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2018 IL App (5th) 170361WC-U

FILED: October 2, 2018

NO. 5-17-0361WC

IN THE APPELLATE COURT

OF ILLINOIS

FIFTH DISTRICT

WORKERS' COMPENSATION COMMISSION DIVISION

MICHAEL D. WOOD,)	Appeal from
Appellant,)	Circuit Court of
v.)	Montgomery County
THE ILLINOIS WORKERS' COMPENSATION)	No. 17MR24
COMMISSION <i>et al.</i> (Centre Crown Mining, LLC,)	
Appellee).)	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 21, 2012, petitioner, Michael D. Wood, filed an application for adjustment of claim pursuant to the Workers' Compensation Act (820 ILCS 305/1 *et seq.* (West 2012)). He claimed benefits from his previous employer, Centre Crown Mining, LLC (Centre Crown). On February 10, 2016, after a hearing, the arbitrator found that (1) petitioner failed to

prove he had contracted the alleged occupational disease of coal workers' pneumoconiosis (CWP) and (2) the three-year period of limitation in section 6(c) of the Workers' Occupational Diseases Act (820 ILCS 310/6(c) (West 2012)) barred any claim arising from occupational diseases other than CWP. On January 17, 2017, the Illinois Workers' Compensation Commission (Commission) affirmed and adopted the arbitrator's decision, over a dissent. Petitioner sought judicial review. On August 28, 2017, the Montgomery County circuit court affirmed the Commission's decision, concluding 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 December 16, 2015. Substantially, the following evidence was adduced in the hearing.

¶ 5

A. Petitioner's Testimony

¶ 6

1. *His Career in Coal-Mining*

¶ 7

Petitioner was born on December 29, 1946, making him 68 years old as of the date of arbitration. He retired from coal mining on April 3, 2009, at age 62, not because of any impairment but simply because he had reached retirement age and was ready to retire. He had worked in the coal-mining industry for 27 years, and all of his work had been underground, where he was exposed to coal dust, silica dust, rock dust, and the fumes of roof bolt glue.

¶ 8

He began his coal-mining career in May 1977, with Consolidation Coal Company (Consolidation Coal), in Coffeen, Illinois. (Some of the years between 1977 and 2009 he spent in other occupations.) For the first six months at Consolidation Coal, he was a general laborer, cleaning up the conveyor belts and erecting posts to support the mine. Then, for about a year and a half, he was a belt man, a job that required him to move the belt toward the face of the mine as

the unit was moving and to withdraw the belt as the unit was withdrawing. Then he was a tubing man, which entailed running tubing from the continuous mining machine to the exhaust fan so the dust could be sucked up and sent down into the return air line.

¶ 9 In 1981, petitioner left Consolidation Coal and began working at Freeman United Crown Mine III, in Farmersville, Illinois. This mine went by several different names over the years, and eventually Centre Crown acquired it, but petitioner worked at this same mine until his retirement, in 2009. For the sake of simplicity, we will refer to this mine just as “Freeman.”

¶ 10 For his first 12 years at Freeman, petitioner was a roof bolter. His job was to drill holes into the roof of the mine and glue bolts or pins into the holes so that structures could be installed to support the roof. The drilling would make rock dust, and when pins broke, there would be an odor of epoxy glue. His next job at Freeman was as a mine examiner, a job he had for two years. His duties were to go through the mine before the beginning of each shift and inspect the faces and escape routes, check for gases and other dangerous conditions, and report any concerns to the mine manager. His final job at Freeman was that of a shuttle car operator, which entailed moving coal from the face of the mine, where it was being cut, and piling it onto the belts so it could be carried out of the mine. This was an especially dusty job, which he performed for the final five or six years of his coal-mining career.

¶ 11 Petitioner never again was employed after he retired from coal mining.

¶ 12 *2. His Reported Shortness of Breath*

¶ 13 Petitioner testified he first noticed a breathing problem when walking from his house to his barn. It was a distance of 100 yards, and he could not traverse it without pausing to catch his breath. Also, he found he was breathing heavily after walking a mile with his wife. He never had been a smoker.

¶ 14 Petitioner's treating physician was Phillip Johnson, and petitioner never mentioned his breathing problem to him. He discussed it only with Glennon Paul, a physician to whom his attorney had sent him.

