No. 14-2157

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

WEST VIRGINIA CWP FUND,
as carrier for PEN COAL CORP.,

Petitioner

v.

KENNETH GREGORY

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
UNITED STATES DEPARTMENT OF LABOR,

Respondents

On Petition for Review of an Order of the Benefits Review Board,
United States Department of Labor

BRIEF FOR THE FEDERAL RESPONDENT

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STATEMENT REGARDING ORAL ARGUMENT

Oral argument is unnecessary in this case because the dispositive issues have been authoritatively decided and the facts and legal arguments are adequately presented in the briefs. *See* Fed. R. App. P. 34(a). If argument is scheduled, however, the Director, as the administrator of the Black Lung Benefits Act, requests an opportunity to participate.

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JURISDICTIONAL STATEMENT

This case involves a 2009 claim for benefits under the Black Lung Benefits Act ("BLBA" or "the Act"), 30 U.S.C. §§ 901-944, filed by Kenneth Gregory, a former coal miner. On April 30, 2013, Administrative Law Judge Peter Silvain issued a decision awarding Mr. Gregory benefits and ordering his former

employer, Pen Coal Corporation, to pay them. Joint Appendix ("A.") 72. Pen Coal appealed this decision to the United States Department of Labor Benefits Review Board on May 15, 2013, within the thirty-day period prescribed by 33 U.S.C. § 921(a), as incorporated into the Act by 30 U.S.C. § 932(a). The Board had jurisdiction to review the ALJ's decision pursuant to 33 U.S.C. § 921(b)(3), as incorporated by 30 U.S.C. § 932(a).

The Board affirmed the award on April 25, 2014, and then denied Pen Coal's motion for reconsideration on August 28, 2014. A.73, 80. Pen Coal petitioned this Court for review on October 27, 2014. This Court has jurisdiction over the petition because 33 U.S.C. § 921(c), as incorporated by 30 U.S.C. § 932(a), allows an aggrieved party sixty days to seek review of a final Board decision in the court of appeals in which the injury occurred. Mr. Gregory's exposure to coal mine dust – the injury contemplated by 33 U.S.C. § 921(c) – occurred in West Virginia, within this Court's territorial jurisdiction. A.26-27, 75.

ISSUE STATEMENT

In black lung proceedings, an ALJ is charged with evaluating the credibility of witnesses and weighing conflicting evidence. Here, the ALJ considered all the evidence and credited the opinion of Dr. Stark, a pulmonary specialist who has treated Mr. Gregory since 1996, over the opinions of Pen Coal's medical experts. Does substantial evidence support the ALJ's weighing of the medical opinion evidence?

STATEMENT OF THE CASE

A. Legal Framework

The BLBA provides disability compensation and certain medical benefits to former coal miners who are totally disabled by pneumoconiosis, a respiratory impairment commonly referred to as "black lung disease." Pneumoconiosis can take two forms, clinical and legal, *Harman Min. Co. v. Looney*, 678 F.3d 305, 308 (4th Cir. 2012), but only legal pneumoconiosis is at issue in this case. Legal pneumoconiosis consists of "any chronic lung disease or impairment . . . arising out of coal mine employment" and specifically may include "any chronic restrictive or obstructive pulmonary disease." 20 C.F.R. § 718.201(a)(2).

In lay terms, restrictive disease makes it more difficult to inhale, while obstructive disease makes it more difficult to exhale. *See Gulf & Western Indus. v. Ling*, 176 F.3d 226, 229 n.6 (4th Cir. 1999). In medical terms, restrictive disorders

are characterized by a reduction in lung volume, while obstructive disorders are characterized by a reduction in airflow. *The Merck Manual* 1855, 1853. Chronic bronchitis is an obstructive lung disease. *Peabody Coal Co. v. Opp*, 746 F.3d 1119, 1121 n.2 (9th Cir. 2014). When caused by exposure to coal mine dust, chronic bronchitis is a form of "legal pneumoconiosis." *Sunny Ridge Mining Co., Inc. v. Keathley*, 773 F.3d 734, 739 (6th Cir. 2014).

An ALJ may make a finding of pneumoconiosis based on a doctor's diagnosis of the disease, so long as the doctor takes a history and conducts objective tests and a physical examination. 20 C.F.R. § 718.202(a)(4). The ALJ is also required to take note of a treating physician's opinion. 20 C.F.R. § 718.104(d).

Coal mine dust exposure need not be the sole cause of a claimant's respiratory impairment. *Westmoreland Coal Co., Inc. v. Cochran*, 718 F.3d 319, 323 (4th Cir. 2013). Rather, a miner is entitled to benefits if his totally disabling respiratory impairment is "substantially aggravated by" coal mine dust. 20 C.F.R. § 718.201(b).

