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Carla Bender
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Court, IL

2018 IL App (4th) 170662WC-U
No. 4-17-0662WC
Order filed October 30, 2018

IN THE

APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

MICHAEL REINIESCH,	)	Appeal from the Circuit Court
	)	of Macoupin County.
Appellant,	)	
	)	
v.	)	No. 16-MR-109
	)	
THE ILLINOIS WORKERS'	)	
COMPENSATION COMMISSION, *et al.*,	)	Honorable
	)	Kenneth Deihl,
(Monterey Coal Co., Appellee).	)	Judge, Presiding.

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

ORDER

¶ 1 *Held*: The decision of the Illinois Workers' Compensation Commission denying claimant's application for benefits under the Workers' Occupational Disease Act was not contrary to the manifest weight of the evidence where—though conflicting evidence existed—there was ample expert medical testimony supporting the decision.

¶ 2 I. INTRODUCTION

¶ 3 Claimant, Michael Reiniesch, appeals an order of the circuit court of Macoupin County confirming a decision of the Illinois Workers' Compensation Commission (Commission)

denying him benefits under the Workers' Occupational Diseases Act (Act) (820 ILCS 310/1 *et seq*. (West 2006)). The Commission found that claimant failed to prove he suffered from an occupational disease. For the reasons that follow, we affirm.

¶ 4 II. BACKGROUND

¶ 5 The following evidence was presented at the arbitration hearing on March 18, 2015. Claimant testified that he had worked for respondent (Monterey Coal Company) for 34 years, all of them underground. Claimant described the various job duties he held over the years. He testified that he was exposed to silica dust, the fumes of roof-bolting glue, and diesel fumes throughout his employment with respondent. He last worked in the mine on December 30, 2007. That was the day the mine closed. Claimant never returned to coal mining or worked anywhere else since that date. At the time he left coal mining, he was having problems with his breathing and his knees. During his last 8 to 10 years of employment, claimant began noticing problems with his breathing. When he went hunting, he "couldn't stay out in the field following [his] dogs as long." Hills bothered him. At work, it took him longer to travel from one place to another. Now, he can only walk about eight blocks before he gets short of breath. Going up and down his basement stairs once is difficult. His problems got worse over time. He now carries an inhaler.

¶ 6 Claimant acknowledged that he smokes cigarettes. He smokes between a pack-and-a-quarter to a pack-and-a-half per day. He started smoking in his mid to late teens. Claimant takes cholesterol medication and a low-dose aspirin. He has a "small leak" in one of his heart valves. He formerly took medication for high blood pressure, but he has been able to control that through dietary changes.

¶ 7 On cross-examination, claimant testified that he smokes less than he used to. He has had three knee operations. Claimant stated that he has arthritis. This primarily causes him problems

when he gets up in the morning or when he has to get up from the floor after playing with his seven-year-old grandson.

¶ 8 The evidence deposition of Dr. Bruce Weber, claimant's family physician, was presented by claimant. In the course of his practice, Weber regularly treats coal miners and former coal miners. He regularly encounters patients with lung diseases. Weber testified that he has been treating claimant since 1985. Weber reviewed a series of interrogatories he had responded to earlier. They indicated that he believed claimant had bronchitis. Claimant's chronic bronchitis was caused or aggravated by this job as a coal miner. Claimant has COPD (chronic obstructive pulmonary disorder). Claimant's COPD was caused or aggravated by this job as a coal miner. Claimant has coal workers' pneumoconiosis (CWP) and emphysema, which are causally related to his employment with respondent. Further exposure to a coal-mine environment would present risks to claimant's health relative to claimant's bronchitis, CWP, emphysema, hyperactive-airway disease, and COPD. Moreover, claimant "no longer has the pulmonary capacity to perform the manual labor of a coal miner on a full-time basis. Weber has prescribed claimant medications for pulmonary conditions in the past.

