ILLINOIS OFFICIAL REPORTS

Appellate Court

***Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*, 2013 IL App (5th) 120564WC**

Appellate Court Caption	FREEMAN UNITED COAL MINING COMPANY, Appellant, v. THE ILLINOIS WORKERS' COMPENSATION COMMISSION *et al.* (David Sims, Appellee).
District & No.	Fifth District Docket No. 5-12-0564WC
Rule 23 Order filed	September 30, 2013
Motion to publish granted	October 28, 2013
Opinion filed	October 28, 2013
Held (*Note: This syllabus constitutes no part of the opinion of the court but has been prepared by the Reporter of Decisions for the convenience of the reader.*)	The finding of the Illinois Workers' Compensation Commission that claimant proved that he suffered from coal workers' pneumoconiosis and that the disease was causally connected to his work as a coal miner for over 30 years was upheld on appeal, since the Commission's decisions that claimant suffered from an occupational disease arising from exposure to the hazards of coal mining, that he was disabled within the statutory time frame, and that he was permanently partially disabled to the extent of 10% of the person as a whole were not against the manifest weight of the evidence.
Decision Under Review	Appeal from the Circuit Court of Christian County, No. 12-MR-56; the Hon. Bradley T. Paisley, Judge, presiding.
Judgment	Affirmed.

Counsel on Appeal	Julie A. Webb and Kenneth F. Werts, both of Craig & Craig, LLC, of Mt. Vernon, for appellant. Bruce R. Wissore, of Culley & Wissore, of Harrisburg, for appellee.
Panel	JUSTICE HUDSON delivered the judgment of the court, with opinion. Presiding Justice Holdridge and Justices Hoffman, Harris, and Stewart concurred in the judgment and opinion. Justice Hoffman specially concurred, with opinion, joined by Presiding Justice Holdridge and Justice Stewart.

OPINION

¶ 1 On December 19, 2007, claimant, David Sims, filed an application for adjustment of claim pursuant to the Workers' Occupational Diseases Act (Act) (820 ILCS 310/1 to 27 (West 2006)) seeking benefits from respondent, Freeman United Coal Mining Company. In his application, claimant alleged that as a result of inhaling coal-mine dust, he experiences shortness of breath and exercise intolerance. Following a hearing, the arbitrator denied benefits, finding that claimant failed to prove by a preponderance of the evidence that he suffers from an occupational disease which arose out of and in the course of his employment with respondent. The Illinois Workers' Compensation Commission (Commission) reversed, finding that claimant met his burden of proving he has coal workers' pneumoconiosis (CWP) and that the disease is causally connected to his employment as a coal miner. The Commission further determined that claimant established disablement within two years after the date of his last exposure to the hazards of the occupational disease (see 820 ILCS 310/1(f) (West 2006)) and that claimant provided timely notice of the disablement to respondent (see 820 ILCS 310/6(c) (West 2006)). The Commission awarded claimant 50 weeks of permanent partial disability (PPD) benefits, representing 10% of the person as a whole (see 820 ILCS 305/8(d)(2) (West 2006); 820 ILCS 310/7 (West 2006)). The circuit court of Christian County confirmed the decision of the Commission. On appeal, respondent contends that the Commission's findings are against the manifest weight of the evidence. In particular, respondent challenges the findings that claimant has an occupational disease, that he proved disablement within the statutory time frame, and that claimant is permanently partially disabled to the extent of 10% of the person as a whole. We affirm.

¶ 2 I. BACKGROUND

¶ 3 The following factual recitation is taken from the evidence presented at the arbitration hearing held on February 8, 2011. Claimant worked as an underground coal miner for approximately 31 years, beginning in 1977. During his career as a coal miner, claimant held a variety of positions, including those of laborer, roof bolter, miner operator, shuttle-car operator, and parts runner. In these positions, claimant was regularly exposed to various substances, including coal and rock dust, diesel fumes, and glue fumes. In the late 1990s, claimant noticed a change in his breathing while working in the coal mines, especially with heavy lifting and while walking long distances.

¶ 4 Claimant last worked for respondent on August 30, 2007, when he was laid off after the mine in which he worked was closed. At that time, claimant was 52 years old. Claimant testified that but for the mine closing, he would have reported to work for his next shift. Claimant retained his panel rights after being laid off, but was never recalled. At the end of 2007, claimant withdrew from the panel and began to draw a regular retirement pension.

