

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 26 August 2009

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In the Matter of:

H.G.A.¹,
 Claimant,
 v.
CANNELTON INDUSTRIES, INC.,
 Employer,
 and
DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
 Party in Interest.

Case No. 2008 BLA 05677

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APPEARANCES:

Roger Foreman, Esq.
For the Claimant

Ashley Harman, Esq.
For the Employer

Before: Stuart A. Levin
Administrative Law Judge

Decision and Order

This proceeding arises from a claim for benefits filed August 13, 2001, under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq (the Act). Regulations implementing the Act are published by the Secretary of Labor in Title 20 of the Code of Regulations. The matter is now before the Office of Administrative Law Judges on remand from the Benefits Review Board. In its Decision and Order (BRB No. 06-0684 BLA) issued on May 31, 2007, the Board reviewed a decision awarding benefits issued by Judge Robert D. Kaplan on May 16, 2006. Judge Kaplan had concluded that Claimant had at least 33 years of coal mine employment and had, since the denial of a prior claim in 1986, developed complicated pneumoconiosis which arose out his coal mine employment, and Employer appealed.

¹ Effective August 1, 2006, the U.S. Department of Labor implemented a policy to avoid using claimants' names in the caption or body of any Black Lung or Longshore decision or order posted on the DOL website. In lieu of identifying the claimant by name, the policy requires the use of the claimant's initials.

In its decision vacating the award of benefits, the Board initially held that Judge Kaplan could, in the exercise of his discretion, find that Dr. Blue's biopsy diagnosis of a two centimeter lesion and extensive and severe fibrosis was sufficient to constitute a diagnosis of "massive lesions" within the meaning of 20 C.F.R. 718.304(b), *see*, Board Dec. at 5, but the Board agreed with the Employer that Judge Kaplan's conclusion that the two centimeter lesion identified by biopsy is equivalent to a one centimeter opacity on x-ray represented an improper substitution of Judge Kaplan's opinion for the opinion of the experts. *Id.* at 6. The Board also noted that the decision awarding benefits failed to reconcile Dr. Blue's finding with Dr. Mangano's opinion that the largest area of fibrosis measured only one centimeter, and the further fact that Drs. Scott and Scatarige noted one centimeter lesions" on x-ray and CT scan but not a large "opacity" as required by the regulations. *Id.* at 6. Citing Director v. Eastern Associated Coal Corp., [Scarbro], 250 F.3d 256 (4th Cir. 2000), the Board questioned whether a one centimeter lesion found by biopsy and a one centimeter "lesion" on x-ray and CT scan is "equivalent to a one centimeter "opacity" on an x-ray. Finally, the Board concluded that the decision awarding benefits failed to discuss the medical opinion evidence together with the x-ray, CT scan, and biopsy evidence before the irrebuttable presumption was invoked. Thus the Board's remand instructions require reconsideration "of the evidence supporting equivalency, and ... all relevant evidence." If the irrebuttable presumption is not triggered, the elements of the "subsequent claim for benefits" must be reconsidered. *Id.* at 7.

On remand, the parties requested, and were granted time to submit additional evidence and file briefs. Employer's exhibits 1 through 1ix, the May 31, 2007 CT scan readings of Drs. Scott, Wheeler, Carlson and Miller, Claimant's unnumbered exhibits including Dr. Alexander's report and curriculum vitae, Dr. Cohen's report and curriculum vitae, Dr. Carlson's notes, Dr. Newman's notes, and Edward White Hospital notes are, without objection, admitted into evidence. On April 7, 2009, the District Director advised all parties that notice had been received that Claimant passed away on April 3, 2009.

X-Ray and CT Scan Data

The record in this matter contains several chest x-ray interpretations and interpretations of CT scans. The chest x-ray evidence is evaluated pursuant to Section 718.304(a) while the CT scan results are considered pursuant to Section 718.304(c). Melnick v. Consolidation Coal Co., 16 B.L.R. 1-31 (1991)(en banc).

The record shows that on August 7, 1986, Judge Ellin O'Shea found that Claimant established the presence of simple pneumoconiosis by x-ray. More recently, Claimant's medical records include a chest X-ray report dated August 8, 2002. Dr. Frank A. Reda, III found some strandy linear densities at each lung base and in the right mid lung. The physician described the densities as fairly symmetric with somewhat nodular pleural thickening superlaterally on each side. Dr. Reda opined that his findings were most consistent with parenchymal and pleural fibrosis. (CX 1). On October 23, 2001, Dr. Sargent a "B" reader detected the opacities of pneumoconiosis 1/1 in all of Claimant's lung zones. On May 13, 2002, Dr. Wheeler subsequently reread the x-ray as revealing minimal interstitial fibrosis but as negative for pneumoconiosis. As Employer notes, Dr. Alexander subsequently interpreted a May 31, 2002 x-ray as positive for pneumoconiosis, 2/1 with an area of coalescence in the right upper zone. On

January 22, 2003, Dr. Wheeler reread the x-ray dated May 31, 2002, as negative for pneumoconiosis, but probable healed TB. On January 23, 2003, Dr. Scott re-read the x-ray dated May 31, 2002, as negative for pneumoconiosis, but probable healed TB. On January 23, 2003, Dr. Scatarige re-read the x-ray dated May 31, 2002, as negative for pneumoconiosis, but minimal TB with a few small nodules but not CWP and a 1 cm. focal mass or infiltrate in right lung apex. EX 1. In summary, there is evidence that the May 31, 2002 x-ray revealed a "1 cm. focal mass or infiltrate R[t] apex," but Employer notes correctly that no chest x-ray interpretation specifically mentions "large opacities."

Claimant's medical records include a chest X-ray report dated August 10, 2002. Dr. Kevin W. Carroll noted that Claimant was status post right thoracotomy. The physician also noted persistent interstitial lung disease and mild left base atelectasis or scar. (CX 1). Claimant had a chest X-ray taken on August 11, 2002. Dr. Carroll found post surgical changes in Claimant's right chest without evidence of pneumothorax. (CX 1). Claimant's medical records also include a chest X-ray report dated August 12, 2002. Dr. David H. Turkel noted post surgical changes on Claimant's right with findings suggesting mild congestive heart failure but found no pneumothorax. (CX 1). Claimant had a chest X-ray taken on August 14, 2002. Dr. William B. Hearn found Claimant was status post chest tube removal and no evidence of pneumothorax. (CX 1).

Similarly, the CT scan results show multiple nodules, one of which measured up to 1.8 cm. but none were specifically interpreted as showing complicated pneumoconiosis. Thus, on February 6, 2002, Dr. Knific interpreted the results of a CT scan as revealing the presence of moderately severe, diffuse bilateral interstitial lung disease. He described it as likely fibrotic and opined that it could be related to Claimant's previous employment. Dr. Knific also mentioned that he found two to three solid, non-calcified, non-specific right lung nodules that did not show up on x-ray. At the time, the largest nodule he noticed in the right lung apex measured 10-15 mm. DX 8. Dr. Alexander reviewed the CT scan and described an area of coalescence in the mid and right upper lung zones, the largest of which measured 14 x 10 MM, which he described as consistent with complicated pneumoconiosis, category A. On January 23, 2003, Dr. Wheeler reread the February 6, 2002 CT scan as showing negative for CWP and multiple nodules that were "not CWP because pattern is asymmetrical and involve periphery RUL and right apex while CWP typically gives small symmetrical nodules in central mid and upper lungs." On January 23, 2003, Dr. Scott also re-read the February 6, 2002 CT scan as negative for CWP but revealing multiple nodules and a 1.5 cm mass right apex which he thought was probably due to healed inflammatory process such as TB. On January 24, 2003, Dr. Scatarige reread the February 6, 2002 CT scan as negative for pneumoconiosis, but revealing indeterminate nodules, peripheral interstitial fibrosis with one 1 x 1.8 cm pretracheal node.

