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Carla Bender
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2018 IL App (4th) 180089WC-U
No. 4-18-0089WC
Order filed October 30, 2018

IN THE

APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

LESTER STEVENS, Plaintiff-Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION (Mike Frerichs, Illinois State Treasurer, as *ex officio* Custodian of the Rate Adjustment Fund and Freeman United Coal Mining Company, Defendants-Appellees).	)	Appeal from the Circuit Court of Sangamon County. No. 17-MR-159 Honorable Esteban Sanchez, 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*: (1) The Commission's finding that claimant failed to sustain his burden of establishing he suffers from an occupational disease in the form of coal workers' pneumoconiosis arising out of and in the course of his employment as a coal miner was not against the manifest weight of the evidence; and (2) the Commission's finding that claimant failed to sustain his burden that he suffers from an occupational disease in the form of chronic bronchitis, a chronic cough,

or asthma arising out of and in the course of his employment as a coal miner was not against the manifest weight of the evidence.

¶ 2 Claimant, Lester Stevens, appeals from the judgment of the circuit court of Sangamon County confirming a decision of the Illinois Workers' Compensation Commission (Commission) denying his application for benefits pursuant to the Workers' Occupational Diseases Act (Act) (820 ILCS 310/1 *et seq*. (West 2006)). A majority of the Commission found that claimant failed to prove by a preponderance of the evidence that he suffers from any occupational disease arising out of and in the course of his employment as a coal miner for respondent, Freeman United Coal Mining Company. We affirm.

¶ 3 I. BACKGROUND

¶ 4 On July 1, 2008, claimant filed an application for adjustment of claim alleging that he experiences shortness of breath and exercise intolerance as a result of the inhalation of coal mine dust while he was employed by respondent. The matter proceeded to an arbitration hearing on September 29, 2015. The following factual recitation is taken from the evidence presented at the arbitration hearing.

¶ 5 Claimant began working as a coal miner in 1976. During his 31-year career with respondent, claimant worked various positions including laborer, shuttle-car operator, roof bolter, and repairman. With the exception of the last six months of his employment, claimant's entire career was spent underground. Claimant testified that during his employment with respondent, he was regularly exposed to coal dust, silica dust, roof-bolting-glue fumes, diesel fumes, and smoke from coal fires. Claimant last worked for respondent on August 28, 2007, when respondent closed the Crown II mine where claimant was assigned. Claimant testified that he had the option of working at another mine and could probably do the work of a coal miner, but elected not to because of breathing problems and other health concerns. At the time the

Crown II mine closed, claimant was 53 years old.

¶ 6 Claimant testified that he first noticed breathing problems two or three years after he first began working as a coal miner. Claimant testified that the coal and rock dust caused problems when he exerted himself, particularly when he was dragging motors and other parts down the belt line. In 1982, claimant began treating with Dr. Glennon Paul, whom he has seen on and off since. Claimant testified that from the time he initially noticed breathing problems until the time he ceased working in the mine, his condition worsened. He further testified that from the date he left the mine through the date of the arbitration hearing, his condition has remained the same.

¶ 7 Claimant testified that he is able to walk on level ground at a normal pace for one hundred to two hundred feet before becoming short of breath and is able to climb one flight of stairs before having to stop and rest. Claimant testified that he is no longer able to hunt due to the walking involved. In addition, claimant cannot rake leaves or push a lawnmower uphill. Claimant acknowledged smoking about half a pack of cigarettes a day for 15 to 18 years, but stated that he quit smoking in 1990. Claimant takes medication for diabetes, sinus problems, and high cholesterol. He also carries a Combivent inhaler.

¶ 8 Medical records from Central Illinois Allergy and Respiratory Service, Ltd., where claimant treats with Dr. Paul, were admitted into evidence. The handwritten notes of Dr. Paul are mostly illegible. However, claimant's progress notes indicate that his respiratory system was charted as normal at times and abnormal at other times. Claimant also had frequent episodes of sinusitis. Claimant was seen on January 23, 2003, with complaints of congestion and drainage. At that time, it was noted that claimant experienced an asthma flare up and had increasing shortness of breath, a cough, wheezing, and tightness in the chest. Upon examination, the respiratory system revealed normal inspiratory and expiratory effort and no wheezes or rales.

The diagnosis was influenza, sinusitis and asthma exacerbation "with 21% improvement in the FEV_1 after bronchodilators." On January 3, 2009, claimant presented with post nasal drip, a cough productive of thick sputum, chest tightness, and dyspnea on exertion. Claimant was diagnosed with acute exacerbation of bronchitis and chronic sinusitis status post endoscopic sinus surgery. On July 7, 2011, claimant presented with complaints of severe coughing, wheezing, and shortness of breath with head fullness. A chest X ray was negative and a sinus X ray revealed right-sided sinusitis. Claimant was diagnosed with asthma and sinusitis. An X ray of claimant's chest from June 8, 2012, showed claimant's lungs were clear with stable, small densities probably representing granulomas and no pleural fluid.

¶ 9 Dr. Paul testified by evidence deposition on March 27, 2012. Dr. Paul is the medical director of respiratory therapy at St. John's Hospital and a clinical assistant professor of medicine at Southern Illinois University Medical School. Dr. Paul is also the senior physician at Central Illinois Allergy and Respiratory Service, Ltd., a practice which treats patients with respiratory diseases, allergic diseases, and some internal medicine problems. In his practice, Dr. Paul has had occasion to treat coal miners for coal-mine-induced lung disease and has frequently examined coal miners at the request of coal companies. He reads approximately 5000 chest X rays a year and interprets about the same number of pulmonary-function tests. Dr. Paul is not a B-reader.

¶ 10 Dr. Paul testified that he provided care and treatment to claimant beginning in the early 1970s, and continuing through the date of his deposition. Over the course of this treatment, Dr. Paul performed pulmonary-function tests, took blood gases, conducted physical examinations, recorded patient histories, took chest X rays, and admitted claimant to the hospital. Dr. Paul noted that claimant had frequent episodes of sinusitis. Claimant also reported wheezing,

coughing, and shortness of breath quite frequently. Every time claimant got an upper respiratory-tract infection, he would go into asthmatic bronchitis which sometimes required acute treatment with IV Aminophyllin and nebulizer treatments. Claimant's symptoms would wax and wane over time. Dr. Paul testified that claimant would become short of breath after walking about four flights of stairs or one mile. However, when his lung disease became exacerbated, he could not walk at all. Claimant's treatment included a burst of Prednisone, an Albuterol inhaler, and Theo-Dur. Dr. Paul described claimant's smoking history as "mild exposures" which he classified as "mildly significant."