¶ 9 On cross-examination, Weber acknowledged that he did not know what claimant had been doing since respondent's mine closed in December 2007. He last saw claimant on February 4, 2014. At that time, claimant reported smoking two-and-a-half packs of cigarettes per day. Weber agreed that this was a "significant smoking habit." Smoking is the "number one cause of COPD in the United States." It is also "the number one cause of both chronic bronchitis and emphysema." A pulmonary function study performed in April 2013 indicated a "moderate restriction." A physical examination in April 2013 was "clear." A November 2013 study "was interpreted as normal" and did not show "any obstructive problem." Weber characterized this

study as "inconsistent." Claimant's continuing use of cigarettes presented a continuing risk to his health and made his conditions worse. Claimant had pneumonitis in March 2011, but would not be suffering any lasting effects from it. Weber diagnosed chronic bronchitis, COPD—which encompassed emphysema, bronchitis, and hyperactive airways disease—and CWP. CWP is irreversible; any restrictive problem it causes should "stay here."

¶ 10 On redirect-examination, Weber noted he also diagnosed claimant with asthmatic bronchitis. This would be consistent with a reactive airways disease. Weber prescribed Albuterol. A reactive airways disease is "characterized by a waxing and waning of symptoms or pulmonary function abilities." This could lead to "waxing and waning obstructive findings."

¶ 11 Weber further stated that an X ray taken on February 1, 2014 showed "probable emphysematous changes." Any damage sustained as a result of working in a coal mine would remain regardless of whether claimant smoked cigarettes. Even if every coal miner developed the COPD, CWP, and similar problems, smoking would remain their number one cause since, statistically speaking, the number of coal miners in the country would not be sufficient to change the statistics.

¶ 12 On recross-examination, Weber acknowledged that notes from an office visit on April 21, 2008, indicate that claimant was exhibiting "no cough and no shortness of breath." Weber's physical examination on November 7, 2013, was "normal" regarding claimant's chest. However, he added, on redirect, that this would not preclude a pulmonary disease or injury.

¶ 13 Claimant also presented the testimony of Dr. Glennon Paul via evidence deposition. Paul testified that the vast majority of his work as an expert witness had been on behalf of coal mining companies. He examined claimant on June 12, 2008. He authored a report following that examination. Paul found claimant's physical examination to be normal. A methacholine test

showed a 17% fall in lung function. A 20% reduction is considered positive, though Paul added that claimant was "in the bronchitic range." He was not sure whether the result was due to asthmatic conditions or smoking. However, he stated that it was most likely both. Paul opined that claimant has asthmatic bronchitis and that it was causally related to coal mining, including exposure to coal dust, adhesives, diesel fuels, and roof-bolting-glue fumes.

¶ 14 Paul further opined that claimant has CWP and it was caused by exposure to coal dust. Paul did not diagnose emphysema. He found abnormalities in claimant's X ray showed abnormalities consistent with pneumoconiosis. Paul also reviewed a B-reading from Dr. Smith. Exposure to a mining environment would endanger claimant's health. Claimant has "clinically significant pulmonary impairment" caused by coal dust and smoking. Paul testified that claimant was totally and permanently disabled from working as a coal miner.

¶ 15 Paul testified that the symptoms of asthmatic bronchitis wax and wane. There is no cure for CWP or asthmatic bronchitis. Spirometry testing measures lung function globally; therefore, one could have localized lung damage and pulmonary function results within normal limits. Even a person who has had a lung lobe removed could have test results within the range of normal. Only comparing an individual's current and past test results would show impairment. Pulmonary function testing will not identify the etiology of a condition. CWP is a progressive disease. It can progress even after a coal miner is no longer exposed to coal dust.

¶ 16 Paul explained that COPD is an "umbrella term" that encompasses a number of obstructive diseases. It includes chronic bronchitis and emphysema. Coal dust exposure can cause or aggravate emphysema and chronic bronchitis.

