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Is the Doctor Hostile—Obstructive Impairments and the Hostility Rule in Federal Black Lung Claims

Timothy F. Cogan
*Cassidy, Myers, Cogan, Voegelin & Tennant, L.C.*

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I. INTRODUCTION

The purpose of the Federal Black Lung Act of 1972 (hereinafter the Act) is to provide claimants, who are totally disabled due to pneum-
moconiosis, with access to federal benefits.\(^1\) In order to fulfill this remedial purpose, “the Act must be liberally construed to include the largest number of miners as benefit recipients.”\(^2\) Despite the Act’s remedial purpose and liberal construction, however, black lung claimants are confronted with many barriers that either deter or completely prevent them from obtaining access to federal benefits.\(^3\) The struggles of claimants in receiving benefits are demonstrated by their low success rate. The recent success rate for federal black lung claimants is merely 6%; meaning that only 6% of the applicants for federal black lung benefits will ultimately succeed in obtaining those benefits.\(^4\) In

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3. Various barriers limit a claimant’s access to federal black lung benefits. First, claimants are faced with difficulties in obtaining legal counsel to represent them because of the often prolonged length of time that a claimant’s attorney may be involved in a given case without compensation. This author estimates that the average length of time, from the time that a claimant’s file is opened to the date that the claimant’s attorney receives any payment for his or her attorney’s fees, is often nearly a decade.

The rate at which claimants’ counsel are paid, even if the claimant is ultimately successful, is another barrier. In the non-black lung case of Rum Creek v. Caperton, the Court refused to rule on the propriety of attorney’s fees, holding that the district court’s order was not final and remanded for a final and expeditious determination of the attorney’s fees. 971 F.2d 1148 (4th Cir. 1992). The net effect of such procedural obstacles is that claimant’s attorneys find extreme difficulty and delay in being compensated for their efforts. In Broyles v. Director, OWCP, the Court indicated that the attorney’s fees sought by claimant’s counsel were obscene and reduced the fees from $300,000 to $34,000, a figure representing just over 10% of the original trial court award. 974 F.2d 508 (4th Cir. 1993).

Another barrier to a claimant’s access to federal benefits is the fact that their employers, as a result of their vast financial resources, have much greater access to physicians who typically testify that the claimant is not disabled due to coal workers pneumoconiosis. In order to even the playing field between employers and employee/claimants, various courts of appeals have decried the role of expert testimony in black lung administrative proceedings. For example, the Sixth Circuit, in Woodward v. Director, OWCP, noted that “when one party is able to hire significantly more experts because it has infinitely more resources, the truth-seeking function of the administrative proceeding is skewed and directly undermined.” 991 F.2d 314, 321 (6th Cir. 1993). The result of such an unequal playing field is that claimants have difficulty finding attorneys and financing the litigation.

comparing this 6% success rate to the success rate of disability claimants in other contexts, this author finds that the federal black lung claimants are far less successful. For example, claimants in the Social Security Disability context at the Administrative Law Judge (hereinafter ALJ) level enjoy a win rate of approximately 75%; this is more than twelve times the success rate for federal black lung claimants.

The hostility rule can significantly affect this success rate. The hostility rule is an evidentiary rule that can render a doctor’s opinion unreliable where that opinion is based on a philosophy or basic premise that is at odds with the Act. Some physicians testify that black lung cannot cause an obstructive impairment and, instead, they insist that black lung only causes a restrictive impairment. This article examines the distinction between the restrictive and obstructive impairments and ultimately concludes that, when a doctor testifies to the belief that black lung cannot cause an obstructive impairment, that medical opinion may be properly disregarded as hostile to the Act.

5. Preface, Social Security Practice Guide. As the Sixth Circuit stated in Director, OWCP v. Kyle, "[A]dministrative practice . . . did not comport with legislative intent, and twice Congress was impelled to specify its intentions more clearly 'in order to insure as broad coverage as possible'." 819 F.2d 139, 143 (6th Cir. 1987), cert. den. 488 U.S. 997 (1988), (quoting Echio v. Director, 744 F.2d 327, 330 (3rd Cir. 1984)).

