physical examination of the chest "dullness to percussion and decreased air movement in the right lung base where he has had pleural scarring on chest x-ray." No rales or wheezes were heard. The examination of the extremities showed no clubbing or edema.

The doctor stated that the Claimant's chest x-ray is negative – 0/0. The ventilatory test suggested "moderate airflow obstruction with possibility of suboptimal effort[.]" He saw no evidence of restriction. The MVV results were "severely decreased" in this "effort dependent" part of the test. The arterial blood gas tests showed normal gas exchange.

Dr. Hippensteel concluded:

> This man does not have evidence of coal workers' pneumoconiosis but has evidence of pulmonary impairment related to scarring from his ruptured esophagus and surgery for it, added to by his cigarette smoking history and chronic bronchitis. The scarring in his chest does not appear to be related to coal mine dust deposition in his lungs and his chest x-ray, diffusion and normal gas exchange are against coal workers' pneumoconiosis as well.

(EX 4 p. 3).

Dr. Hippensteel also reviewed Mr. Lawson's pertinent records, and added:

> Although this man has evidence of variable pulmonary impairment on testing, I think the overall evidence is against coal workers' pneumoconiosis as a diagnosis in this man, but shows that he has chronic bronchitis which is a disease of the general public and which is somewhat responsive to bronchodilator therapy which this man has used regularly for a long time. He has also had scarring from previous bilateral chest surgery associated with esophageal rupture that has nothing to do with coal mine dust inhalation. If his smoking history is factual, it would appear to have little impact on his present function.
>
> Since his functional tests have been variable, it can be stated that he does not have enough permanent dysfunction from a pulmonary standpoint to keep him from going back to his job in the mines. I would also note that if his impairment were caused from coal workers' pneumoconiosis, it would be expected to cause a fixed or progressive level of impairment rather than what he showed on these tests. This man has other medical problems that impair him as a whole man and those, including his age, overall make him unable to return to his job in the mines. I think these conclusions from the review of extensive medical evidence in this case, can be made with a reasonable degree of medical certainty.

(EX 4 at 13). Dr. Hippensteel is board certified in internal medicine, with certification in the subspecialties of pulmonary disease, critical care medicine, and is a B-reader. He has been a Clinical Associate Professor of Medicine at the University of Virginia since 1988. (EX 4).

Dr. Hippensteel testified at a deposition that was taken on April 26, 2004. (EX 14). In addition to addressing the medical report and examination, Dr. Hippensteel also noted his review of the deposition testimony of Dr. Castle on April 16, 2004. Dr. Hippensteel surveyed the Claimant's problems with the ruptured esophagus, noting that procedures to address this problem required the insertion of two chest tubes. According to Dr. Hippensteel, the effects of this condition and its remedies led to scarring on the chest wall as well as some pleural thickening, which affected the area around the pleural space. (EX 14 at 11-12). During his physical examination of the Claimant, Dr. Hippensteel noted a ventral hernia, which could also affect breathing. (EX 14 at 13).

Dr. Hippensteel opined that the Claimant does not suffer from pneumoconiosis. He said that the "s" type opacities found by some radiologists are not indicative of pneumoconiosis. When asked about his diagnosis of chronic bronchitis, Dr. Hippensteel stated that this was not an industrial bronchitis. He felt that the Claimant's bronchitis was not derived from coal mine dust exposure because industrial bronchitis would subside after the cessation of exposure. The doctor also testified that the studies hinted at some asthmatic bronchitis, a disease of the general public. This type of bronchitis was evident because the testing showed some partial reversibility.

Dr. Hippensteel concluded that the Claimant's impairment was "variable." It appears that, assuming an impairment that occasionally would preclude a return to the mines, Dr. Hippensteel would not attribute to this to coal mine dust exposure. He emphasized that coal mine dust inhalation did not cause Mr. Lawson's chronic bronchitis. (EX 14 at 34).

Dr. James R. Castle. Dr. Castle examined the Claimant on December 3, 2003. He also conducted an extensive review of the Claimant's pertinent medical records and presented his conclusions in a medical report dated February 24, 2004. (EX 3). The Claimant related a history of difficulty with progressively worsening shortness of breath dating from the 1980's. Mr. Lawson claimed that he could walk no more than one (1) block on level ground, or climb five or six (5 or 6) steps, without stopping because of shortness of breath. The Claimant also said that he has had a productive cough for the last seven or eight (7 or 8) years. He also said that he experiences wheezing, particularly when he gets out of breath. This condition is aggravated by hairsprays and perfumes.

Mr. Lawson told Dr. Castle that he was told about six (6) years ago that he had an enlarged heart, but that he does not have chest pain. He also said that he experienced a soreness in the chest after taking a breathing test, an event that caused him to use a prednisone inhaler for a few weeks to recover. The Claimant denied any history of asthma or TB, but said that he had taken up smoking at age 18 and that he stopped this habit in 1968. He claimed to have averaged no more than eight or ten (8 or 10) cigarettes per day.

Dr. Castle recorded a coal mine employment history of 23 years in the mines, which the Claimant left in 1987. Mr. Lawson last worked as a section foreman from 1980 until 1987, and before that was a production foreman, foreman, continuous miner operator, shuttlecar operator, inside laborer and loader. His last work as a section foreman required considerable walking. He

also was required on occasion to performed the heavy labor of regular mining work. A review of systems indicated arthritis and the need to sleep with one or two pillows. Sleep is sometimes interrupted, and at times, Mr. Lawson must sit up on the side of the bed and use Advair.