¶ 15 In addition to his breathing problem—which, petitioner testified, had stayed about the same—he had an enlarged prostate gland, high blood pressure, and high cholesterol, all which were under control with medications. Also, in 2007, he underwent surgery for diverticulitis, and in 2011 he had a hip replacement.

¶ 16 B. The Testimony of Dr. Glennon Paul

1. *His Qualifications*

¶ 17 Dr. Glennon Paul was board-certified in internal medicine and in allergies and immunology. He was the medical director of the respiratory therapy department of St. John's Hospital, in Springfield, Illinois; the senior physician at Central Illinois Allergy and Respiratory Clinic; and a clinical assistant professor of medicine at Southern Illinois University School of Medicine. He read 15 to 20 chest X-rays per day. He had been treating coal miners since the 1970s. He denied, however, that he was either an A reader or a B reader, and he denied he was board-certified in pulmonary medicine. (An A reader, or first reader, is “a qualified and licensed physician who reads chest radiographs in the normal course of practice” but who has not passed the B reader examination. 42 C.F.R. §§ 37.51(a), 37.52(a). A B reader, or final reader (42 C.F.R. § 37.52(b)), is “a physician who has 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. Office of Workers' Compensation Programs, United States Department of Labor*, 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)).)

¶ 18 *2. The History He Obtained from Petitioner*

¶ 19 Paul examined petitioner once, on November 20, 2012, at the request of petitioner’s attorney. (By contrast, petitioner represents to us in his brief that Paul examined him on April 27, 2015, but because respondent provides a supporting citation to the record whereas petitioner does not do so, we will accept respondent’s representation that Paul examined petitioner once, on November 20, 2012. See Ill. S. Ct. R. 341(h) (eff. Nov. 1, 2017) (“Statement of Facts, which shall contain the facts necessary to an understanding of the case, stated accurately and fairly ***, and with appropriate reference to the pages of the record on appeal ***.”).) Petitioner told him he had been a coal miner for 27 years and that he coughed from time to time and had shortness of breath on exertion.

¶ 20 *3. The Results of His Pulmonary Function Testing*

¶ 21 According to Paul, pulmonary function testing revealed that petitioner had a mild restrictive lung disease. The diffusing capacity of his lungs, their capacity to bring oxygen into the bloodstream, was moderately decreased.

¶ 22 *4. His Interpretation of the Chest X-Ray*

¶ 23 Paul had petitioner undergo a chest X-ray, in which Paul found fibronodular lesions, *i.e.*, CWP, throughout both lung fields.

¶ 24 On cross-examination, respondent’s attorney asked Paul:

“Q. Do you know what type of opacity was present on the film?

A. Coal dust opacity. When you have a round one, they coalesce[,] and then you have an oblong one, and when you have a round one that you coalesce

with two other round ones, you might have a square one. So[,] it really doesn't make much difference except that you know that there's coal dust in the lungs.

Q. Do you know what profusion the film revealed?

A. You're talking about how much the film was overloaded with coal dust particles?

Q. The concentration of small opacities in the affected areas of the lungs.

A. I didn't measure that. They were just all over the place."

¶ 25

5. His Diagnosis

¶ 26

Paul diagnosed CWP, and he opined that petitioner probably had it at the time he retired from coal mining. This was, according to Paul, a clinically significant, radiographically apparent, and physiologically significant pulmonary impairment resulting from the inhalation of coal dust and glue fumes, and it was permanent and incurable. Not only did the disease, in its present level of severity, totally disable petitioner from working any longer as a coal miner, but the disability could become worse over time. Because coal dust remained trapped in the lungs, the CWP could continue to progress. Macules, or spots, could continue to form around the trapped coal dust, scarring the lungs more and more—even if petitioner never again inhaled coal dust. Regardless of whether this pulmonary impairment was detectable by spirometry (Paul found it was), the lungs necessarily were impaired at any sites of scarring. The fibrotic or scarred areas of the lungs were nonfunctional; they were incapable of absorbing oxygen into the bloodstream.

¶ 27

Paul testified that even if these fibrotic areas were undetectable in X-rays (he, however, detected them in an X-ray), they still might be found in a biopsy or autopsy. Negative X-rays did not negate the existence of CWP. Also, pneumoconiosis might be found by a

pulmonary function study, physical examination, or biopsy that was not found radiographically.

¶ 28 In Paul’s opinion, petitioner had CWP, restrictive lung disease, and reduced carbon monoxide diffusing capacity, all of which Paul attributed to the 27 years petitioner had worked in coal mines.