6. This abysmally low success rate is doubly disturbing in that many of the rejected claims involve miners with long exposures. One example is Walter Wiley who had 17 years of exposure but whose claims was ultimately rejected. Wiley, 892 F.2d at 499. The rule in the Fourth Circuit is that a lengthy employment in the mines is at least relevant in determining whether there is a totally disabling respiratory impairment. Hubbard v. Califano, 582 F.2d 319 (4th Cir. 1978) (citing Phillips v. Mathews, 555 F.2d 1182, 1183 (4th Cir. 1977)). See also Pittston Coal Group v. Sebben, 488 U.S. 105, 118 (1988) (noting that "disabling pneumoconiosis rarely manifests itself in miners with fewer than 10 years of coal mine experience").
II. A General Overview

A. The Governing Law

The Federal Black Lung Act requires proof of three things for a claimant to recover: First, the claimant must prove disease or pneumoconiosis. Second, the claimant must prove disease causation. This requires a showing that the disease arose out of coal mine employment. Third, the claimant must establish disability causation, defined as an inability to do coal mine employment, or its functional equivalent, caused by pneumoconiosis. The Act and regulations, in an apparent attempt to simplify decision-making and to lessen a claimant’s burden of proof, include presumptions, triggered frequently by the length of coal mine employment. Most of the presumptions are rebuttable. Triggering such presumptions shifts the burden of proof to the employer.

The three branches of our federal government have complicated substantive black lung law. There are three sets of applicable regulations: those found at 20 C.F.R. Section 410, 20 C.F.R. Section 727 (the interim regulations), and at 20 C.F.R. Section 718. Congress has several times revised the Act (e.g. the Black Lung Benefits Reform Act of 1977) and such revisions have required the reopening of claims.

The Black Lung Benefits Act has resulted in a “complex and highly technical regulatory program.” Even the United States Supreme Court noted the “Byzantine character of these regulations.”

7. Sebben, 488 U.S. at 113, 126.
8. Id.
9. Id.
17. Id. at 699 (citing Sebben, 488 U.S. at 109).
Administration of the Act moved from the Department of Health, Education and Welfare (HEW) (Part B) to the Department of Labor (DOL) (Part C).

The Supreme Court has five times visited the Act. In *Usery v. Turner*,\(^\text{18}\) the Court upheld presumptions in the Act against due process claims. The Court concluded that, because Congress had evidence indicating doubts about reliability of negative x-rays, it was not arbitrary for Congress to select ten and fifteen year figures as reference points for presumptions of disability due to pneumoconiosis.\(^\text{19}\) *Mullins Coal Co. v. Director, OWCP*\(^\text{20}\) held that a single positive item of qualifying evidence is not necessarily sufficient to trigger the interim presumptions.\(^\text{21}\) In *Pittston Coal Group v. Sebben*,\(^\text{22}\) DOL interim regulations were found more restrictive than HEW regulations to the extent that the DOL invocation provision did not permit invocation of the presumption without ten years of coal mining experience.\(^\text{23}\) *Pauley v. Bethenergy*\(^\text{24}\) held that certain rebuttal provisions in DOL regulations are not more restrictive than HEW.\(^\text{25}\) Most recently, *Director, OWCP v. Greenwich Collieries*\(^\text{26}\) found that the “true doubt rule” is contrary to the Administrative Procedures Act.\(^\text{27}\) In so doing, the court merely alludes to its black lung context.\(^\text{28}\)

**B. Definition of Pneumoconiosis**

The statute defines pneumoconiosis as “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.”\(^\text{29}\) The phrase “arising
out of coal mine employment” serves to expand the definition by allowing for the compensation of miners who suffer from respiratory problems that may bear some relationship to their coal mine employment.30 The statute also permits compensation for disease that is significantly related to dust exposure during coal mine employment.31 It also permits compensation where disease is “aggravated by” exposure in coal mine employment.32

In result, there is clinical coal workers pneumoconiosis (CWP) and the broader term, legal or statutory pneumoconiosis.33 The latter is “a disease arising from work in a coal mine.”34 The regulations define pneumoconiosis as follows:

For the purposes of the Act, ‘pneumoconiosis’ means any chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers, pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment. For purposes of this definition, a disease ‘arising out of coal mine employment’ includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.35

20 C.F.R. Section 727.202 states:

For the purposes of the Act, ‘pneumoconiosis’ means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosianthro-silicosis, massive pulmonary fibrosis, progressive massive fibrosis silicosis, or silicotuberculosis arising out of coal mine employment. For purposes of this definition, a disease ‘arising out of coal mine employment’ includes any chronic pulmonary disease resulting in

30. Rose v. Clinchfield Coal, 614 F.2d 936, 938 (4th Cir. 1980).
32. Id.
33. Consolidation Coal Co. v. Hage, 908 F.2d 393 (8th Cir. 1990).
respiratory or pulmonary impairment significantly related to, or aggravated by, dust exposure in coal mine employment.\textsuperscript{36}

Thus, although a medical text might differentiate between coal workers' pneumoconiosis (CWP) and silicosis, the term silicosis is included within the legal definition of CWP.