¶ 11 Dr. Paul testified regarding a physical examination of claimant he conducted on August 21, 2008, at the request of claimant's attorney. On that date, Dr. Paul noted mild wheezing when claimant exhaled, but no shortness of breath. Although claimant's pulmonary-function studies were normal, Dr. Paul noted that claimant's measurable pulmonary function would vary. He stated that the date of the examination "was a good day" as claimant "wasn't having any trouble at that time and you could just detect a little bit of inflammation at that time by listening to him." Dr. Paul also administered a methacholine test, which was negative. Dr. Paul testified that the negative methacholine test meant that claimant was not asthmatic at that time. Dr. Paul testified that during the course of claimant's treatment his reactivity was usually in the bronchitic range, meaning it was "not too bad on the pulmonary function, but it had a lot of inflammation which causes coughing and respiratory distress." Dr. Paul also reviewed a chest X ray as part of the August 21, 2008, examination, although he could not recall the date of the film. The X ray showed fibronodular lesions throughout all lung fields. When asked by respondent's attorney what the profusion rating of the film revealed, Dr. Paul responded, "I don't quite understand what you mean." Dr. Paul later explained that he is more concerned whether an individual has a

disease than "what the number would be." Dr. Paul's diagnoses on August 21, 2008, included sinusitis and CWP complicated by bronchitis.

¶ 12 Dr. Paul testified that based on his treatment of claimant, it was his opinion that claimant has asthma, asthmatic bronchitis, and chronic bronchitis. These conditions are 100% attributable to claimant's coal mine exposure. Dr. Paul further opined that claimant has CWP. Dr. Paul testified that in order to have CWP, one must not only have coal mine dust deposited in his lungs, but also a tissue reaction to it, which is called scarring or fibrosis. The scarring cannot perform the function of normal, healthy lung tissue. By definition, if one has CWP he has some impairment in the function of the lung at the site of scarring, whether it can be measured by spirometry or not. Dr. Paul testified that it is possible to have CWP that is radiographically significant and have normal pulmonary-function testing, normal blood gases, normal physical examination of the chest, and no shortness of breath. Dr. Paul testified that if an individual has CWP and ends his exposure to coal mine dust, the disease can still progress.

¶ 13 Dr. Paul further testified that his records contain references to sinusitis and that sinusitis sometimes occurs when people have upper respiratory-tract infections such as bronchitis, asthma, or asthmatic bronchitis. Dr. Paul testified that claimant's exposures as a coal miner were aggravating factors in his sinusitis. Dr. Paul testified that in light of his diagnoses of CWP, bronchitis, asthmatic bronchitis, and asthma, claimant could not have any further exposure to the environment of a coal mine without endangering his health. He testified that on a good day, claimant would have the capacity to do heavy manual labor and that on a bad day he would not have the ability to leave his house.

¶ 14 Dr. Robert Cohen examined claimant on October 14, 2008, upon referral of the United States Department of Labor for a black lung evaluation. Dr. Cohen authored a report of his

findings dated March 2, 2009, and testified by evidence deposition on October 29, 2009. Dr. Cohen is a senior attending physician at Stroger Hospital of Cook County and is the medical director of the hospital's pulmonary physiology and rehabilitation section. Dr. Cohen is also the medical director of the black lung clinic at Stroger Hospital and the National Coalition of the Black Lung and Respiratory Disease Clinic. Dr. Cohen has been a B-reader since 1998.

¶ 15 Dr. Cohen took a patient history from claimant, but did not review claimant's treatment records. Claimant's main complaint was dyspnea on exertion. Claimant reported shortness of breath when walking less than one mile or climbing two flights of stairs. Claimant also reported that he had not been able to hunt for the last eight years. Claimant's pulmonary-function tests, including spirometry, lung volumes, blood gases both at rest and with exercise, diffusing capacity, and cardiopulmonary exercise were all normal. Based on all the data available to him, Dr. Cohen testified that claimant has clinically significant pulmonary impairment, including a cough and dyspnea on exertion. Dr. Cohen acknowledged that exertional shortness of breath can be due to many causes, including causes unrelated to pulmonary disease, but he attributed claimant's pulmonary impairment to his 31 years of exposure to coal mine dust and his 8 pack years of smoking, with the coal mine dust exposure being more significant.

¶ 16 Dr. Cohen interpreted a grade-one chest X ray dated December 13, 1999, as positive for CWP, profusion 1/0 with q/q opacities in all lung zones. He made identical interpretations of grade-one chest X rays dated December 31, 2002, February 10, 2004, and December 16, 2004. He interpreted a grade-three chest X ray from an unspecified date in 2007 as positive for CWP, profusion 1/1 with p/q opacities in all lung zones. Dr. Cohen interpreted a grade-one chest X ray dated September 20, 2008, as positive for CWP, profusion 1/0 with q/q opacities in all lung zones. Based on claimant's history as a coal miner and his positive chest X rays, Dr. Cohen

diagnosed claimant with CWP. Dr. Cohen testified that claimant should not have further exposure to coal mine dust as further exposure could result in a worsening scarring process in the lungs. He testified that CWP is a respiratory disease that is permanent and has no cure.

¶ 17 Dr. Cohen also diagnosed claimant with a chronic cough, which he based on claimant's report of a chronic non-productive cough. He testified that because the cough was non-productive, it did not meet the criteria for chronic bronchitis. Dr. Cohen testified that claimant's cough was related to his 31 years of coal mine dust exposure. Dr. Cohen testified that claimant's smoking history was relatively insignificant, but could also be contributory in small part. He noted the chronic cough seemed to be stable in that it had not progressed in the recent past. Despite his diagnoses, Dr. Cohen testified that, from a pulmonary standpoint, claimant was capable of heavy manual labor.

¶ 18 Dr. Henry Smith, a board-certified radiologist and B-reader, interpreted a grade-one chest X ray dated December 3, 1999, as positive for pneumoconiosis, profusion 1/0 with p/s opacities in the middle and lower lung zones. He made identical interpretations of grade-one chest X rays dated December 31, 2002, and February 10, 2004. Dr. Smith interpreted a grade-one chest X ray of December 16, 2004, as positive for CWP, profusion 1/0 with s/p opacities in the middle and lower lung zones. He interpreted a grade-two chest X ray of an unspecified date in 2007 as positive for CWP, profusion 1/1 with p/p opacities in all lung zones. He interpreted a grade-one chest X ray of March 24, 2008, as positive for CWP, profusion 1/1 with s/p opacities in the middle and lower lung zones. He also interpreted a grade-two chest X ray of September 20, 2008, as positive for CWP, profusion 1/1 with p/s opacities in all lung zones.

¶ 19 Dr. Michael Alexander, a board-certified radiologist and B-reader, interpreted a grade-two chest X ray of October 30, 2007, as positive for CWP, profusion 1/1 with p/p opacities in all

lung zones. He made an identical interpretation of a grade-two chest X ray dated March 24, 2008.