¶ 5 At the time of the arbitration hearing, claimant continued to experience breathing problems. Claimant stated that he notices a change in his breathing after walking only about one block and that he has to stop after walking only three blocks. Claimant also stated that he can climb only about two flights of stairs before he notices changes in his breathing. Claimant testified that he smoked "occasionally" until 1996 or 1997, at which time he began to smoke half a pack of cigarettes per day. Since retiring from coal mining, claimant has worked at a small-engine repair shop he owns and as a part-time truck driver. Claimant testified that he has never held a job that did not involve manual labor and that he does not know how to type or use a computer.

¶ 6 Dr. Robert Cohen examined claimant on April 8, 2008. Dr. Cohen is a senior attending physician at Stroger Hospital of Cook County, the medical director of the hospital's pulmonary physiology and rehabilitation section, the medical director of the hospital's black lung clinic, and the medical director of the National Coalition of the Black Lung and Respiratory Disease Clinic. Dr. Cohen has been a B-reader since 1998. Dr. Cohen testified that claimant presented with complaints of dyspnea on exertion which interfered with activities such as lawn mowing, leaf raking, shoveling, and carrying timber. Claimant described these symptoms as being present for five years prior to the date he saw Dr. Cohen. Claimant also related that he was only able to walk about five blocks before becoming short of breath. In addition, claimant reported a cough with sputum production nearly every day for the last 10 years. According to the history given to Dr. Cohen, claimant started smoking at age 39 and had a 10-pack-year history of smoking. Claimant denied taking any breathing medication.

¶ 7 Upon physical examination, Dr. Cohen noted a few inspiratory rhonchi that were heard over the right lower lobe which did not clear upon coughing. Dr. Cohen attributed the inspiratory rhonchi to scarring of the lungs. Dr. Cohen administered resting and exercise pulmonary function testing. The resting pulmonary function testing was normal with the exception of a mild diffusion impairment. The resting arterial gases were normal. Dr. Cohen testified that the cardiopulmonary exercise test was a maximal test as indicated by the fact

that claimant had some acidosis at peak exercise. The work capacity was "low normal" at 84% of claimant's reference value adjusted for body weight. Claimant had a high breathing reserve with a normal breathing frequency, and the indices of gas were normal. Claimant did not have a ventilatory limit to exercise. Dr. Cohen read a quality two chest X ray dated March 28, 2008, as positive for pneumoconiosis, category 1/0, with q/r-shaped opacities in all lung zones. Dr. Cohen made an identical interpretation on a chest X ray dated October 3, 2007.

¶ 8 Dr. Cohen testified that based on his evaluation of claimant, and within a reasonable degree of medical certainty, claimant has CWP which was caused by his 31 years of exposure to coal-mine dust. Dr. Cohen also diagnosed chronic bronchitis caused by claimant's exposure to coal-mine dust and his tobacco use. Dr. Cohen opined that, based on the diagnosis of CWP, claimant could not have any further exposure to coal-mine dust without endangering his health. Further, Dr. Cohen advised claimant not to work in any job where he will be exposed to pulmonary toxins, such as coal-mine dust or any other smoke, dust, or fumes.

¶ 9 On cross-examination, Dr. Cohen testified that he examined claimant on one occasion and that he did not review any of claimant's treatment records. Dr. Cohen admitted that claimant did not present to him with a past history of black lung and that claimant never represented that he left coal mining due to breathing problems or upon the advice of a physician. Dr. Cohen also stated that he would not have diagnosed claimant with black lung absent the positive reading of his films. Dr. Cohen acknowledged that exertional dyspnea can be due to many causes, including deconditioning and cardiac pulmonary anxiety. He further acknowledged that smoking can be associated with cough, sputum, and shortness of breath. He also noted that smoking is associated with a reduction in diffusing capacity when it causes lung disease. Dr. Cohen could not say that the results from testing on claimant were reduced from what they were 30 years prior.

¶ 10 Dr. Henry Smith, a board-certified radiologist and certified B-reader, interpreted a chest X ray of August 17, 2006, as positive for pneumoconiosis, category 1/0, with p/s opacities in the mid- to lower-lung zones. Dr. Smith interpreted the chest X ray of October 3, 2007, as positive for CWP, category 1/1, with s/p opacities in all lung zones.