\section*{C. The Reasoned Report Requirement}

A physician's report must represent "the documented opinion of a physician exercising reasoned medical judgment."\textsuperscript{37} A doctor's report may be rejected as unreasoned—even absent a conclusion that the doctor is hostile. In \textit{Lusk v. Eastern Associated Coal},\textsuperscript{38} for example, the ALJ rejected a medical report, in part, because the doctor did not accurately characterize the smoking history.\textsuperscript{39}

Similarly in \textit{Youghiogheny & Ohio Coal Co. v. McAngues},\textsuperscript{40} the Court affirmed an award of benefits. The ALJ had rejected the opinion of a non-treating physician, essentially because it was unreasoned.\textsuperscript{41} The doctor had indicated that the reason for the miner's impairments on the day of an examination was that the miner must have had a respiratory infection on that day.\textsuperscript{42} The miner had testified that he had no such cold and the examining doctor made no such findings. The ALJ was found to have logically given less weight to the non-examining doctor because of the speculation of a respiratory infection.\textsuperscript{43}

In a recent case, the Fourth Circuit reversed a denial of benefits where the ALJ relied on the opinions of physicians who assumed "that obstructive disorders cannot be caused by coal-mine employment."\textsuperscript{44}

\begin{itemize}
\item \textsuperscript{36} 20 C.F.R. § 727.202 (1994) (emphasis added).
\item \textsuperscript{37} 20 C.F.R. § 727(a)(4) (1994).
\item \textsuperscript{38} 17 Black Lung Rep. 3-171 (ALJ 1992).
\item \textsuperscript{39} \textit{Id.} at 3-185.
\item \textsuperscript{40} 996 F.2d 130, 133 (6th Cir. 1993).
\item \textsuperscript{41} \textit{Id.}
\item \textsuperscript{42} \textit{Id.}
\item \textsuperscript{43} \textit{Id.} at 135-36.
\item \textsuperscript{44} \textit{Warth v. Southern Ohio Coal Co.}, 1995 U.S.App. LEXIS 20216 (July 31, 1995) (citing Eagle v. Armco, Inc., 943 F.2d 509, 511 at n.2 (4th Cir. 1991) (The opinion of an expert "that breathing coal mine dust does not cause chronic obstructive lung disease...\)).
\end{itemize}
Likewise, the hostility rule can render a report by a physician as something less than "the documented opinion of a physician exercising reasonable medical judgment." When a physician's testimony is based on a premise that is fundamentally at odds with the basic thrust of the Act, that opinion may be rejected in its entirety as being "hostile" and therefore, lacking reasonable medical judgment.

III. EXPRESSIONS OF THE HOSTILITY RULE

A physician's opinion that is based upon a medical philosophy at variance from the policies of the Black Lung Act does not offer substantial evidence in support of a factual proposition. Typically, though certainly not always, the rule appears in the "rebuttal inquiry," where the employee is attempting to impeach the employer's expert.

The standard example of a situation where the rule arises is when a doctor states that he does not believe in something that is fundamental to the Act, such as a belief that simple pneumoconiosis can never be totally disabling. The Fourth Circuit, in Thorn v. Itmann Coal, rejected the opinion from a consultative examination because the doctor believes that "simple pneumoconiosis does not 'as a rule' cause total disability." The same dogma was rejected in Kaiser Steel v. Director, OWCP, where the court affirmed a claimant's award. In Kaiser, the medical opinion was rejected for the same reason as it was rejected in Thorn: the doctor testified that simple pneumoconiosis is not disabling. The Kaiser Court held that this premise is contrary to the Act.