¶ 20 Dr. Ashkay Sood, a B-reader, interpreted a grade-three chest X ray from an unspecified date in 2007 as positive for CWP, profusion 1/0 with s/t opacities in the left lower lung zone.

¶ 21 Respondent introduced into evidence records from the National Institute of Occupational Safety and Health (NIOSH) of B-readings of claimant's chest X rays. A chest X ray dated June 20, 1979, was interpreted by B-reader Jay Gordonson as being negative for CWP and by A-reader Lon Rademacher as positive for CWP, profusion 0/1 with p opacities in the right lower lung zone. A chest X ray dated September 28, 1993 was interpreted by B-reader Ralph Shipley as positive for CWP, profusion 0/1 with q/q opacities in all lung zones. The same X ray was interpreted by B-reader Philip Williams as negative. A chest X ray dated March 31 1998, was interpreted by B-reader Williams and B-reader Paul Wheeler as negative. A chest X ray dated May 7, 2007, was interpreted by B-reader Lee Siden and B-reader John Penker as negative for CWP.

¶ 22 At respondent's request, Dr. Jerome Wiot reviewed several of claimant's chest X rays. Dr. Wiot has been a board-certified radiologist since 1959. He was previously the president of the American Board of Radiology and served as an examiner for the board. He was also past president of the American College of Radiology and, as a member of the task force on pneumoconiosis, helped develop the weekend symposium which eventually became the B-reader program. Dr. Wiot has been a B-reader since the program's inception in 1970.

¶ 23 Dr. Wiot testified that in reviewing a chest X ray for CWP, the B-reader looks at the profusion, or the degree of involvement. The profusion is rated on a 12-point scale and expressed as a fraction ranging from 0/- to 3/4 or 3/X. As Dr. Wiot explained:

> "And as a patient becomes more and more involved *** with the disease process, why his profusion, as it's called, goes up. So we start out at 0/-, which is—no miners have that. 0/-, as I always kid, is a 17-year old high school kid. But then it goes 0/-, or 0/0, 0/1, and it goes on up to 3/X or 3/4.
>
> And so when you do the interpretation, what you do is, you take the film of interest and you compare it with the standard films. And there are standard films, 0/0, 1/1, 2/2, 3/3. And you make a determination as to where the degree of profusion is. If it's—let's say you're looking at the film and you've got the standard 2/2 up, and it's a little bit more than a 2/2, but not quite a 3/3 then it becomes a 2/3. If it's a little bit less than a 2/2, but not a 1/1[,] it becomes a 2/1."

Dr. Wiot testified that while a profusion reading of 1/0 is a positive film, a profusion reading of 0/1 is a negative film. Dr. Wiot further explained that the B-reader also looks at the opacity type, whether rounded or irregular, the degree of thickness, and the lung zones involved. Dr. Wiot testified that in CWP, the primary opacity is predominantly rounded and the secondary opacity is predominantly irregular. Dr. Wiot further testified that CWP invariably begins in the upper lung zones, predominantly on the right side, and moves into the mid and lower lung zones as it progresses. Asbestosis, in contrast, begins at the bottom of the lungs and progresses upwards.

¶ 24 Dr. Wiot reviewed X rays of claimant's chest dated December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, March 24, 2008, and September 20, 2008. He classified all of the films as quality one with the exception of the 1999 film, which he found to be quality two because it was slightly overexposed. Dr. Wiot's interpretation of the films was that there was no evidence of CWP. Dr. Wiot testified that the films showed that claimant had a deposition of subpleural fat on both lateral chest walls, which is a normal variant unrelated to

coal dust exposure. He also noted a small calcified granuloma along the right lung base which was not of any clinical significance.

¶ 25 At respondent's request, Dr. David Rosenberg reviewed claimant's medical and radiological records. Dr. Rosenberg is board certified in internal medicine, pulmonary disease, and occupational medicine. He has been a B-reader since 2000. Dr. Rosenberg is the medical director of corporate health at the University Hospitals of Cleveland, where he treats patients for CWP. Dr. Rosenberg is a member of the American Thoracic Society, the American College of Chest Physicians, and the American College of Occupational and Environmental Medicine.

¶ 26 Dr. Rosenberg interpreted claimant's chest X rays taken December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, and March 24, 2008. He testified that all of the X rays were of diagnostic quality and that none showed the presence of CWP. According to Dr. Rosenberg, claimant does not have CWP or any associated impairment or disability related to his past coal mine dust exposure. From the data set available to him, Dr. Rosenberg testified that there is no evidence of a decline in pulmonary function over time for claimant that could be explained by anything other than aging.

¶ 27 Dr. Rosenberg recounted that claimant's medical records indicated he had a flare-up of asthma in 2003. This diagnosis was based on clinical findings noted at that time, claimant's symptoms and examination, and claimant's pulmonary-function tests, which showed a 21% improvement in air flow after the administration of bronchodilators. At a later point in time additional pulmonary-function tests were performed and claimant did not have a significant response to bronchodilators or the bronchodilators were not administered. Dr. Rosenberg testified that this isolated occasion when claimant had a positive reaction to bronchodilators is, by definition, asthma. Dr. Rosenberg testified that there are exposures in the underground coal

mine that could aggravate claimant's asthma, but that would be on a temporary basis and it should respond with appropriate treatment. The fact that claimant has asthma does not mean that he should not be working in an underground coal mine.

¶ 28 Dr. Rosenberg testified that long-term coal mine employment and inhalation of coal mine dust can result in a chronic cough. However, the irritant effect of coal dust would dissipate within months of a miner leaving the coal mine. Thus, it would be unlikely that two years after exposure had ceased the chronic cough would be related to the coal mine. Most likely, the cough claimant described is related to his chronic sinus disease as well as his past history of asthma, for which he has been treated. Both chronic sinus disease and asthma are common etiologies for a nonproductive cough. Dr. Rosenberg agreed with Dr. Cohen that claimant does not have chronic bronchitis. He explained that, by definition, chronic bronchitis is a chronic cough and sputum production. Dr. Rosenberg added that even if claimant had chronic bronchitis related to past coal-mine dust exposure, it would have ceased within months of the time he stopped working in the coal mine.

¶ 29 At respondent's request, Dr. Peter Tuteur reviewed claimant's medical and radiological records. Dr. Tuteur completed a pulmonary fellowship at the University of Pennsylvania and then spent two years in the United States Air Force as a pulmonary consultant. He later joined the faculty at Washington University School of Medicine, Department of Internal Medicine, Pulmonary Critical Care Division. Dr. Tuteur is board certified in internal medicine and pulmonary diseases. He was the director of the pulmonary function lab at Washington University School of Medicine for more than 30 years.