Dr. Razak Dosani was brought in as a consultant in the hospital because of Claimant's abnormal May 6, 2002 CT scan. Dr. Dosani noted that Claimant's chest X-ray and CT scan dated February 6, 2002, showed diffuse bilateral interstitial lung disease with minimal increase and that the CT scan showed three small right lung nodules that were not seen on chest X-ray. The CT scan in May 6, 2002, showed atherosclerotic aorta, that one lymph node in the precarinal space had increased in size, an unchanged nodular density in the parenchyma, and bilateral interstitial lung. Dr. Alexander, a "B" reader, also interpreted the May 6, 2002 CT scan as showing a pattern typical of pneumoconiosis "with coalescence of small opacities in the right

apex” as well as other nodules. He opined that CT scan was consistent with complicated pneumoconiosis, category A. On May 13, 2003, Dr. Wheeler reread the May 6, 2002 CT scan as negative for pneumoconiosis, but probable healed TB. On January 23, 2003, Dr. Scott reported that the May 6, 2002 CT scan was unchanged from the February 6, 2002 CT scan. On January 24, 2003, Dr. Scatarige re-read the May 6, 2002 CT scan as again showing multiple nodules, one measuring 1 x 1.8 cm, but no CWP.

A May 31, 2007, CT scan was interpreted by Drs. Carlson, Wheeler, Scott, and Miller. While Drs. Miller and Carlson found the results consistent with pneumoconiosis, Drs. Scott and Wheeler saw no indications of pneumoconiosis. As Employer notes, however, no physician described large opacities consistent with complicated pneumoconiosis on this CT scan.

In summary, while Dr. Alexander identified opacities on the CT scans that he opined were consistent with complicated pneumoconiosis, Drs. Scott, Wheeler, and Scatarige saw a 1.5 mass in the upper apex of Claimant’s right lung but interpreted it as something other than pneumoconiosis. Dr. Knific, described interstitial disease lung disease which he attributed to Claimant’s employment, but he did not specifically diagnose complicated pneumoconiosis, while Drs. Dosani and Hummel noted multiple nodules, including a mass larger than 1 cm. in the right lung apex. As Employer notes, none of the CT scan interpretations specifically mention large opacities.

Biopsy Evidence

Because they were uncertain about the etiology of the nodules in Claimant’s right lung, and particularly the large mass in the apex, the doctors caring for him at the time recommended that he undergo a biopsy. The procedure was performed by Dr. Hummel on August 9, 2002, and involved a right thoracotomy with a wedge excision of the right lower lobe nodule, and right upper and middle lobe lobectomy. Dr. Hummel’s reports in the hospital records show that the purpose of the procedure was to assess the multiple right lung nodules, and particularly the large nodule in the right apex. During the biopsy procedure, Dr. Hummel physically observed the right lung tissue and reported the presence of “extensive black lung changes, multiple anthracotic nodes along the peritracheal space.” He also saw large nodes in all three right lung zones, and reported multiple nodes in the upper and middle lobes, “several being larger than 1 cm.” Cx 1. The samples he excised were then evaluated by Dr. Mary Blue, a pathologist.

A Surgical Pathology report prepared by Dr. Blue dated August 20, 2002, described the results of the biopsy. Four specimens were taken and labeled mediastinal adenopathy, right lower lobe, paratracheal node, and right upper and middle lobe. Although the mediastinal adenopathy, right lower lobe, and paratracheal node samples, as Dr. Blue reported, consisted of nodules less than 1 centimeter in diameter, the right upper and middle lobe sample consisted, in part, of “[m]ultiple firm nodular areas. . . [t]he largest of which measures 2 centimeters in diameter.” Dr. Blue diagnosed the right upper and middle lobe sample as containing “[e]xtensive severe fibrosis with anthracosis.” (CX 1). Section 718.201(a)(1) defines “anthracosis” as clinical pneumoconiosis. Consequently, I find that Dr. Blue described the 2 cm. anthracotic nodule with fibrosis as pneumoconiosis which, if equivalent to a 1 cm. opacity on x-ray, would be equivalent to a diagnosis of complicated pneumoconiosis.

Dr. William E. Mangano also prepared a Surgical Pathology Report dated June 17, 2004. He opined that although the lymph node, right lower lung lobe, and the paratracheal lymph node samples consisted of nodules less than 1 centimeter in diameter, the right upper and middle lung lobes sample consisted, in part, of: “diffuse and nodular fibrosis with anthracotic pigment, replacing large portion of lung biopsy (largest nodular area of fibrosis 1.0 cm). Diffuse and nodular areas of histiocytes with anthracotic pigment. Changes consistent with emphysema. Pleura with fibrosis.” Dr. Mangano opined that the biopsy samples were “entirely consistent with coal workers’ pneumoconiosis.” (CX 2). Employer contends that Dr. Mangano “did not specifically diagnose complicated coal workers’ pneumoconiosis. He did, however, diagnose an area of nodular fibrosis and concluded that the biopsy sample was “entirely consistent with coal workers’ pneumoconiosis.” As a consequence, his opinion does not diminish or contradict Dr. Blue’s diagnosis that the nodule was pneumoconiosis.

Subsequent to the Board’s remand, Employer submitted additional evidence in the form of a consultation report by Dr. Everett Oesterling. Dr. Oesterling, a pathologist, reviewed the biopsy slides prepared by Dr. Blue and found on microscopic examination: “multiple small micronodular areas which are beginning to coalesce. However, the greatest dimension in any of these does reach 1.7 cm.” Oesterling at 4. Thus, Dr. Oesterling described a mass measuring 1.3 x 1.2 cm. with black pigment and pink fibers, a mass measuring 1.2 x .8 cm. with black pigment, a mass with black pigment with fibrosis measuring 1.7 x .9 cm., *see* Oesterling at 3, and a mass with black pigment and fibrosis measuring 7 mm. *Id.* at 4; and he reports: “thus this again is a micronodule of coal workers’ pneumoconiosis.” He concluded, however, that the 1.7 cm. nodule was not progressive massive fibrosis because it did not satisfy the medical definition of progressive massive fibrosis which requires a nodule measuring at least 2 cm.

Medical Definition of Progressive Massive Fibrosis

Before discussing the issue of x-ray equivalency, Employer notes that Dr. Oesterling qualified his discussion of Claimant’s pathology by noting that the 1.7 cm. nodule he found would not qualify medically as a “progressive massive fibrosis” because the College of American Pathologists and recent textbooks by Leslie and Wick and by Cagle define “progressive massive fibrosis” as: “an area greater than 2 cm. in maximum dimension [with] a consistency of vulcanized rubber.” Dr. Oesterling concluded: “Thus this gentleman does not have progressive massive fibrosis.” Oesterling at 4. Although Dr. Oesterling’s analysis of the biopsy data will be accorded substantial evidentiary weight, his conclusion based upon the medical definition he applied is accorded no weight.