On physical examination of the chest, Dr. Castle observed a normal AP diameter. He also noted a "normal percussion note" and detected "decreased tactile fremitus only over the right lower lobe posteriorly." Dr. Castle also observed "some decrease in breath sounds in the same area and along the right lateral chest wall." Mr. Lawson otherwise exhibited normal and equal breath sounds throughout, with no "rales, rhonchi, wheezes, rubs, crackles, or crepitations." Dr. Castle found no cyanosis, clubbing or edema on examination of the extremities. Dr. Castle interpreted a chest x-ray as negative for pneumoconiosis. He saw indications of cardiomegaly and effusion or scar likely due to pleural thickening. The doctor also interpreted the results of arterial blood gas and pulmonary function studies, and reviewed the results of an EKG.

Based upon his physical examination and review of pertinent testing, Dr. Castle concluded:

1. No evidence of coal workers' pneumoconiosis by radiographic evaluation, physical examination, and physiologic testing.
2. Moderate chronic obstructive pulmonary disease.
3. History of ruptured esophagus requiring thoracic surgery.
4. History of hypertension.
5. Abnormal [EKG] with possible coronary artery disease.
6. Probable hypertensive cardiovascular disease.

Dr. Castle then outlined in detail his examination of the other medical evidence in this and the prior claims, devoting nearly fourteen (14) pages of review. Based on this survey, Dr. Castle concluded:

> After a very thorough and extensive review of all the submitted medical data in the above referenced claim[.] ... It is my opinion with a reasonable degree of medical certainty based upon a thorough review of all the data, including medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gases, and other data that Mr. Calvin Lawson does not suffer from coal workers' pneumoconiosis.
>
> Mr. Lawson clearly worked in or around the underground mining industry for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host. He worked for at least 23 years and four (4) months in the mining industry and last worked in 1987 [as a] section foreman.
>
> Another risk factor for the development [of] pulmonary diseases is that of tobacco abuse. Mr. Lawson gave a significantly variable history of tobacco abuse. He testified in court that he had smoked at least one pack of cigarettes daily. On other occasions he indicated that he never smoked more than one-half pack of cigarettes daily. He indicated that he began smok[ing] regularly at age 15 on some occasions. It is likely that he has an excess of a 20 pack-year smoking history. This is a sufficient enough time to have caused them to develop chronic

obstructive pulmonary disease, i.e. chronic bronchitis/emphysema and/or lung cancer and/or atherosclerotic cardiovascular disease if he were a susceptible host.

Another risk factor for the development [of] pulmonary symptoms and disease is that of thoracic surgery. He developed a ruptured esophagus in 1988 requiring extensive thoracic and abdominal surgery for treatment of his ruptured esophagus with associated mediastinitis. Subsequent to that he has developed evidence of a restrictive pulmonary process associated with radiographic findings of significant pleural thickening.

Another risk factor for the development of pulmonary symptoms is that of cardiac disease. He has long-standing findings of cardiomegaly by chest x-ray as well as long-standing hypertension which has been intermittently poorly controlled. This can result in not only symptoms of shortness of breath but radiographic findings as well as physiologic findings.

At no time did he demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have a consistent finding of rales, crackles, or crepitations. He did demonstrate diminished breath sounds related to significant pleural thickening and elevated right hemidiaphragm from his previous thoracic surgery.

* * *

The recent valid physiologic studies have shown evidence of a mild reduction in the forced vital capacity with a moderate reduction in the FEV1 indicating mild to moderate airway obstruction. The total lung capacity was 86% predicted. The diffusing capacity was also normal after correction for alveolar volume. These findings are indicative of a restrictive process around the lung rather than inside the lung parenchyma. These findings are indicative of the pleural scarring which has taken place in both sides of this gentleman's chest as a result of his previous extensive thoracic surgery for a ruptured esophagus. The resulting mediastinitis, thoracic surgery, chest tube insertions, and pleural scarring has progressed to cause these findings. These findings have developed since my previous examination in 1997. It is my opinion that these findings are not indicative of coal workers' pneumoconiosis or impairment due to coal workers' pneumoconiosis. He does have evidence of a mild to moderate degree of airway obstruction which has been variable over time due to his previous tobacco smoking habit. It has been suggested that this may be due to some degree of asthmatic bronchitis as indicated by the significant variability over time.

The resting arterial blood gases that have been done most recently have been essentially normal and have not demonstrated a disabling abnormality of blood gas transfer mechanisms.

Therefore, for the reasons stated above, it is my opinion with a reasonable degree of medical certainty that he does not have evidence of coal workers' pneumoconiosis by physical examination, radiographic evaluation, or physiologic testing.

> It is my opinion that Mr. Lawson is permanently and totally disabled as a result of a pulmonary process which resulted from his previous extensive surgery for a ruptured esophagus with resultant pleural scarring bilaterally. He also has evidence of a mild to moderate degree of airway obstruction due to his previous tobacco smoking habit. As noted by Dr. Ranavaya, it is my opinion that this could be contributed to by asthmatic bronchitis which is a disease of the general public at large. It is my opinion that he is not permanently and totally disabled as a result of any pulmonary process which has resulted from his coal mining. It is my opinion that he is likely disabled as a whole man because of hypertensive cardiovascular disease, cardiomegaly, degenerative arthritis, and other non coal dust induced medical problems.

(EX 3 at 18-20). Dr. Castle is board certified both in internal medicine and pulmonary disease, and is a B-reader. He has been Clinical Professor of Medicine at the University of Virginia College of Medicine since 1993. (EX 3).