B. Procedural History

This is Mr. Gregory's second claim for black lung benefits. An ALJ denied his previous claim in 2008, and Mr. Gregory took no further action.[1] A.74 n.1.

Mr. Gregory filed the instant claim for benefits in December 2009. A.1-4. A "subsequent claim" like Mr. Gregory's must be denied unless the claimant can prove that something significant has changed since the last claim was denied. *See* 20 C.F.R. § 725.309(c). The ALJ here determined that Mr. Gregory demonstrated such a change, namely that he is now totally disabled, A.54-56, and Pen Coal has not challenged this determination. Once a claimant proves a change in condition, none of the findings made in relation to the previous claim are binding. 20 C.F.R. § 725.309(c)(5); *Lisa Lee Mines v. Rutter*, 86 F.3d 1358, 1360-61 (4th Cir. 1996) (en banc).

Following a hearing in November 2011, the ALJ awarded benefits. A.31-72. Specifically, the ALJ found that Mr. Gregory's coal mine work caused chronic bronchitis, and the chronic bronchitis worsened a pre-existing problem with Mr. Gregory's trachea,[2] resulting in a totally disabling respiratory impairment. A.58,

[1] Mr. Gregory filed a third application for benefits, but because he voluntarily withdrew it, A.74 n.1, it is treated as if it had never been filed. 20 C.F.R. § 725.306(b).

[2] The trachea, commonly called the windpipe, is the tube that connects the throat to the lungs. Dorland's Illustrated Medical Dictionary 1944 (32nd ed. 2012).

69. In coming to this conclusion, the ALJ credited the medical opinion of Mr. Gregory's treating physician, Dr. Stark, as supported by the opinion of Dr. Baker, and discredited Pen Coal's experts, Drs. Tuteur and Crisalli. A.67-69.

Pen Coal appealed to the Benefits Review Board, arguing that the ALJ improperly weighed the medical evidence. A.76. The Board found that the ALJ, as trier of fact, has the discretion to determine the weight and credibility of the medical experts' opinions. A.76-77. The Board therefore affirmed the ALJ's determination that legal pneumoconiosis contributed to Mr. Gregory's total disability. A.77-78.

FACTS

A. Mr. Gregory's Smoking History & Coal Mine Employment

Mr. Gregory smoked about a pack of cigarettes a day for thirty-seven years, but he quit in 1992. A.33. Mr. Gregory worked at various surface coal mines, sometimes called strip mines, for twenty-five years, most recently for Pen Coal. A.22, 33. He primarily worked as a dozer operator, but he did other work when needed, including loading coal, sweeping, and loading holes,[3] sometimes working around drills. A.17, 20, 32.

[3] "Loading holes" generally refers to placing explosives in a drilled hole. *See Strawser v. Patriot Mining Co.*, BRB No. 12-0627, 2013 WL 5786375, *2-3 (Sept. 23, 2013) (unpublished); Kentucky Coal and Energy Education Project, Glossary of Mining Terms, *available at* http://www.coaleducation.org/glossary.htm#L

Mr. Gregory's coal mine work was dusty, and he inhaled dust while doing all of these jobs. A.18, 20-21, 23. The last few years of his employment, Mr. Gregory operated a dozer with an enclosed cab. However, dust still found its way into the cab and covered the dashboard. A.21. Mr. Gregory quit coal mine work in 2001. At trial, he testified that he could not return to coal mine employment: "I couldn't stand that dust." A.23.

B. Relevant Medical Evidence

Pen Coal does not dispute that Mr. Gregory is totally disabled. The disputed medical issues are (1) whether Mr. Gregory has legal pneumoconiosis and (2) if so, whether legal pneumoconiosis caused his disability. In evaluating these issues, the ALJ considered the opinions of six doctors, three of whom found Mr. Gregory totally disabled due to legal pneumoconiosis and three of whom did not. A.67. Of these six doctors, the ALJ fully credited only the opinion of Mr. Gregory's treating physician, Dr. Stark, while partially crediting Dr. Baker. The ALJ discredited Pen Coal's doctors, including Dr. Tuteur and Dr. Crisalli. Pen Coal's arguments at this stage of the litigation challenge the ALJ's weighing of these four doctors' opinions. This brief will describe only those opinions in detail.[4]

[4] Mr. Gregory's treatments records also contain notes of a heart catheterization performed by Dr. Paulus on an out-patient basis. Dr. Paulus noted the presence of pneumoconiosis. A.157.

