2018 IL App (5th) 170359WC-U

FILED: October 2, 2018

NO. 5-17-0359WC

IN THE APPELLATE COURT

OF ILLINOIS

FIFTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

WARREN SPANN, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.* (Tri County Coal, LLC, Appellee).	))))))))	Appeal from Circuit Court of Montgomery County No. 17MR23 Honorable Douglas L. Jarman, Judge Presiding.

JUSTICE CAVANAGH delivered the judgment of the court.

Presiding Justice Holdridge and Justices Hoffman, Hudson, and Barberis concurred in the judgment.

ORDER

¶ 1 *Held*: By finding that petitioner failed to prove he had contracted an occupational disease that arose out of and in the course of his employment, the Illinois Workers' Compensation Commission did not make a finding that was against the manifest weight of the evidence.

¶ 2 On August 8, 2012, petitioner, Warren Spann, filed an application for the adjustment of a claim pursuant to the Workers' Compensation Act (820 ILCS 305/1 *et seq.* (West 2012)). He claimed benefits from his former employer, Tri County Coal, LLC (Tri County). On October 5, 2015, after a hearing, the arbitrator found that petitioner had not contracted an occupational disease that arose out of and in the course of his employment. On

January 20, 2017, the Illinois Workers' Compensation Commission (Commission) affirmed and adopted the arbitrator's decision. Petitioner sought judicial review. On August 28, 2017, the Montgomery County circuit court affirmed the Commission's decision, concluding that it was not against the manifest weight of the evidence. Petitioner appeals. We affirm the judgment.

¶ 3 I. BACKGROUND

¶ 4 The arbitration hearing was held on August 28, 2015. Essentially, the following evidence was adduced in the hearing.

¶ 5 A. Petitioner's Testimony

¶ 6 1. *His Career in Coal-Mining*

¶ 7 Petitioner, who was born on April 2, 1956, worked 31 years in coal mines, during the period of 1975 to January 3, 2012. All of his work was underground.

¶ 8 He got his first coal mining job on August 19, 1975, at Old Ben Coal Company, in Sesser, Illinois. He worked there for about 1½ years as a shuttle car operator, hauling coal from the face of the mine, where it was being drilled out, and piling it onto a conveyor belt so it could be removed from the mine. This was dusty work.

¶ 9 From January to May 1977, he worked for Ziegler Coal Company, in Murdock, Illinois, as a shooter. He described that job as follows. "We shot coal down. Once the face was drilled[,] we went in and shot it[,] and it busted up[,] and the loader would come in behind us and [load] it." This job likewise raised a lot of coal dust.

¶ 10 From 1977 to 1979, he worked for Freeman Coal Company (Freeman), in the Orient No. 6 Mine, in Waltonville, Illinois. At first, he was a roof bolter, drilling holes into the roof of the mine and inserting bolts to secure and support the roof. Afterward, for six years, he ran the continuous miner machine, which cut coal from the face of the mine—one of the dustier

areas of the mine.

¶ 11 From 1980 to 1981, he worked for Freeman in the Orient No. 4 Mine, again as a roof bolter.

¶ 12 In 1981, he returned to Freeman's Orient No. 6 Mine, in which he "r[a]n a scoop on the section[,] hauling roof bolt materials to the roof bolters and scooping up the places and *** dump[ing] [the coal dust and gob] at the face." He doubled as an operator of the continuous miner machine. Also, for a couple of years, he was a long-wall repairman, using a shearer on "a block of coal a thousand f[ee]t wide." When the sheared-off coal fell from the wall, it would make a lot of dust.

¶ 13 From 1997 to 2007, petitioner worked at Freeman's Crown II Mine, in Virden, Illinois. His job classification there was that of a repairman. He repaired and maintained the machinery, down in the mine, where he was exposed to the same environment as the miners: the coal dust, the rock dust, and the sometimes overpowering odor of roof bolt glue.

¶ 14 Finally, in March 2008, he took a job as an underground repairman in Tri County's Crown III Mine. He testified:

> "A. *** I was a repairman on a production unit[,] which was a lot of dust. When they are cutting coal[,] you maybe have to work on a piece of machinery[,] and the miner being on the outby [*sic*] side of you[,] then you are eating all the dust there. They used glue bolts everywhere and diesels, a lot of diesels there.
>
> * * *
>
> Q. And you would inhale those diesel fumes?
>
> A. Yes."

¶ 15 2. *His Shortness of Breath and Other Health Problems*

¶ 16 In approximately 2009, while working as a repairman in the Crown III Mine, petitioner began noticing he was becoming tired and short of breath sooner than he used to. His breathing problem kept getting worse to the point that he had to leave coal mining, on January 3, 2012, at age 55.

¶ 17 He then worked as an over-the-road truck driver for Shawnee Express, Inc., out of Herrin, Illinois. After about 15 months, poor health forced him to give up that job, too.