The employer took the deposition of Dr. Castle on April 16, 2004. (EX 11). He was questioned about the medical examination conducted by himself and the above-referenced report. Dr. Castle initially testified about the Claimant's ruptured esophagus and resulting surgery and mediastinitis (massive infection resulting from the ruptured esophagus). He noted that such a condition has a high mortality rate. (EX 11 at 17). He also reviewed the medications that Mr. Lawson has been taking. He specifically noted that Mr. Lawson has been using Advair, a treatment for asthma, and three bronchodilators. (EX 11 at 12).

Dr. Castle was asked about the Claimant's need at times to sit up in bed to catch his breath, and the need to use two pillows for sleep, and remarked that these symptoms are typically related to a cardiac condition. He opined that changes that appeared on the 1997 x-ray that he had reviewed – the elevated right hemidiaphragm and pleural scars – resulted from the surgery and inflammation from the ruptured esophagus. (EX 11 at 16). He testified that the effects of the chest surgery would be consistent with the linear type opacities that had been seen on his x-rays. (EX 11 at 19).

Dr. Castle opined that the Claimant is disabled from returning to his former coal mine work as a result of a pulmonary impairment. (EX 11 at 22). He explained that this inability to work "resulted from the extensive surgery that he had with resultant pleural thickening." None of this disability is due to coal mine dust exposure. (EX 11 at 23-24). He also opined that the Claimant does not suffer from pneumoconiosis. Dr. Castle's opinion pertained not only to clinical pneumoconiosis, but also to "legal" pneumoconiosis. (EX 11 at 25).

Discussion

"Material Change in Conditions"

After the expiration of one year from the denial of the previous claim, a subsequent claim must be denied on the basis of the prior denial unless a miner demonstrates with the submission of additional material that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d)(2004).

To assess whether this change is established, I must consider all of the new evidence,

favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. *See* ***Lisa Lee Mines v. Director, OWCP*** [***Rutter***], 86 F.3d 1358, 1362-63, 20 B.L.R. 2-227 (4th Cir. 1996) (en banc), *cert. denied*, 519 U.S. 1090 (1997). The Board has ruled that the focus of the material change standard is on specific findings made against the miner in the prior claim; an element of entitlement which the prior administrative law judge did not explicitly address in the denial of the prior claim does not constitute an element of entitlement "previously adjudicated against a Claimant." *See* ***Allen v. Mead Corp.***, 22 B.L.R. 1-63 (2000) (*en banc*). If a Claimant establishes the existence of that element, he has demonstrated, as a matter of law, a change in the applicable conditions of entitlement in a subsequent claim, and would then be entitled to a full adjudication of his claim based on the record as a whole. *See* ***Rutter***, 86 F.3d at 1362-63.

In this case, the previous (third) claim was denied by the District Director because the Claimant failed to establish any element of entitlement.[20] For the reasons stated below, I find that the Claimant has proven a change in an applicable condition of entitlement by establishing total respiratory disability.

Total Respiratory Disability

The Claimant may establish a change in an applicable condition of entitlement by establishing total respiratory disability. Section 718.204(b) defines "total disability" as follows:

> A miner shall be considered totally disabled if ... pneumoconiosis as defined in § 718.201 prevents or prevented the miner:
>
> (1) From performing his or her usual coal mine work; and (2) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time.

The regulations at Section 718.204(b) provide the following five methods to establish total disability:

> (1) pulmonary function (ventilatory) studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinions; and (5) in limited circumstances, lay testimony. 20 C.F.R. § 718.204(b).

I note that *any* loss in lung function may qualify as a total respiratory disability under Section 718.204(b)(2). *See* ***Carson v. Westmoreland Coal Co.***, 19 B.L.R. 1-16 (1964), *modified on recon*., 20 B.L.R. 1-64 (1996). *See generally*, ***Jewell Smokeless Coal Co. v. Street***, 42 F.3d 241, 19 B.L.R. 2-1 (4th Cir. 1994). A mild or moderate pulmonary impairment qualifies as a

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[20] In order to assess whether the Claimant has proven a change in one of the applicable conditions of entitlement, the focus at this stage is on whether the subsequent claim record establishes total respiratory disability. In the event the record as a whole is evaluated, should the Claimant overcome the Section 725.309 bar, *all* of the elements of entitlement are subject to adjudication. Collateral estoppel and *res judicata* do not preclude the inquiry into whether the Claimant has established the existence of pneumoconiosis. *See* ***Sellards v. Director, OWCP***, 17 B.L.R. 1-77 (1993). In this subsequent claim filed under the amended regulations, "no findings made in connection with the prior claim ... shall be binding on any party in the adjudication of the subsequent claim." 20 C.F.R. § 725.309(d)(4)(2004).

total respiratory disability if that impairment would preclude a miner from performing his usual coal mine work.

Initially, I find that the Claimant has not demonstrated total respiratory disability at Section 718.204(b)(2)(iii), because the record does not show the presence of cor pulmonale with right sided congestive heart failure. *See* ***Newell v. Freeman United Coal Mining Co.***, 13 BLR 1-37 (1989), *rev'd on other grounds*, 933 F.2d 510, 15 BLR 2-124 (7th Cir. 1991). I also find that the Claimant has not demonstrated total respiratory disability at Section 718.204(b)(2)(ii) on the basis of arterial blood gas testing.

I do find that the Claimant has demonstrated total respiratory disability at Section 718.204(b)(2)(i) on the basis of ventilatory study results. The newly submitted ventilatory tests are uniformly qualifying in the pre-bronchodilator trials. I am mindful of Dr. Branscomb's critique of the study administered by Dr. Rasmussen. (EX 7). Nevertheless, I consider the qualifying results obtained by Dr. Ranavaya in his complete pulmonary evaluation for the Director to be sufficient to demonstrate total respiratory disability. 20 C.F.R. § 718.204(b)(2)(i).