1. Dr. Stark

Dr. Stark, a pulmonary specialist, is Mr. Gregory's treating physician. A.22-23. Dr. Stark has treated Mr. Gregory since at least 1996, A.247, usually at King's Daughters' Medical Center, e.g., A.158, but also at Tristate Pulmonary Associates, A.141-42. As long ago as 1999, Dr. Stark described Mr. Gregory in his treatment notes as "well known" to his practice. A.158.

Dr. Stark has examined Mr. Gregory dozens of times, A.142, 171-72, 174-75, 251, 254-75, 278-79, 284-85, 295, ordered numerous chest x-rays, A.138-39, 141-45, 148, and other pulmonary tests, A.117-18, 121-31, 140, 146, 164-66, 229-31, 247-49, and performed or ordered various procedures related to Mr. Gregory's trachea and lungs, A.103-04, 140, 147, 167, 169-70, 177-78. At the time of trial, Mr. Gregory was seeing Dr. Stark every three months. A.26. Mr. Gregory testified "All I got to do if I've got to go to the hospital is call Stark and he's there." A.26.[5]

In 1993, Mr. Gregory was hit by a coal truck. A.39. He suffered traumatic injuries, including rib fractures and pneumothorax (an accumulation of air or gas in the pleural space), which were treated with a chest tube and tracheostomy (the insertion of a breathing tube into the trachea). A.174, 275. Treatment

[5] The Director has provided a timeline and summary of Dr. Stark's treatment of Mr. Gregory's respiratory condition in an addendum to this brief.

complications focused on Mr. Gregory's trachea. A.158. In 1996, Dr. Stark diagnosed Mr. Gregory with tracheomalacia, which means his trachea is soft and floppy instead of rigid in the area of the previous tracheostomy. A.174, 272.

In April 1998, Mr. Gregory's tracheomalacia worsened, making it difficult for him to breathe. A.174-75. Dr. Stark inserted a silastic (silicone and plastic) stent into the trachea, and Mr. Gregory's breathing improved. A.177-78, 264. By the following year, however, the stent had shifted, and Mr. Gregory was again having difficulty breathing. A.171-72. In July 1999, Dr. Stark removed the silastic stent and replaced it with a wire mesh stent. A.167, 169-70. Dr. Stark continues to monitor Mr. Gregory's trachea and to note tracheomalacia in his treatment notes. *See*, *e.g.*, A.284-85. However, the wire mesh stent appears to have resolved Mr. Gregory's acute tracheal problems. At a visit two months after its insertion, Dr. Stark indicated Mr. Gregory's breathing had stabilized, and his cough was better. A.258.

In addition to treating Mr. Gregory's tracheal problem, Dr. Stark has monitored the health of Mr. Gregory's lungs over the years. As noted above, Dr. Stark regularly examined him, finding respiratory abnormalities such as persistent sputum production, cough, and crackles[6]; A.260, 285, 254,263, 278, 284; and he

[6] Crackles are a noise sometimes made by the lungs of a person with a respiratory disease. Dorland's Illustrated Medical Dictionary 1576 (32nd ed. 2012).

ordered repeated chest x-rays and pulmonary function tests (PFTs). A.138-39,141-45,148, 247-49, 274-75. Dr. Stark's treatment records reveal his consistent opinion that Mr. Gregory has chronic bronchitis, which is a form of chronic obstructive pulmonary disease (COPD).[7] A.158-60, 171-72, 262, 278, 295-96. In 2005, Dr. Stark attributed Mr. Gregory's chronic bronchitis to coal dust exposure. A.296. He concluded that Mr. Gregory's "chronic dust exposure has caused an industrial bronchitis" that worsened his tracheomalacia and caused him to be totally disabled and incapable of engaging in coal mine work. A.296. In 2008, Dr. Stark also diagnosed Mr. Gregory with restrictive lung disease. A.278-79.

2. Dr. Baker

Dr. Baker, who is Board-certified in internal medicine and pulmonary disease, has examined Mr. Gregory three times, on April 29, 2005, October 9, 2010, and October 7, 2011. A.39, 47, 399. He took chest x-rays and conducted pulmonary function and arterial blood gas studies. *Id*. Based on the test results, Mr. Gregory's history, and the physical examination, Dr. Baker diagnosed Mr. Gregory with COPD. He found that Mr. Gregory has a severe obstructive defect, a moderate degree of restriction, and chronic bronchitis. A.358. He concluded that

[7] COPD is a lung disease characterized by airflow obstruction. *The Merck Manual* 1889 (19th ed. 2011). COPD encompasses chronic bronchitis, emphysema, and certain forms of asthma. *Id*.

Mr. Gregory's long exposure to coal dust significantly contributed to these conditions. *Id*.