¶ 18 All the while, up until the date of the arbitration hearing, his stamina had been decreasing, and now he could not walk 5 minutes at a normal pace on level ground or climb 15 or so stairs without pausing and catching his breath. He has had to hire someone to mow his yard, and going grocery shopping with his wife is physically arduous.

¶ 19 He takes no medication for his breathing problem, but he takes medication for diabetes and high cholesterol.

¶ 20 B. The Testimony of Dr. Glennon Paul

¶ 21 1. *His Background and Qualifications*

¶ 22 Dr. Glennon Paul has been the medical director of respiratory therapy at St. John's Hospital, in Springfield, Illinois, for over 35 years, and for the first 10 of those years, he simultaneously was the director of respiratory therapy at Memorial Hospital, also in Springfield. In addition, he has been the medical director of the Central Illinois Allergy and Respiratory Clinic for 40 years. He has performed black-lung examinations on coal miners for 40 years, more often at the request of coal companies than at the request of coal miners.

¶ 23 2. *The Results of Pulmonary Function Testing*

¶ 24 On November 13, 2012, at the request of petitioner's attorney, Paul examined petitioner. He had petitioner undergo spirometry, a "forced expiratory maneuver which

measure[d] the ventilatory capacity of the lungs and indicate[d] the degree of pulmonary impairment." *Newberg v. Chumley*, 824 S.W.2d 413, 415 (Ky. 1992).

¶ 25 Spirometry has three parts: "forced vital capacity (FVC), forced expiratory volume in the first second (FEV1)[,] and the ratio of these measurements expressed as a percentage (FEV1/FVC ratio)." *Id.* FVC is "the volume of air that a person can breath[e] out after a full breath with maximum effort." Patrick M. Hanlon & Anne M. Smetak, Asbestos Reform in the States, SM038 ALI-ABA 31, 61 (2006). FEV1 is "the volume of air that a person can expel in one second with maximum effort." *Id.* at 60-61. FVC and FEV1 usually are measured in liters. *Diaz v. Johnson Matthey, Inc.*, 893 F. Supp. 358, 364 (D.N.J. 1995).
" 'FEV1/FVC' is the ratio between the amount of air that a person can expel in the first second and the total amount of air he can expel, all with maximum effort." Hanlon, *supra*, at 61. "These measurements are used to determine whether the patient has any pulmonary function impairment by comparing the individual's measurements to a set of predicted measurements for that individual based on age and other physical characteristics." Lester Brickman, *Disparities Between Asbestosis and Silicosis Claims Generated by Litigation Screenings and Clinical Studies*, 29 Cardozo L. Rev. 513, 574 n.197 (2007).

¶ 26 Paul found that petitioner had an FVC of 60%, a FEV1 of 62%, and a FEV1/FVC of 81%.

¶ 27 3. *His Interpretation of an X-Ray*

¶ 28 According to Paul's report, dated January 8, 2013, a chest X-ray "show[ed] fibronodular lesions throughout both lung fields." Paul testified he did not know the date of the X-ray he had reviewed.

¶ 29 4. *His Diagnosis*

¶ 30 Paul diagnosed petitioner as having coal worker's pneumoconiosis (CWP), restrictive lung disease, and obstructive lung disease, all of which, in his opinion, had resulted from petitioner's inhalation of coal dust. ("*Restrictive lung disease*, or interstitial lung disease, makes it difficult to fill the lungs with air, and for the body to get enough oxygen. [Citation.] *Obstructive lung disease* includes three disease processes that make it difficult to empty the lungs of air: (1) chronic bronchitis, (2) emphysema, and (3) asthma." (Emphases added.) *Peabody Coal Co. v. Director, Office of Workers' Compensation Programs*, 746 F.3d 1119, 1121 n.2 (9th Cir. 2014). CWP is a restrictive lung disease. *Newberg*, 824 S.W.2d at 415.) Paul testified that breathing silica and diesel and glue fumes likewise could damage the lungs.

¶ 31 C. The Opinion of Dr. Henry K. Smith

¶ 32 1. *His Interpretations of the X-Rays and CT Scan*

¶ 33 At petitioner's request, Henry K. Smith, a board-certified radiologist and B reader, examined two chest X-rays and a CT scan. (B readers, or final readers, are physicians who have "demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services" (*Woodward v. Director, Office of Workers' Compensation Programs*, 991 F.2d 314, 316 n.4 (6th Cir. 1993)) or, more specifically, the National Institute for Occupational Safety and Health (National Institute) (42 C.F.R. § 37.52(b)(2)).)

¶ 34 The first X-ray was taken on October 9, 2009, and Smith rated its technical quality as 1. He interpreted the X-ray as positive for pneumoconiosis, profusion 1/0, with p/p opacities in all lung zones.