In Scarbro, the Court addressed this precise issue. The Court observed that the medical definition of progressive massive fibrosis is not controlling, and deemed it a mistake for an employer to assume: “that the statutory definition of “complicated pneumoconiosis” must be congruent with a medical or pathological definition....Rather, the presumption under § 921(c)(3) is triggered by a congressionally defined condition, for which the statute gives no name but which, if found to be present, creates an irrebuttable presumption that disability or death was caused by pneumoconiosis. The statute provides three methods for establishing the existence of the condition, but these methods would not necessarily be useful as diagnostic guidelines in a clinical setting. In short, the statute betrays no intent to incorporate a purely medical definition.”

Scarbro at 258.² Consequently, I find that Dr. Oesterling described a 1.7 cm. nodule of pneumoconiosis which, if equivalent to a 1 cm. opacity on x-ray, would be equivalent to a diagnosis of complicated pneumoconiosis.

Reconciling the Biopsy Findings

Before considering the “equivalency” issue, the Board directed that an effort be made to reconcile, first Dr. Blue’s biopsy finding of a two centimeter nodule with Dr. Mangano’s finding that the largest nodular area of fibrosis measured one centimeter, and next to reconsider the issue of equivalency between a measured biopsy finding of a one centimeter “nodule” and the finding of “large opacity” on an x-ray. Subsequent to the Board’s remand, Dr. Oesterling identified multiple micronodular areas which were beginning to coalesce, the largest of which measured 1.7 cm. Dr. Hummel, the surgeon who performed the biopsy procedure, noted in his surgical report that the large nodule in the right apex was 1.5 cm.

Thus, Dr. Mangano found a 1 cm. area of nodular fibrosis, Dr. Blue found a nodular area measuring 2 cm., Dr. Hummel reported that the nodule was 1.5 cm., and Dr. Oesterling measured a 1.7 cm. area of micronodular coalescence. Although instructed by the Board to “reconcile” the various findings relating to the size of the largest area of coalescence, the record does not provide evidence sufficient to explain the differences in the dimension of the largest nodular area described by the physicians who measured it. By way of speculation, it may be suggested that each physician was perhaps describing a different area of coalescence; and if that were the case, the largest lesion would be 2 cm. as reported by Dr. Blue. That scenario is unlikely, however, because the principal purpose of the biopsy, as reported in the hospital records, was to assess the largest mass in the right apex detected by the x-rays and CT scans. Alternatively, it might be suggested that all the pathologists located the largest nodule, but one physician measured more carefully than the other three. It is not, however, possible on this record to determine which pathologist most accurately measured the nodule. In the end, it is simply not possible to “reconcile” what on this record is irreconcilable.

Rather than reconcile the measurements, I have instead accorded greater weight to the measurement provided by Dr. Oesterling. Initially, it may be observed that, because Dr. Hummel was in the process of performing the surgical procedure at the time he assessed the size of the nodule, he probably had less time to measure it than the pathologists who were afforded the leisure of measuring the nodule in the laboratory. His measurement, while not necessarily less accurate, is, under the circumstances, likely to be marginally less accurate than the pathologist’s. Thus I have accorded the measurement by Dr. Oesterling the greatest weight because, on an imperfect record, his measurement is within .2 cm. of Dr. Hummel’s and .3 cm. of the measurement recorded by Dr. Blue. Further, assuming the pathologists were measuring the same area, and there is on this record substantial evidence they were, Dr. Oesterling’s measurement of 1.7 cm. is not only closest to Dr. Hummel’s but closest to the 1.57 cm. average of the measurements of all three pathologists (1cm. + 2cm.+ 1.7 cm. = 3.7cm. ÷ 3 = 1.57 cm.). Lastly, I find Dr. Oesterling’s measurement persuasive because his report was sponsored into evidence by Employer, and neither Employer nor Claimant challenged his measurement. Considering the

² Under circumstances strikingly similar to those involved here, Dr. Kleinerman, the pathologist in Scarbro, also concluded that, in his medical opinion, the 1.7 cm. lesions he observed did not satisfy the medical criteria for complicated pneumoconiosis. The Scarbro court, nevertheless, affirmed the finding of complicated pneumoconiosis.

evidence in context, I, therefore, find that the presence of a 1.7 cm. micronodule of pneumoconiosis was established by the biopsy evidence.³ Nevertheless, it remains to be determined whether, as required by Scarbro, the existence of this 1.7 cm. nodule was equivalent to what would appear as a one centimeter opacity on an x-ray. If so, it would under Scarbro be considered a significant indicator of the existence of complicated pneumoconiosis pending consideration of other relevant evidence. Scarbro at 259.

Equivalence of Biopsy and X-Ray Findings

The Court in Scarbro held that complicated pneumoconiosis: “in the statutory sense, is established by the application of congressionally defined criteria, and, as we have been careful to note, the most objective measure of the condition specified by § 921(c)(3) is obtained through x-rays.”⁴ Thus, all of the evidence must be considered and evaluated to determine whether “the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray.” Scarbro at 257. This then is the definition of the “equivalency” issue remanded by Board for further consideration.

In his decision awarding benefits, Judge Kaplan endeavored to apply the equivalency test. He noted that nodules of at least 1 cm. were found on Claimant’s x-ray and CT scan, and he determined that the physicians who described these lesions as tuberculosis or other inflammatory process were less persuasive than the biopsy results. He found that the 2 cm. nodule described by Dr. Blue on Claimant’s biopsy was equivalent to the finding on chest x-ray of an opacity greater than 1 cm. Judge Kaplan noted that the x-ray and CT scan evidence was also interpreted as showing the existence of 1 cm. lesions and this “bolstered” Dr. Blue’s conclusion.

Equivalency Absent A Medical Equivalency Opinion

On appeal, the Board disagreed with Judge Kaplan. Although no physician addressed the question of equivalency on the record as it then existed, the Board concluded that Judge Kaplan substituted his opinion for the opinion of the medical experts on the question of equivalency. Yet, like the record before Judge Kaplan, the record before the Court in Scarbro also failed to provide a medical assessment of equivalency. *See*, Scarbro at 259. Nevertheless, the Court concluded that: “We are given no reason to believe that nodules of 1.7 centimeters would not produce x-ray opacities greater than one centimeter.” The Court then inferred that: “To the contrary, the 1991 x-ray, showing opacities greater than one centimeter in diameter, provides persuasive evidence that the miner's lesions did in fact show as opacities of that size.” *Id.* Thus, Scarbro teaches that it is not necessary for a physician to specifically establish the “equivalency” between the measurement of a nodule identified by biopsy or autopsy and the size of an opacity shown on an x-ray. To the contrary, the Court in Scarbro inferred from other evidence of record the equivalency which the doctors failed to provide.

³ It is noted that Dr. Ghio challenges Dr. Oesterling’s diagnosis, and his opinion is considered in detail *infra*.

⁴ While x-rays may be an objective diagnostic tool, in 99.9% of adjudications, reports containing interpretations or readings of x-ray films are placed in evidence not the x-ray films themselves, and the objectivity and accuracy of the interpretation in evidence may be no greater than the objectivity of the particular physician who interpreted the x-ray or his or her skill as a reader. Thus the Court in Scarbro noted that: “the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader.”

Diagnosing the 1.7 cm Mass

Credibility of Drs. Wheeler, Scott, and Scaratige

Prior to the biopsy, Claimant's x-rays and CT scans all revealed what was variously described by the doctors as a coalescence, mass, or lesion in the right lung apex. Before considering the size equivalency between that "mass," or "lesion," and an "opacity," ascertaining what the mass represented was the main concern of Claimant's physicians. According to Drs Wheeler, Scott and Scaratige, the x-rays and CT scans did not reveal pneumoconiosis, and, therefore, regardless of its size the mass was not complicated pneumoconiosis. For the reasons which follow, however, I accord their opinions little weight in this proceeding.