¶ 30 Dr. Tuteur testified that his review of claimant's medical and radiological records revealed that claimant was exposed to sufficient amounts of coal mine dust to produce CWP in a

susceptible host. In addition, claimant's smoking history put him at increased risk for the development of health problems associated with tobacco smoke, including chronic obstructive pulmonary disease, chronic bronchitis, emphysema, arteriosclerotic heart disease, and lung cancer. Dr. Tuteur testified that claimant reportedly had no specific allergies, but did have chronic sinusitis with acute exacerbations documented as early as 1992. Dr. Tuteur found that claimant experienced productive cough and wheezing only with upper respiratory infections. Dr. Tuteur testified this was presumably from drainage during episodes of acute chronic sinusitis. Claimant's chronic medications included Albuterol and theophylline preparations with systemic corticosteroids used during acute exacerbations of upper respiratory infections.

¶ 31 Dr. Tuteur testified that claimant's pulmonary examinations were normal with the exception of one occasion when wheezing was heard. Pulmonary-function studies reviewed were associated with normal spirometry, normal residual volume, and normal total lung capacity. Dr. Tuteur reviewed chest X ray reports from six different readers concerning six different examinations between 1994 and 2008. Only one report indicated the presence of changes compatible with CWP. Dr. Tuteur personally reviewed five of the films from 1999 to 2008 and found them all to be quite similar. Striking to Dr. Tuteur was the obese physiognomy and the associated subpleural fat. Dr. Tuteur also noted calcification typical of an old healed infectious granulomatous disease.

¶ 32 Dr. Tuteur concluded that claimant had no evidence of the presence of CWP or any other coal mine dust induced disease and no evidence to support a diagnosis of any primary pulmonary condition. Claimant does have chronic sinusitis associated with recurrent exacerbations. Dr. Tuteur attributed claimant's sinusitis to multiple meatal obstructions which results in improper drainage of the sinuses. When drainage occurs, productive cough and wheezing develop, which

resolve without objectively demonstrated air flow obstruction on pulmonary-function testing as late as August 21, 2008. Dr. Tuteur testified that the inhalation of coal mine dust may transiently aggravate chronic sinusitis, but the exposure is not a cause of the sinusitis and it does not result in permanent problems. Dr. Tuteur further testified that claimant does not have chronic daily productive cough and thus does not meet the criteria for chronic bronchitis.

¶ 33 Dr. Tuteur testified that claimant has not suffered any permanent functional impairment as a consequence of his coal mine exposure. Dr. Tuteur testified that claimant's exercise tolerance was the ability to walk one block and climb four flights of stairs, which was appropriate for his age. He agreed with Dr. Cohen that claimant is capable of heavy manual labor from a pulmonary standpoint. He reviewed the methacholine challenge testing done by Dr. Paul and agreed that it was a negative test, indicating the absence of bronchial reactivity. Dr. Tuteur added that it is an infrequent occurrence that a person who leaves the coal mine with a normal radiograph later develops an abnormal one.

¶ 34 Based on the foregoing evidence, the arbitrator denied claimant's application for benefits, concluding that claimant failed to prove by a preponderance of the evidence that he suffers from CWP. In reaching this conclusion, the arbitrator relied on the findings of the NIOSH B-readers that: (1) claimant's X rays of June 20, 1979, September 28, 1993, and March 31, 1998, were all negative for CWP; and (2) claimant's X ray of May 7, 2007, three months prior to the mine closure, did not reveal any evidence of CWP. The arbitrator stated that she placed greater weight on opinions of the NIOSH readers because NIOSH is the governmental agency responsible for administering a health-surveillance program for the benefit of coal miners, NIOSH is not a party to this action, and the NIOSH X rays were taken and reviewed for reasons independent of litigation. The arbitrator recognized that claimant's alleged condition of CWP may have

developed in the time period subsequent to his final NIOSH X ray of May 7, 2007. Nevertheless, the arbitrator found "the reverberation of opinions amongst B-readers Drs. Wiot, Rosenberg, and Tuteur compelling in conjunction with the significant number of negative x-ray interpretations performed at the behest of NIOSH" and noted "the totality of the evidence demonstrates that a significant majority of B-readers concur that [claimant] does not have [CWP]."

¶ 35 The arbitrator did not find persuasive the chest X ray interpretations of Dr. Cohen, Dr. Smith, Dr. Sood, and Dr. Paul for various reasons. The arbitrator explained that the chest X ray interpretations of Dr. Cohen and Dr. Smith were inconsistent with the permanent nature of the scarring and opacities of CWP. In this regard, the arbitrator observed that Dr. Cohen's interpretations of claimant's chest X rays demonstrate that claimant's condition regressed from a profusion of 1/1 in 2007 to a profusion of 1/0 in September 2008. Similarly, Dr. Smith's interpretations of claimant's chest X rays demonstrate that claimant's opacities found in the upper lung zone in 2007 resolved or otherwise were not present in March 2008, but reappeared in September 2008. The arbitrator noted that Dr. Sood interpreted only one chest X ray from 2007 and found it to be positive for CWP, profusion 1/0 in only the left lower zone. The arbitrator found Dr. Sood's interpretation inconsistent with all of the other B-readers, including claimant's experts. Finally, the court noted that Dr. Paul is not a B-reader or a board-certified pulmonologist, he could not testify as to the date of the chest X ray he reviewed in making his diagnosis of CWP, and he did not assign the film a profusion rate. The arbitrator further observed that although Dr. Paul had treated claimant since 1982, he did not diagnose him with CWP until one year after the Crown II mine closed and approximately two months after claimant had filed his application for adjustment of claim.

¶ 36 The arbitrator further concluded that claimant failed to prove by a preponderance of the evidence that he suffers from any other pulmonary condition which is causally related to the exposures of his coal mine employment. Regarding claimant's chronic cough, the arbitrator observed that there were conflicting medical opinions regarding whether this condition was related to claimant's exposure to coal mine dust. Dr. Cohen, who did not review claimant's treatment records, linked claimant's chronic cough to his exposure to coal mine dust. However, Dr. Rosenberg and Dr. Tuteur, both of whom did review claimant's treatment records, related claimant's chronic cough to his chronic sinus disease. While the arbitrator found claimant's chronic sinusitis to be a medically significant condition, she concluded the cause of the sinusitis was not claimant's exposure to coal mine dust, but rather multiple meatal obstructions which do not allow the sinus to drain properly. The arbitrator acknowledged testimony that inhalation of coal dust may transiently aggravate claimant's sinusitis, but found that any aggravation caused by such exposure was intermittent and temporary in nature and did not result in a permanent aggravation or disablement.

¶ 37 The arbitrator also found that claimant did not prove by a preponderance of the evidence that he had chronic bronchitis. In this regard, the arbitrator acknowledged that Dr. Paul diagnosed claimant with the condition and related it to claimant's exposure to coal mine dust. However, the arbitrator found more persuasive the opinions of Dr. Cohen, Dr. Rosenberg, and Dr. Tuteur, who testified that claimant did not meet the criteria for having chronic bronchitis in that he did not have a chronic daily productive cough.