The last method by which the Claimant may demonstrate total respiratory disability is by a documented and reasoned medical opinion of total disability. 20 C.F.R. § 718.204(b)(2)(iv). I find the Mr. Lawson has demonstrated total respiratory disability at Section 718.204(b)(2)(iv) on the basis of the newly submitted medical opinion evidence of record. Although Dr. Hippensteel is less than certain about the nature and extent of the Claimant's pulmonary impairment, citing the variability of Mr. Lawson's impairment as shown on his testing, and Dr. Ranavaya assessed a mild pulmonary impairment that would not preclude the Claimant's last coal mine employment, Drs. Castle and Rasmussen are clear that the Claimant is prevented from returning to the mines on the basis of a pulmonary or respiratory impairment. I find total disability demonstrated at 20 C.F.R. § 718.204(b)(2)(iv).

Finally, after independently weighing all relevant evidence pursuant to 20 C.F.R. § 718.204(b)(2), like and unlike, including lay testimony, and considering the sometimes taxing exertional requirements of Mr. Lawson's last coal mine work as a section foreman who also had to perform other mining tasks, I find that the Claimant has established total respiratory disability on the basis of the newly submitted evidence on this subsequent claim. *See* ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19 (1987); ***Shedlock v. Bethlehem Mines Corp***., 9 B.L.R. 1-195 (1986), *aff'd on recon. en banc*., 9 B.L.R. 1-236 (1987). *See generally* ***Poole v. Freeman United Coal Mining Co.***, 897 F.2d 888, 894, 13 BLR 2-348 (7th Cir. 1990). Although the non-qualifying arterial blood gas tests, and the opinions from Drs. Hippensteel and Ranavaya constitute contrary probative evidence, I am persuaded by the medical opinions of Drs. Castle and Rasmussen, as well as the qualifying ventilatory tests,[21] that Mr. Lawson does not have the pulmonary or respiratory capacity to return to his previous coal mine employment. I therefore find that he has established total respiratory disability, a condition of entitlement previously rejected in the denial of his first claim for benefits.

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[21] I find that, despite the absence of a statement of cooperation and comprehension in Mr. Lawson's performance of the ventilatory tests conducted by Drs. Castle, Hippensteel and Rasmussen, these studies are in "substantial compliance" with the regulations. *See* ***Director, OWCP v. Siwiec***, 894 F.2d 635, 13 BLR 2-259 (3d Cir. 1990).

Merits of Entitlement

In view of this finding, I conclude that the Claimant is entitled to an adjudication of this subsequent claim on the basis of the record as a whole.[22] *See* ***Lisa Lee Mines v. Director, OWCP*** [***Rutter***], 86 F.3d at 1362-63.

Total Respiratory Disability

Upon review of the record as a whole, and for the reasons as set forth in the above subsequent claim analysis, I find that the Claimant has established that he suffers from a totally disabling pulmonary or respiratory impairment. I have accounted for the tests and medical opinions that accompanied Mr. Lawson's first three (3) claims for benefits. Applying the subsequent claim analysis, however, I credit the more recent disability assessments by Drs. Castle and Hippensteel, as buttressed by the qualifying ventilatory tests. This more recent evidence with respect to the nature and extent of any respiratory disability is more probative of the nature and extent of the Claimant's disability, especially evidence of the extent of any disability at the time of the hearing. *See* ***Cooley v. Island Creek Coal Co.***, 845 F.2d 622, 624, 11 B.L.R. 2-147 (6th Cir. 1988). *See also* ***Coffey v. Director, OWCP***, 5 B.L.R. 1-104 (1982).

Pneumoconiosis

Under the Act, to receive benefits, a claimant must prove several facts by a preponderance of the evidence. First, the coal miner must establish the presence of pneumoconiosis.[23] Pneumoconiosis under the Act is defined as both clinical pneumoconiosis and/or any respiratory or pulmonary condition significantly related to or significantly aggravated by coal dust exposure:

> 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, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

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[22] In view of the finding that the Claimant has met the threshold for an adjudication of the merits of the claim, the entire record has been evaluated to determine whether Mr. Lawson has established entitlement to benefits. Although this consideration requires a *de novo* evaluation of the record as a whole, and the records of Mr. Lawson's previous claims and the listing of their exhibits have been reviewed in their entirety, not all of the evidence may be separately listed herein except as warranted by the discussion of issues for this claim. *See* ***Wheeler v. Apfel***, 224 F.3d 891, 895 n. 3 (8th Cir. 2000); ***Walker v. Bowen***, 834 F.2d 635, 643 (7th Cir. 1987), *overruled on other grounds*, ***Pope v. Shalala***, 998 F.2d 473 (7th Cir. 1993). I incorporate by reference the listings, and not the analyses, of the evidence submitted in the previous claims.

[23] 20 C.F.R. § 718.201.

20 C.F.R. § 718.201.

Note that the definition appears to combine the first two elements of entitlement, pneumoconiosis and cause of pneumoconiosis. However, the miner bears the burden of establishing both that he or she has pneumoconiosis and that the pneumoconiosis arose out of coal mine employment.

There are four methods for determining the existence of pneumoconiosis:

(1) Under 20 C.F.R. § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4).

This claim arises within the territorial jurisdiction of the Fourth Circuit. Thus, absent contrary evidence, while evidence relevant to any of the above categories may demonstrate the existence of pneumoconiosis, the adjudicator, in the final analysis, must weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis. ***Island Creek Coal Co. v. Compton***, 211 F.3d at 211. *See* ***Penn Allegheny Coal Co. v. Williams***, 114 F.3d 22, 21 B.L.R. 2-104 (3rd Cir. 1997).