¶ 17 On cross-examination, Paul stated that he only saw claimant on one occasion—his examination. Claimant revealed a history of "significant" smoking. Paul agreed that "the

number one cause of bronchitis in the United States is cigarette smoking." Once a miner is no longer exposed to the mining environment, "he only has a small chance of progression of his CWP." The B-reading Paul relied on indicated the lowest level of CWP (there are three categories, numbered one, two, or three).

¶ 18 Dr. Henry Smith, a B-reader, reviewed a chest X ray and prepared a report. He wrote, "There is interstitial fibrosis of classification p/p, bilateral upper, mid and lower zones involved, of a profusion 1/1." His impression was "[s]imple coal-worker's pneumoconiosis with small opacities, primary p, secondary p, upper, mid and lower zones bilaterally, profusion 1/1."

¶ 19 Respondent also submitted reports from three B-readers—Dr. Meyer, Dr. Shipley, and Dr. Tarver. They all found no evidence of CWP. Meyer and Tarver found the X ray to be of quality one, while Shipley classified it as quality two.

¶ 20 Dr. Peter G. Tutuer examined claimant on respondent's behalf. His testimony was presented via evidence deposition. He examined claimant on February 14, 2013. Tutuer prepared a written report. Claimant reported a "significant" history of cigarette smoking. Smoking is the "Number One cause [*sic*] of obstructive lung disease, including COPD, emphysema, and chronic bronchitis." Claimant's carboxyhemoglobin level was 6.3, which is consistent with smoking between one and two packs of cigarettes per day. Claimant also reported having pneumonia in 2011. Tutuer noted residuals from claimant's pneumonia, particularly left pleural thickening and some "irregular markings" that were consistent with centrilobular emphysema. Tutuer observed no evidence of CWP.

¶ 21 Claimant's resting oxygen saturation level was 97%, which was within the normal range. Oxygen saturation measured during exercise was "stable and normal," however, "[t]here was a

slight decrease." The FEV1[1] value did not change with exercise, which is also normal. The physical examination of claimant's chest "was normal except for a slight prolongation of expiration." This suggested an airflow obstruction consistent with pulmonary studies. The studies did not indicate a restrictive problem. Total lung capacity was normal, which Tutuer characterized as the "quintessential measurement required to assess the presence or absence of a restrictive abnormality." Airflow obstruction was mild. Albuterol did not result in "significant improvement."

¶ 22 Tutuer acknowledged that the FEV1 value he obtained was reduced relative to that measured by Dr. Paul. He attributed this to claimant's intervening pneumonia. In addition, claimant's continued smoking would also be a factor, though claimant's fall was "a little bit more than" one would expect from smoking alone.

¶ 23 Tutuer stated that claimant's history indicates chronic bronchitis and that there is also evidence of emphysema. Claimant's COPD, Tutuer opined, was the result of smoking cigarettes. Further, claimant's COPD, which was mild, resulted in no disability. Claimant would be able to work as a coal miner. Tutuer found no evidence of CWP or any "dust-related lung disease." At the time Tutuer saw claimant, claimant was not taking any medications for breathing problems, nor was he under treatment for a lung problem.

¶ 24 On cross-examination, Tutuer agreed that a clinical history of a reactive condition might include wheezing. He added that this was a "nonspecific symptom." Asthma and bronchial reactivity tends to run in families. Tutuer noted that claimant's drop of 17%, measured by Dr.

[1]" 'FEV' stands for forced expiratory volume. FEV1 is the amount of air you can force from your lungs in one second." https://www.healthline.com/health/fev1-copd (last visited September 5, 2018)

Paul, was a negative result. He disagreed with Paul's characterization of the result as being "nearly positive." He stated, "[T]he test is very similar to pregnancy," "[y]ou're either pregnant or you're not pregnant." Moreover, claimant had one close relative out of five that had asthma or an allergy. This did not constitute a "strong family history" of a problem.