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46. See, e.g., Thorn v. Itmann Coal Co., 3 F.3d 713, 719 (4th Cir. 1993) (citing leading cases on the hostility rule).
47. 3 F.3d 713 (4th Cir. 1993).
48. 3 F.3d at 719. The doctor's "premise" was "antithetical" to the law: simple pneumoconiosis plus 10 years of coal mine employment is presumed to be totally disabling to a miner. 3 F.3d at 719, (citing 20 C.F.R. § 727.203(a)).
49. 757 F.2d 1078 (10th Cir. 1985).
50. Id. at 1083.
51. Id.
The test is whether the conclusion of the expert is based "on a premise fundamentally at odds with the statutory and regulatory scheme." In support of its holding, Thorn cites hostility rule cases from the Seventh, Tenth, and Eleventh Circuits. In short, these cases stand for the proposition that a medical opinion based on a premise that is in conflict with the Act should be disregarded as hostile.

A similar medical opinion was rejected in Consolidation Coal Co. v. Hage. Hage approved of the actions of an ALJ who discounted the opinion of a physician who testified for the employer because the physician "espoused the dogmatic view that only progressive massive fibrosis (PMF) was to be regarded as pneumoconiosis entitling a miner to Black Lung benefits." The Eighth Circuit noted that the statute stated that pneumoconiosis included—but was not limited to—progressive massive fibrosis. Progressive massive fibrosis is the end stage of coal workers pneumoconiosis. It is the term used when opacities on x-rays are greater than one centimeter.

Hage also approved of the ALJ, who took with a "grain of salt" the opinion of a physician who changed his mind after reading the article by the physician who limited the definition of pneumoconiosis to PMF. Likewise, in Black Diamond Coal Mining Co. v. Benefits Review Board, a physician's testimony was held hostile to the Act where he would not diagnose pneumoconiosis absent "positive x-ray evidence of the disease."

53. Robbins v. Jim Walter Resources, Inc., 898 F.2d 1478, 1482 (11th Cir. 1990); Wetherill v. Director OWCP, 812 F.2d 376, 382 (7th Cir. 1987); Kaiser Steel Corp., 757 F.2d 1078 (10th Cir. 1985).
54. Id.
55. 908 F.2d 393, 396 (8th Cir. 1990).
56. Id. at 396 (citing Clark v. Crown Construction, 887 F.2d 149, 156 (8th Cir. 1989)) (citations omitted).
57. Hage, 908 F.2d at 396 (citing 20 C.F.R. § 727.202 (1978)).
60. 758 F.2d 1532, (11th Cir. 1985). See also Thorn, 3 F.3d at 719 (citing Black Diamond Coal Co. V. Benefits Review Board, 758 F.2d 1532 (11th Cir. 1985)) ("True rebuttal is more than merely questioning or criticizing the quality of claimant's proof").
61. Black Diamond Coal Mining Co., 758 F.2d at 1534.
In *Kaiser Steel Corp. v. Director, OWCP,* a physician’s testimony was correctly discounted as directly conflicting with the Act. The opinion of a doctor with beliefs inconsistent with the Act may be rejected when an ALJ concludes that such belief “forms a primary basis for the doctor’s conclusion that the miner’s pneumoconiosis is not disabling.”

IV. THE BELIEF THAT BLACK LUNG CANNOT CAUSE AN OBSTRUCTIVE IMPAIRMENT AMOUNTS TO HOSTILITY TO THE ACT OR REGULATIONS

A. The Importance of the Regulations

The regulations occupy a role virtually the equal of the statute. In *Kozele v. Rochester and Pittsburgh Coal Co.*, the Board indicated that a physician cannot “merely interpret objective evidence under a different, more restrictive standard than provided by the interim presumption.” Thus, for example, a physician is precluded from stating that results that meet standards set out in the applicable regulations are “normal.”

B. The Epidemiological Studies Published by Niosh

Published in 1992 were studies of more than 7,000 United States coal miners. These are entitled *Pulmonary Function of U.S. Coal Miners Related to Dust Exposure Estimates* and *Exposure—Response Relationship for Coal Mine Dust and Obstructive Lung Disease Following Enactment of the Federal Coal Mine Health and Safety Act of 1969.* These exhaustive epidemiological studies published by the Di-

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62. 757 F.2d 1078, 1082 (10th Cir. 1985). See also Amax Coal Co. v. Director, OWCP, 801 F.2d 958, 963 (7th Cir. 1986).
65. 6 Black Lung Rep. 1-378, 1-381, n.3. *Thorn* suggests that a premise antithetical to the law includes the regulations as well as the Act itself. 3 F.3d at 719.
67. Noah S. Seixas, Thomas G. Robbins, Michael D. Attfield, Lawrence H. Moulton,
vision of Respiratory Disease Studies of NIOSH (National Institute for Occupational Safety & Health) established a link between the inhalation of coal dust and obstructive airway disease.\textsuperscript{68}