¶ 29 C. The Testimony of Dr. Henry K. Smith

¶ 30 1. *His Qualifications*

¶ 31 Henry K. Smith was a board-certified radiologist and a B reader.

¶ 32 In petitioner’s chest X-ray of March 7, 2012, “Dr. Smith found interstitial fibrosis, p/s, mid to lower zones bilaterally, profusion 1/0,” to quote from petitioner’s brief. He rated the technical quality of the X-ray as 2. These notations or symbols that Smith used came from the radiographic classification system of the 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).

¶ 33 Under the ILO system, the first thing a reader of the X-ray must do is rate the technical quality of the X-ray. See 20 C.F.R. § 718.102(a). A technical quality of 2 means that the X-ray is “[a]cceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis.” ILO, *supra*, § 3.1, at 3.

¶ 34 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.*

¶ 35 The letter p signifies small, rounded opacities with diameters up to about 1.5 millimeters, and the letter s signifies small, irregular opacities with widths 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. Thus, by writing “p/s,” Smith signified that most of the small opacities were rounded and had diameters up to about 1.5 millimeters but that he also found a significant, though lesser, quantity of small opacities that were irregular in shape and were up to 1.5 millimeters in width. See *id.* at 5-6. (If he had found *only* small, rounded opacities with diameters up to 1.5 millimeters, the ILO system would have instructed him to write “p/p.” See *id.* at 6.)

¶ 36 The reader must note where in the lungs he or she found these 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 and s opacities in the middle third and bottom third of the lungs.

¶ 37 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 areas of the lung.” (Emphasis in original.) *Id.* at 3. The ILO has issued standard radiographs 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.*

¶ 38 In the description of profusion, the reader is supposed to use the forward slash again. The numerator is the category of profusion on which the reader has finally 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.*

¶ 39 So, again, 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 the 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 would describe the profusion of small opacities as 1/0—as Smith described it. See *id.* In other words, Smith ultimately called the X-ray of March 7, 2012, a 1 for profusion but seriously considered calling it a 0 (or a normal X-ray) before deciding it was a 1.

¶ 40 Also, Smith interpreted a computerized axial tomography (CT) scan of petitioner's chest, dated May 12, 2008. According to his interpretation, it showed CWP with small, rounded (p) opacities and, in all lung zones, a profusion of 1/0 to 1/1.

¶ 41 D. Records from the National Institute

¶ 42 Records from the National Institute were admitted in evidence. (Through the Coal Workers' Health Surveillance Program, coal miners can obtain periodic chest radiographs. The National Institute has administered the program since its inception, in 1970. www.cdc.gov/niosh/topics/cwhsp/default.html.)

¶ 43 Petitioner was administered a chest X-ray on April 14, 1997, and an A reader and a B reader both interpreted it as completely negative.

¶ 44 Two B readers interpreted a chest X-ray of February 29, 1996, as completely negative.

¶ 45 One B reader interpreted a chest X-ray of August 21, 2000, as completely negative. Another B reader interpreted the X-ray as negative for pneumoconsiosis, profusion 0/1, with t/t opacities in all zones of the lungs. (The letter t signifies small, irregular opacities with

widths exceeding about 1.5 millimeters and up to 3 millimeters. ILO, *supra*, § 3.2, at 5.)

¶ 46 Two B readers interpreted a chest X-ray of September 7, 2005, as showing no parenchymal or pleural abnormalities consistent with pneumoconiosis. (The pleura are a pair of membranes lining the thorax and enveloping the lungs.)

¶ 47 Two B readers interpreted a chest X-ray of May 8, 2007, as showing no abnormalities consistent with pneumoconiosis.

¶ 48 E. The Testimony of Dr. Cristopher Meyer

¶ 49 1. *His Qualifications*

¶ 50 Cristopher Meyer earned his certification in radiology in 1992, and he had been a B reader since 1999. He had taught thoracic imaging at the University of Maryland and the University of Cincinnati. He still taught interventional radiology and the interpretation of chest X-rays, CT scans, and high-resolution CT scans. Since 2000, he had served as an examiner on the American Board of Radiology. He was on the committee tasked with writing the new examination for radiology residents. He wrote examination questions.