Dr. Baker initially had an incorrect understanding of Mr. Gregory's smoking history. A.356. At deposition, on receipt of an accurate smoking history, Dr. Baker gave his opinion that both smoking and coal mine work contributed to Mr. Gregory's lung problems. A.420, 422. He referenced medical literature showing that smoking and coal dust exposure are additive when it comes to respiratory impairments. A.420, 422.

Dr. Baker was aware that Mr. Gregory had been struck by a coal truck and had a tracheal stent inserted. A.357. Although he speculated that the stent might have been due to tracheomalacia, Dr. Baker was uncertain that was the cause as he had not reviewed Dr. Stark's medical records. A.413-14.

3. Dr. Tuteur

Like Dr. Baker, Dr. Tuteur is Board-certified in internal medicine and pulmonary disease. Dr. Tuteur did not examine Mr. Gregory, nor did he review Dr. Stark's treatment records before completing his initial report. A.384-90. Dr. Tuteur concluded that Mr. Gregory has both a restrictive abnormality and an airflow obstruction. He attributed these lung problems to the coal truck crash, cigarette smoking, and obesity, and not to pneumoconiosis. A.387-89, 449.

Before being deposed, Dr. Tuteur reviewed some of Dr. Stark's treatment records. A.434. At deposition, Dr. Tuteur repeated the conclusions set out in his initial report. A.447-54. He also explained his belief that non-smokers rarely, if ever, develop chronic bronchitis, making it more likely Mr. Gregory's respiratory problems are due to smoking. A.451, 453. According to Dr. Tuteur, only one percent of non-smoking coal miners will develop COPD, while twenty percent of smokers will. A.451.

4. Dr. Crisalli

Dr. Crisalli, too, is Board-certified in internal medicine and pulmonary disease. A.297. He examined Mr. Gregory once, on May 22, 2006, at the request of Pen Coal, reviewed some treatment records, and was deposed. A.297-301, 306-34. Dr. Crisalli concluded that Mr. Gregory did not have "coal workers' pneumoconiosis." A.300. He also found that the large majority of Mr. Gregory's pulmonary function tests and arterial blood gas studies produced variable (and invalid) results, and therefore failed to demonstrate "any type of pulmonary abnormality in Mr. Gregory." A.327, 334. To the extent the pulmonary function tests were reliable, Dr. Crisalli believed the results were within normal limits and tended to rule out any restrictive lung condition. A.301.

Dr. Crisalli attributed any breathing problems Mr. Gregory might have to obesity. A.301. He concluded that Mr. Gregory's lungs would not prevent him

from returning to coal mine work, though his obesity and problems related to his trachea might. *Id.*

C. The ALJ and Board Decisions

On April 30, 2013, the ALJ issued a decision awarding Mr. Gregory benefits. A.31. He first concluded that Mr. Gregory suffers from a totally disabling respiratory impairment. A.58. Next, the ALJ declined to invoke the fifteen-year presumption, despite Mr. Gregory's twenty-five years of coal mine employment. He found that Mr. Gregory failed to establish that the dust conditions at the surface mines where he was employed were "substantially similar" to those of an underground mine. A.60.

The ALJ went on to consider whether Mr. Gregory proved that he has pneumoconiosis. The ALJ credited the medical opinion of Dr. Stark that Mr. Gregory has chronic bronchitis caused by coal mine employment, and the bronchitis worsens the tracheomalacia. A.69. The ALJ noted Dr. Stark's familiarity with Mr. Gregory, his long-term treatment of the tracheomalacia, and his repeated diagnosis of chronic bronchitis. A.69. The ALJ found Dr. Stark's opinion well-reasoned and well-documented. *Id*.

The ALJ further found Dr. Stark's opinion to be supported by that of Dr. Baker, who also believes Mr. Gregory has COPD caused at least in part by coal dust inhalation. A.69. While the ALJ found Dr. Baker's opinion to be incomplete

on its own because he had limited information about Mr. Gregory's tracheomalacia, the ALJ found merit in Dr. Baker's explanation that the effects of coal dust exposure and smoking are additive or synergistic and may together cause COPD. A.67. He concluded that, together, the opinions of Dr. Stark and Dr. Baker supported a finding of legal pneumoconiosis. A.67, 69.

The ALJ discredited Dr. Tuteur's opinion that Mr. Gregory did not have legal pneumoconiosis. A.68. The ALJ recognized that Dr. Tuteur believed the "major explanation" for Mr. Gregory's respiratory problems involved his tracheomalacia. A.68. But the ALJ further understood that Dr. Tuteur "entertained" the possibility of other causes. *Id*. In this regard, the ALJ rejected Dr. Tuteur's diagnosis of smoking-induced COPD because Dr. Tuteur's belief that non-smoking miners rarely develop the disease is "not in accord with the prevailing view of the medical community." *Id*.