¶ 35 These notations or symbols that Smith used (profusion 1/0 and p/p) come from

the radiographic classification system of the International Labour Office (ILO), a United Nations organization. See ILO, Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconiosis (rev. ed. 2011); 20 C.F.R. § 718.102(d)(1).

¶ 36 Under the ILO system, the first thing the reader of an X-ray must do is rate the technical quality of the X-ray. See 20 C.F.R. § 718.102(a). Smith gave the X-ray of October 9, 2009, a technical quality of 1. The number 1 means that the X-ray is of "[g]ood" technical quality. ILO, *supra,* § 3.1, at 3.

¶ 37 The next thing the reader must do is describe the "[p]arenchymal [(tissue)] abnormalities." *Id.* § 3.2, at 3. "Parenchymal abnormalities include both small and large opacities." *Id.* If the opacities are small, the reader must describe them "by *profusion, affected zones of the lung, shape (rounded or irregular),* and *size*." (Emphases in original.) *Id.*

¶ 38 The letter p signifies small, rounded opacities with diameters up to about 1.5 millimeters. *Id.* at 5. The forward slash (/) enables the reader to record the predominant shapes and sizes on the left (or numerator) side of the forward slash and the less extensive, though significant, shapes and sizes on the right (or denominator) side. *Id.* at 6. By writing "p/p," Smith signified that all of the small opacities were rounded and had diameters up to about 1.5 millimeters and that he found no significant quantity of small opacities that were of other shapes and sizes. See *id.*

¶ 39 Next, the reader of the X-ray must note where in the lungs he or she found the opacities. "Each lung field is divided into three zones (upper, middle, lower) by horizontal lines drawn at approximately one-third and two-thirds of the vertical distance between the lung apices and the domes of the diaphragm." *Id.* at 5. Smith found p opacities in all three of the lung zones.

¶ 40 In addition to the shape, size, and location of small opacities, the reader must

describe the "*profusion* of small opacities," that is, "the concentration of small opacities in affected zones of the lung." (Emphasis in original.) *Id.* at 3. The ILO has issued standard radiographs for that purpose, to illustrate the four categories of profusion: 0, 1, 2, and 3. *Id.* at 3-4. "Category 0 refers to the absence of small opacities or the presence of small opacities that are less profuse than category 1." *Id.* at 4. The profusion increases in the direction of category 3. *Id.*

¶ 41 In the description of profusion, the reader will use the forward slash again. The numerator is the category of profusion on which the reader ultimately has decided, and if the reader seriously considered an alternative category, the denominator is the alternative category. *Id.* If the reader did not seriously consider an alternative category of profusion, the denominator will be the same as the numerator (for example, 2/2). *Id.*

¶ 42 Thus, the ILO has issued four standard radiographs (or X-rays)—0, 1, 2, and 3 or, to use the forward slash, 0/0, 1/1, 2/2, and 3/3—and the reader compares the radiograph in question to those standard radiographs and decides on the level of profusion. If it is a close case and the reader wavered between, say, 0 or 1 but ultimately settled on 1 as the most comparable standard radiograph, the reader will describe the profusion of small opacities as 1/0—as Smith described it. See *id.* In other words, Smith ultimately decided to call the X-ray of October 9, 2009, a 1 for profusion but seriously considered calling it a 0 (or a normal X-ray) before deciding it was a 1.

¶ 43 The other X-ray that Smith interpreted was taken on March 28, 2012. He gave it a technical quality of 1 and interpreted it as positive for pneumoconiosis, profusion 1/0, with p/s opacities in the bilateral middle and lower zones. (The letter s signifies small, irregular opacities with widths up to about 1.5 millimeters. *Id.* at 5.)

¶ 44 Smith also reviewed a chest CT scan taken on January 11, 2010. In it, he found

diffuse interstitial fibrosis with small opacities throughout the upper, middle, and lower zones bilaterally, with a classification of p/p and a profusion of 1/0 to 1/1.

¶ 45 D. The Testimony of Dr. Cristopher A. Meyer

¶ 46 At the request of counsel for Tri County, Cristopher A. Meyer, a radiologist and B reader, interpreted two X-rays and two CT scans.

¶ 47 The first X-ray was taken on October 9, 2009. Meyer gave it a technical quality of 1, and he interpreted it as a normal chest X-ray, with no CWP.

¶ 48 The second X-ray was taken on March 28, 2012. He gave it a technical quality of 2 due to poor contrast and the patient's obesity. It showed no CWP.

¶ 49 The first CT scan was taken on October 9, 2007. It was of diagnostic quality and showed no CWP or lymphadenopathy, but it showed calcified nodules consistent with granulomatous disease.

¶ 50 The follow-up CT scan of January 11, 2010, likewise showed no CWP. In the left lower lobe, however, there was a solid nodule, and, in the right upper lobe, there was a second nodule. When this follow-up CT scan was compared to the CT scan of October 9, 2007, those nodules were new. Also, several other nodules that had appeared in the earlier scan had resolved.