¶ 51 Meyer further testified:

“I also have served on several educational and scientific committees, including the scientific program committee for the Radiology Society of North America and the American Roentgen Ray Society, which involved reviewing the scientific abstracts that are submitted for their annual meetings and deciding which are of high enough merit to be presented. I’ve done the same scientific sessions committee for the Society of Thoracic Radiology between 2005 and 2009. I am on the American College of Radiology Guidelines and Standards Committee for Thoracic Radiology and chairman of the Rules Committee for the

Society of Thoracic Radiology. I'm a past member of the North American Society of Cardiovascular Imaging[,] serving on their curriculum committee to define the recommended curriculum for radiology residents.

Q. You've done research through the years; is that correct?

A. That is correct.

Q. *** Just give us a flavor of the research you've done through the years as it relates to occupational lung disease.

A. Sure. So[,] I have worked with the occupational lung physicians at the University of Cincinnati[,] and much of the occupational lung research that I've done has been in regard to asbestosis, and specifically related to asbestos claims from Libby, Montana. I was also involved in a very large research project reviewing over 700 chest X-rays for Dr. Franzblau from the University of Michigan, comparing the use of digital radiography and analog or regular conventional chest X-rays in the classification system of occupational lung disease. I traveled to South Africa to do research on silica versus TB in gold miners this summer.

On the academic side, I have spent much of my career working and publishing in interstitial lung disease, of which occupational lung disease is one subcategory, *** and I have written a book chapter on occupational lung disease.”

¶ 52

2. His Findings

¶ 53

At the request of Centre Crown, Meyer interpreted three X-rays and two CT scans of petitioner's chest. He testified he examined all of the films at one time, in a series.

¶ 54

The first X-ray was from May 8, 2007. He rated it as having a technical quality of

3 due to underexposure, poor contrast, artifacts (artificial distortions), and its being a copy. Even so, the X-ray was of diagnostic quality, and in his interpretation, it showed no evidence of CWP. See *id.*, § 3.1, at 3 (defining a grade 3 technical quality as “[a]cceptable, with some technical defect but still adequate for classification purposes”).

¶ 55 The second X-ray was from February 16, 2012. He rated its technical quality as 2 due to under-inflation. See *id.* (defining a grade 2 technical quality as “[a]cceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis”). It showed an atherosclerotic calcification (hardening) in the thoracic aorta and some degenerative spurring of the spine—but no CWP. The lungs appeared to be essentially clear.

¶ 56 The third X-ray was from March 7, 2012. He rated its technical quality as 2 due to poor contrast and mottling. It showed no lymphadenopathy (disease affecting the lymph nodes) and no CWP.

¶ 57 One of the CT scans was from May 12, 2008. Because it was taken at two-millimeter intervals (too large of an interval, in Meyer’s view) and because it showed only the base of the lungs, he regarded it as of limited use in an evaluation for the presence or absence of CWP. It showed a right lower lobe calcified granuloma (grainy scar tissue) and a four-millimeter left lower lobe non-calcified nodule. There were calcified hilar and subcarinal lymph nodes, which also were consistent with granulomatous disease. Otherwise, the bases of the lungs appeared normal.

¶ 58 The other CT scan, taken on November 6, 2008, was essentially identical to the one taken on May 12, 2008. It showed no CWP—but, again, “[t]he CT scans, because they were limited to the bases, couldn’t rule out CT-detectable CWP in the upper lobes.”

¶ 59 3. *His Policy of Refraining from Reviewing Other Medical Records*

¶ 60 Meyer testified that most B readers preferred not to know everything about a patient, because their task was solely to look at the X-ray and decide whether it showed anything consistent with CWP. He believed that if a B reader received additional medical information, such as the patient's history, the results of pulmonary function testing, and the measurements of blood gases, it might bias his or her interpretation of the X-ray.

¶ 61 *4. The Hardest Part of the B Reader Examination*

¶ 62 Meyer testified that the B reader examination was six hours long and was made up of 120 X-rays to categorize. Radiologists, occupational physicians, and pulmonologists were the three main groups of doctors who took the examination, and the pass rate was 60%.

¶ 63 The "critical component" of the examination, the most difficult part, was distinguishing between a profusion of 1/0 and a profusion of 0/1. Respondent's attorney asked Meyer:

"Q. Is that a point of emphasis in the class as well?"

A. Absolutely. Typically[,] there are multiple examples of zero over one and one over zero, trying to help all the physicians train their eyes to that abnormality. In fact, even in the syllabus they emphasize that it is one of the most challenging distinctions to be made in the field of radiology."