The ALJ likewise gave little weight to Dr. Crisalli's opinion that Mr. Gregory did not have legal pneumoconiosis. A.67. Dr. Crisalli was the only doctor to conclude that Mr. Gregory had no restrictive impairment. The ALJ accordingly gave less weight to Dr. Crisalli's opinion, given its inconsistency with the most recent and probative medical evidence. *Id*.

Finally, the ALJ considered whether Mr. Gregory's total respiratory disability is due to his legal pneumoconiosis. A.70-71. Again, the ALJ credited

Dr. Stark's opinion that chronic bronchitis substantially contributed to Mr. Gregory's total disability and discredited Dr. Tuteur's opinion because he did not diagnose pneumoconiosis, and Dr. Crisalli's because he did not diagnose a totally disabling respiratory impairment. A.70-71.

On April 25, 2014, the Benefits Review Board affirmed the award of benefits. A.73. The Board held that the ALJ acted within his discretion in crediting Dr. Stark's opinion, as supported by Dr. Baker, over the opinions of Dr. Tuteur and Dr. Crisalli. A.76-77. Because it affirmed the ALJ's decision on the merits, the Board declined to address Mr. Gregory's argument that the ALJ erred in refusing to apply the fifteen-year presumption. A.78 n.9.

SUMMARY OF ARGUMENT

Given the deferential substantial evidence standard of review, it is not surprising that Pen Coal couches its argument in terms of the legal sufficiency of the evidence. But a close reading reveals that Pen Coal's entire argument comes down to an attack on the ALJ's decision to credit one doctor over another. And that makes this an easy case to decide because this Court "'defer[s] to the ALJ's evaluation of the proper weight to accord conflicting medical opinions.'" *Harman Mining Co. v. Looney*, 678 F.3d 305, 310 (4th Cir. 2012) (quoting *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 342 (4th Cir.1996)).

Pen Coal primarily contends that the ALJ's reliance on the opinion of Dr. Stark is improper "as a matter of law." That dramatic overstatement is incorrect. Dr. Stark, Mr. Gregory's long-time treating doctor, examined and tested Mr. Gregory dozens of times for more than a decade. Based on his intimate knowledge of Mr. Gregory's respiratory condition, Dr. Stark diagnosed chronic bronchitis caused by coal mine dust. Although Dr. Stark did not delineate the underlying basis for his diagnosis, this Court has held that a medical opinion by a doctor who conducts objective tests and a physical examination need not contain any further explanation, and an ALJ has discretion to rely on such an opinion. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 212 (4th Cir. 2000).

Pen Coal also argues that the ALJ improperly gave less weight to its medical experts. But the ALJ reasonably discredited Dr. Tuteur based on his idiosyncratic beliefs, which have been rejected by the medical community. And he reasonably gave less weight to Dr. Crisalli based on his less-than-complete understanding of Mr. Gregory's health. These reasonable judgments are entitled to deference, and the Court should affirm the award below.

ARGUMENT

I. The ALJ Acted Within His Discretion in Crediting the Opinion of Dr. Stark, as Supported by Dr. Baker, Over the Opinions of Drs. Tuteur and Crisalli

A. Standard of Review

Pen Coal's brief is dedicated to challenging the ALJ's credibility determinations and weighing of the medical opinion evidence. This Court must affirm the ALJ's decision if it is in accordance with the law and supported by substantial evidence. *Mingo Logan Coal Co. v. Owens*, 724 F.3d 550, 556-57 (4th Cir. 2013). The evidence is substantial if a reasonable mind would accept it as adequate to support the finding under review. *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753, 756 (4th Cir. 1999). Accordingly, this Court will uphold ALJ decisions that rest within the "realm of rationality," and will not reweigh the evidence or set aside an inference "merely because it finds the opposite conclusion more reasonable." *Doss v. Itmann Coal Co.*, 53 F.3d 654, 659 (4th Cir. 1995).

Subject to the substantial evidence requirement, this Court defers to the ALJ's evaluation of the proper weight to give conflicting medical opinions. *Harman Mining Co. v. Looney*, 678 F.3d 305, 310 (4th Cir.2012). The ALJ, in turn, is not bound to accept any medical expert opinion but "must evaluate the evidence, weigh it, and draw his own conclusions." *Lane v. Union Carbide Corp*., 105 F.3d 166, 173 (4th Cir. 1997).

B. Dr. Stark's opinion is legally sufficient to support an award of benefits, and substantial evidence supports the ALJ's decision to credit it.

In its attempt to avoid the substantial evidence standard, Pen Coal argues that Dr. Stark's opinion is insufficient as a matter of law to support an award of benefits. Pet'r Br. 11, 14, 19. This argument has no merit.