As noted above, Drs. Wheeler, Scatarige, and Scott are well-credentialed radiologists and "B" readers, but they have demonstrated, in this proceeding, an inability, on numerous occasions over an extended period of time, to detect the presence of pneumoconiosis by x-ray or CT scan. Indeed, the existence of simple pneumoconiosis in Claimant's lungs was revealed to physicians interpreting x-rays as early as 1986, as found by Judge Ellin O'Shea in a decision issued on August 7, 1986. Subsequently, Dr. Sargent, a "B" reader, found simple pneumoconiosis in all lung zones, and Dr. Alexander found simple pneumoconiosis on x-ray and complicated pneumoconiosis, category A by CT scan. Dr. Knific also found interstitial disease lung disease which he attributed to Claimant's employment, and a May 31, 2007, CT scan was interpreted by Drs. Carlson, and Miller as consistent with pneumoconiosis. Yet, Drs. Scott, Scatarige, and Wheeler have been able to detect or discern simple or complicated pneumoconiosis on any of the x-rays or CT scans they reviewed. Moreover, there can be little doubt that the August 9, 2002, biopsy, at least, confirmed the existence of simple pneumoconiosis as found on the x-ray evidence by Judge O'Shea in 1986 and later on the x-rays interpreted in this proceeding by Drs. Sargent and Alexander.

The record shows that where other radiologists saw opacities indicative of simple pneumoconiosis, Drs. Wheeler, Scott, and Scaratige, denied on multiple occasions that the multiple x-rays and CT scan results they read showed simple pneumoconiosis. Dr. Scott saw a healed inflammatory process such as healed TB, Dr. Wheeler saw healed TB and opined that multiple nodules he saw were: "not CWP because pattern is asymmetrical and involve periphery RUL and right apex while CWP typically gives small symmetrical nodules in central mid and upper lungs," while Dr. Scatarige saw indeterminate nodules, which he nevertheless, concluded were not coal workers' pneumoconiosis.

With the exception of the May 31, 2007, CT scan, Drs. Scott, Wheeler, and Scaratige were re-reading films that were produced prior to the biopsy. They were thus looking at films with the same shadows and opacities that Drs. Alexander and Sargent, were interpreting. The biopsy demonstrated that Drs. Sargent and Alexander correctly identify the opacities of simple pneumoconiosis and that Drs. Wheeler, Scott, and Scatarige were wrong to rule out pneumoconiosis. Moreover, where Dr. Scatarige could only identify "indeterminate" nodules, other radiologists identified the opacities indicative of the pneumoconiosis revealed by the biopsy; and where Drs. Wheeler and Scott saw a healed inflammatory process such as TB, the pathologists who examined the biopsied tissue reported no indication of TB, active or healed.

Finally, Drs. Carlson, and Miller interpreted a May 31, 2007, CT scan as consistent with pneumoconiosis, but Drs. Scott and Wheeler found it negative for pneumoconiosis.

To be sure, other radiologists, as discussed above, have interpreted an occasional x-ray as negative for pneumoconiosis, but Drs. Wheeler, Scaratige, and Scott have been unable to detect pneumoconiosis on any of the x-rays or CT scans they reviewed. Highly qualified experts can misread x-rays on occasion; but this record belies the notion that the errors by Drs. Wheeler, Scaratige, and Scott were mere oversight. In this instance, Drs. Wheeler, Scaratige, and Scott so consistently failed to appreciate the presence of simple pneumoconiosis on so many occasions that the credibility of their opinions is adversely affected.

I am, of course, mindful of the distinction between assessing an expert's credibility and improperly shifting the burden of proof. In two cases, for example, which, incidentally, also involved Drs. Wheeler and Scott among others, the Board reversed decisions by other trial judges which afforded diminished evidentiary weight to negative x-ray interpretations. In both cases, the Board held that the judge "implicitly" shifted the burden of proof to the employer. In Childress v. Island Creek Coal Co., BRB No. 06-0443 BLA (March 27, 2007), although the judge specifically stated that she had not required the employer to identify a definite etiology for the abnormalities revealed on x-rays, the Board held that she "improperly" required: "employer ... to affirmatively establish either the absence of the large opacities or that they were not related to pneumoconiosis or coal dust exposure." In Willis v. Westmoreland Coal Co., BRB No. 06-0397 BLA (March 27, 2007), the Board, relying upon Fourth Circuit's holdings in Lester and Scarbro, reversed a decision which it characterized as "implicitly" requiring: "employer's medical experts, who read claimant's x-rays as negative for large opacities or any form of pneumoconiosis, to also ascertain a definite etiology for the large opacities ... in order to disprove the existence of complicated pneumoconiosis under Section 718.304(a)." Of course, burden of proof and witness credibility are two distinct legal concepts and neither Lester nor Scarbro discuss witness credibility.

Thus, Lester, in accordance with the Supreme Court's decision in Mullins Coal Co. v. Director, 484 U.S. 135, (1987), places the burden of proof upon Claimant. Scarbro discusses, *inter alia*, the three ways in which complicated pneumoconiosis may be established and the defenses which are available against a claim of complicated pneumoconiosis. The issue of expert credibility arises, however, during the process of weighing conflicting expert opinion evidence to determine whether a claimant has met his burden of proof or an employer has established its defense; and nothing in Lester or Scarbro impairs a trier of fact's authority to assess the credibility of any expert.

In this instance, Drs. Scaratige, Wheeler, and Scott, time and again, failed to detect the presence of simple pneumoconiosis in the lungs of a miner who presented with x-ray evidence of the disease to other highly qualified radiologists. Although Drs. Wheeler, Scott, and Scaratige are also highly credentialed, they have failed to demonstrate, in this particular instance, their competence in recognizing presence of simple pneumoconiosis in this miner; and their credibility as experts in this proceeding is diminished accordingly. Indeed, the court in Scarbro specifically mentioned "incompetence" as a factor which is permissible to consider in weighing expert opinion evidence.

The Board has observed that, under Scabro, an employer does not have the burden of proof in establishing the cause of the abnormalities, but Scabro does make clear that an employer can defeat a claim for complicated pneumoconiosis by showing that the: “opacities are not there or are not what they seem to be, perhaps because of an intervening pathology.” That is precisely the tact Drs. Wheeler, Scott, and Scatarige have taken with this miner, contending that his lung abnormalities are not what other radiologists have interpreted as pneumoconiosis. Under these circumstances, it does not “shift the burden of proof to Employer,” either implicitly or explicitly, to observe that one of the Scabro defenses is not available to the Employer because the evidence it relies upon to establish the defense is not credible. The x-ray evidence is positive for simple pneumoconiosis; and despite their impressive credentials, Drs. Scott, Wheeler, and Scatarige have not demonstrated competence in identifying the opacities indicative of simple pneumoconiosis in this particular Claimant’s lungs either by x-ray or by CT scan.