These studies indicate that every year of underground mining prior to the imposition of dust controls led to drop in the average FEV1 score between five and ten milliliters per year of dust exposure. Then, for every year of underground mining after dust controls were imposed there was an average drop in the FEV1 of two to three milliliters of dust exposure.\textsuperscript{69}

Other studies confirm this relation between coal dust exposure and obstructive disease.\textsuperscript{70} Some of these are reported in the appendix.\textsuperscript{71}

Another summary comes from\textit{Freeman-United Coal Mining Co. v. Office of Workers Compensation Programs}, where the court stated:

Physicians retained by coal companies add that [coal workers pneumoconiosis] is a restrictive lung disease, that is, it impedes breathing in, rather than an obstructive one, such as emphysema, that makes it difficult to breathe out. . . . Not all physicians agree, however, that coal workers pneumoconiosis is always restrictive rather than obstructive or even that it always produces x-ray abnormalities. Whoever is right, the black lung statute has been interpreted to define coal workers pneumoconiosis in accordance with the second, the broader, view, as any chronic lung disease caused in whole or in part by exposure to coal dust. So if in attempted rebuttal of the statutory presumption of pneumoconiosis the coal company tendered a doctor's report which merely stated that the miner has no signs of clinical pneumoconiosis (as that doctor understood the term), without commenting on the possibility that he might have another chronic lung disease caused or exacerbated by inhaling coal dust, the rebuttal would indeed fail.\textsuperscript{72}

The Benefits Review Board agrees, finding that benefits must be awarded to miners with obstructive lung disease.\textsuperscript{73} In addition, the

\textsuperscript{68} See \textit{supra} notes 66 and 67.
\textsuperscript{69} Id.
\textsuperscript{70} See JACQUELINE F. WADE, COMPREHENSIVE RESPIRATORY CARE: PHYSIOLOGY AND TECHNIQUE 144 (3rd ed. Mosky 1982) (pneumoconiosis is classified as both an obstructive and restrictive disease).
\textsuperscript{71} See, e.g., CECIL, TEXTBOOK OF MEDICINE § 559, at 2281 (1985).
\textsuperscript{72} 957 F.2d 302, 303 (7th Cir. 1992) (citations omitted).
\textsuperscript{73} See e.g., Heavilin v. Consolidation Coal, 6 Black Lung Rep. 1-1209 (Ben.Rev.Bd.
Secretary of Labor has taken the position that coal dust may cause an obstructive impairment in *Eifler v. Peabody Coal Co.* Moreover, NIOSH has taken the position before Congress that coal dust can and does cause obstruction. These obstructions can occur with or without CWP and can be associated with significant impairment. This discovery fell under the term “obstructive lung disorder.”

C. Applying the Hostility Rule to the Belief that Pneumoconiosis Cannot Cause an Obstructive Impairment

A restrictive impairment “denotes a pattern of abnormalities in lung function . . . characterized by reduction in lung volume.” An obstructive impairment “denotes the constellation of abnormalities that result from limitation in expiratory airflow, whatever its cause. . . . [It] is found in patients with asthma, bronchitis, emphysema, advanced bronchiectasis, or other disease that cause narrowing of the tracheobronchial system.”

The regulations indicate that pulmonary or respiratory impairment means the inability to perform normally any of the three components of respiration: ventilation, perfusion, and diffusion. Pulmonary ventilation is the process of exchange of air between the lungs and the ambient air, as opposed to the alveolar ventilation, in which gas ex-

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74. Case No. 87-BLA-0591, filed November 30, 1992 (citing sentiment from Dr. Cohen of Chicago that pneumoconiosis could cause an impairment obstructive, restrictive, or a combination of both. Dr. Cohen relied upon NIOSH studies.)
75. *See Testimony by NIOSH Director, J. Donald Millar, August 1, 1991, unpublished*, given before the Labor, HHS, and Ed. Subcomm. of the Senate Comm. on Appropriations ("bronchitis and emphysema also result from coal mine dust inhalation.")
77. *Cecil, Textbook of Medicine* § 57, at 376.
change with the blood takes place. It includes the distribution of air within the tracheobronchial system to the gas exchange units of the lungs.