There is no evidence relevant to § 718.202 (a)(2). Accordingly, the Claimant can not establish the existence of pneumoconiosis under this section. Further, none of the enumerated presumptions apply in this case under § 718.202(a)(3). I will therefore turn to the x-ray and medical opinion evidence to determine whether the Claimant has established the presence of pneumoconiosis under either provision for purposes of this subsequent claim.

X-Ray Evidence

The record includes the following x-rays from the initial three (3) claims:

X-RAY DATE	***READING DATE***	***EXH.***	***PHYSICIAN/ QUALIFICATIONS***	***INTERPRETATION***
04-11-1974	04-11-1974	DX 2	Navani, BCR	no abnormality
04-24-1981	04-24-1981	DX 1	Fleenor, A	1/0
03-03-1987	03-03-1987	DX 1	Fleenor, A	1/0
03-31-1987	04-01-1987	DX 2	Navani, BCR	quality 1, no pneumoconiosis
03-31-1987	04-20-1987	DX 2	Cole, B/BCR	quality 1, no pneumoconiosis
09-01-1987	09-25-1987	DX 1	Robinette, B	1/0
10-27-1987	10-27-1987	DX 1	Myers, B	1/0, p/p
05-12-1988	05-16-1988	DX 1	Castle, B	negative
06-13-1996	06-13-1996	DX 2	Paranthaman, B	Quality 1, 0/0
06-13-1996	07-03-1996	DX 2	Gaziano, B	Quality 2, no pneumoconiosis
01-07-1997	01-31-1997	DX 2	Castle, B	Quality 1, negative
01-07-1997	03-13-1997	DX 2	Shipley, B/BCR	no pneumoconiosis
01-07-1997	03-24-1997	DX 2	Spitz, B/BCR	no pneumoconiosis
01-07-1997	09-10-1997	DX 2	Cole, B/BCR	Quality 2, no pneumoconiosis
04-02-1997	04-02-1997	DX 2	Gopalon	no pleural effusion, mild cardiomegaly
04-02-1997	09-22-1997	DX 2	Cole, B/BCR	Quality 3, no pneumoconiosis
11-12-1998	11-12-1998	DX 3	Ramakrishnan	1/2, p/s, pleural thickening
09-16-1999	09-16-1999	DX 3	Ramakrishnan	right diaphragm elevated, fibrosis
11-30-2000	11-30-2000	DX 3	Paranthaman, B	Quality 1, pleural abnormalities consistent with pneumoconiosis (pleural thickening)
11-30-2000	12-14-2000	DX 3	Barrett, B/BCR	no pneumoconiosis

Discussion: Section 718.202(a)(1)

Weighing the x-ray evidence of record together, I find that the Claimant has not demonstrated the existence of pneumoconiosis on the basis of this evidence. Although there are at lease five (5) uncontradicted positive readings, and I shall also find that the October 17, 2002 film read as positive by Drs. Ranavaya and DePonte is a positive film, notwithstanding the negative rereading by Dr. Spitz, a board certified B-reader with impressive academic credentials, the record also contains ten (10) films which I find not to be positive for pneumoconiosis.

Certainly, I am not required to defer to the numerical superiority of x-ray evidence. ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990). *See also* ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1984). Moreover, the adjudicator should not blindly defer to later x-rays, especially where earlier films are positive. Thus, the later negative films do not trump earlier positive readings solely on the basis of recency. *See* ***Adkins v. Director, OWCP***, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992).

Nevertheless, I find that the preponderance of the x-rays do not prove that it is more likely than not that Mr. Lawson suffers from pneumoconiosis. *See generally* ***Napier v. Director, OWCP***, 890 F.2d 669, 671, 13 B.L.R. 2-117 (4th Cir. 1989) (rational basis for ALJ to resolve conflicting interpretations of x-rays by deferring to rereadings by B-readers); ***Edmiston v. F&R Coal Co.***, 14 B.L.R. 1-65 (1990). The record contains early positive readings of four (4) films by Drs. Fleenor, Myers and Robinette. (DX 1). Two (2) negative films that were taken in the same time period as the positive films, were read by Drs. Castle, Cole and Navani, who collectively possess superior credentials. (DX 2). These positive films, submitted for Mr. Lawson's first claim, demonstrated a slight edge in favor of a positive finding of the disease when considered for the first claim. However, the early positive x-rays are followed by a number of negative films that were considered for the Claimant's second claim for benefits. These films, taken between June 13, 1996 and April 2, 1997, are uniformly negative. (DX 2). For the third claim, I shall consider the film taken on November 12, 1998, as a positive x-ray. (DX 3). Finally, the October 17, 2002 film that was taken for the Department of Labor, and interpreted as positive by Drs. Ranavaya and DePonte, is also found to be positive. (DXs 12, 13; CX 3). Contrary to these six (6) positive x-rays are at least ten (10) x-rays that I find to be negative.[24]

In assessing the probative value of the interpretations, especially with regard to the later readings by the dually qualified Dr. DePonte, who submitted three (3) positive interpretations and possesses qualifications superior to others who read films for the Claimant, I defer to the negative interpretations of the latter two (2) films by Drs. Wiot and Wheeler, who hold dual qualifications and have more extensive academic experience in the field of radiology. *See* ***Worhach***. *See also* ***Napier***, 890 F.2d at 771 (rational for ALJ to resolve conflicting interpretations of x-rays by deferring to rereadings by B-readers over positive reading by B-reader).