Furthermore, in determining whether Claimant’s simple pneumoconiosis, which has been established on this record, has progressed to complicated pneumoconiosis, it is necessary to consider whether the experts who deny the existence of complicated pneumoconiosis were able to recognize the existence of the simple pneumoconiosis from which it allegedly conglomerated or coalesced. Although all cases of simple pneumoconiosis do not progress to complicated pneumoconiosis, the Courts, and in the past the Board, would permit the tier of fact to discount an expert’s opinions regarding the presence of complicated pneumoconiosis if the expert was also unable to detect the presence of an established case of simple pneumoconiosis in a miner. Indeed, all cases of simple pneumoconiosis do not hasten death, but in Soubik v. Director, 366 F.3d 226 (3rd Cir. 2004), the Court observed that a physician’s failure to diagnose the presence of coal workers’ pneumoconiosis would have an adverse effect on his or her ability to assess whether a miner’s death was due to the disease. Similarly, although simple pneumoconiosis is not always totally disabling, in Tapley v. Bethenergy Mines, Inc., BRB No. 04-0790 BLA (May 26, 2005)(available on the Board’s website), the Board, employing logic similar to Soubik, held that: “it is proper to discredit the opinions of two experts with regard to disability causation where these physicians concluded that the miner did not suffer from either legal or clinical pneumoconiosis contrary to the ALJ findings.”

Adopting the reasoning in Soubik and Tapley, which is equally applicable here: “Common sense suggests that it is usually exceedingly difficult for a doctor [like Dr. Wheeler, Dr. Scatarige, or Dr. Scott] to properly assess” a progression of simple pneumoconiosis to complicated pneumoconiosis “if [he] does not believe” or is unable to discern that simple pneumoconiosis is present. *See, Soubik, supra*. Drs. Wheeler, Scott, and Scatarige were unable, contrary to the preponderance of the expert evidence in the record and the findings of Judge O’Shea in a prior proceeding, to diagnose the presence of simple pneumoconiosis; and, under such circumstances, it is proper to question their ability properly to assess whether the simple pneumoconiosis, which they failed to recognize, conglomerated or coalesced into the complicated pneumoconiosis diagnosed by other experts. Soubik; Tapley. For these reasons, Drs. Wheeler, Scott, and Scatarige, are not credible when they opine that large mass in the apex of the right lung revealed on the x-ray and CT scan is not CWP. As authorized by Soubik and Tapley, I accord their etiology assessments little weight.

Equivalency of “Lesions,” “Masses,” and “Opacities”

In its decision on appeal, the Board noted that the x-rays and CT scans showed evidence of “lesions” of 1 cm. or greater, but none were read as showing an opacity” of 1 cm. or greater. *See*, BRB Dec. at 6. The Board also determined that Judge Kaplan’s equivalency determination was unsupported by substantial evidence: “because the record contains no medical evidence indicating that the lesion found by Dr. Blue on biopsy would be expected to yield an opacity of greater than one centimeter if seen on x-ray.” *See*, Board Dec. at 6. The Board noted further that since the x-ray was not interpreted as showing a large opacity that would be classified as Category A, B, or C.... the instant case is distinguishable from the court’s decision in *Scarbro*.” *See*, BRB Dec. at fn.6. Although the absence of an x-ray interpretation categorizing the 1.7 cm. mass as an A, B, or C opacity distinguishes this case from *Scarbro*, it is respectfully submitted that distinction in this instance does not require an outcome different from *Scarbro*.

Turning to the “equivalency” assessment which remains at the heart of this remand, the Board observed that no physician has interpreted an x-ray as revealing Category A, B, or C opacities, and no physician has opined that the 1.7 cm. nodule identified by biopsy would be “equivalent” to a 1 cm. opacity on an x-ray. Thus, on the record before it, the Board distinguished the situation here from *Scarbro*. It is respectfully submitted, however, that there are, based upon the evidence developed on remand, now other distinctions between the record here and the record in *Scarbro* which makes this an equally compelling case.

In this particular instance, “equivalency” is more than amply established because the record evidence is sufficient to support a reasonable inference that the 1 cm. mass in the right apex identified on the x-ray is the actual 1.5 cm. right apex mass which Drs. Scott and Scatarige saw on the CT scan, and it is the same nodule that was excised, measured, and biopsied as a 1.7 cm. nodule of pneumoconiosis. Furthermore, while no x-ray was interpreted as showing a large opacity, the record establishes that the 1.7 cm. nodule of pneumoconiosis established by biopsy showed up on the CT scan as 1.5 cm. nodule in the right apex, and there is now medical opinion evidence in the record that this nodule would be equivalent to a 1 cm. or greater opacity on an x-ray.⁵

By the time Drs. Scatarige re-read the May 31, 2002 x-ray, on January 23, 2003, found the 1 cm. mass, and recommended a CT scan to assess it, Claimant’s physicians had detected it, taken steps to diagnose it, and had removed it for biopsy. The record shows that on May 31, 2002, Dr. Dosani recommended a bronchoscopy to assess the right upper lobe nodule and others. On the same day, hospital records show that Claimant underwent the bronchoscopy, followed later by a CT scan, followed by a PET scan, and an examination on June 18, 2002, by Dr. Hummel, who noted the multiple nodules and the PET scan indication of a 1.5 cm. right apical focus of increased intensity. He recommended that Claimant undergo a biopsy which was performed on August 9, 2002. Indeed, a principal purpose of the biopsy was to recover and diagnose the large mass in the right apex seen on the x-ray, the CT scan, and the PET scan. Thus

⁵ In its decision, the Board framed the question as whether a one centimeter lesion found by biopsy and a one centimeter “lesion” on x-ray and CT scan is “equivalent to a one centimeter “opacity” on an x-ray. Based upon the record developed on remand, the question now is whether a 1.7 cm. lesion found by biopsy which appeared as a 1.5 cm. lesion found by CT scan is equivalent to a 1 cm. opacity on an x-ray.

Dr. Hummel not only excised the mass but performed an upper and middle lobectomy, and the macro and microscopic examination of the apex tissue, according to the pathology reports, mention no masses of any etiology larger than the 1.7 cm nodule of pneumoconiosis.

Thus there is ample evidence in the record to reasonably infer that the 1 cm. mass in the right apex revealed on the x-ray, showed up as the 1.5 cm. mass in the right apex identified on the CT scan, and infer further that it is the chief structure that triggered the diagnostic tests which followed. It was the nodule Dr. Hummel specifically noted, went after, and excised along with several others. Moreover, Dr. Blue specifically stated that the largest mass which she measured in the right apex was pneumoconiosis, and Dr. Oesterling concurred that largest nodule he identified was pneumoconiosis. Assuming the competence of the surgeon and the pathologists, and given that one of the principal purposes of the biopsy was to assess the large mass in the right lung apex, it seems reasonable to infer and conclude that the lesion in the right apex which appeared on the x-ray as a 1 cm. mass, and showed up on the CT scan as a 1.5 cm. mass, is the 1.7 cm. nodule of pneumoconiosis diagnosed by biopsy. This inference is, moreover, supported by Dr. Alexander's confirmation that: "the description and location of the [largest lesion biopsied] would account for the area of apical coalescence on the May 31, 2002 x-ray and it would correspond to the 14 x 10 mm right apical mass seen on the February 6, 2002 and May 6, 2002 CT scans." Nor has any physician opined that the 1.7 cm. nodule in the right lung apex was not the mass which appeared as the 1 cm. mass in the x-ray or as the 1.5 cm. mass on the CT scan.

Thus the Court's observation in Scarbro that: "We are given no reason to believe that nodules of 1.7 centimeters would not produce x-ray opacities greater than one centimeter" is equally applicable here. Dr. Alexander concluded that a mass that size: "would certainly be consistent with a large opacity of category A complicated pneumoconiosis," and Dr. Cohen further commented in his report that the 1.7 cm. nodule biopsied: "would clearly be expected to project to a size of greater than 1 cm on CT scan." Cohen at 12.⁶ Furthermore, the equivalency opinions expressed by Drs. Cohen and Alexander are entirely consistent with Scarbro.