¶ 11 At respondent's request, Dr. Jerome Wiot reviewed claimant's radiographic films. Dr. Wiot is a physician and diagnostic radiologist. He is board certified in radiology and a certified B-reader. Dr. Wiot was the past president of the American Board of Radiology and served as an examiner for the board. Dr. Wiot was also the past president of the American College of Radiology, and, as a member of the Task Force on Pneumoconiosis, he helped develop a weekend symposium which eventually became the modern day B-reader program. Dr. Wiot testified that he has been teaching the B-reading program since the first weekend the course was held in 1970. Dr. Wiot testified that according to government statistics, for those individuals who do not pass the B-reading examination, the most common reason is over-reading, which means that the reader sees something that is not there. Dr. Wiot therefore reasoned that experience is very important in reading chest X rays to understand what is normal and what is abnormal.

¶ 12 Dr. Wiot testified that when reviewing a film for the presence of pneumoconiosis, the reader considers the profusion, opacity type, lung zones, and film quality. He stated that profusion refers to the "[d]egree of involvement" or "[h]ow many [nodules] there are." Opacity type involves a determination whether the nodules appear on the film as a rounded or irregular shape. Dr. Wiot stated that with CWP, the nodules are primarily rounded with irregularly shaped secondary opacities. Dr. Wiot also testified that the opacities are graded for thickness. Thus, rounded opacities are graded in ascending order of thickness as "p," "q," or "r." Similarly, irregular opacities are graded in ascending order of thickness as "s," "t," or "u." Dr. Wiot noted that with CWP, the nodules are classified primarily as a "q" with some "t" classifications, although he acknowledged that "you can have everything else." Dr. Wiot further testified that CWP "invariably" begins in the upper lung fields, and most often on the right side, and later progresses to the mid and lower zones.

¶ 13 Dr. Wiot reviewed a chest X ray dated August 17, 2006, from Springfield Clinic, a chest X ray dated October 3, 2007, from Harrisburg Medical Center, and a chest X ray dated March 28, 2008, from Taylorville Memorial Hospital. Dr. Wiot graded the films as quality one. Dr. Wiot found no evidence of CWP on these films.

¶ 14 On cross-examination, Dr. Wiot testified that one cannot rule out CWP based on X ray alone because a pathological examination could reveal the disease through microscopic changes not seen on a radiograph. Dr. Wiot did not dispute that the size and location of each nodule may vary from miner to miner, although he added that they "tend" toward the upper lobes of the lung. Dr. Wiot admitted that he did not have claimant's patient history when he was examining the films at issue. Asked whether it was preferable to review a patient's radiographs with or without the review of their associated medical records, Dr. Wiot responded:

> "I personally prefer to assume, when the film is sent to me, that the individual's been adequately exposed to develop [CWP] if he's going to. I don't want to know about his pulmonary function. I don't want to know that he only was exposed two years as opposed to 30 years.
>
> What you are asking me to do when you send me an x-ray to look at is: Are the radiographic findings compatible with coal workers' pneumoconiosis? You're not saying to me is this coal worker's pneumoconiosis. You're saying: Is this compatible with coal workers' pneumoconiosis?"

Dr. Wiot further explained that he does not want to be influenced by a patient's exposure history when reading an X ray. In contrast, Dr. Wiot explained that if he was treating a patient, he would want to know everything he can about the patient. The following colloquy then ensued:

> "Q. If you have read the chest x-ray as being consistent with coal workers' pneumoconiosis and you're satisfied that there's been adequate coal mine exposure to support those changes, entries and treatment records of clear lungs on physical examination of the chest wouldn't have anything to do with your reading, would they?
>
> A. It means nothing.
>
> Q. Pulmonary function testing wouldn't have any?

A. It means nothing.

Q. Whether there are or are not complaints of shortness of breath in the treatment records, that would have nothing to do with it?

A. (Shook head.)"

¶ 15 Dr. Wiot acknowledged that "theoretically," a person with simple CWP will have the same level of pneumoconiosis when he left mining as he does at the time of diagnosis. Dr. Wiot testified, however, that he has seen cases where CWP progresses after exposure ceases. Dr. Wiot agreed that the only treatment for CWP is removal of the patient from any further coal dust exposure. Dr. Wiot also admitted that a person can have a chest X ray showing CWP and still have a normal physical examination, normal pulmonary function testing, and normal arterial blood-gas testing.