Medical Opinion Evidence

I turn next to the question of whether the Claimant has demonstrated the existence of pneumoconiosis on the basis of a reasoned medical opinion diagnosis of the disease. 20 C.F.R. § 718.202(a)(4).

20 C.F.R. § 718.104(d)(1) - (4). The regulations also provide that:

> [i]n appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in

[24] The x-rays taken on March 31, 1987, May 12, 1988, June 13, 1996, January 7, 1997, April 2, 1997, November 30, 2000, June 26, October 13, and December 3, 2003, and April 12, 2004. The important fact is not the number of readings, but the number of films.

> support of the adjudicative officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

20 C.F.R. § 718.104(d)(5). A physician's analysis must be based on adequate documentation. *See* ***Lane v. Union Carbide Corp.***, 105 F.3d 166, 172, 21 B.L.R. 2-34 (4th Cir. 1997). *See generally* ***Lango v. Director, OWCP***, 104 F.3d 573, 576, 21 B.L.R. 2-12 (3d Cir. 1997); ***Trumbo v. Reading Anthracite Co.***, 17 B.L.R. 1-85 (1993); ***Clark v. Karst-Robbins Coal Co.,*** 12 B.L.R. 1-149 (1989)(*en banc*); ***Fields v. Island Creek Coal Co.,*** 10 B.L.R. 1-19 (1987); ***Lucostic v. U.S. Steel Corp.,*** 8 B.L.R. 1-46 (1985).

The Claimant has offered the opinions of treating physicians. These experts must likewise document their findings and rationalize their conclusions in light of that documentation. In the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." ***Eastover Mining Co. v. Williams***, 338 F.3d 501, 513, 22 B.L.R. 2-625 (6th Cir. 2003). If a treating physician's opinion is not credible, an administrative law judge need not accord additional weight to the treating physician's opinion. *See* 20 C.F.R. § 718.104(d)(5). *See also* ***Jericol Mining, Inc. v. Napier***, 311 F.3d 703 (6th Cir. 2002); ***Wolfe Creek Collieries v. Director, OWCP*** [***Stephens***], 298 F.3d 511, 22 B.L.R. 2-495 (6th Cir. 2002); ***Peabody Coal Co. v. Groves***, 277 F.3d 834, 22 B.L.R. 2-320 (6th Cir. 2002).

The record includes the following medical opinions that were introduced in the prior three claims:

Dr. Paranthaman. Dr. Paranthaman examined the Claimant for the Department of Labor on March 31, 1987. (DX 1). He referenced a negative x-ray, and diagnosed chronic bronchitis, hypertension and ventricular premature heartbeats. The doctor recorded a 20 pack year smoking habit. Dr. Paranthaman attributed the chronic bronchitis "due to smoking and/or coal dust exposure."

On August 30, 1996, Dr. Paranthaman issued a report for the Department based on a complete pulmonary evaluation for the second claim. (DX 2). This time, he recorded a ten year smoking history, at the rate of 1/2 pack per day. He diagnosed pleural thickening related to the Claimant's esophageal surgery, hypoxemia and chronic bronchitis "probably" related to Mr. Lawson's coal dust exposure. Dr. Paranthaman ruled out smoking as a contributor, because the Claimant had stopped that habit in 1968, and he said that his symptoms began in 1980. In a separate letter, he wrote that

> deterioration in the pulmonary function studies are either due to progression of chronic bronchitis and pulmonary emphysema, previously caused by cigarette smoking and/or coal dust exposure or it is due to the effect of esophageal rupture requiring surgical intervention ...
>
> [w]hile it may not be possible tp be absolutely certain about the cause of the deterioration in the pulmonary function [tests], I conclude that it is probably due to progression of pulmonary emphysema caused by cigarette smoking and

considerably aggravated by coal dust exposure. ... I conclude that Mr. Lawson has coal workers' pneumoconiosis based on his work history.

Dr. Fonseca. Dr. Fonseca submitted a brief letter report on January 23, 1988. He recorded a 25 pack/year smoking history. The doctor diagnosed COPD and possible underlying coal workers' pneumoconiosis. The COPD was due to smoking and coal dust exposure. The pulmonary impairment precluded the Claimant from working an eight hour day, thus rendering him totally disabled. (DX 1).

Dr. Fleenor. Dr. Fleenor had been the Claimant's treating physician since 1979. He read two (2) x-rays as positive for pneumoconiosis. He also noted that the Claimant has suffered from an infection associated with black lung, for which Mr. Lawson has received antibiotics. (DX 1).

Dr. Robinette. Dr. Robinette diagnosed pneumoconiosis, citing a positive x-ray, but could not document a functional impairment due to pneumoconiosis. His September 29, 1987 report shows that he recorded a fifteen (15) pack/year smoking habit. On examination, he observed diminished breath sounds, but also noted that "no audible wheezes or rhonchi were heard." The extremities showed no obvious cyanosis, clubbing or edema. (DX 1).

Dr. Endres-Bercher. Dr. Endres-Bercher issued a report on May 12, 1988. He recorded a smoking history of 29 years at the rate of 1/2 pack per day. He saw no evidence of pneumoconiosis or a disabling pulmonary or respiratory impairment. (DX 1).

Dr. Gary Williams. Dr. Williams has been one the Claimant's treating physicians. He wrote on January 2, 1997, that Mr. Lawson suffered from significant dyspnea and pulmonary disease, and advised that an exercise test would be contraindicated.