The nodule of complicated pneumoconiosis measured by autopsy in Scarbro was identical in size to the nodule of complicated pneumoconiosis identified here by biopsy. Considering the size of nodule, the Court found: "no reason to believe that nodules of 1.7 centimeters would not produce x-ray opacities greater than one centimeter." Unlike Scarbro in which "equivalency" was inferred and merely supported, in general, by the x-rays, the credible medical opinion evidence here affirmatively establishes equivalence between a 1.7 cm. nodule identified by biopsy and a 1 cm. or greater opacity on x-ray. In addition, the Court in Scarbro found that the 1.7 cm. nodule qualified as a "massive lesion" as that term is used in prong (B) of the statute and regulation. Accordingly, I find that the 1.7 cm. nodule of pneumoconiosis biopsied in this case qualifies as a massive lesion under prong B. I further find the evidence sufficient to conclude that the 1.7 cm. massive lesion in the right apex of Claimant's right lung is equivalent to a 1 cm. or greater opacity on an x-ray.

⁶ It should be noted that although Drs. Wheeler, Scott, and Scaratige denied that Claimant's x-rays revealed pneumoconiosis, including among other reasons because they did not reveal the pattern they expected to see with pneumoconiosis or because it was not in a place in the lungs they would expect to find pneumoconiosis, Dr. Wheeler, Scott, and Scaratige never suggested that the mass was not pneumoconiosis because it did not appear as an "opacity."

Other Medical Evidence

As previously discussed, the CT scan evidence, was interpreted by Dr. Alexander as showing complicated pneumoconiosis, category A, however, he was the only physician to specifically diagnose the disease. The CT scan diagnostic interpretations by Drs. Scott, Wheeler, and Scaratige have been discredited and will not further be considered here. Following the biopsy procedure on August 9, 2002, none of the x-rays or CT scans revealed large opacities or complicated pneumoconiosis. Accordingly the other medical opinions in evidence will be reviewed for the light they may shed on the diagnosis of complicated pneumoconiosis revealed by the biopsy.

Dr. Zaldivar reported in June, 1979, that Claimant's shortness of breath was due to chronic bronchitis with no impairment. Dr. Charnvitayapong reported in 2001 that Claimant was experiencing shortness of breath and he diagnosed, among other conditions, pneumoconiosis. Dr. Rashid, in March, 2002, participated in the hospital work-up that eventually led to the biopsy.

Dr. Razak Dosani examined Claimant and issued a History and Physical Examination report dated May 31, 2002. He stated that he was consulted because of Claimant's abnormal CT scan, and noted that Claimant had a known case of [coal] worker pneumoconiosis and has some restrictive lung disease by pulmonary function tests. He also noted that Claimant had a coal mine employment history and that Claimant had a four pack-year smoking history. On physical examination he found that Claimant's breath sounds were equal bilaterally with no wheezing or rales heard. Dr. Dosani diagnosed Claimant with abnormal chest X-ray, lymph node enlargement in the subcarinal region along with multiple nodules, interstitial lung disease, history of coal workers' pneumoconiosis, history of asbestos exposure, history of gastroesophageal reflux disease, chronic obstructive lung disease, and benign prostatic hypertrophy. (CX 1). Dr. Dosani recommended further testing that eventually led to the biopsy conducted on August 9, 2002.

Claimant's medical records also include a History and Physical Examination report by Dr. Hummel. He was consulted when the CT scan showed multiple right lung nodules and a follow-up CT scan showed some enlargement of the nodules as well as some hilar lymphadenopathy. Dr. Hummel performed the biopsy procedure on August 9, 2002 and the notes documenting his observations during the procedure have previously been discussed in detail. Dr. Hummel continued to treat Claimant after the procedure and reported that he was disabled by severe pulmonary insufficiency and black lung silicosis.

Dr. Andrew Ghio, a Board certified internist and with a sub-specialty in pulmonary medicine and a "B" reader, prepared a report dated February 7, 2009. Dr. Ghio reviewed Claimant's medical and work histories, including his x-rays, CT scans, and the pathology reports, pulmonary function and blood gas test results, and concluded that the Claimant did "not have medical coal workers' pneumoconiosis but rather demonstrates clinical, radiographic, and pathological evidence of IPF/UIP or a post-inflammatory condition." He noted that pneumoconiosis is defined as a fibrotic reaction of the lung to coal dust exposure and is characterized by the presence of a coal macule, and macules were not mentioned by any of the pathologists. Thus notwithstanding Dr. Oesterling's observations of multiple nodules with "reactive pleural fibrosis," or "subpleural fibrous response," or "pleural reactive fibrosis, then

black pigment, and resultant fibrosis,” in the tissue he examined, according to Dr. Ghio, Drs. Oesterling and Blue described the pathology most consistent with IFP (idiopathic pulmonary fibrosis)/UIP (usual interstitial pneumonia).

According to Dr. Ghio a complicated lesion of coal workers’ pneumoconiosis will demonstrate necrosis and coal at the center of the lesion such that when it is cut, a liquefied combination of tissue and coal will exude.” In addition, he opines that Claimant’s clinical course was consistent with IPF/UIP. Finally, although he notes that the pathology report by Dr. Blue mentions “extensive severe fibrosis with anthracosis,” and although Dr. Ghio acknowledges that pneumoconiosis is defined as “anthracosis” he states: “The pathologist [Dr. Blue] does not describe or specify the patient as having coal workers’ pneumoconiosis.”

In a consulting medical opinion dated March 20, 2009, Dr. Robert Cohen, a Board certified internist with a sub-specialty in internal medicine and critical care and a “B” reader, reviewed Claimant’s history, hospital treatment records, the x-ray, CT scan, and biopsy results and pathology reports by Drs. Blue, Mangano, and Oesterling, the medical reports by Drs. Zaldivar, Alexander, Brooks, Pell, Rashid, Charnvitayapong, Hummel, Carlson, and that pulmonary function and blood gas data. He concluded that the biopsy pathology meets the criteria for progressive massive fibrosis and that Claimant has a respiratory impairment sufficient to prevent him from performing the physical requirements of a machine operator in the mines. He noted that Claimant had decades of exposure to occupational coal dust and rejected the opinion of Dr. Ghio that he has interstitial lung disease of “unknown causes.” He explained that the IPF that Dr. Ghio diagnosed is a rapidly progressive condition whereas Claimant’s history shows that he had a gradually progressing fibrosing process. He explained further that according to the American Thoracic Society and the European Respiratory Society: “a diagnosis of IPF in the presence of a surgical biopsy showing UIP patterns of fibrosis requires exclusion of other known causes of interstitial lung disease such as ... environmental exposures.” He noted further that studies show that miners with severe interstitial fibrosis had a relatively benign clinical course, and that major differences between IPF and interstitial fibrosis are occupational prevalence and exposure risk factors. Dr. Cohen thus rejected Dr. Ghio’s diagnosis of IFP/UIP and concluded that Claimant’s coal dust exposure significantly contributed to the development of his lung scarring and his resulting pulmonary impairment. Dr. Cohen opined that Claimant’s 4 pack-year history of cigarette smoking was a “negligible” factor, and concluded that Claimant suffers from progressive massive fibrosis.