Perfusion is literally "the act of pouring through," especially the passage of a fluid through a specific organ. It includes the movement of oxygen and carbon dioxide across the alveolar-capillary membrane between the gas in alveolar spaces and the blood in the pulmonary capacities.

Diffusion is literally "the act of becoming widespread." It is the flow of mixed venous blood through the pulmonary arterial circulation, distribution of the blood to the capillaries of the gas exchange units, and removal of the blood from the lungs through the pulmonary vein. A gas exchange impairment is described in Pauley as the reduction in the ability of the lung to transfer oxygen to the blood, and more particularly in the transfer of oxygen from the lung alveoli. Also demonstrating such an impairment is the single breath DLCO, which measures the diffusing capacity of the lungs for carbon dioxide. Respiratory acidosis indicates impairment in the oxygen carbon dioxide exchange.

FVC is the forced ventilatory capacity. It is not included in the 20 C.F.R. Section 727 prescriptions, where presumptions are triggered by ten or more years of coal mine employment and by positive x-ray.

80. CECIL, TEXTBOOK OF MEDICINE § 57.
81. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1160.
82. CECIL, TEXTBOOK OF MEDICINE § 57.
83. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 443.
84. CECIL, TEXTBOOK OF MEDICINE § 57.
85. 501 U.S. at 684.
86. Id. at 2530. See also 20 C.F.R. § 718.105 (a) (giving this as the purpose of arterial blood gas studies); 20 C.F.R. § 727.203(a)(3) (giving entitlement levels for blood gas studies demonstrating an impairment); 20 C.F.R. pt. 404, subpt. P, App 1, § 3.02 (c)(2) (1994) (being the 1994 Social Security Disability regulations, giving blood gas table values as indications of gas exchange impairment).
88. 20 C.F.R. pt. 404, subpt. P, App 1, § 3.00 (F).
89. Thorn, 3 F.3d at 716 (citing DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 27 (25th ed. 1974)).
biopsy or autopsy, 727.203(a)(1); ventilatory studies, (a)(2); and blood
gas studies, (a)(3). FVC is mentioned in the regulations at 20 C.F.R.
Section 718.103 (a). The FEVI, or forced expiratory volume in one
second, measures the chronic obstructive pulmonary disease.90

Some doctors retained by coal companies say that black lung is
only a restrictive lung disease and thus could only be shown by re-
duced FVC volumes or an impairment of gas exchange.91 The DOL
rejects this: "Neither the Act nor the Secretary’s regulations make
entitlement to black lung benefits depend upon proof that the miner
suffers from a restrictive ventilatory impairment or impairment of gas
exchange, rather than an obstructive impairment."92

Some doctors conclude that coal dust can never affect a miner’s
breathing tubes. Under this thinking, if it could never affect a miner’s
airways, then it could not cause an obstruction. They say that it is only
an interstitial lung disease. Thus, the same doctors claim pneumoconio-
sis is only capable of producing a restrictive impairment.93

The ALJ in Hage found that the miner had chronic obstructive
pulmonary disease. "That condition, we have held (on the basis of
medical testimony), constitutes a type of ailment which Congress
deems sufficient to entitle a claimant to Black Lung benefits."94

Hage takes a position arguably more extreme than this article. It
referred to dictum in another eighth circuit case as a “negative preg-
nant,” where a claim was denied because the claimant’s condition was
restrictive rather than obstructive.95

90. 20 C.F.R. pt. 404, subpt. P, App 1, § 3.02 (A). See Appendix B to 20 C.F.R. §
718 (1) (ix).
91. See generally 1994 SSD regulations, 20 C.F.R. pt. 404, subpt. P, App 1, § 3.02
(B), giving FVC as indication for restrictive lung impairment. See testimony described by
the government in Eifler, supra note 74, stating that pneumoconiosis only produces a restric-
tive impairment or an impairment of gas exchange.
92. Eifler, supra note 74, DOL Letter/Brief to ALJ, 11/30/95, p. 5.
93. Consolidation Coal Co. v. Hage, 908 F.2d 393 (8th Cir. 1990).
94. Hage, 908 F.2d at 395.
95. Id. at 395 n.14.
Some sources find that obstruction is the most common impairment resulting from exposure to coal dust.\textsuperscript{96} Pneumoconiosis is usually classified as both an obstructive and restrictive disease.\textsuperscript{97}