¶ 25 Tutuer agreed that a person with a reactive airways disease would likely exhibit waxing and waning symptoms. He further agreed that the inhalation of coal mine dust can cause COPD, emphysema, and chronic bronchitis. The inhalation of silica dust can cause chronic bronchitis, as can the inhalation of glues and adhesives. These are diseases that can get worse over time.

¶ 26 Tutuer acknowledged that chronic bronchitis, emphysema, and COPD can have multiple causes. He further agreed that no test could tell for certain what caused claimant's lung problems. Tutuer explained that his opinion that it was smoking rather than exposure to coal dust or adhesive fumes that caused claimant's problems was based on the "likelihood or odds." That is, smoking one-and-a-half pack of cigarettes per day for 45 years is more likely to result in COPD than working underground in a coal mine for 33 years. However, Tutuer agreed that independent of smoking, exposure to coal dust could cause COPD, emphysema, and chronic bronchitis. Tutuer also acknowledged that the Federal Register and the American Thoracic Society state that the risk from coal mining is about the same as the risk from smoking. Having pulmonary function tests that result in normal readings does not preclude the existence of some lung damage, disease, or injury. Spirometry will not identify the etiology of a problem. Tutuer took, but did not pass, the B-reader test.

¶ 27 He believed that coal-mine dust inhalation results in lung disease less than 2% of the time. This is contrary to the positions of the American Thoracic Society and the National

Institute for Occupational Safety and Health (NIOSH). Tutuer defined a "reasonable degree of medical certainty" as 95% certain.

¶ 28 On redirect-examination, Tutuer stated that, to a reasonable degree of medical certainty, none of the clinically or physiologically significant findings pertaining to claimant were the result of claimant's exposure to coal dust. Rather, claimant's problems are related to cigarette smoking. Tutuer observed no evidence of bronchial reactivity or chemically-induced bronchial reactivity. He found no evidence of asthma. However, he acknowledged that "a very small minority of coal miners can develop COPD with FEV1 drops in response to coal mine dust."

¶ 29 The arbitrator found that claimant failed to prove by a preponderance of the evidence that he suffers from CWP. He credited the opinions of the three B-readers (Shipley, Meyer, and Tarver) who concluded that claimant did not show any indication of that condition. He found the "reverberation of the opinions amongst [them] convincing." He found that their opinions were entitled to more weight than that of Dr. Smith, who opined conversely. The arbitrator found Weber's opinion suspect in that he had not reviewed an X ray interpreted by a B-reader and the pulmonary function testing he relied on was "undermined by a subsequent normal pulmonary function study [on] November 12, 2013." Weber admitted that the condition is irreversible, so the subsequent study should have shown some restriction if the results of the earlier study were caused by CWP.

¶ 30 The arbitrator also found claimant failed to prove by a preponderance of the evidence that he suffered from an "an obstructive pulmonary disease, including asthmatic bronchitis, chronic bronchitis, emphysema or hyperactive airways disease, causally related to the exposures of his coal mining employment." The arbitrator relied on "the normal physical examination, normal baseline pulmonary function testing, and negative methacholine challenge test." He rejected

Paul's interpretation of the 17% fall on the methacholine challenge as being "suspect." He further noted the "lack of persistent and/or frequent reports of symptomatology or treatment relative to asthmatic bronchitis with Dr. Weber." The arbitrator also pointed out that Weber did not formulate his diagnosis of chronic bronchitis until five years after claimant ceased working at respondent's mine. He concluded, "The Arbitrator finds this temporal disparity, coupled with [claimant's] general pulmonary normalcy as demonstrated in the record, undermines the suggestion of a causal relationship between any symptomatology consistent with [chronic bronchitis] or any chronic obstructive pulmonary disease and his employment." Accordingly, the arbitrator held that claimant failed to prove that he suffered from an occupational disease arising out of and in the course of his employment and that there was any causal nexus between his current condition and his exposure to the conditions of the mine. The Commission affirmed and adopted the decision of the arbitrator. The trial court confirmed, and this appeal followed.