¶ 64 *F. The Testimony of Dr. Jeffrey W. Selby*

¶ 65 *1. His Qualifications*

¶ 66 Jeffrey W. Selby was board-certified in medicine and pulmonology and had been a B reader since 1985. He had a general pulmonary practice, which included the treatment of CWP and other occupational lung diseases.

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

¶ 68 At the request of Centre Crown, Selby examined petitioner and reviewed the chest X-rays taken on May 8, 2007, and February 16 and March 7, 2012, as well as the CT scans.

¶ 69 He rated the X-ray from May 8, 2007, as having a technical quality of 2 due to under-inflation, and in it, he found calcified and non-calcified granulomas but no CWP. He likewise rated the X-ray of March 7, 2012, as having a technical quality of 2 due to under-inflation. Again, he found granulomas but no CWP. He found no CWP in any of the X-rays or CT scans. In addition to reviewing the X-rays and CT scans already taken, Selby caused a new chest X-ray to be taken, on April 24, 2013. It likewise showed no parenchymal or pleural abnormalities consistent with CWP.

¶ 70 *3. Pulmonary Function Testing*

¶ 71 Selby testified he also reviewed the records of pulmonary function testing that petitioner underwent on April 29, 2005. The results of the exercise testing were what Selby would have expected from a normal, healthy, 66-year-old male. Petitioner had normal lung volumes and normal diffusion capacity. His spirometry was normal.

¶ 72 *4. Selby's Opinion on Petitioner's Ability to Work*

¶ 73 In Selby's opinion, petitioner was capable of heavy manual labor, and he did not suffer from any respiratory or pulmonary abnormality as a result of inhaling coal dust in his career as a coal miner. He had the respiratory and pulmonary capacity to perform any and all of his previous coal mine duties, including his last job as a shuttle car operator. Petitioner was obese and out of shape, which, Selby suggested, contributed to his shortness of breath on exertion. Even being out of shape, though, he showed no cardiac or pulmonary limitations in the exercise test.

¶ 74 Selby admitted, however, that, notwithstanding the results of his examination, it

was possible that petitioner had CWP. Selby just had not found any evidence of it.

¶ 75 G. Petitioner's Medical Records

¶ 76 Centre Crown introduced petitioner's medical records in evidence.

¶ 77 An entry of August 13, 2012, by a primary-care physician, Dr. Johnson, included a notation of "Black Lung Disease."

¶ 78 A treatment CT scan of the abdomen, dated April 10, 2007, revealed "some scattered atelectatic or fibrotic changes" in the "lung bases," calcified granulomas in the right lower lobe, and a three-millimeter non-calcified indeterminate pulmonary nodule in the left lower lobe. (Atelectasis is a partial or complete collapse of the lungs.)

¶ 79 An entry of July 22, 2007, noted subsegmental atelectasis, fibrosis, or both in a chest X-ray taken that day.

¶ 80 An entry of May 22, 2007, referred to a CT scan taken of the abdomen on May 19, 2007, which showed a three-millimeter pulmonary nodule in the left lung.

¶ 81 A CT scan of May 12, 2008, showed evidence of prior granulomatous disease and a non-calcified pulmonary nodule in the base of the left lung.

¶ 82 A CT scan taken on November 6, 2008, showed a pulmonary nodule in the posterolateral left lower lung, a seven-millimeter calcified granuloma in the posterior right lung base, and a four-millimeter non-calcified pulmonary nodule in the posterolateral left lower lung.

¶ 83 According to records from Litchfield Family Practice, petitioner was diagnosed with sinusitis in 1999 and 2013, bronchitis in 1999 and 2000, and an upper respiratory infection in 2007.

¶ 84 II. ANALYSIS

¶ 85 This case was a typical battle of the experts.

¶ 86 Petitioner asserts: “The opinions of Dr. Paul, [petitioner’s] expert; Dr. Johnson, [petitioner’s] primary care physician; and b-reader/radiologist Dr. Smith are more credible than the opinions of Dr. Meyer and Dr. Selby. *** [P]etitioner has CWP.” Petitioner gives reasons why, in his view, we should believe Paul, Johnson, and Smith over Meyer and Selby.