¶ 51 In Meyer's opinion, such a waxing and waning of nodules suggested an inflammatory process that was different from CWP. In a case of CWP, once a coal-dust macule had formed, one would not have expected it to go away. The development of new nodules in so short a time was inconsistent with CWP.

¶ 52 E. The Testimony of Dr. Jeffrey W. Selby

¶ 53 1. *His Interpretations of the X-Rays*

¶ 54 On July 18, 2013, at the request of counsel for Tri County, Jeffrey W. Selby, a

physician board-certified in internal medicine and pulmonary disease and a B reader, examined petitioner and X-rayed his chest.

¶ 55 He rated the X-ray as having a technical quality of 2 due to under-inflation, and in it he found no parenchymal or pleural abnormalities consistent with pneumoconsiosis.

¶ 56 He also looked at the X-rays taken on October 9, 2009, and March 28, 2012, and found no abnormalities consistent with pneumoconiosis in them, either.

¶ 57 2. *Pulmonary Function Testing*

¶ 58 Spirometry, administered by Selby, showed an FVC of 78%, an FEV1 of 78%, and an FEV1/FVC ratio of 80%. He regarded those results as normal. He found no improvement after the use of a bronchodilator (a drug that dilates the bronchi).

¶ 59 In addition, Selby measured petitioner's diffusion capacity, the capacity of the lungs to absorb oxygen into the bloodstream, and he found it to be 61% of the predicted value. He testified that 61% was low but that the lowness of the number in this case was due not to any problem with the lung tissue but, rather, to the crowding of the lungs by the abdomen. Therefore, he "corrected [the reading] for alveolar volume." (Alveoli are the air sacs in the lungs.) Selby explained:

> "A. Because the very protuberant, tight, obese belly is pushing up against the lung volumes, it reduces the actual size of the lung as measured. And because of that, for his height, it would seem, though, that his diffusion capacity is low, but, in fact, the alveolar tissue that is able to communicate with the carbon monoxide gas is [111%] of predicted. In other words, it's working above normal."

¶ 60 Lung volumes were normal, except for residual volume (the amount of air left in the lungs after exhalation), which was low, again, because of petitioner's extreme obesity. Selby

testified: "[W]e know that small lung volumes are essentially useless in determining airway obstruction, according to the American Thoracic Society." The crowding of the lungs by the abdomen, reducing their volume, explained not only the shortness of breath upon exertion but also the spirometry results. "Residual volume would be down. Total lung capacity would be down. Forced vital capacity would be down. FEV1 would be down. And diffusion capacity would be reduced." An electrocardiogram suggested heart disease, which could be another cause of the shortness of breath. In any event, according to Selby, there was no evidence of bronchospasms or hyperactive airway disease, such as asthma, and there was no evidence of respiratory or pulmonary abnormalities resulting from inhaling coal dust or working in a coal mine.

¶ 61 3. *Cross-Examination of Dr. Selby Regarding Dr. Eagleton's Findings*

¶ 62 Petitioner's attorney cross-examined Selby regarding a pulmonary function test that Dr. Lanie E. Eagleton, a clinical professor at Southern Illinois University School of Medicine, administered to petitioner on June 3, 2011. In a letter of June 16, 2011, to petitioner's primary-care physician, Dr. Dennis Swenie, Eagleton wrote:

> "His FEV1 was 2.35[,] which is 71% of predicted[,] and he was 78% of forced vital capacity[,] which was 3.03 and 73% of predicted. *** Following inhale bronchodilator, he had a 12% improvement in the FVC, 15% improvement in the [here the document becomes illegible] 14% improvement in the FVC. This would be compatible with the no necessarily diagnostic [*sic*] of asthma[,] and he did have a baseline mixed obstructive restrictive lung disease ***."

Selby testified that in his opinion the readings that Eagleton had obtained actually were normal and that a 15% response to a bronchodilator was "just barely significant."

¶ 63 In response to Selby's opinion that Eagleton's spirometric results were normal, petitioner's attorney asked Selby:

> "Q. All right. That is not based on the [American Medical Association's] Guides to Impairment but on the standard way you look at a set of [pulmonary function tests]. Right?
>
> A. Yes."

¶ 64 F. The Testimony of Dr. Joseph J. Renn III

¶ 65 1. *His Qualifications*

¶ 66 Joseph J. Renn III testified he was a physician whose practice had been clinical, academic, and consultative. He described his board certifications as follows: "Internal medicine [b]oards, pulmonary [b]oards, the American College of Forensic Examiners[,] and the Board of Forensic Medicine[,] and I'm a fellow in the American College of Forensic Examiners." He had been a B reader since 1981, and he had been board-certified in pulmonary disease since 1980.