¶ 16 Dr. David Rosenberg reviewed claimant's medical records and radiographic films at respondent's request. Dr. Rosenberg is the medical director of Corporate Health at the University of Cleveland. In addition, he is board certified in internal medicine, pulmonary disease, and occupational medicine, and he is a B-reader. Dr. Rosenberg read the report of Dr. Wiot, the records of Dr. Smith, the records of Dr. Cohen, records from Springfield Clinic, and various X rays. Dr. Rosenberg's review of the records revealed a 10-pack-year smoking history and a history of sinusitis. Dr. Rosenberg interpreted the X rays dated August 17, 2006, October 3, 2007, and March 28, 2008. He did not detect any changes in claimant's films over time, and he interpreted all three films as category 0/0, or negative for pneumoconiosis. Dr. Rosenberg testified that claimant's treatment records did not outline chronic bronchitis but rather intermittent treatment for respiratory infections. Moreover, he stated that the inspiratory rhonchi that Dr. Cohen noted in his examination could be related to claimant's sinusitis or his history of smoking. In Dr. Rosenberg's opinion, there was no evidence that claimant's pulmonary function had been affected by his dust exposure on the job. Moreover, Dr. Rosenberg believed that claimant was capable of heavy manual labor.

¶ 17 On cross-examination, Dr. Rosenberg testified that while it is up to each individual, a patient with pneumoconiosis should minimize his or her exposure to coal-mine dust–the lower the exposure, the better. He also acknowledged that it is possible for a patient with radiographically significant CWP to have a normal pulmonary function test, a normal blood-gas test, and a normal physical examination of the chest. Further, Dr. Rosenberg conceded that testing in the range of normal pulmonary function does not indicate that an individual has lungs free of injury or disease.

¶ 18 Medical records of the Springfield Clinic dating back to 1995 were admitted into evidence. Those records reveal the following. On November 25, 1996, claimant complained of deep cough, which was productive. The doctor charted that claimant continued to smoke a half a pack of cigarettes per day. Upon examination, occasional inspirational wheezes were noted, while there were no expiratory wheezes or rales. In succeeding office visits where examinations of the lungs were recorded, they were noted to be clear without wheezing or rhonchi, and no shortness of breath at rest was noted. These visits occurred between May 2004 and January 2007. On August 15, 2000, claimant gave a history of smoking three-quarters of a pack per day for the past 25 years. On April 4, 2010, claimant completed a new

patient questionnaire in which he denied shortness of breath and provided a history of smoking a pack a day for 20 years. A chest X ray dated August 17, 2006, was interpreted as negative, and a chest X ray of December 6, 2006, was interpreted as showing no active pulmonary disease. On April 15, 2009, claimant underwent an examination for his truck-driving job. At that time, claimant denied shortness of breath, lung disease, emphysema, and chronic bronchitis, and a review of the lungs was negative for abnormal breath sounds or impaired respiratory function. On June 10, 2009, July 8, 2009, January 13, 2010, May 3, 2010, and November 11, 2010, examination of the lungs revealed no abnormal breath sounds and claimant denied shortness of breath.

¶ 19 Citing the absence of a history of shortness of breath in the medical records, the arbitrator concluded that claimant failed to prove by a preponderance of the evidence the presence of an occupational disease such as CWP or bronchitis. The Commission reversed the decision of the arbitrator in part, finding that claimant met his burden of establishing the presence of CWP causally related to his work as a coal miner. In so holding, the Commission cited the opinions of Drs. Cohen and Smith, both of whom diagnosed CWP. The Commission also noted that both Dr. Rosenberg and Dr. Wiot testified that treatment records are not relevant to a determination of pneumoconiosis, as the diagnosis is dependent on radiographic evidence. The Commission further determined that claimant showed disablement within two years after his last exposure to coal-mine dust and that claimant provided respondent with timely notice of disablement. The Commission awarded claimant 50 weeks of PPD benefits, representing 10% loss of the person as a whole. The circuit court of Christian County confirmed the decision of the Commission. This appeal by respondent followed.

¶ 20 II. ANALYSIS

¶ 21 On appeal, respondent first argues that the Commission's finding that claimant suffers from the occupational disease process of CWP is against the manifest weight of the evidence. 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. *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. *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. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009). 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. *Docksteiner v. Industrial Comm'n*, 346 Ill. App. 3d 851, 856-57 (2004). For a finding to be contrary to 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).