The Act's implementing regulations allow an ALJ to find pneumoconiosis based on a physician's "reasoned" opinion, so long as the opinion is based on "objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories." 20 C.F.R. § 718.202(a)(4). That's what the ALJ did here. Noting Dr. Stark's treatment of Mr. Gregory "for many years," the "many objective tests" he conducted on Mr. Gregory, and his "familiarity with [Mr. Gregory's] medical and social histories," the ALJ concluded that Dr. Stark's opinion meets the requirements of Section 718.202(a)(4). A.66, 69.

Pen Coal argues, however, that the ALJ could not credit Dr. Stark's opinion because it was not sufficiently explained. This Court has rejected similar arguments. In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 212 (4th Cir. 2000), the Court affirmed an ALJ's reliance on an opinion that "did not offer any explanation" for the doctor's diagnosis. Recognizing that "it is the province of the ALJ to evaluate the physicians' opinions," the Court held that an ALJ "may choose

to discredit an opinion that lacks a thorough explanation, but is not legally compelled to do so." *Id*. Because the doctor in *Compton* relied on the factors set out in Section 718.202(a)(4) – the claimant's medical history, exposure to coal dust and cigarette smoke, physical examination, and pulmonary function tests – the Court found the doctor's report to be a "reasoned medical opinion." *Id*. at 212. *See also Harman Mining*, 678 F.3d at 311 ("The ALJ did not err in giving determinative weight to Dr. Forehand's opinion because, despite its brevity, the ALJ found that the totality of the report indicated that it was 'well-reasoned.'"); *Nance v. Benefits Review Board*, 861 F.2d 68, 70-71 (4th Cir. 1998) (affirming ALJ's causation finding based on physician's checking the "yes" box that "whatever condition [the miner] has is related to dust exposure in [the miner's] coal mine employment").

Other courts have come to the same conclusion. In *Poole v. Freeman United Coal Mine Co.*, 897 F.2d 888, 893-94 (7th Cir. 1990), the Seventh Circuit concluded that a doctor's completion of a DOL form, "without elaborating upon his diagnoses, opinion as to causation, or medical assessment," constituted a documented and reasoned medical judgment. The doctor there had conducted a physical examination, ordered numerous tests, and taken medical and work histories. *Id*. "Considering all the sources of information available to the physician and the conclusions reached, the ALJ, as fact-finder, properly decided

that [the doctor's] medical reports were reasoned….[and] it was beyond the Board's power to reweigh the evidence." *Id*.

Conley v. Nat'l Mines Corp., 595 F.3d 297 (6th Cir. 2010), cited by Pen Coal, does not hold otherwise. Pet'r Br. 20. The question in that survivor's claim was whether pneumoconiosis "hastened" the miner's death, and the Sixth Circuit required evidence that "a specifically defined process" reduced the miner's life by "an estimable time." *Id*. at 303-04. Where death is not involved, however, the Sixth Circuit agrees with this Court that an ALJ's decision to credit a medical opinion lacking "an articulate rationale" is "essentially a credibility matter." *Wolf Creek Collieries v. Stephens*, 298 F.3d 511, 522 (6th Cir. 2002); *see also Peabody Coal Co. v. Groves*, 277 F.3d 829, 836 (6th Cir. 2002) (affirming ALJ's credibility finding despite employer's allegation that the doctor's opinion was conclusory and not supported by the underlying documentation).

Pen Coal ignores these cases, but Dr. Stark's opinion satisfies the requirements that this Court and others have set out for a reasoned medical opinion. He has examined Mr. Gregory multiple times a year since 1996, A.174-75, 251, 254-75, 278-79, 284-85, 295, is familiar with his work and smoking histories, A.275, and has ordered dozens of pulmonary tests and procedures over nearly two decades of treatment, A.98, 103-04, 117-18, 121-32, 138-48, 161-66, 229-31, 239-42, 247-49, 273. While Pen Coal suggests Dr. Stark's opinion is

unscientific, it fails to identify any errors in his treatment notes and test results. Pet'r Br. 19. Moreover, his diagnosis of industrial bronchitis is completely consistent with the underlying medical science, which establishes a link between coal dust exposure and the disease. 65 Fed. Reg. 79939-40 (Dec. 20, 2000). The idea that the ALJ was not permitted to credit Dr. Stark on this record is completely without merit.