¶ 67 2. *His Interpretations of X-Rays*

¶ 68 At the request of counsel for Tri County, Renn did B readings of two chest X-rays, one from August 28, 2002, and the other from March 28, 2012. Counsel provided Renn the X-ray of March 28, 2012, but to look at the X-ray of August 28, 2002, Renn had to travel to the National Institute, in Morgantown, West Virginia, because the National Institute had taken the X-ray pursuant to the Coal Workers' X-ray Surveillance Program and would not allow the original X-ray to be removed from its facility. So, Renn went to Morgantown, taking the X-ray of March 28, 2012, with him so he could look at the two X-rays side by side. The National Institute had light boxes for that purpose as well as the standard ILO radiographs for use in the B reading system.

¶ 69 Renn found both films to be of diagnostic quality, although, he noted, the film of August 28, 2002, was of marginal diagnostic quality in that it was overexposed, petitioner had not fully inhaled, and the diaphragm was elevated. Renn testified that particular care had to be taken in the interpretation of an overexposed film because the overexposure could make opacities disappear. Underinflation of the lungs posed just the opposite risk: "you'll have crowding of the lung bases[,] and it will appear that there are linear opacities when, in reality, it's just failure to fully inflate the lungs."

¶ 70 Notwithstanding those imperfections in the X-ray of August 28, 2002, Renn was able to read it, and when comparing it to the X-ray of March 28, 2012, he found no significant change. He could tell that petitioner had lost some weight between 2002 and 2012. In the 2002 film, he saw a calcified granuloma on the right hilum that he did not see in the 2012 film. He also saw some apical thickening (thickening of the top of the lung), which had no clinical significance and was unrelated to dust. Neither of the films showed pneumoconiosis.

¶ 71 G. Upper Respiratory Complaints

¶ 72 On August 9, 2010, petitioner complained to one of his treating physicians, Christopher Reyes, of facial fulness, a runny nose, and a sore throat. He told Reyes he had been suffering from those conditions for three days. Reyes found the chest and lungs to be clear, and he diagnosed sinusitis.

¶ 73 In Swenie's patient chart for the period of August 2006 to August 2011, there are 13 entries for allergic rhinitis, 1 entry for bronchitis, 1 entry for acute sinusitis, and 1 entry for "respiratory abnormality."

¶ 74 II. ANALYSIS

¶ 75 A. The Foundation of Meyer's, Selby's, and Renn's Opinions

¶ 76 Petitioner argues that "[w]hen an expert fails to take a patient history that is central to CWP, chronic bronchitis, [chronic obstructive pulmonary disorder (COPD)], emphysema, [and] sinusitis and ignores the only patient histories directed to said diseases, and misleads about the medical records, his opinion cannot be credible." He cites *People v. Wilhoite*, 228 Ill. App. 3d 12, 21 (1991), for the proposition that "[e]xpert testimony is of no weight when it ignores much of the best evidence available." Also, he cites *Turpin v. Merrell Dow Pharmaceuticals, Inc.*, 959 F.2d 1349, 1360 (6th Cir. 1992), for the proposition that "[e]xpert testimony that is no more than a belief or personal opinion and that is not grounded in science has no evidentiary value."

¶ 77 To lay an adequate foundation for expert testimony, the proponent of the expert testimony must not only establish the expert's credentials but also must establish that the information on which the expert bases his or her opinion is reliable. *People v. Simmons*, 2016 IL App (1st) 131300, ¶ 115. The information is reliable if "it is 'of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject.' " *Id.* (quoting Ill. R. Evid. 703 (eff. Jan. 1, 2011). Since petitioner's own experts relied on radiographic information, it evidently is undisputed that physicians customarily and reasonably rely on radiographic information when determining whether a patient has pneumoconiosis. See *id.* Tri County's experts—Meyer, Selby, and Renn—based their opinions on radiographs. (In addition, Selby administered a pulmonary function test.) It follows that the foundational requirement in *Simmons* was satisfied. Whether Meyer, Selby, and Renn additionally should have taken a patient history (actually, as Tri County points out, Selby took a patient history) goes to the weight, not the admissibility, of their opinions.

¶ 78 "The Commission's determination of factual issues, including the resolution of

conflicting medical evidence, and the credibility and weight of testimony, will not be disturbed unless against the manifest weight of the evidence." *McLean Trucking Co. v. Industrial Comm'n*, 96 Ill. 2d 213, 219 (1983). A decision is against the manifest weight of the evidence only if the "clearly evident, plain, and indisputable" weight of the evidence demands the opposite decision. (Internal quotation marks omitted.) *Board of Education, School District No. 90 v. United States Fidelity & Guaranty Co.*, 115 Ill. App. 2d 416, 425 (1969). In other words, to be against the manifest weight of the evidence, the decision would have to be "unreasonable, arbitrary, or not based on the evidence." *Enbridge Energy (Illinois), L.L.C. v. Kuerth*, 2018 IL App (4th) 150519-B, ¶ 62. A trier of fact could fairly and reasonably take the view that in the absence of a pathological examination of tissue specimens, *i.e.*, lung tissue removed in a biopsy or autopsy, the "best evidence"—indeed, the indispensable evidence—of CWP is radiographic. The federal government appears to take that position. See 20 C.F.R. § 718.102(d)(1) ("To establish the existence of pneumoconiosis, a film chest X-ray must be classified as Category 1, 2, [or] 3 *** in accordance with the [ILO] classification system ***.").