¶ 22 In this case, the Commission relied primarily on the opinions of Drs. Cohen and Smith to find that claimant suffered injuries as a result of exposure to an occupational disease. Dr. Cohen examined claimant on April 8, 2008. At that time, claimant reported shortness of

breath upon exertion for approximately 5 years and a cough with sputum production for approximately 10 years. Upon physical examination, Dr. Cohen noted a few inspiratory rhonchi, which he attributed to scarring of the lungs. Dr. Cohen reviewed claimant's chest X ray dated March 28, 2008, as positive for pneumoconiosis, category 1/0, with q/r-shaped opacities in all lung zones. Dr. Cohen made an identical interpretation on a chest X ray dated October 3, 2007. Dr. Cohen testified that based on his evaluation, and within a reasonable degree of medical certainty, claimant has CWP which was caused by claimant's 31 years of exposure to coal-mine dust. Dr. Cohen opined that based on the diagnosis of CWP, claimant could not have any further exposure to coal-mine dust without endangering his health and that he should not work in any job where he will be exposed to pulmonary toxins. Dr. Smith interpreted a chest X ray of August 17, 2006, as positive for pneumoconiosis, category 1/0, with p/s opacities in the mid- to lower-lung zones and the chest X ray of October 3, 2007, as positive for CWP, category 1/1, with s/p opacities in all lung zones. Thus, based on Dr. Smith's reading of these films, the CWP progressed from the mid- and lower-lung zones to the upper zones between August 17, 2006, while claimant was still coal mining, and October 3, 2007, a little more than a month after he left coal mining. We note that Dr. Cohen's and Dr. Smith's opinions are in accord with the statutory presumption found in the Act. See 820 ILCS 310/1(d) (West 2006) ("If a miner who is suffering *** from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall *** be a rebuttable presumption that his or her pneumoconiosis arose out of such employment.").

¶ 23 Respondent acknowledges the opinions of Dr. Cohen and Dr. Smith, but argues that the Commission erred in relying on their X ray interpretations to the exclusion of the readings by Dr. Wiot and Dr. Rosenberg. According to respondent, of the physicians who interpreted claimant's chest X rays, Dr. Wiot was the most experienced, and he testified that CWP "invariably" begins in the upper lung zones. Yet, Dr. Smith interpreted the chest X rays as showing opacities progressing from the mid- and lower-lung zones to the upper lung zones. Respondent further asserts that the Commission erred in relying on the opinions of Dr. Cohen and Dr. Smith because their readings of claimant's October 3, 2007, chest X ray were inconsistent. Dr. Cohen interpreted the film as positive for CWP category 1/0 with q/r opacities in all lung zones, while Dr. Smith interpreted the film as positive for CWP category 1/1 with s/p opacities in all lung zones. In contrast, respondent notes, both Dr. Wiot and Dr. Rosenberg interpreted all three chest X rays as negative for CWP.

¶ 24 We do not find these alleged discrepancies sufficient to disturb the finding of the Commission. Although Dr. Cohen and Dr. Smith differed in their interpretations of the category of CWP and the shape of the opacities on the October 2007 X ray, they both agreed that claimant had CWP. Indeed, as respondent tacitly concedes, the Commission had before it conflicting medical opinions on the issue whether claimant suffered from an occupational disease. The Commission resolved this conflict in claimant's favor, as was its province to do. *Hosteny*, 397 Ill. App. 3d at 674. Moreover, while respondent emphasizes Dr. Wiot's testimony that CWP "invariably" begins in the upper lung fields, he did not dispute that the location of CWP abnormalities can vary from miner to miner. Given the record as a whole, and in light of the Commission's role in weighing the evidence, we cannot say that a conclusion opposite to the one reached by the Commission is clearly apparent. As such, the

Commission's decision that claimant suffers an occupational disease as a result of his exposure to the hazards of coal mining is not against the manifest weight of the evidence.

¶ 25 Respondent next argues that the Commission's finding that claimant proved he suffered disablement within the statutory time frame is against the manifest weight of the evidence. Section 1(f) of the Act (820 ILCS 310/1(f) (West 2006)) provides, in relevant part, that "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 ***." Section 1(e) of the Act (820 ILCS 310/1(e) (West 2006)) provides two ways to establish disablement. See *Forsythe v. Industrial Comm'n*, 263 Ill. App. 3d 463, 470 (1994). A claimant can establish disablement by showing "an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS 310/1(e) (West 2006). Alternatively, section 1(e) defines disablement as "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." 820 ILCS 310/1(e) (West 2006). Whether a claimant has provided sufficient evidence of disablement is a question of fact for the Commission, and its decision in this regard will not be reversed unless it is against the manifest weight of the evidence. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Comm'n*, 386 Ill. App. 3d 779, 783-84 (2008).