¶ 38 Finally, the arbitrator found that Dr. Paul's records were contradictory as to whether claimant suffers from asthma. Ultimately, however, the arbitrator determined that claimant failed to prove by a preponderance of the evidence that he had asthma as a result of his exposure

to coal mine dust. The arbitrator found compelling a negative methacholine challenge test administered by Dr. Paul in 2008, and Dr. Tuteur's opinion as to the significance of that result. As a result of her findings, the arbitrator denied claimant benefits under the Act.

¶ 39 A majority of the Commission affirmed and adopted the decision of the arbitrator. The dissenting commissioner would have found that claimant established by a preponderance of the evidence that he suffers from CWP, asthma, sinusitis, and bronchitis caused as a direct result of his exposure to coal dust during the 31 years he spent working for respondent as a coal miner. The dissenting commissioner assigned little or no weight to respondent's experts because none of them examined or met with claimant. The dissenting commissioner also noted that Dr. Wiot had been previously discredited by the Commission and Dr. Tuteur is not a B-reader. Finally, the dissenting commissioner noted that the last chest X ray interpreted by the NIOSH B-readers was taken several months before claimant stopped working for respondent. On judicial review, the circuit court of Sangamon County confirmed the decision of the Commission. This appeal ensued.

¶ 40 II. ANALYSIS

¶ 41 On appeal, claimant argues that the Commission erred in finding that he did not suffer an occupational disease in the form of CWP that arose out of and in the course of his employment with respondent. He also argues that the Commission erred in finding that he did not suffer an occupational disease in the form of a chronic cough, chronic bronchitis, or asthma that arose out of and in the course of his employment with respondent.

¶ 42 The claimant in an occupational disease case has the burden of proving both that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n,*

2013 IL App (5th) 120564WC, ¶ 21; *Anderson v. Industrial Comm'n*, 321 Ill. App. 3d 463, 467 (2001). Whether an employee suffers from an occupational disease and whether there is a causal connection between the disease and the employment are questions of fact. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21; *Bernardoni v. Industrial Comm'n*, 362 Ill. App. 3d 582, 597 (2005); *Anderson*, 321 Ill. App. 3d at 467. It is the function of the Commission to decide questions of fact, judge the credibility of witnesses, and resolve conflicting medical evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th), ¶ 21; *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). This is especially true with respect to medical issues, where we owe heightened deference to the Commission due to the expertise it has long been recognized to possess in the medical arena. *Long v. Industrial Comm'n*, 76 Ill. 2d 561, 566 (1979).

¶ 43 The Commission's determination on a question of fact will not be disturbed on review unless it is against the manifest weight of the evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21; *Docksteiner v. Industrial Comm'n*, 346 Ill. App. 3d 851, 856-57 (2004). For a factual finding to be against the manifest weight of the evidence, an opposite conclusion must be clearly apparent. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 539 (2007). "The test is not whether this or any other tribunal might reach an opposite conclusion but whether there is sufficient factual evidence in the record to support the Commission's determination." *Navistar International Transportation Corp. v. Industrial Comm'n*, 331 Ill. App. 3d 405, 415 (2002). "A reviewing court will not reweigh the evidence, or reject reasonable inferences drawn from it by the Commission, simply because other reasonable inferences could have been drawn." *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64 (2006).

¶ 44 A. CWP

¶ 45 Claimant first argues that the Commission erred in finding that he did not suffer an occupational disease in the form of CWP that arose out of and in the course of his employment with respondent. We disagree. The Commission's finding that claimant failed to establish that he had CWP is amply supported by the evidence. The Commission's conclusion rested upon the independent opinions of the NIOSH readers, who interpreted various X rays of claimant's chest to be negative for CWP, as well as the opinions of respondent's experts, Dr. Wiot, Dr. Rosenberg, and Dr. Tuteur. A chest X ray dated June 20, 1979, was interpreted by NIOSH B-reader Gordonson as being negative for CWP. A chest X ray dated September 28, 1993 was interpreted by NIOSH B-reader Williams as negative for CWP. A chest X ray dated March 31 1998, was interpreted by NISOH B-readers Williams and Wheeler as negative for CWP. A chest X ray dated May 7, 2007, was interpreted by NIOSH B-readers Siden and Penker as negative for CWP. Although NIOSH A-reader Rademacher and B-reader Shipley read the June 1979 and the September 1993 films, respectively, as positive for CWP with a profusion of 0/1, Dr. Wiot testified that a profusion rating of 0/1 is a negative film. Moreover, Dr. Wiot, who is a B-reader himself, interpreted X rays of claimant's chest from December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, March 24, 2008, and September 20, 2008. Dr. Wiot testified that while the films showed a deposition of subpleural fat on both lateral chest walls and a small calcified granuloma along the right lung base, there was no evidence of CWP. Dr. Wiot further testified that the deposition of subpleural fat was a normal variant unrelated to coal dust exposure and the calcified granuloma was not of any clinical significance. Dr. Rosenberg, who is also a B-reader, interpreted the films dated December 3, 1999, December 31, 2002, February 10, 2004, December 16, 2004, and March 24, 2008, as negative for CWP. In addition, Dr. Tuteur reviewed five films from 1999 to 2008 and found no convincing evidence to suggest the

presence of CWP. Although Dr. Tuteur is not a B-reader, he is board certified in multiple disciplines, including pulmonary diseases, and was the director of the pulmonary function lab at Washington University School of Medicine for more than 30 years.

¶ 46 Dr. Paul and B-readers Dr. Cohen, Dr. Smith, Dr. Alexander, and Dr. Sood all found claimant had CWP. Dr. Paul, claimant's long-time physician, diagnosed claimant with CWP based on his treatment of claimant and his reading of an unspecified X ray. B-reader Dr. Cohen interpreted X rays of claimant's chest from December 13, 1999, December 31, 2002, February 10, 2004, December 16, 2004, and September 20, 2008, as positive for CWP with a profusion rating of 1/0. Dr. Cohen also interpreted an X ray of claimant's chest from an unspecified date in 2007 as positive for CWP with a profusion rating of 1/1. B-reader Dr. Smith interpreted X rays of claimant's chest from December 3, 1999, December 31, 2002, February 10, 2004, and December 16, 2004, as positive for CWP with a profusion rating of 1/0. Dr. Smith also interpreted X rays of claimant's chest from an unspecified date in 2007, March 24, 2008, and September 20, 2008, as positive for CWP with a profusion rating of 1/1. B-reader Dr. Alexander interpreted X rays of claimant's chest dated October 30, 2007, and March 24, 2008, as positive for CWP with a profusion of 1/1. B-reader Dr. Sood interpreted an X ray of claimant's chest from an unspecified date in 2007 as positive for CWP with a profusion rating of 1/0.