Furthermore, the Act's implementing regulations actually require the ALJ to take note of a treating physician's opinion. 20 C.F.R. § 718.104(d) states that the fact-finder "*must* give consideration to the relationship between the miner and any treating physician whose report is admitted into the record" (emphasis added). It further sets out several factors the ALJ "shall" take into consideration, including the nature of claimant's relationship with the treating physician, the duration of that relationship, and the frequency and extent of treatment. *Id*. The ALJ here may not have cited the regulation, but he expressly considered these factors in his decision. A.33, 69. His determination to accord weight to Dr. Stark's opinion based on these factors is reasonable, supported by substantial evidence, and entitled to affirmance by this Court. S*ee Mingo Logan Coal Co. v. Owens*, 724 F.3d 550, 559 (4th Cir. 2013) (ALJ's decision to give "significant weight" to treating physicians was "appropriate" in light of § 718.104(d)).

Indeed, this Court has repeatedly "emphasized the importance of the miner's treating physician's opinion." *See, e.g., Collins v. Pond Creek Mining Co.*, 751 F.3d 180, 185 (4th Cir. 2014). While Pen Coal correctly notes that the ALJ may not "mechanistically credit[], to the exclusion of all other testimony," the opinion of a treating physician, *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997), the ALJ here did no such thing. Rather than giving Dr. Stark controlling weight based solely on treating-physician status, the ALJ properly took into consideration the fact that Dr. Stark "treated [Mr. Gregory] for many years," "reviewed many objective tests," and was extremely "familiar[] with his medical and social histories." A.69, 71. The ALJ then weighed Dr. Stark's opinion against the other opinions in the record and found Dr. Stark's opinion to be the "most persuasive." A.69, 71. This is exactly what the ALJ is supposed to do. *See Collins*, 751 F.3d at 183 (ALJ may give special consideration to treating physician); *Consolidation Coal Co. v. Held*, 314 F.3d 184, 187-88 (4th Cir. 2002) (same).

Pen Coal's argument that Dr. Stark's opinion can't be trusted is particularly remarkable given its position that tracheomalacia is the major cause of Mr. Gregory's respiratory problems. Dr. Stark first diagnosed Mr. Gregory's tracheomalacia back in 1996; he was the surgeon who inserted the stents to treat the problem; and he has been regularly monitoring Mr. Gregory's condition ever

since. A.26,169-70,177-78,272-73,284. Surely, Dr. Stark was well-positioned to assess the cumulative impact of the tracheomalacia, the stents, and Mr. Gregory's twenty-five years of coal dust exposure.

Indeed, Pen Coal's failure to appreciate the significance of Dr. Stark's continuing treatment of Mr. Gregory's tracheomalacia leads to its erroneous claim that the ALJ should have rejected Dr. Stark's opinion as he did Dr. Paulus's. Pet'r Br. 21. The ALJ found Dr. Paulus's one word notation of pneumoconiosis unexplained. A.66. But Dr. Paulus saw Mr. Gregory only twice, once in 1996 and once in 2003, for heart problems, not for his respiratory condition. His involvement extended to conducting a bicycle stress test and performing an outpatient heart catheterization. A.98, A.154-57.[8] Unlike Dr. Stark, Dr. Paulus conducted no chest x-rays, pulmonary function tests, arterial blood gas studies, or CT scans. In short, Pen Coal's attempt to put both doctors on an equal footing demonstrates a singular disregard for the facts.

Pen Coal also attacks the ALJ's finding that Dr. Baker's opinion supports Dr. Stark's conclusions. Pet'r Br. 22-23. Pen Coal wrongly claims that the ALJ discredited Dr. Baker. In fact, the ALJ "f[ou]nd merit in Dr. Baker's reasoning" that coal dust exposure can cause COPD and chronic bronchitis. A.67. The ALJ

[8] From Dr. Paulus's notes, it is unclear whether he diagnosed pneumoconiosis, or was simply reporting it as part of Mr. Gregory's medical history.

accordingly found it supported Dr. Stark's diagnosis of industrial bronchitis, which he fully credited. A.69. This is a permissible weighing of the evidence. *See Harman Mining*, 678 F.3d at 311 ("The ALJ recognized that Dr. Robinette's opinion was 'not sufficiently unequivocal' to 'stand on its own,' but provided support for Dr. Forehand's opinion, on which she relied 'most heavily.'").

The ALJ had the opinions of six doctors before him. He fully credited Dr. Stark, partially credited Dr. Baker, and rejected or gave less weight to the remaining opinions. The ALJ's weighing of this evidence is entitled to deference, and the Court should affirm these findings. *Id.* at 310; *Lane v. Union Carbide Corp*., 105 F.3d 166, 173 (4th Cir. 1997).

C. The ALJ permissibly discredited Dr. Tuteur

Pen Coal next argues that the ALJ irrationally rejected Dr. Tuteur's opinion for "espous[ing] the erroneous view that the risk of developing clinically meaningful airway obstruction from smoking compared to coal dust inhalation is twenty to one." A.68. However, the ALJ's decision is rational and supported by substantial evidence.