¶ 26 In this case, the Commission determined that claimant showed disablement within two years after he left coal mining. The Commission relied upon the opinions of Dr. Cohen and Dr. Smith that claimant suffers from CWP and that he should not have further exposure to coal-mine dust. The Commission also noted Dr. Wiot's testimony that because CWP progresses slowly, the disease tends not to progress once an individual leaves mining. Respondent does not dispute the evidence cited by the Commission. According to respondent, however, the medical prohibition against additional coal-mine exposure only applies when it affects one's employability, and in this case there was no evidence that claimant had to forego a job opportunity due to a limitation on environmental exposures. Respondent, however, cites no authority for this position. As such, it is forfeited. Ill. S. Ct. R. 341(h)(7) (eff. Feb. 6, 2013) (requiring appellant's argument to include citation to relevant authority); *Ameritech Services, Inc. v. Illinois Workers' Compensation Comm'n*, 389 Ill. App. 3d 191, 208 (2009) (noting that arguments on appeal are forfeited in the absence of supporting legal authority). Forfeiture notwithstanding, we find this contention without merit. The supreme court has stated that for purposes of section 1(e) of the Act, an employee is considered disabled from earning full wages at the work in which he was engaged when last exposed to the hazards of the occupational disease or equal wages in other suitable employment where he can no longer work without endangering his life or health. *Owens-Corning Fiberglas Corp. v. Industrial Comm'n*, 66 Ill. 2d 247, 252 (1977). In this case, the evidence is clear that claimant, as a result of an occupational illness, was unable to engage in the type of work he had performed for almost 31 years without further endangering his health. Dr. Cohen advised claimant to avoid any position which would expose him to pulmonary toxins. Dr. Wiot agreed that the only treatment for CWP is the removal of the

patient from any further coal-dust exposure. Dr. Rosenberg testified that a patient with pneumoconiosis should minimize his or her exposure to coal-mine dust. Accordingly, we conclude that the Commission's finding of disablement within the statutory time frame is not against the manifest weight of the evidence.

¶ 27 Finally, respondent challenges the Commission's finding that claimant is permanently partially disabled to the extent of 10% of the person as a whole. According to respondent, claimant failed to prove a disability related to the presence of an occupational disease. We disagree. A determination of the extent of a claimant's disability is a question of fact, and the Commission's decision will not be set aside unless it is against the manifest weight of the evidence. *Peabody Coal Co. v. Industrial Comm'n*, 355 Ill. App. 3d 879, 883 (2005). As noted above, when conflicting medical evidence is presented, it is for the Commission to determine which testimony will be accepted. *Hosteny*, 397 Ill. App. 3d at 674. In this case, claimant testified that he first noticed breathing problems in the late 1990s and that his problems have continued over time. Claimant noted, for instance, that as a result of his breathing problems, he can only walk one block before noticing a change in his breathing and three blocks before he has to stop. Claimant also testified that he can only climb about two flights of stairs before experiencing breathing problems. Further, claimant told Dr. Cohen that his breathing problems interfere with his normal activities. Under these circumstances, we cannot say that the Commission's award of PPD benefits to the extent of 10% of the person as a whole is against the manifest weight of the evidence.

¶ 28 III. CONCLUSION

¶ 29 For the reasons set forth above, we affirm the judgment of the circuit court of Christian County, which confirmed the decision of the Commission.

¶ 30 Affirmed.

¶ 31 JUSTICE HOFFMAN, specially concurring.

¶ 32 I concur completely in the majority's opinion. I write separately because I am prepared to take the issue of disablement resulting from coal workers' pneumoconiosis one step further.

¶ 33 From the expert testimony adduced in this case and numerous other CWP cases that we have addressed, I believe that the following propositions are uncontroverted: CWP is a tissue reaction in the form of scarring or fibrosis caused by exposure to coal-mine dust; it causes a reduction in useful functioning lung tissue; the disease is progressive; and, the only treatment for CWP is to remove a sufferer from any further exposure to coal dust.

¶ 34 Recovery under the Workers' Occupational Diseases Act (Act) (820 ILCS 310/1 to 27 (West 2006)) is contingent upon a claimant proving, among other things, that he has suffered a disability as a result of the exposure of his employment. 820 ILCS 310/1(d) (West 2006). The Act defines disablement, in part, as an "impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body." 820 ILCS

310/1(e) (West 2006).

¶ 35 I believe that once a claimant has established that he suffers from CWP he has also satisfied the statutory definition of disablement as a matter of law.

¶ 36 Presiding Justice Holdridge and Justice Stewart join in this special concurrence.