¶ 47 As the foregoing evidence illustrates, the Commission was presented with conflicting medical evidence as to whether claimant demonstrated CWP. Unless the evidence on one side is so compelling as to render the opposite conclusion clearly apparent, we must defer to the Commission, which, as noted above, is uniquely situated to weigh competing medical evidence and to resolve any evidentiary conflicts. *Long*, 76 Ill. 2d at 566; *Freeman United Coal Mining Co.*, 2013 IL App (5th), ¶ 21; *Hosteny*, 397 Ill. App. 3d at 674. As discussed more thoroughly

below, the Commission in this case resolved the conflict in the evidence in respondent's favor, concluding that the X ray interpretations of claimant's experts were not persuasive. The Commission noted that the X ray interpretations of Dr. Cohen and Dr. Smith were inconsistent with the permanent nature of the scarring and opacities of CWP. The Commission found Dr. Sood's X ray interpretation inconsistent with the interpretations of all of the other B-readers. The Commission also discounted Dr. Paul's opinion because he is not a B-reader or a board-certified pulmonologist, he was unable to specify the date of the chest X ray he reviewed, he did not assign the film a profusion rating, and he did not diagnose claimant with CWP until one year after claimant left respondent's employ and approximately two months after claimant filed his request for workers' compensation benefits. Given the evidence of record and the Commission's role in weighing such evidence, we cannot say that a conclusion opposite that reached by the Commission is clearly apparent.

¶ 48 Claimant argues that the Commission's reliance on the X ray interpretations of the NIOSH B-readers was misplaced as the NIOSH interpretations are not relevant. Claimant notes that the oldest X rays interpreted by NIOSH were taken in 1979, 1993, and 1998, or about 29, 14, and 9 years before claimant's last exposure to coal mining. Claimant further notes that his final NIOSH X ray was taken on May 7, 2007, several months *prior* to his last exposure to coal mining. Thus, claimant asserts, the most recent NIOSH X ray interpretations cannot "rule out" CWP in claimant because, as the Commission recognized, claimant's alleged condition of CWP may have developed in the time period subsequent to his final NIOSH X ray. Claimant further contends that since these X rays cannot "rule out" the existence of CWP, the Commission's attempt to bolster its reliance on the interpretations of the NIOSH B-readers because NIOSH is not a party to this action and is the governmental agency responsible for administering a health-

surveillance program for the benefit of coal miners rings hollow. We disagree.

¶ 49 While the older X rays may not be entitled to as much weight as the more recent X rays, we still find them relevant to demonstrate the progression, or lack thereof, of CWP in claimant during the years of his employment as a coal miner. In this regard, the record demonstrates that claimant began working as a coal miner in 1976. Thus, the X rays interpreted by NIOSH, were taken 3 years, 17 years, 22 years, and 31 years into his employment with respondent. Dr. Tuteur noted it is an infrequent occurrence that a person who leaves the coal mine with a normal radiograph develops an abnormal one. Based on these readings and the testimony of record, the Commission could have reasonably concluded that since claimant did not have CWP as of May 2007, it was unlikely that he would have developed the disease after May 2007. Indeed, such a conclusion is supported by the X ray interpretations of Dr. Wiot, Dr. Rosenberg, and Dr. Tuteur. Moreover, claimant's argument that the most recent NIOSH X ray interpretations cannot "rule out" CWP because, as the Commission recognized, the disease may have developed in the time period subsequent to his final NIOSH X ray, is unconvincing. To obtain benefits under the Act, the claimant bears the burden of proving an occupational disease, such as CWP, by a preponderance of the evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th) 120564WC, ¶ 21. It is not the employer's burden to prove the absence of, or "rule out," CWP. Claimant's case relied greatly on the testimony of experts who interpreted certain X rays of claimant's chest as positive for CWP. Respondent rebutted this evidence by presenting the testimony of other experts who interpreted the same X rays as negative for CWP. This created a conflict in the medical opinion evidence which was for the Commission to resolve. *Freeman United Coal Mining Co.*, 2013 IL App (5th), ¶ 21; *Hosteny*, 397 Ill. App. 3d at 674. As noted previously, the Commission's finding that claimant failed to prove that he had CWP was

sufficiently supported by the evidence. Accordingly, we must defer to the Commission's finding.

¶ 50 Claimant also argues that the Commission's analysis contains several errors of fact regarding the evidence of CWP. For instance, claimant observes that the Commission cited "the reverberation of opinions amongst B-readers Drs. Wiot, Rosenberg, and Tuteur" to buttress its reliance on the NIOSH B-readers' interpretations of his chest X rays. Claimant points out that this statement is factually incorrect as Dr. Tuteur is *not* a B-reader. According to claimant, the Commission's decision on CWP should be reversed based on this factual error alone. We disagree. While Dr. Tuteur is not a B-reader, his credentials lead us to believe that any error made by the Commission in identifying him as such was harmless. Dr. Tuteur is board certified in internal medicine and pulmonary diseases. He completed a pulmonary fellowship at the University of Pennsylvania and spent two years in the United States Air Force as a pulmonary consultant. He was a member of the faculty at Washington University School of Medicine, Department of Internal Medicine, Pulmonary Critical Care Division. In addition, Dr. Tuteur was the director of the pulmonary function lab at the Washington University School of Medicine for more than 30 years. Thus, while Dr. Tuteur is not a B-reader, it was reasonable for the Commission to credit his interpretations of claimant's X rays given his background in the field of pulmonary medicine. See *Rural Electric Convenience Co-op Co. v. Illinois Commerce Comm'n*, 109 Ill. App. 3d 243, 246 (1982) (noting that an expert's testimony is to be considered in light of his qualifications, the quality of his testimony, and his credibility). Consequently, this factual error does not require reversal of the Commission's decision.