Credibility of Dr. Ghio

With the exception of the CT scan data and the reports by Drs. Ghio and Cohen, the other medical evidence sheds little light of the biopsy finding of massive lesions of pneumoconiosis in Claimant’s right lung. According to Dr. Ghio, the biopsied tissue reveals IFP/UIP rather than simple and complicated pneumoconiosis; however, I accord less weight to his opinion than the contrary opinions of Drs. Blue, Oesterling, and Cohen. Initially, Dr. Ghio is not a pathologist. His specialty is internal medicine with a subspecialty in pulmonary medicine. Thus unlike Drs. Blue, Mangano, and Oesterling, he has neither the credentials nor demonstrated expertise in assessing the pathology revealed by biopsied tissue earned by Drs. Blue and Oesterling.

In Dr. Ghio’s opinion, a complicated lesion of coal workers’ pneumoconiosis will demonstrate necrosis and coal at the center of the lesion such that when it is cut, a liquefied

combination of tissue and coal will exude, and none of the pathologists described such a lesion. In addition, he notes that none of the pathologists mentioned the presence of macules. According to Dr. Oesterling, however, the Leslie and Wicks textbook states that progressive massive fibrosis has a consistency of “vulcanized rubber.” Indeed, based on Dr. Oesterling’s review of the criteria of the College of American Pathologist’s, the only distinction between the nodules he examined and the medical criteria for diagnosing progressive massive fibrosis was the size of the nodule, and that issue has already been addressed herein in detail. Nothing in the criteria Dr. Oesterling reviewed required a nodule to exude liquified tissue and coal or that the pathologist mention “macules,” as a prerequisite to a diagnosis of complicated pneumoconiosis. Nor do the applicable regulations impose such criteria.

Further, there are apparent discrepancies in Dr. Ghio’s analysis which render his report less than well reasoned. He states, for example, that the Charleston Area Medical Center pathologist, Dr. Blue did not describe the patient as having coal workers’ pneumoconiosis. According to Dr. Ghio, Dr. Blue mentioned “extensive severe fibrosis and anthracosis” but described only anthracotic pigment and fibrosis, but no macules. According to Dr. Ghio, Dr. Blue, therefore, did not describe or specify the patient as having coal workers’ pneumoconiosis.

Yet, Dr. Ghio later acknowledged that pneumoconiosis is “defined as a fibrotic reaction of the lung to coal dust exposure and notes that, by the regulation, it includes a diagnosis of “anthracosis.” It thus would appear that Dr. Blue expressly described a fibrotic reaction and diagnosed it as “anthracosis.” By definition, it would, therefore, appear she specified the condition defined by the regulations as pneumoconiosis. To be sure, Dr. Blue failed to mention a “macule” as Dr. Ghio would require; but again, Dr. Ghio does not specify the basis for his conclusion that a “macule” must be mentioned. I do not, therefore, substitute my opinion for his by observing that this portion of Dr. Ghio’s report is not well reasoned. Furthermore although Dr. Ghio did not mention it, Dr. Oesterling specifically diagnosed “coalworkers’ pneumoconiosis” at page 4 of his report.

Dr. Ghio further described pneumoconiosis as fibrotic reaction of the lungs to coal dust. Dr. Blue described “extensive severe fibrous with anthracosis.” Dr. Oesterling observed multiple nodules with “black pigment within a meshwork of nucleated fibers” or black pigment with “reactive pleural fibrosis,” or black pigment with “subpleural fibrous response,” or “pleural reactive fibrosis, then black pigment, and resultant fibrosis.” To be sure, the regulations specify that the presence of “anthracotic pigmentation” will not, alone, support a diagnosis of pneumoconiosis, *see*, 718.202(a)(2), but it is clear that Drs. Blue and Oesterling found more than anthracotic pigment. Their reports specifically state that they found fibrotic responses in association with the anthracotic pigment; and to the extent that Dr. Ghio dismisses their findings as non-indicative of pneumoconiosis because, “macules” were not mentioned, *see*, Ghio report at the bottom of page 4 and the top of page 5, his opinion is not well reasoned in this regard.

Dr. Ghio also concludes that the pathology and Claimant’s clinical course are most consistent with IFP/UIP or a post-inflammatory condition not pneumoconiosis. Dr. Cohen, however, disagreed. Dr. Cohen noted that Claimant had decades of exposure to occupational coal dust and rejected Dr. Ghio’s diagnosis of IFP/UIP. Dr. Cohen challenged Dr. Ghio’s opinion that Claimant’s clinical course was consistent with IFP/UIP, explaining that IPF is a rapidly progressive condition whereas Claimant’s history shows that he had a gradually progressing fibrosing process. He explained further that according to the American Thoracic Society and the

European Respiratory Society, “a diagnosis of IPF in the presence of a surgical biopsy showing UIP (usual interstitial pneumonia) patterns of fibrosis requires exclusion of other known causes of interstitial lung disease such as ... environmental exposures.” He observed that Dr. Ghio did not exclude Claimant’s occupational exposure to coal dust, and cited studies showing that major differences between IPF and interstitial fibrosis are occupational prevalence and exposure risk factors. Dr. Cohen thus rejected Dr. Ghio’s diagnosis of IFP/UIP and concluded that Claimant’s coal dust exposure significantly contributed to the development of his lung scarring and his resulting pulmonary impairment and that his 4 pack year history of cigarette smoking was a “negligible” factor. Dr. Cohen concluded that claimant suffers from progressive massive fibrosis.

Both Dr. Cohen and Dr. Ghio are internists with a subspecialty in pulmonary medicine and seem equally credentialed. Unlike Dr. Ghio, however, Dr. Cohen relies not only on Claimant’s clinical course which he describes as more consistent with the slow response of pneumoconiosis than the rapid response of IFP/UIP, he cites and relies upon medical literature which indicates occupational and environmental exposure must be accorded greater consideration when diagnosing IFP/UIP than Dr. Ghio accorded it. Dr. Cohen thus reported, and his contention is not refuted on this record, that according to the American Thoracic Society and the European Respiratory Society: “a diagnosis of IPF in the presence of a surgical biopsy showing UIP (usual interstitial pneumonia) patterns of fibrosis requires exclusion of other known causes of interstitial lung disease such as ... environmental exposures.” He also distinguished IFP from interstitial fibrosis based upon prevalence and risk factors which Dr. Ghio did not consider, and Dr. Cohen concluded that Claimant does have progressive massive fibrosis. I find Dr. Cohen’s analysis more comprehensive, better reasoned, and better documented than Dr. Ghio’s; and for all of the foregoing reasons, I have accorded less weight to Dr. Ghio’s assessment that the biopsied tissue reveals IFP/UIP or an inflammatory than the contrary opinions of Drs. Blue, Oesterling, and Cohen that Claimant had simple and complicated pneumoconiosis.

Total Disability

The record shows that Claimant’s pulmonary function and blood gas studies prior to the August 9, 2002 biopsy did not qualify as indicative of a totally disabling respiratory or pulmonary impairment, and no physician opined that he was totally disabled prior to that time. It should be noted, however, that while all evidence must be considered before the irrebuttable presumption of total disability may be invoked, the presence of a totally disabling respiratory condition need not be demonstrated as a prerequisite element before the presumption may be triggered. The irrebuttable presumption itself would be meaningless if a Claimant were required to demonstrate that he is totally disabled before the presumption of total disability could be applied. Consequently, while the pulmonary function and blood gas data were not indicative of total disability, the record shows that he was experiencing shortness of breath and x-rays showed the existence of pneumoconiosis as early as 1986. By March, 2002, x-rays and CT scan results were indicating the presence of a mass in his right lung that a biopsy confirmed was progressive massive fibrosis. Employer notes, however, that Dr. Brooks did not consider Claimant totally disabled and denied that he was suffering from pneumoconiosis, and Dr. Ghio related Claimant’s deteriorating condition to the 2002 thoracic surgery and IFP/UIP.