Dr. James Castle. Dr. Castle examined the Claimant in 1997 and submitted a report dated February 17, 1997. He found no pneumoconiosis and no respiratory impairment. He explained that there were no clinical findings, viz. rales, crackles or crepitations that would indicate an interstitial pulmonary process. There were likewise no x-ray findings of pneumoconiosis.

Dr. Castle's deposition testimony was taken on December 1, 1997. He reiterated his findings and conclusions from the medical report. He also explained that the finding of diminished breath sounds over the right lower lobe corresponded to the area of the elevated diaphragm and scar tissue that would be related to Mr. Lawson's previous surgery. (Deposition at 27). He also testified that Mr. Lawson represented to him a smoking habit of 15 years at the rate of 1/2 pack per day.

Dr. Alexander Sy. Dr. Sy reported on April 2, 1997, a diagnosis of chronic bronchitis, coal workers' pneumoconiosis, obstructive sleep apnea and hypertension. On examination of the chest, Dr. Sy observed that the breath sounds were "clear with no wheezing, rhonchi, crackles or rub." He made no positive findings on examination of the extremities.

Drs. Gregory Fino and A. K. Dahhan. Drs. Fino and Dahhan reviewed the Claimant's medical records at the request of the Employer. The former physician opined in a November 11, 1997 consultation review that there was an insufficient basis for a finding of either pneumoconiosis or a pulmonary or respiratory impairment.

Dr. Dahhan reported on November 6, 1997, that his review uncovered no basis for a

diagnosis of pneumoconiosis. He also pronounced that the Claimant was not disabled. Dr. Dahhan noted that the various pulmonary function studies that had been conducted to date demonstrated an "intermittent obstructive ventilatory abnormality" that would be "inconsistent with the permanent adverse affects of coal dust on the respiratory system."

Drs. Joseph Smiddy and Gary Williams. For his third claim, Mr. Lawson secured a number of opinions from Drs. Joseph Smiddy and Gary Williams, who had treated him. On November 12, 1998, Dr. Smiddy opined that the Claimant suffered from coal workers' pneumoconiosis "with associated underlying industrial bronchitis related to coal dust and obstructive lung disease primarily related to coal dust as [Mr. Lawson] has not smoked in many years."

In later progress and treatment notes, Dr. Smiddy observed decreased breath sounds. He maintained his diagnosis of pneumoconiosis, citing multiple positive x-rays by B-readers,[25] and opined that the Claimant was disabled. In his most recent report, dated April 26, 2001, Dr. Smiddy recorded a variety of medications that the Claimant was using. On physical examination, he again found decreased breath sounds, but no rales, rubs or rhonchi. The extremities revealed no clubbing, cyanosis or edema.

Dr. Williams submitted numerous brief letter progress reports. He has treated the Claimant since 1991. On June 3, 1999, Dr. Williams wrote that the Claimant's respiratory impairment was worsening to the point where he needed to use an inhaler twice a day. His diagnosis of pneumoconiosis was based on a positive x-ray (November 12, 1998) and a history of coal mine dust exposure.

On April 20, 2000, Dr. Williams reported severe COPD and probable coal workers' pneumoconiosis. He reiterated his diagnosis on May 15, 2000, stating that Mr. Lawson's 23 years in underground mines "plus exposure on strip jobs for several more years" explained the fact that his impairment was due at least in part to occupational exposure. On September 7, 2000, Dr. Williams wrote that Mr. Lawson's "pulmonary symptoms are wax and wane and at his best he will be permanently disabled from his significant pulmonary disease."

Discussion: Section 718.202(a)(4)

Upon review of the medical opinion evidence as a whole, including the symptoms, examinations and clinical testing that serve as a partial basis for the doctors' conclusions, I find that the Claimant has failed to demonstrate on the basis of medical opinion evidence that he suffers from pneumoconiosis or any pulmonary or respiratory impairment that is significantly aggravated by, or substantially related to, his coal mine dust exposure.

I have given due consideration to the Claimant's treating physicians, especially Drs. Fleenor, Williams and Smiddy, as well as to the credentials of the physicians of record. I have carefully evaluated the credentials and opinions by Dr. Rasmussen, who submitted the most comprehensive report in favor of this claim. I am concerned somewhat because Dr. Rasmussen

[25] In a report that was prepared on April 26, 2001, Dr. Smiddy cited to a positive x-ray that was interpreted at "1/1" by Dr. Westerfield.

assumes a ten pack/year cigarette smoking history. As further discussed below, I find that the Claimant has a twenty pack/year history of cigarette use. Dr. Rasmussen's somewhat optimistic view of Mr. Lawson's smoking history detracts from the weight to accorded his conclusion with respect to the etiology of the Claimant's pulmonary impairment and the cause of any pulmonary disability. *See generally*, ***Maypray v. Island Creek Coal Co.***, 7 B.L.R. 1-683 (1985).

I am most persuaded, however, by the more comprehensive reports and opinions from Drs. Castle and Hippensteel. Both of these physicians not only examined the Claimant, but they also surveyed in depth the whole range of medical exhibits that have been involved in the four (4) claims filed by Mr. Lawson. *See* ***Balsavage v. Director, OWCP***, 295 F.3d 390, 396, 22 B.L.R. 2-386 (3d Cir. 2002). These experts have persuasively accounted for the Claimant's lengthy coal mine employment and dust exposure in rendering their opinions as to the etiology of Mr. Lawson's pulmonary or respiratory impairment. *Cf.* ***Peabody Coal Co. v. Hill***, 123 F.3d 412, 417, 21 B.L.R. 2-192 (6th Cir. 1997) (administrative law judge found that employer's experts failed adequately to account for miner's coal mine dust exposure). The opinions of these physicians are supported by the opinions of Drs. Fino and Dahhan, as well as Dr. Castle's 1997 opinion and deposition testimony.