¶ 31 III. ANALYSIS

¶ 32 On appeal, claimant contends that the Commission's decision is contrary to the manifest weight of the evidence. Claimant states that "it is not necessary for [him] to ask this court to weigh the evidence regarding CWP or asthmatic bronchitis, and [he] will not contest those diseases" because "there is universal agreement, even by Dr. Tutuer, that [he] suffers from emphysema, chronic bronchitis, and COPD." Accordingly, we will limit our consideration to these three diseases as well.

¶ 33 Whether a claimant suffers from an occupational disease occurring in the course of and arising out of employment presents a question of fact, which we review using the manifest weight standard. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶ 21. Thus, we will reverse only if an opposite conclusion is clearly apparent. *Id.*

Resolving conflicts in the record, judging the credibility of witnesses, assigning weight to evidence, and drawing reasonable inferences therefrom are matters for the Commission in the first instance. *Beattie v. Industrial Comm'n*, 276 Ill. App. 3d 446, 449 (1995). Furthermore, we owe substantial deference to the Commission's resolution of medical questions, as its expertise in this realm has long been recognized. *Long v. Industrial Comm'n*, 76 Ill. 2d 561, 566 (1979). It was claimant's burden in the proceedings below to establish each and every element of his claim by a preponderance of the evidence. *Navistar International Transportation Corp. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1202 (2000). It is axiomatic that employment need only be a cause, not the sole or main cause, of a condition for a claimant to recover under the Act. *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 596 (2005).

¶ 34 The Commission, adopting the decision of the arbitrator, cited significant evidence in support of its position and also provided reasons for its rejection of evidence favorable to claimant. Notably, the Commission relied on "the normal physical examination, normal baseline pulmonary function testing, and negative methacholine challenge test." Furthermore, it observed that Weber did not diagnose chronic bronchitis until five years after claimant was no longer exposed to the conditions at respondent's mine. It relied on this "temporal disparity" and further pointed to claimant's "general pulmonary normalcy." Moreover, there was a "lack of persistent and/or frequent reports of symptomatology or treatment relative to asthmatic bronchitis with Dr. Weber." It rejected Paul's interpretation of the 17% fall on the methacholine challenge as being "suspect," which is consistent with Tutuer's testimony that a drop of 17%, is a negative result. In sum, there is substantial evidence supporting the Commission's determination.

¶ 35 Nevertheless, claimant insists that this decision is against the manifest weight of the evidence. Claimant first points to the testimony of Paul and Weber that claimant's coal mining

was a cause of his emphysema, chronic bronchitis, and COPD. He then asserts that Tutuer testified that such diseases *could be* caused by mining. Claimant mischaracterizes this testimony. In fact, Tutuer opined that "to a reasonable degree of medical certainty, none of the clinically or physiologically significant findings pertaining to claimant were the result of claimant's exposure to coal dust." Regardless of hypothetical possibilities of what exposure to coal dust might cause, Tutuer flatly opined that, with regard to claimant, it did not cause the diseases of which claimant complains. Indeed, Tutuer attributed claimant's condition to smoking. Moreover, that Tutuer acknowledged that he could be wrong in some cases might affect the weight to which his testimony was entitled (a matter primarily for the Commission (*Beattie*, 276 Ill. App. 3d at 449)), but it does not alter the fact that he opined that no causal connection existed in this case. Further, claimant points to certain purported inconsistencies in Tutuer's testimony, particularly regarding the possibility that claimant's condition could have multiple causes, one of which was mining. However, resolving such inconsistencies is a matter for the Commission. *Id*.

¶ 36 Claimant asserts that "there is no basis whatsoever in this record to support an opinion that [claimant's] COPD, emphysema, and chronic bronchitis could not be related to coal mining." First, Tutuer's testimony provides such a basis. Second, and more importantly, claimant seems not to appreciate that the burden of proof on such issues is with him. See *Navistar International Transportation Corp.*, 315 Ill. App. 3d at 1202. Respondent was not required to prove that no causal condition existed between these conditions and claimant's coal mining. In a similar vein, claimant later argues that "[f]or [claimant] not to be worthy of some level of award, the record must show that the diseases of which even [r]espondent's expert

agrees exist must have zero contribution from his 34 years of underground coal mining." This is simply not the law.