¶ 87 We lack authority, however, to make a *de novo* assessment of credibility. *Dig Right In Landscaping v. Illinois Workers Compensation Comm’n*, 2014 IL App (1st) 130410WC, ¶ 29. “It is for the Commission to judge the credibility of witnesses, including expert witnesses [citation], and where conflicting medical testimony is presented[,] it is for the Commission to determine which testimony is to be accepted.” *Martin v. Industrial Comm’n*, 91 Ill. 2d 288, 294 (1982).

¶ 88 This is not to suggest that the credibility of a medical expert is absolutely unassailable on review regardless of what the medical expert said on the witness stand. Our standard of review is to ask whether the Commission’s findings of fact are against the manifest weight of the evidence—and that includes the Commission’s finding that some medical experts were more credible than others. See *McLean Trucking Co. v. Industrial Comm’n*, 96 Ill. 2d 213, 219 (1983) (“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.”). But the manifest weight of the evidence is a substantially deferential standard of review. 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.”). Even if we ourselves believed Paul, Johnson, and Smith over Meyer and Selby, that would not be enough to justify overturning the Commission’s

determination of credibility (see *Benson v. Industrial Comm'n*, 91 Ill. 2d 445, 450 (1982)); instead, we would have to be able to say, without exaggeration, that it was *arbitrary* and *unreasonable* of the Commission to believe Meyer and Selby over Paul, Johnson, and Smith (see *Enbridge Energy (Illinois), L.L.C. v. Kuerth*, 2018 IL App (4th) 150519-B, ¶ 62).

¶ 89 Petitioner argues that, for eight reasons, we ought to disbelieve Meyer and Selby.

¶ 90 First, petitioner argues that Meyer's reading of the X-ray taken on May 8, 2007, is irrelevant because the X-ray was taken two years before petitioner's last exposure to coal dust and four years before the running of the two-year period of limitation in section 1(f) (820 ILCS 310/1(f) (West 2012)) and because, as Meyer admitted, CWP can first appear in an X-ray during the last month of coal-mine exposure. Petitioner argues that the National Institute's readings are irrelevant for the same reason: they were of X-rays taken years before he retired.

¶ 91 Arguably, however, the preretirement X-ray readings had *some* relevance even though they were not dispositive. After all, the primary issue in the case was whether petitioner had CWP, and the preretirement readings tended to make it less probable that he had CWP *when those X-rays were taken*. See 50 Ill. Adm. Code § 9030.70(a) (2016); Ill. Rs. Evid. 401, 402 (eff. Jan. 1, 2011). In any event, this evidentiary issue is relatively unimportant, considering that Meyer looked not only at the X-ray of May 8, 2007, but also at four other X-rays, including those taken on February 16 and March 7, 2012. Petitioner retired from coal-mining in April 2009, so two of the X-rays that Meyer reviewed were taken some three years after petitioner's retirement—and Meyer found no CWP in them, either.

¶ 92 Second, petitioner notes that the CT scans “caught the bases of the lungs and revealed calcified granulomas in the right lower lobe and a tiny non-calcified indeterminate pulmonary nodule in the left lower lobe three millimeters in size.” The significance of this

information is unclear. Petitioner cites no evidence of any link between granulomatous disease and CWP. See Ill. S. Ct. R. 341(h)(7) (eff. Nov. 1, 2017) (“Argument, which shall contain the contentions of the appellant and the reasons therefor, with citation of the authorities *and the pages of the record relied on.*” (Emphasis added.)). By our information, granulomatous disease is a genetic disorder in which certain immune cells are dysfunctional and unable to ward off infections from some kinds of bacteria and fungi. See MEDLINEplus Health Information, Medical Encyclopedia: Chronic Granulomatous Disease (available at <http://www.nlm.nih.gov/medlineplus/ency/article/001239.htm> (a service of the United States National Library of Medicine and the National Institutes of Health)); *People v. Vara*, 2016 IL App (2d) 140849, ¶ 37 n.3 (taking judicial notice of a public website maintained by the United States government). As for the “tiny non-calcified indeterminate pulmonary nodule in the left lower lobe three millimeters in size,” “indeterminate” means “from which a diagnosis of the underlying cause cannot be made.” New Oxford American Dictionary 863 (2001). That is, it is unknown whether inhaling coal dust caused the pulmonary nodule. It is unknown what caused it.