I credit the conclusions of the Employer's experts that the nature of the Claimant's pulmonary or respiratory condition is neither clinical pneumoconiosis, consistent with my finding that the x-rays as a whole do not prove the existence of the disease, and that the Claimant does not suffer from industrial bronchitis, or that his chronic bronchitis is not derived from coal mine dust exposure. Both Drs. Castle and Hippensteel also voiced a familiarity with the broader definition of "legal" pneumoconiosis, have accounted for that possibility in rendering their opinions, and have adequately explained why the Claimant's pulmonary condition does not meet that definition. *See generally* ***Stiltner v. Island Creek Coal Co.***, 86 F.3d 337, 341, 20 B.L.R. 2-246 (4th Cir. 1996).

I am mindful that Drs. Paranthaman and Smiddy discounted the effects of the Claimant's cigarette smoking on his present obstructive pulmonary disease because that habit ceased in 1980. Nevertheless, not only did Dr. Castle opine that smoking was involved in the formation of Mr. Lawson's current pulmonary or respiratory condition, but Dr. Ranavaya, who diagnosed clinical pneumoconiosis by x-ray, nevertheless concluded that the Claimant's smoking history could be involved in the chronic bronchitis. The difficulty with assessing what role, if any, has been played by cigarette smoking is made more pronounced because the Claimant has become a less accurate historian by the passage of years. He told Dr. Paranthaman in 1987 that he smoked for twenty pack/years. Dr. Fonseca recorded a twenty-five pack/year history.[26]

At the very least, I would find that the medical opinion evidence is no more than equally probative. In the final analysis, taking into account the "qualifications of the respective physicians, the explanations of their medical opinions, the documentation underlying their medical judgments and the sophistication and bases of their diagnoses," *see* ***Sterling Smokeless Coal Co. v. Akers***, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997), I find that the medical

[26] I find that the Claimant smoked for at least twenty years at the rate of one pack per day. Mr. Lawson testified on September 20, 1988, at the hearing for his first claim to the effect that he smoked about twenty years. (Tr. [9-20-88] 14).

opinions of the Employer's experts are sufficient to preclude a finding of pneumoconiosis at Section 718.202(a)(4). These opinions are extensively documented, their conclusions are more adequately explained, especially when subjected to deposition questioning, and they are better supported by their underlying documentation.[27] *See generally* ***Clark v. Karst-Robbins Corp.***, 12 B.L.R. 1-149 (1989)(en banc); ***Lucostic v. United States Steel Corp.***, 8 B.L.R. 1-46 (1985). Moreover, I have reviewed the credentials of all of the experts of record in making this analysis of the respective probative weight of the medical opinions.

I thus find that the Claimant has not demonstrated the existence of pneumoconiosis on the basis of medical opinion evidence at Section 718.202(a)(4).

Because this claim arises within the territorial jurisdiction of the Fourth Circuit, all relevant evidence must be considered at Section 718.202(a). *See* ***Compton***. The Claimant has not demonstrated the existence of pneumoconiosis at any subsection. Nevertheless, viewing the record as a whole, and evaluating all of the evidence pursuant to *Compton*, I find that pneumoconiosis has not been established at Section 718.202(a). Because the Claimant has not proven that he suffers from pneumoconiosis, or any pulmonary or respiratory impairment significantly related to, or substantially aggravated by, coal mine employment, he is not entitled to benefits under the Act. ***Perry***.

Disability Causation

Even assuming that the Claimant had established the existence of pneumoconiosis, I nevertheless find that he would not establish disability causation. The Claimant would be considered totally disabled due to pneumoconiosis, if his disability is a contributing cause of, or is due at least in part to pneumoconiosis. ***Scott v. Mason Coal Co.***, 289 F.3d 263, 268, 22 B.L.R. 2-372 (4th Cir. 2002); ***Milburn Colliery Co. v. Hicks***, 138 F.3d 524, 529, 21 B.L.R. 2-323 (4th Cir. 1998). The Secretary's regulations provide at Sections 718.204(c)(1)(i) and (ii) that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. §§ 718.204(c)(1)(i), (ii) (2004).

In this case, I find that the Claimant would not establish disability causation. Assuming that he suffered from pneumoconiosis, I primarily credit the opinion from Dr. Castle that "Mr. Lawson is permanently and totally disabled as a result of a pulmonary process which resulted

[27] For example, many of the findings on examination of the chest observed by some physicians of record appear to be relatively unremarkable. Although Dr. Ranavaya observed a "minimally prolonged expiratory phase" and "few expiratory wheez[es]," Dr. Rasmussen detected reduced breath sounds, but heard no rales, rhonchi or wheezes. Drs. Castle and Hippensteel made essentially normal observations in reporting on their examinations of the chest and extremities, although some decreased breath sounds were heard by Dr. Castle, and Dr. Hippensteel detected a dullness and decreased air movement in the area he thought would have been affected by the Claimant's surgery and related scarring. Dr. Robinette noted diminished breath sounds, but also found no audible wheezes or rhonchi. Dr. Sy observed clear breath sounds, and also found no wheezing, rhonchi, crackles or rub.

from his previous extensive surgery for a ruptured esophagus with resultant pleural scarring bilaterally." (EX 3).

CONCLUSION

Because the Claimant has failed to establish the existence of pneumoconiosis, an essential element of entitlement, and, assuming the existence of that disease, has not proven disability causation, I must find that he has not qualified for benefits under the Act.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is hereby ordered that the claim of Calvin B. Lawson is denied.

A
DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117,