"[C]oal workers' pneumoconiosis may manifest itself in different types of pulmonary impairment."\textsuperscript{98} Simple pneumoconiosis may not produce the kind of significant ventilatory impairment that can be seen on pulmonary function studies, although it may reduce the ability of the lungs to transfer oxygen, which could be more apparent on blood gas studies.\textsuperscript{99}

 Numerous cases have permitted an award of benefits to a claimant with an obstructive impairment who has been found otherwise eligible for benefits.\textsuperscript{100} The Seventh Circuit had originally suggested that the opinion that black lung does not cause obstructive impairments is contrary to the Act.\textsuperscript{101} However, in \textit{Blakley}, one doctor testified that "coal dust exposure does not cause obstructive impairment"\textsuperscript{102} and the Seventh Circuit concluded that this opinion "does not rise to the level of 'hostility.'"\textsuperscript{103} In so concluding, the \textit{Blakley} court reasoned that the Act and the regulations do not necessarily establish that dust exposure from coal mines causes obstructive pulmonary disease. Rather, the

\textsuperscript{97} JACQUELINE F. WADE, \textit{COMPREHENSIVE RESPIRATORY CARE: PHYSIOLOGY AND TECHNIQUE} 144 (3rd ed. Mosby 1982).
\textsuperscript{98} Tussey v. Island Creek, 982 F.2d 1036, 1040 (6th Cir. 1993) (citing Gurule v. Director, OWCP, 2 Black Lung Rep. (MB) 1-772, 1-777 to 1-778 (Ben.Rev.Bd. 1979), aff'd, 653 F.2d 1368 (10th Cir. 1981), \textit{abrogated on other grounds}, Likman v. Director, OWCP, 896 F.2d 1248 (10th Cir. 1990)).
\textsuperscript{100} See, \textit{e.g.}, Brown v. Rock Creek Mining Co., 996 F.2d 812, 814 (6th Cir. 1993). \textit{See generally} Oliver v. Director, 888 F.2d 1239 (8th Cir. 1989).
\textsuperscript{101} Mitchell v. OWCP, 25 F.3d 500, 507 at n.12 (1994 7th Cir.) (perhaps a diagnosis of "chronic obstructive pulmonary disease was sufficient to prove that Mr. Mitchell had pneumoconiosis") (citing earlier opinion in the same case, 855 F.2d 491, n.7, itself citing \textit{Old Ben Coal v. Prewitt}, 755 F.2d 588, 591 (7th Cir. 1985) (indicating that even if chronic obstruction might not meet the technical definition of pneumoconiosis, it fits the statutory definition)).
\textsuperscript{102} Blakley v. Amax Coal Co., 54 F.3d 1313, 1321 (7th Cir. 1995).
\textsuperscript{103} Id.
court indicated that "the facts and medical opinions in each specific case answer this question."\textsuperscript{104}

\textit{Clark v. Crown Construction Co.},\textsuperscript{105} rejected an attack on a physician's opinion as "contrary to the policy embodied in the statute."\textsuperscript{106} The claimant argued that the doctor's opinion restricted benefits to underground miners only, contrary to Congressional intent. The Court hinted that an ALJ could have rejected a doctor's opinion to the extent that it was "medical dogma" inconsistent with the Act. However, the Court found that the ALJ could \textit{deny} benefits because of a lack of airways obstruction, since the claimant only had restrictive impairments and, further, refused to see the physician's opinion as contrary to the statutory public policy.\textsuperscript{107}

This belief, restricting pneumoconiosis solely to a restrictive impairment, is similar to \textit{Thorn v. Itmann}\textsuperscript{108} and \textit{Consolidation Coal v. Hage},\textsuperscript{109} insofar as those cases reject beliefs about whether simple pneumoconiosis causes an impairment. Here the focus is on the kind of impairment shown. Both this theory and that in those cases reject attempts to limit the definition of pneumoconiosis. Instead, the Act "should be liberally construed to include the largest number of miners within its entitlement provisions."\textsuperscript{110} A narrow view of pneumoconiosis is contrary to the intent of the Black Lung Benefits Reform Act, which "expanded the definition of pneumoconiosis to include 'sequelae' of the disease. . . ."\textsuperscript{111}