¶ 51 Claimant also observes that the Commission wrote that "a significant majority of the b-readers concur that Claimant does not have CWP." Claimant argues that this is an error of both

fact and analysis in that respondent had two B-readers interpret the X rays of his chest as negative for CWP (Dr. Wiot and Dr. Rosenberg) while claimant had four B-readers interpret the chest X rays as positive for CWP (Dr. Smith, Dr. Alexander, Dr. Cohen, and Dr. Sood). According to claimant, if the Commission had correctly interpreted the evidence, the Commission would have awarded him benefits. Claimant's analysis is flawed. We initially point out that the weight to be accorded medical opinion testimony is not simply a matter of adding up the number of experts. *Cinch Manufacturing Corp. v. Industrial Comm'n*, 393 Ill. 131, 134 (1946) (holding that the weight of the evidence in a workers' compensation case does not lie with the party producing a greater number of expert witnesses on its behalf); *ABF Freight System v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 141306WC, ¶ 22 (holding that the number of witnesses testifying to a particular fact is not controlling). Even if it were, however, the Commission's statement that a significant majority of the B-readers found that claimant did not have CWP is supported by the evidence if one considers the NIOSH B-readers. More significantly, the Commission cited several reasons for crediting respondent's experts over those of claimant. The Commission found the chest X ray interpretations of Dr. Cohen and Dr. Smith inconsistent with the permanent nature of the scarring and opacities of CWP. In this regard, the Commission observed that Dr. Cohen's interpretations of claimant's chest X rays demonstrate that claimant's condition regressed from a profusion of 1/1 in 2007 to a profusion of 1/0 in September 2008. Similarly, Dr. Smith's interpretations of claimant's chest X rays demonstrated that claimant's opacities found in the upper lung zone in 2007 resolved or otherwise were not present in March 2008, but reappeared in September 2008. Moreover, the Commission found the sole chest X ray interpretation by Dr. Sood inconsistent with all of the other B-readers, including claimant's experts. As noted above, unless the evidence on one side is

so compelling as to render the opposite conclusion clearly apparent, we must defer to the Commission, which is uniquely situated to weigh competing medical evidence and to resolve conflicts in the evidence. *Long*, 76 Ill. 2d at 566; *Freeman United Coal Mining Co.*, 2013 IL App (5th), ¶ 21; *Hosteny*, 397 Ill. App. 3d at 674. Given the inconsistencies identified by the Commission in the testimony of claimant's experts, we cannot say that a conclusion opposite that reached by the Commission is clearly apparent.

¶ 52 Claimant also criticizes the Commission for relying on Dr. Wiot's medical opinion. The arbitrator, whose decision was affirmed and adopted by the Commission, noted that the Commission had previously found Dr. Wiot's opinions not to be persuasive because, while Dr. Wiot is qualified, the overwhelming majority of his work is for insurance companies and employers. The arbitrator stated that she did not find Dr. Wiot's opinion on its own to be dispositive, but rather found his opinion in conjunction with the opinions of Dr. Rosenberg, Dr. Tuteur, and the NIOSH B-readers, to be persuasive. Claimant insists that this analysis "cannot stand," and, given the flaws in the Commission's reliance on Dr. Tuteur and the NIOSH readings, leaves only Dr. Rosenberg's opinion to carry the weight of persuasion. However, the fact that the Commission discredited Dr. Wiot in a previous case does not compel the same conclusion here. The cases cited by the arbitrator, and tacitly relied on by claimant, were decisions of the Commission. Decisions of the Commission in unrelated cases are not precedential authority in cases before this court. *S & H Floor Covering, Inc. v. Workers' Compensation Comm'n*, 373 Ill. App. 3d 259, 266 (2007). Moreover, each case must stand on its own facts. See *Weheimer v. UNR Industries, Inc.*, 213 Ill. App. 3d 6, 31 (1991). We do not know the particular factual circumstances surrounding the Commission's finding that Dr. Wiot was unpersuasive in these other cases. For these reasons we reject this argument as a basis to

overturn the Commission's decision.

¶ 53 Claimant also criticizes the Commission for giving no weight to Dr. Smith's X ray interpretations. The Commission noted that Dr. Smith interpreted the 2007 X ray of claimant's chest as positive with a profusion rating of 1/1 in all lung zones. He then interpreted the March 24, 2008, X ray of claimant's chest as positive for CWP with a profusion ration of 1/1 in the mid and lower zones. Finally, he interpreted the September 20, 2008, X ray of claimant's chest as positive for CWP with a profusion rating of 1/1 in all lung zones. As noted previously, the Commission found Dr. Smith's interpretations inconsistent with the permanent nature of the scarring and opacities of pneumoconiosis, explaining that Dr. Smith's interpretations "would demonstrate that Claimant's opacities found in the upper lung zone in 2007 resolved or otherwise were not present on March 24, 2008, and then reappeared on September 20, 2008." Claimant argues that Dr. Smith's readings demonstrate that he did not see the opacities of CWP in the upper lung zones on the March 2008 X ray. While claimant presents a reasonable explanation for the difference in readings, the Commission's finding that Dr. Smith's reading of the X rays was not consistent with the permanent nature of the scarring and opacities of CWP was also reasonable. See *Durand*, 224 Ill. 2d at 64 (prohibiting a reviewing court from rejecting reasonable inferences of the Commission simply because other reasonable inferences could be drawn).

¶ 54 Claimant also criticizes the Commission for giving less weight to Dr. Sood's reading because he found CWP in only one lung zone. Claimant argues that the "B-reading rules" are that if one zone is positive, the entire reading is positive. Claimant asserts that the finding of the Commission regarding Dr. Sood's interpretation is "hostile to the B-reading system." Again, however, the Commission's finding was a reasonable interpretation of the evidence. In this

regard, Dr. Wiot testified that CWP invariably begins in the *upper* lung fields and that if it begins on one side, it more often begins on the *right*. It then moves into the mid and lower lung zones as it progresses. Dr. Cohen agreed that the most common finding for opacities related to coal-mine-dust exposure involved the *upper* lung zones with *right-sided* predominance. Dr. Sood's interpreted the X ray of claimant's chest from 2007 as having opacities in the *lower left* lung zone with a profusion rating of 1/0. The Commission determined this interpretation was not consistent with the usual presentation of CWP. This was a reasonable conclusion based on the evidence before the Commission.

¶ 55 Claimant also complains that the Commission's analysis is inconsistent because it discounted Dr. Paul's opinion on the basis he is not a B-reader while it gave "great weight" to Dr. Tuteur's opinion, despite the fact that he is not a B-reader either. However, issues of credibility fall uniquely within the province of the Commission. *Hosteny*, 397 Ill. App. 3d at 674. The Commission had before it evidence of each physician's credentials. While the evidence suggested that both Dr. Paul and Dr. Tuteur had distinguished careers, the Commission noted that Dr. Tuteur was board certified in pulmonary diseases while Dr. Paul was not. This distinction in certification provided the Commission with a reasonable basis to credit Dr. Tuteur's opinion over that of Dr. Paul.

¶ 56 Claimant further notes that the Commission did not find Dr. Paul's opinion persuasive because he did not assign a profusion rating to the film he interpreted. Claimant complains that this distinction was unjustified since did Dr. Tuteur also failed to assign a profusion rating to the films he read. However, Dr. Tuteur interpreted the five films he read as showing no active disease. Thus, there was no need to assign a profusion rating to the films. Claimant also argues that it was improper to assign less weight to Dr. Paul's opinion since he did not diagnose

claimant with CWP until one year after the Crown II mine closed. Claimant argues that since CWP can appear after the date of last exposure, such a finding is inconsistent with the facts of the case. Claimant reads the Commission's remarks out of context. The Commission actually observed that although Dr. Paul had treated claimant since 1982, he did not diagnose him with CWP until one year after the Crown II mine closed *and approximately two months after claimant had filed his application for adjustment of claim*. It was within the province of the Commission to question the credibility of Dr. Paul's diagnosis given his long-term treatment of claimant and the timing of the CWP diagnosis in relation to the filing of claimant's application for adjustment of claim.