Dr. Brooks performed a post-biopsy examination of Claimant on March 9, 2004, and reviewed his medical records. He concluded that Claimant had only a mild impairment and more likely suffered from a chronic respiratory infection, possibly tuberculosis, than pneumoconiosis. Yet, the record contains no credible medical evidence that Claimant had tuberculosis, and a May 31, 2007 CT scan was interpreted by Drs. Carlson and Miller as consistent with pneumoconiosis.⁷ I accord Dr. Brooks' diagnostic conclusion that Claimant more likely suffered from a chronic respiratory infection than pneumoconiosis less weight than the biopsy evidence, the CT scan interpretations of Drs. Carlson and Miller, and the diagnosis of black lung silicois by Dr. Hummel and pneumoconiosis by Dr. Newman. Further, Dr. Ghio's evaluation has been found less credible than Dr. Cohen's evaluation of Claimant's condition, and Dr. Cohen concluded that Claimant was totally disabled by pneumoconiosis.

The record shows that Drs. Pell, Carlson, and Newman treated Claimant for various conditions following the biopsy, including pneumoconiosis. Dr. Newman, for example, treated him on several occasions for, among other ailments, severe bilateral pulmonary fibrosis and severe dyspnea due to pneumoconiosis in 2008. Dr. Carlson treated him in the hospital and in his office for several conditions, including coal workers' pneumoconiosis and pulmonary fibrosis. None of these doctors mentioned complicated pneumoconiosis; but Dr. Carlson and Dr. Newman noted that Claimant was oxygen dependent. Dr. Hummel, the surgeon who performed the biopsy, further confirmed in a letter dated May 12, 2004, that he had been treating Claimant since 2002, and that he was disabled due to his "severe pulmonary insufficiency and black lung silicosis."

I am mindful of Employer's argument that Dr. Hummel's opinion is not reasoned; however, Dr. Hummel observed that, as Claimant's treating physician, it is his opinion that: "there is no therapy available to him other than oxygen therapy." Moreover, according to Drs. Carlson and Newman, Claimant was oxygen dependent; and the conclusion by a treating physician that an oxygen dependent miner is disabled by his respiratory condition, I find, is a reasoned medical opinion. Thus, I accord the disability and etiology evaluations of Dr. Cohen and Hummel, greater weight than the contrary opinions of Drs. Ghio and Brooks in light of Claimant's oxygen dependency due, as described by Dr. Hummel, to "severe pulmonary insufficiency and black lung silicosis." Furthermore, to the extent that Claimant's respiratory disability was, in part, due to the surgery performed in 2002, as Dr. Ghio suggested, I find and conclude, based upon the hospital records, which include the reports of Drs. Dosani, Rashid, and Hummel, that the surgery was necessitated and performed to assess the multiple nodules which appeared on the x-rays, CT scans, and PET scan, and which the biopsy confirmed was simple pneumoconiosis and progressive massive fibrosis. Accordingly, disability caused by the surgical removal of portions of Claimant's right lung is also attributable to the work-related pneumoconiosis.

Post-Biopsy Complicated Pneumoconiosis

Finally, Employer notes that Claimant's treatment records after 2002, document his respiratory decline but do not mention complicated pneumoconiosis or progressive massive

⁷ Drs. Scott and Wheeler saw no indications of pneumoconiosis on this CT scan; however, their interpretations are accorded less weight for the reasons hereinbefore discussed.

fibrosis. Employer is correct. As Dr. Hummel, reported in his surgical notes, he excised the larger nodules in Claimant's right lung for purposes performing the biopsy. Thus, Dr. Alexander observed that the conglomerate fibrotic masses of complicated coal workers' pneumoconiosis were removed from the lung during the surgical procedure.

Nevertheless, the removal of the progressive massive fibrosis for the purpose of biopsy does not vitiate the application of the irrebuttable presumption on the ground that the miner no longer had complicated pneumoconiosis after the procedure. Indeed, the total or partial removal of a large nodule of pneumoconiosis for purposes of biopsy is recognized by the statute and the regulations as an appropriate diagnostic tool to establish the presence of complicated pneumoconiosis. The removal or reduction in the size of a lesion by the excision of all of it or a piece of it during the procedure does not vitiate application of the irrebuttable presumption. *See*, Section 921(c)(3)(B) of the Act and Section 718.304(b). To the contrary, the courts have clearly indicated that the availability of the irrebuttable presumption is based upon the size of the lesion prior to removal. *See*, Double B Mining, Inc., v. Blankenship, 105 F.3d 650 (4th Cir. 1999) (remanded for consideration of whether a 1.3 cm. lesion would, if x-rayed "**prior to removal**" of a portion of lung, have showed as one-centimeter opacity.") (emphasis added); Valley Camp Coal, Co., v. Director, 105 F.3d 650, 1997 WL 3640 (4th Cir. 1997) (mass removed by surgery and later shown to be complicated pneumoconiosis by biopsy coupled with x-rays showing large opacities qualified for the irrebuttable presumption of complicated pneumoconiosis under 20 C.F.R. § 718.304(b)).

Conclusion

The Court in Scarbro, citing Lester v. Director, 993 F.2d 1143, 1145 (4th Cir.1993), observed that the statutory requirements of Prongs (A), (B), and (C) "are stated in the disjunctive; therefore a finding of statutory complicated pneumoconiosis may be based on evidence presented under a single prong" so long as the evidence under each prong of Section 921(c)(3) is reviewed to determine whether complicated pneumoconiosis is present. As explained by the Court, complicated pneumoconiosis may be found under circumstances in which the x-ray evidence does not show large opacities under prong A, but the other evidence establishes that Claimant: "has a 'chronic dust disease of the lung,' commonly known as complicated pneumoconiosis." Scarbro at 257.

In this instance, the x-ray evidence has been considered under Section 921(c)(3)(A) of the Act and does not show large opacities; however, the biopsy evidence considered under Section 921(c)(3)(B), and the other medical evidence, including the CT scans and the credible medical opinions in evidence reviewed in accordance with Section 921(c)(3)(C), establish that Claimant had a 1.7 cm. nodule of progressive massive fibrosis in the apex of his right lung which would be equivalent to a 1 cm. opacity on an x-ray. It further shows that he was suffering from a severe, progressively worsening respiratory impairment which Dr. Cohen specifically diagnosed as complicated pneumoconiosis. I, therefore, conclude, that medical evidence considered under prongs A, B, and, C separately, and, upon consideration of the record as a whole, demonstrates that Claimant, during his lifetime, had the disease commonly known as complicated pneumoconiosis. He is, therefore, entitled to invoke the irrebuttable presumption that he suffered from totally disabling pneumoconiosis arising out of coal mine employment in accordance with Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), and its implementing regulations found at 20

C.F.R. §718.304. *See, Scarbro; Lester, supra.* Since the record does not show when Claimant's total disability commenced, benefits will be awarded commencing August, 2001, the month in which he filed his "subsequent" claim.

ORDER

IT IS ORDERED that Employer pay to Claimant all benefits to which he is entitled under the Act as augmented by reason of his dependent spouse, commencing August, 2001.

A

Stuart A. Levin
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).