¶ 93 Third, petitioner argues that although Meyer and Selby both interpreted the X-rays and CT scans as being negative for CWP, Meyer and Selby “were inconsistent in their interpretations of the films.” Meyer gave the X-ray of May 8, 2007, a quality rating of 3 due to underexposure, poor contrast, the presence of artifacts, and its being a copy, whereas Selby gave the X-ray a quality rating of 2 due to under-inflation. Also, Selby found granulomas in the X-ray, whereas Meyer mentioned no granulomas. Although Meyer and Selby gave the same quality rating of 2 to the X-ray of March 7, 2012, they gave different reasons for that rating: Meyer said it was because of poor contrast and mottling, whereas Selby said it was because of under-inflation. And, again, Selby found granulomas, which Meyer did not mention. Similarly, Meyer

and Selby both gave the X-ray of February 16, 2012, a quality rating of 2, but their reasons were not entirely identical: Meyer said it was because of under-inflation, whereas Selby said it was not only because of poor inspiration (which sounds like under-inflation) but also because of an elevated right hemi-diaphragm. And, yet again, Selby found granulomas, whereas Meyer did not mention granulomas.

¶ 94 We disagree that the Commission *had* to disbelieve Meyer and Selby because of these discrepancies. A quality rating of an X-ray is not an *interpretation* of the X-ray, and the difference between a quality rating of 2 or 3 and the reasons for a quality rating could be, to some extent, in the eye of the beholder. As for the granulomas, Meyer could have chosen not to mention them because (1) his task was to evaluate the X-rays for CWP and the granulomas had nothing to do with CWP and (2) he regarded the granulomas as medically insignificant.

¶ 95 Fourth, petitioner criticizes Meyer and Selby for “rel[ying] on only a few medical records, and ignor[ing] other records.” He argues: “When an expert fails to take a patient history which is central to CWP, chronic bronchitis, COPD, asthmatic bronchitis/hyper-reactive airways disease, and emphysema, 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.”

¶ 96 More precisely, the appellate court held in *Wilhoite*: “If the expert’s opinion is without proper foundation, particularly where he fails to take into consideration an essential factor, that opinion is of no weight and must be disregarded.” (Internal quotation marks omitted.) *Id.* Surely, the X-rays were a “proper foundation” for Meyer’s and Selby’s opinions. *Id.* Even petitioner’s experts relied on X-rays when diagnosing him with CWP. Contrary to petitioner’s

argument, the Commission did not have to find that the other medical records were “essential.”

Id. Rather, the Commission could have believed Meyer when he testified it was best for a B reader to avoid looking at any other medical records, so that his or her objectivity in interpreting the X-ray would not be compromised.

¶ 97 Selby seemed to agree with that policy. He was asked:

“Q. Okay. Now, is it true that when you have been given medical records on a miner to review, as well as you’re going to have an examination of him, that it’s your standard practice that you will complete your examination, as well as your report, based on examination prior to looking at the treatment records in order to assure that your opinions aren’t biased by anything that may be contained in these records?

A. That tends to be my standard.”

So, on this view, not only are medical records other than X-rays unessential to a B reader; they threaten the objectivity of the B reader’s analysis.

¶ 98 Besides, if the medical records showed that petitioner suffered at times from asthma and bronchitis, it is unclear what those conditions have to do with CWP. Asthma and bronchitis affect the bronchi of the lungs, whereas, according to Meyer’s testimony, CWP typically afflicts the upper zones of the lungs themselves. Selby testified: “And, obviously, with coal-mine dust, the primary problem there is going to be chronic industrial bronchitis, which virtually never causes significant, long-lasting obstructive lung disease and goes away within a few weeks after removal from the source.”

¶ 99 Fifth, petitioner argues: “[T]he universal testimony is that while a positive X-ray reading is sufficient for a diagnosis of CWP, a negative reading can never rule out the existence

of CWP in a miner. Dr. Paul testified that a negative reading does not rule out the existence of CWP that could be found at biopsy or autopsy.” But there was no biopsy or autopsy, and the germane question is not whether CWP was *ruled out* but whether it was *proved*. A theoretical possibility of CWP will not suffice. The burden was not on Centre Crown to disprove the possibility of an occupational disease; rather, the burden was on petitioner to affirmatively prove the occupational disease. See *Payne v. Industrial Comm’n*, 61 Ill. 2d 66, 69 (1975). The experts differed on whether the X-rays proved CWP, and, again, “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.