¶ 79 Just because they interpreted the radiographic evidence differently than Paul and Smith, it does not follow that Meyer, Selby, and Renn "mis[led] about the medical records." The Commission believed them over Paul and Smith, and we owe substantial deference to that determination of credibility. See *Material Service Corp. v. Industrial Comm'n*, 97 Ill. 2d 382, 387 (1983) ("In the presence of conflicting medical opinion, the Commission's determination is given substantial deference and will be upheld unless it is contrary to the manifest weight of the evidence.").

¶ 80 B. The Relevance of Petitioner's Obesity

¶ 81 Petitioner argues:

> "The Commission erred in finding that [petitioner's] complaints of exertional dyspnea were due to his obesity and deconditioning. Although [petitioner] was, according to Dr. Selby, obese with a [body mass index] of 55.6 [citation], the question before the Commission is not whether [petitioner's] obesity or diabetes were [*sic*] causative or aggravating factors in his pulmonary diseases, but whether his coal mine exposures played any causative or aggravating factor in his diseases. In this case [petitioner] has CWP[,] and his diabetes and obesity history are irrelevant."

¶ 82 Evidence is relevant if it has "*any* tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." (Emphasis added.) Ill. R. Evid. 401 (eff. Jan. 1, 2011). Whether petitioner had pneumoconiosis was a factual issue that was of consequence to the determination of his claim. If his shortness of breath on exertion was due to his abdomen pressing against his lungs (as Selby opined), that fact had *some* tendency to make it less probable than it otherwise would have been that he had pneumoconiosis—because pneumoconiosis was unnecessary to explain his shortness of breath; obesity explained it. Therefore, his obesity was relevant in that way. And if Selby is to be believed, it also explained why the FVC and FEV1 "would be down."

¶ 83 Petitioner is correct that "the question before the Commission [was] not whether [his] obesity or diabetes were causative or aggravating factors in his pulmonary diseases." Rather, the question was whether he had a pulmonary disease, and the Commission answered that question in the negative. On the record before us, it would be an exaggeration to say it is *indisputable* that petitioner has an occupational disease. See *United States Fidelity*, 115 Ill. App. 2d at 425.

¶ 84 Although it is true, as petitioner argues, that his upper respiratory complaints had nothing to do with his obesity or diabetes, it does not necessarily follow that they had anything to do with his work in coal mines. Unlike CWP, sinusitis and bronchitis are not distinctive to coal miners.

¶ 85 C. The National Institute's X-Ray

¶ 86 The arbitrator wrote in his decision: "Records from [the National Institute] for the Coal Workers' Health Surveillance Program were admitted into evidence. A chest [X-ray] of August 28, 2002, was interpreted by two B readers as negative for pneumoconiosis (Respondent's [e]xhibit [No.] 4)." Petitioner argues that this X-ray was irrelevant because his last day of coal mining was January 3, 2012, and under section 1(f) of the Workers' Occupational Diseases Act (820 ILCS 310/1(f) (West 2012)), he had two years after his last date of last exposure for the disablement by pneumoconiosis to manifest itself.

¶ 87 Section 1(f) provides: "No compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease ***." *Id.* Section 1(e) defines " '[d]isablement' " as follows:

> "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment; and 'disability' means the state of being so incapacitated." *Id.* § 1(e).

Petitioner argues in his brief: "The diagnosis of CWP means that there is an impairment in the function of the lungs at the site of the damage of the CWP[,] [regardless of] whether such can be measured or not." Therefore, by petitioner's reasoning, the National Institute's X-ray of August 28, 2002, actually was relevant in that it showed no CWP and, hence, no impairment of lung function on that date—which was "within," or before, "two years after the last day of the last exposure." *Id.* § 1(f); see Merriam Webster's Collegiate Dictionary 1355 (10th ed. 2000) (defining "within" as "before the end of"). The last exposure was January 3, 2012, petitioner's last day at the mine. Two years after that date was January 3, 2014. The date of the National Institute's X-ray, August 28, 2002, was "within," or before, the deadline of January 3, 2014. 820 ILCS 310/1(f) (West 2012).

¶ 88 Even if petitioner intended only to prove a pneumoconiosis that existed during the period of January 3, 2012, to January 3, 2014, the National Institute's X-ray of August 28, 2002, would be relevant for a reason that Selby explained in his testimony. He was asked:

> "Q. Is there a benefit in having serial films to look at, of an individual, and reviewing those films at one time, so far as trying to discern whether there's a disease present or, if present, *a change over time*?
>
> A. That is absolutely correct." (Emphasis added.)