¶ 37 Claimant complains of Tutuer's use of statistics in formulating his opinion. He cites nothing to suggest that this is improper, forfeiting the issue. *Gakuba v. Kurtz*, 2015 IL App (2d) 140252, ¶ 19. Moreover, the basis for an expert's opinion is typically a matter of weight. *Snelson v. Kamm*, 205 Ill. 2d 1, 26 (2003) ("[T]he basis for a witness' opinion generally does not affect his standing as an expert; such matters go only to the weight of the evidence, not its sufficiency."). We also note that claimant does not challenge this methodology on *Frye* grounds. See Ill. R. Evid. 702; *Durbin v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 150088WC, ¶¶ 32-39; c*f. In re Commitment of Simons*, 213 Ill. 2d 523 (2005) (considering admissibility of actuarial instruments in a mental health context). In short, the point claimant is trying to make here is not abundantly clear.

¶ 38 Claimant notes that Paul diagnosed CWP and asthmatic bronchitis. As claimant limited his challenge to emphysema, chronic bronchitis, and COPD, this observation is not pertinent to this appeal. It is true that Weber diagnosed emphysema, chronic bronchitis, and COPD; however, this merely created a conflict in the record with Tutuer's opinion that "to a reasonable degree of medical certainty, none of the clinically or physiologically significant findings pertaining to claimant were the result of claimant's exposure to coal dust." Again, resolution of such conflicts is primarily for the Commission. *Beattie*, 276 Ill. App. 3d at 449. As a medical issue, this is a matter on which we owe substantial deference to the Commission. *Long*, 76 Ill. 2d at 566.

¶ 39 Claimant also attacks the opinions of three B-readers regarding the absence of CWP. While we do not find claimant's attacks persuasive, we note that they are not relevant given how

claimant has chosen to limit the scope of this appeal. Quite simply, claimant's attacks pertain to the weight to which these opinions were entitled. Such matters were heard and resolved by the Commission, and, as medical issues, they are questions upon which we would owe the Commission great deference, if addressing these issues were necessary. *Long*, 76 Ill. 2d at 566. In any event, none of claimant's attacks are so persuasive that we could find the Commission's decision on this point to be contrary to the manifest weight of the evidence.

¶ 40 Claimant asserts that the Commission should have taken notice of various administrative standards that recognize restrictive-airways diseases of less severity. Claimant suggests that diseases of less severity would be consistent with the methacholine test, which showed a 17% fall in lung function. Claimant does not identify where, if anywhere, the Commission was asked to take such notice. In fact, Tutuer testified that this test result was within the normal range, and, it therefore provides support for the Commission's decision.

¶ 41 Claimant certainly identifies evidence in the record indicating that claimant suffers from chronic bronchitis, emphysema, and COPD. We do not doubt that some evidence supports claimant's position; however, none of this rises to a level sufficient for us to conclude that an opposite conclusion is clearly apparent (claimant's persistent failure to provide record citations to substantiate evidentiary claims makes such arguments difficult to evaluate and violates Illinois Supreme Court Rule 341(h)(7) (eff. Nov. 1, 2017) as well). That claimant can identify some evidence supporting his position does not, in itself, mean that an opposite conclusion to the Commission's is clearly apparent. There was also substantial evidence supporting the Commission's decision. Keeping in mind that the burden of proving this claim was on claimant, we simply cannot say that the Commission's decision was against the manifest weight of the evidence.

¶ 42 IV. CONCLUSION

¶ 43 In light of the following, the decision of the circuit court of Macoupin County confirming the decision of the Commission is affirmed.

¶ 44 Affirmed.