\textsuperscript{104} \textit{Id.}
\textsuperscript{105} 887 F.2d 149 (8th Cir. 1989).
\textsuperscript{106} \textit{Id.} at 156.
\textsuperscript{107} \textit{Id.}
\textsuperscript{108} 3 F.3d at 713.
\textsuperscript{109} 908 F.2d 393 (8th Cir. 1990).
\textsuperscript{110} \textit{Supra} note 2.
\textsuperscript{111} \textit{Pauley}, 501 U.S. at 688. The question arises in black lung about proving facts from other cases. This issue arises in this case due to the expert-intensive aspect of federal black lung. The same employer doctors reappear in many cases. Can a party, typically a claimant, prove a fact by reference to a decision in another case? See generally \textit{Kenneth Culp Davis, Administrative Law} (West 1951), concerning a distinction between adjudicative and non-adjudicative facts. This issue could arise in this context where a doctor has been found unreliable in another black lung case.
V. A Neglected Aspect of the Definition is Aggravation

Pneumoconiosis is defined by 20 C.F.R. Section 718.201 as "any respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Additionally, 20 C.F.R. Section 205(c) gives a test for disability causation, including aggravation by exposure to coal dust. Also, 20 C.F.R. Section 718.205(a)(5) states that "[d]eath shall be considered to be due to pneumoconiosis where the cause of death is significantly related to or aggravated by pneumoconiosis."

Campbell v. Consolidation Coal Co. finds that claimant’s thirty-five years of coal mine employment “constitutes sufficient evidence to indicate that his exposure to coal dust at least aggravated his condition. This, coupled with the most recent ventilatory study invoked the presumption and constituted substantial evidence on which the administrative law judge properly based his initial decision.”

A letter from doctor which fails to consider aggravation does not constitute substantial rebuttal under 20 C.F.R. Section 727.2.2(b)(4). Fetty v. Consolidation Coal Co. and Walters v. NACCO rejected medical opinions for failing to discuss aggravation of the miner’s condition with continued exposure.

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114. 811 F.2d 302, 304 (6th Cir. 1987).
115. Id. (emphasis added).
117. 10 Black Lung Rep. 3-230 (ALJ 1987).
119. The question sometimes appears in these cases of whether an ALJ can consider factual matters relating to doctors in black lung cases. This article submits that an ALJ can, provided the facts, resemble "non adjudicative" facts rather than "adjudicative." See Davis Administrative Law. Thus, footnote 2 of Harlan Bell Coal Co. v. Leman, 904 F.2d 1042, 1044 (6th Cir. 1990), identifies Dr. Brent Brandon as a B-reader. An ALJ can consider the fact as established and then give Brandon more weight as such, provided no inference to the contrary arises in the case at bar. Similarly, the ALJ can consider that the doctor maintained an opinion, e.g. that simple pneumoconiosis does not cause total disability, unless there is evidence to the contrary in the case at bar that the doctor no longer so believes.
VI. THE REVERSIBILITY ASPECT

A related objection to the belief that pneumoconiosis might manifest itself in obstructive impairment is that an obstructive impairment might be affected by bronchodilators. The argument goes that this suggests that the impairment is reversible, since it is susceptible to bronchodilators. The argument continues that this is contrary to pneumoconiosis as a progressive irreversible disease.\textsuperscript{120}

This argument is flawed to the extent that it asserts that a progressive disease could show improvement on some indicators. Such an improvement assumes the reliability and validity of the highest scores taken from various indicators.

VII. CONCLUSION

There is little doubt that an ALJ may discount the opinion of a doctor as hostile if that doctor renders an opinion that is contrary to something fundamental to the Act, whether that fundamental aspect be contained in the regulations or in the Act itself.\textsuperscript{121}

Among those things fundamental to the Act is that legal CWP manifests itself in many kinds of impairments, including obstructive impairments and those restrictive. What is less clear, however, is whether an ALJ must reject an opinion where the expert testifies that CWP cannot cause obstructive impairments.\textsuperscript{122} It is the position of this article that an ALJ has a duty to reject such an opinion, either in its entirety, if the dogma infects all of the doctor’s opinions, or so much of those opinions as are infected.

\textsuperscript{120} See Usery, 428 U.S. at 8-9 (disease is progressive “at least in its complicated stage . . . ”).

\textsuperscript{121} See supra text accompanying notes 47-63.

\textsuperscript{122} Compare Blakley, 54 F.3d at 1321 (refusing to reject such an opinion) with Freeman, 957 F.2d at 303. See also supra note 44 and accompanying text.
VIII. APPENDIX