If opacities wax and wane throughout a series of X-rays taken over a period of several years, that could be a sign that the opacities are not CWP, since, as Meyer testified, once a coal macule has formed in the lung, it typically does not go away.

¶ 89 D. The Burden of Proof

¶ 90 Petitioner notes: "[A]ll three of [Tri County's] experts agreed that neither a negative x-ray nor a negative CT scan can rule out the presence of CWP. They cannot prove that

there is no CWP at the tissue level." But Tri County did not have the burden of proving that negative proposition. Instead, petitioner had the burden of affirmatively proving an occupational disease. See *Martin v. Industrial Comm'n*, 91 Ill. 2d 288, 294 (1982); *Payne v. Industrial Comm'n*, 61 Ill. 2d 66, 69 (1975). The experts differed on whether the X-rays and CT scans proved CWP, "and where conflicting medical testimony is presented[,] it is for the Commission to determine which testimony is to be accepted." *Martin*, 91 Ill. 2d at 294.

¶ 91 E. Pulmonary Function Testing

¶ 92 Selby's pulmonary function testing showed an FVC of 78%, an FEV1 of 78%, and an FEV1/FVC of 80%. He opined that those percentages were within the range of normal. Petitioner argues: "Since the [Workers' Occupational Diseases] Act [(820 ILCS 310/1 *et seq.* (West 2016)) contains a Pulmonary Dysfunction Table which lists 80% as the lower limit of normal for the FVC and FEV1 measurements, and Dr. Selby's testing showed an FVC of 78% and an FEV1 of 78%, [petitioner's] testing is not normal." Petitioner does not cite where, in the Occupational Diseases Act, this "Pulmonary Dysfunction Table" may be found. There is no such table in the statute.

¶ 93 Petitioner also criticizes Selby because "he used the Knudson tables of predicted normal in his testing, while the AMA Guides requires use of the NHANES III tables." The "Knudson tables" apparently refers to a 1976 article by R.J. Knudson and others. R.J. Knudson, R. Slatin, M. Lebowitz & B. Burrows, *The Maximal Expiratory Flow-Volume Curve*, 113 American Review of Respiratory Disease 587 (1976). The "AMA Guides" refers to the American Medical Association's Guides to the Evaluation of Permanent Impairment. American Medical Association, Guides to the Evaluation of Permanent Impairment (6th ed. 2007) (AMA Guides). The "NHANES III tables" are the tables in the third National Health and Nutrition

Examination Survey (https://www.cdc.gov/niosh/topics/spirometry/nhanes.html). Under section 8.1b(a) of the Workers' Compensation Act (820 ILCS 305/8.1b(a) (West 2016)), the most current edition of the AMA Guides is to be used to determine the level of impairment when determining *permanent partial disability*—but petitioner cites no statute requiring that the AMA Guides be used in determining whether the worker has an occupational disease or "accidental injury" (820 ILCS 305/8 (West 2016)). As Tri County points out, petitioner's own expert witness, Dr. Paul, "used Crapo" instead of "us[ing] the NHANES predicted in interpreting [petitioner's] pulmonary function testing." "Crapo" apparently refers to R.O. Crapo, A.H. Morris, & R.M. Gardner, *Reference Spirometric Values Using Techniques and Equipment That Meets ATS Recommendations*, 123 American Review of Respiratory Disease 659 (1981).

¶ 94 In any event, because the record appears to lack a copy of the AMA Guides, we are unable to confirm the accuracy of petitioner's representation that an FVC or FEV1 lower than 80% of the predicted values in the Survey's tables shows a pulmonary obstruction in the view of the American Medical Association. Tri County argues that the FEV1/FVC ratio of 80% in Selby's testing and the FEV1/FVC ratio of 81% in Paul's testing showed that petitioner had no pulmonary obstruction. Without the AMA Guides, it is impossible to know who is right. And, again, even if petitioner's interpretation of the AMA Guides were the correct interpretation, he still has not established that any FEV1 and FVC that is less than 80% of the predicted value automatically requires, as a matter of law, a finding of occupational disease. Petitioner cites no case so holding.

¶ 95 Petitioner argues that in addition to the low FEV1 and FVC readings, his diffusing capacity proves he has an occupational disease. Selby measured petitioner's diffusing capacity as 61% of the predicted value. Selby explained, however, that 61% was low not because of any

problem with the lung tissue but, rather, because the belly was "pushing up against the lung volumes." Consequently, he "corrected [the reading] for alveolar volume" and came up with 111% of normal.