¶ 57 Finally, claimant asserts that a foreign jurisdiction has raised serious questions concerning the reliability of B-readings for use in litigation. See *In re Silica Products Liability Litigation*, 398 F. Supp. 2d 563, 625-26 (S.D. Tex. 2005). Claimant's reliance on authority calling into question the use of B-readings is somewhat puzzling given that a sizeable portion of the evidence he presented in support of his claim consisted of B-readings. In any event, claimant cites no compelling rationale to question the use of B-readings in this case.

¶ 58 In short, the Commission's finding that claimant failed to prove that he suffers from CWP rests firmly on the opinions of the NIOSH readers, Dr. Wiot, Dr. Rosenberg, and Dr. Tuteur. While there was evidence to the contrary in the record, it is primarily the function of the Commission to resolve conflicts in the evidence. *Freeman United Coal Mining Co.*, 2013 IL App (5th), ¶ 21; *Hosteny*, 397 Ill. App. 3d at 674. This is especially true with respect to medical issues, where we owe heightened deference to the Commission due to the expertise it has long been recognized to possess in the medical arena. *Long*, 76 Ill. 2d at 566. While there is evidence to support claimant's position, none of it is so compelling or so much more persuasive than the

evidence relied on by the Commission that a conclusion opposite that of the Commission is clearly apparent.

¶ 59 B. Chronic Bronchitis, Chronic Cough, and Asthma

¶ 60 Claimant also contends that the Commission erred in finding that he did not suffer from chronic bronchitis, a chronic cough, or asthma as a result of his employment as a coal miner. We address each condition in turn.

¶ 61 We first address the evidence regarding whether claimant suffered from chronic bronchitis as a result of his employment as a coal miner. Dr. Paul diagnosed claimant with chronic bronchitis, which he attributed to claimant's coal-mine exposure. However, Dr. Cohen, Dr. Rosenberg, and Dr. Tuteur disputed Dr. Paul's diagnosis, finding that claimant's cough was non-productive and therefore insufficient to meet the criteria for a diagnosis of chronic bronchitis. In other words, the Commission was presented with conflicting medical evidence as to whether claimant had chronic bronchitis as a result of his coal-mine exposure. The Commission was persuaded by the evidence that claimant did not have either of these conditions as a result of his employment as a coal miner. There was sufficient evidence in the record to support these findings. Thus, we find no error.

¶ 62 Claimant complains that the Commission did not give any details as to why it believed he did not have chronic bronchitis. We disagree. Dr. Cohen, Dr. Rosenberg, and Dr. Tuteur defined chronic bronchitis as a cough with sputum production. Clearly, the Commission determined that claimant did not meet this definition because his cough was non-productive. Claimant also argues that it was arbitrary for the Commission to find two doctors who never examined claimant (Dr. Rosenberg and Dr. Tuteur) more credible than Dr. Paul, claimant's long-time treating physician, especially since Dr. Rosenberg and Dr. Tuteur based their diagnoses in

part on a review of Dr. Paul's records. However, the Commission is uniquely situated to weigh competing medical evidence and to resolve any evidentiary conflicts. *Long*, 76 Ill. 2d at 566; *Freeman United Coal Mining Co.*, 2013 IL App (5th), ¶ 21; *Hosteny*, 397 Ill. App. 3d at 674. Claimant points to nothing so compelling that would require is to disregard the Commission's findings based on the foregoing.

¶ 63 With respect to claimant's chronic cough, Dr. Cohen related this condition to claimant's employment as a coal miner. Dr. Rosenberg testified that although long-term coal mine employment and the inhalation of coal dust can result in a chronic cough, it would be unlikely that a chronic cough would be related to coal-mine exposure if it still exists two years after such exposure had ceased. Dr. Rosenberg attributed claimant's chronic cough to his sinus disease and his past history of asthma, both of which are common etiologies for a non-productive cough. Dr. Tuteur likewise noted that chronic recurrent sinusitis is a condition that produces a cough as the purulent material that results from the condition and drips down the posterior pharynx and into the lungs. Dr. Paul testified that claimant's exposures as a coal miner were aggravating factors in his sinusitis. Dr. Tuteur attributed claimant's sinusitis to multiple meatal obstructions preventing the sinuses from properly draining. Dr. Tuteur allowed that if one has chronic sinusitis, the inhalation of coal mine dust may transiently aggravate it, but it is not a cause of the sinusitis and it does not result in permanent problems. Thus, the Commission was again presented with conflicting medical evidence as to whether claimant had a chronic cough as a result of his coal-mine exposure. The Commission was persuaded by the evidence that claimant did not have a chronic cough as a result of his exposure to coal mining. There was sufficient evidence in the record to support this finding.

¶ 64 We also conclude that the Commission's finding that claimant failed to prove he had asthma as a result of his exposure to coal dust was supported by the evidence. Dr. Paul diagnosed claimant with asthma, which he attributed to claimant's employment as a coal miner. However, the Commission found Dr. Paul's records to be contradictory with regard to whether claimant in fact suffers from the disease. The Commission gave no weight to Dr. Paul's handwritten progress notes because they were illegible. The Commission also noted that Dr. Paul's typewritten notes only occasionally reference asthma, and the medical records proximate to the date of claimant's last exposure evidence a lack of complaints which necessitated treatment for asthma. The Commission recognized that Dr. Rosenberg's testimony that claimant had an isolated incident in 2003 in which he had a positive reaction to bronchodilators, which, by definition was asthma. However, the Commission also noted that Dr. Rosenberg testified that subsequent pulmonary-function tests were done either without significant response to bronchodilators or without administering bronchodilators. The Commission also observed that methacholine challenge testing completed as part of Dr. Paul's examination of claimant in 2008 was negative indicating that claimant did not suffer from asthma at that time. Upon reviewing Dr. Paul's records, Dr. Tuteur eliminated asthma as a differential diagnosis. Other than the incident in 2003, there were no test results in the medical records supporting a diagnosis of asthma. In light of the foregoing evidence, there was sufficient evidence in the record to support the Commission's conclusion that claimant failed to prove by a preponderance of the evidence that he suffered from asthma as a result of his career as a coal miner.

¶ 65 III. CONCLUSION

¶ 66 For the reasons set forth above, we affirm the judgment of the circuit court of Sangamon County which confirmed the decision of the Commission denying claimant benefits under the Act.

¶ 67 Affirmed.