¶ 100 Sixth, petitioner argues that Paul was more qualified and more credible than either Meyer or Selby because although Paul was not a B reader, he had been the director of respiratory therapy at St. John’s Hospital for 40 years, the first 10 of which he simultaneously was the director of respiratory therapy at Memorial Hospital, Springfield’s only major hospital at the time. He had a lot of experience performing black-lung examinations, and instead of limiting himself to reading the X-rays, he performed a black-lung examination in this case.

¶ 101 Even so, we cannot say it is “clearly evident” that the Commission should have believed Paul over Meyer and Selby. *Ghere v. Industrial Comm’n*, 278 Ill. App. 3d 840, 847 (1996). It is not our place to decide how much weight to give to Paul’s testimony compared to the testimony of Meyer and Selby; that decision is reserved for the Commission. See *id.* Granted, Paul had his accomplishments, but, unlike Selby, he lacked a board certification in pulmonary medicine, and not only was he not a B reader, but he appeared, in his testimony, to be unversed in the ILO system of radiographic classification—which, judging from the federal regulations (20 C.F.R. § 718.102(d)(1)), is the standard system to use when reading X-rays for the presence

of pneumoconiosis. The Commission could have reasonably found that, absent a biopsy or autopsy, radiographic examination was the most accurate way of detecting CWP (see *id.*) and that Meyer and Selby were more believable than Paul because their proficiency in interpreting radiographs for the presence or absence of CWP had been objectively confirmed through the B-reading examination. See *Pavesi v. Director, Office of Workers' Compensation Programs, United States Department of Labor*, 758 F.2d 956, 958 n.1 (3d Cir. 1985) (triers of fact may reasonably regard B readers as having greater expertise than A readers in evaluating X-rays for the presence of pneumoconiosis).

¶ 102 Seventh, petitioner argues that the Commission should have believed Smith over Meyer because (1) unlike Meyer, Smith had never failed the B-reading examination and (2) Smith had more experience as a B reader than Meyer. Again, we are unpersuaded that we have the right to take over the assessment of credibility. See *id.* We have recounted Meyer's professional background in some detail to show that a reasonable trier of fact could be impressed enough to find Meyer to be the more believable expert. The arbitrator wrote: "[T]he [a]rbitrator finds the testimony of Dr. Meyer insightful, informative, and persuasive. His background and experience in radiology, B-reading[,] and [CWP] were impressive and beyond that of [p]etitioner's physician, Dr. Paul, who is not a B-reader." We cannot characterize that assessment as arbitrary or unreasonable.

¶ 103 Eighth, petitioner asserts that "Selby has a problem with the basis of his opinions." Specifically, petitioner claims that the bases of Selby's opinions are flawed in two ways. For one thing, Selby "disagrees with the U.S. Department of Labor (DOL), NIOSH, and the American Thoracic Society (ATS) regarding the role of coal mine exposures to the development of obstructive lung disease versus the role of exposure to cigarette smoke." Selby

opined that in “the tri-state area,” where coal was softer, the risk of contracting chronic obstructive pulmonary disease from inhaling mine dust was not nearly as great as the risk of contracting it from smoking cigarettes. He testified: “I just know that in the course of treating hundreds or thousands of coal miners over the last 25 years or so, it rarely occurs that someone has chronic obstructive pulmonary disease purely from coal mining.” But this difference that Selby perceived between the international studies and his own experience in “the tri-state region,” where he practiced, was not a *basis* he offered for his opinion in the present case; instead, it was something that petitioner’s attorney brought up on cross-examination.

¶ 104 Petitioner further criticizes Selby for “us[ing] the Knudson predicted values for pulmonary function testing rather than the values of [the National Health and Nutrition Examination Study III (NHANES III)], as required by the [American Medical Association (AMA)].” Selby testified, however, as follows:

“Q. So it’s possible that some very good labs may use a predicted equation that’s different than the NHANES III, different from the one that might be recommended by the AMA or the American Thoracic Society, and that would be okay?

A. Right.”

The Commission might well have believed Selby in this respect. As we said, “[i]t is for the Commission to judge the credibility of witnesses.” *Martin*, 91 Ill. 2d at 294.

¶ 105 Besides, using one set of predicted values over another would not have changed the objective contents of the X-rays—and the Commission may well have viewed this case as turning on the X-rays. This would be a defensible view. 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 ***.”).

¶ 106

III. CONCLUSION

¶ 107

For the reasons stated, we affirm the circuit court’s judgment, confirming the Commission’s decision.

¶ 108

Affirmed.