¶ 96 F. Petitioner's Complaint That the Commission Gave No Reason for Its Credibility Determination

¶ 97 The Commission agreed with the arbitrator that Tri County's experts were more credible than petitioner's experts. Petitioner argues that "[m]eaningful review" of this credibility determination is "impossible" because the Commission gave no reason for its credibility determination. In support of his argument, petitioner cites *Skzubel v. Illinois Workers' Compensation Comm'n*, 401 Ill. App. 3d 263, 269 (2011), and *R & D Thiel v. Industrial Comm'n*, 398 Ill. App. 3d 858, 866 (2010).

¶ 98 In *Skzubel*, the claimant had a job delivering newspapers for Four M Distributors (Four M) (*Skzubel*, 401 Ill. App. 3d at 265), which in turn had a contract with the Chicago Sun-Times (*id.* at 264). The arbitrator found that the claimant was not an employee of Four M and that, therefore, she was not an employee of the Sun-Times, either. *Id.* at 265-66. Because of those findings, the arbitrator held all other issues to be moot. *Id.* at 269.

¶ 99 Not only did the Commission in *Skzubel* adopt the arbitrator's finding of the lack of an employment relationship, but the Commission took up an issue the arbitrator never reached and on which the arbitrator had made no factual findings, namely, whether there was an accident. *Id.* at 266. The Commission wrote: " '*In addition to the* [*a*]*rbitrator's findings*, the Commission finds [that the claimant] fail[ed] to prove [an] accident.' " (Emphasis added.) *Id.* The appellate court overturned the finding of the lack of an employment relationship with Four M, concluding it was clearly apparent, from the evidence in the record, that the claimant was in fact an employee of Four M., and the appellate court remanded the case for reconsideration of whether

the claimant also was an employee of the Sun-Times. *Id.* at 268.

¶ 100 In remanding the case, the appellate court overturned "the Commission's cryptic finding that [the] claimant [had] failed 'to prove [an] accident.' " *Id.* at 269. The finding was cryptic because the arbitrator had passed over, as moot, the question of whether an accident had occurred. Thus, there were no underlying findings by the arbitrator on that question. The arbitrator and the Commission were required to make findings of fact and law. *Id.* Although findings could be implied from a decision by the Commission, such an implication was impossible in *Skzubel* because the decision was "so scant" on the question of whether an accident had occurred. *Id.* Therefore, the appellate court "vacate[d] the Commission's conclusory finding that [the] claimant [had] failed to prove [an] accident," and the appellate court remanded the case with directions to "make appropriate findings on this issue." *Id.* at 270.

¶ 101 In the other case that petitioner cites, the Commission disagreed with the arbitrator's assessment of credibility, but the Commission did not explain why. *R & D Thiel*, 398 Ill. App. 3d at 866. The appellate court stated:

> "[W]e are *** faced with the obligation of determining whether the Commission's credibility findings that are contrary to those of the arbitrator are against the manifest weight of the evidence. A resolution of the question can only rest upon the reasons given by the Commission for the variance. When the Commission gives no reasons for a contrary credibility determination, its decision may be lacking in findings that make meaningful judicial review possible; and in such cases, the appropriate remedy is to remand the matter to the Commission with directions to make the necessary findings." *Id.*

¶ 102 Both *R & D Thiel* and *Skzubel* are distinguishable. In the present case, the

Commission did not make "credibility findings that [were] contrary to those of the arbitrator." *Id.* Nor, in the present case, did the Commission address an issue that the arbitrator left unaddressed. *Cf. Skzubel*, 401 Ill. App. 3d at 269. Rather, the arbitrator made detailed factual findings on the issue of whether petitioner had sustained an occupational disease. Those findings equip us to answer the question posed by our deferential standard of review, namely, whether it is *clearly apparent* that the Commission should have believed petitioner's experts over Tri County's experts. See *McLean Trucking*, 96 Ill. 2d at 219 ("The Commission's determination of factual issues, including the resolution of conflicting medical evidence, and the credibility and weight of testimony, will not be disturbed unless against the manifest weight of the evidence."); *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64 (2006) ("Fact determinations are against the manifest weight of the evidence only when an opposite conclusion is clearly apparent—that is, when no rational trier of fact could have agreed with the agency.").

¶ 103 The answer to that question is no. The Commission might well have disbelieved Smith because (1) in the X-ray of October 9, 2009, he found opacities in all lung zones whereas, in the X-ray of March 28, 2012, he found opacities only in the middle and lower zones of the lungs and (2) by all accounts, CWP was a permanent, progressive disease. The Commission might well have believed Meyer, Selby, and Renn over Paul because they were B readers and Paul was not. See *Pavesi v. Director, Office of Workers' Compensation Programs, United States Department of Labor*, 758 F.2d 956, 958 n.1 (3d Cir. 1985).

¶ 104 III. CONCLUSION

¶ 105 For the reasons stated, we affirm the circuit court's judgment, confirming the Commission's decision.

¶ 106 Affirmed.