In promulgating the black lung regulations in 2000, the Department "reviewed all of the medical and scientific evidence" submitted by the public and the National Institute for Occupational Safety and Health (NIOSH). 65 Fed. Reg. 79,939 (Dec. 20, 2000). That evidence demonstrated that the lung function of coal

miners declines in relation to their coal dust exposure, and that the decline "occurs at a similar rate in smokers and nonsmokers." 65 Fed. Reg. 79,939. The Department further found that "the incidence of nonsmoking coal miners with intermediate dust exposure developing moderate obstruction . . . is roughly equal to the incidence of moderate obstruction in smokers with no mining exposure." 65 Fed. Reg. 79,940.

The ALJ here reasonably determined that Dr. Tuteur's opinion is inconsistent with the Department's assessment of the scientific evidence on the incidence of COPD in coal miners. A.68. Dr. Tuteur rejected a diagnosis of chronic bronchitis caused by coal dust in part because of Mr. Gregory's smoking history. Dr. Tuteur stated that "20 percent of most adult cigarette smokers develop a clinically meaningful airflow obstruction," while "this occurs probably around 1 percent of the time in never-smoking coal miners." A.451. Dr. Tuteur's statements are in direct contradiction to the Department's findings.

Tellingly, Pen Coal does not dispute that Dr. Tuteur's views are at odds with the Department's findings and those of the scientific community. Instead, it argues that Dr. Tuteur's comments were "harmless" and "irrelevant to Dr. Tuteur's analysis." Pet'r Br. 33. But Dr. Tuteur made these comments in direct response to a question about the "basis for [his] opinion" that Mr. Gregory did not have legal pneumoconiosis. A.447. The Board and the courts have repeatedly agreed that

ALJs may discredit Dr. Tuteur when he bases his opinion on inaccurate scientific information. *See, e.g., Peabody Coal Co. v. Opp*, 746 F.3d 1119, 1124-25 (9th Cir. 2014) (affirming ALJ's decision to discount Dr. Tuteur's opinion because it was "not in accord with prevailing medical views, as set forth in the regulatory preamble"); *Consolidation Coal Co. v. Beeler*, 521 F.3d 723, 725-26 (7th Cir. 2008) (finding "sensible" ALJ's decision to discredit Dr. Tuteur's opinion that "miners with no smoking history rarely have COPD, while smokers have a one in five chance of developing a severe obstruction"); *Christenberry v. Heritage Coal Co*., BRB No. 14-0232, 2014 WL 7249320 (2014) (unpublished) (same). Accordingly, the ALJ's decision to reject Dr. Tuteur's testimony was both rational and supported by substantial evidence.[9]

Other aspects of Dr. Tuteur's reasoning are equally inconsistent with the Act and the black lung regulations. As Pen Coal itself explains, Dr. Tuteur "excluded chronic bronchitis because Mr. Gregory did not satisfy the WHO [World Health Organization] definition for the disease," which permits the diagnosis only when

[9] Dr. Tuteur's dispute with the scientific community is ongoing. In this case he rejects the findings of a study that the National Institute of Occupational Safety and Health (NIOSH) expressly relied on in assessing the detrimental impact of coal dust exposure on respiratory health. *Compare* A.462-63 *with* NIOSH Bulletin 64 at 23-24 (reviewing the recent literature on the effects of coal dust exposure) (available at http://www.cdc.gov/niosh/docs/2011-172/). NIOSH is an agency in the Center for Disease Control and is the statutory consultant to the Department on black lung issues. 30 U.S.C. § 811(a)(1); 902(f)(1)(D).

no other explanation exists. Pet. Br. 29-30; *see* A.450 (testifying that because other "major explanation[s]" for Mr. Gregory's condition exist, "we don't have chronic bronchitis" "by strict enforcement of the [WHO] definition"). But neither the Act nor the regulations make black lung disease a diagnosis of last resort. *See* 30 U.S.C. § 902(b); 20 C.F.R. § 718.201(a)(2).[10] Just the opposite is the case. Congress adopted various presumptions designed *to aid* claimants in establishing that they are totally disabled by pneumoconiosis because of the difficulty in proving the disease. *See generally Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 10 (1976) ("The Act prescribes several 'presumptions' for use in determining compensable disability[.]") Dr. Tuteur's prescription to look first for any explanation other than coal dust exposure, while serendipitous for Pen Coal, simply turns congressional intent on its head.

Dr. Tuteur's opinion also does not withstand close scrutiny for other reasons. It is riddled with errors and inconsistencies. For instance, he states "there is no evidence of myocardial dysfunction," yet four paragraphs earlier he reports "coronary artery disease" and an "old myocardial infarction." A.386. He states there was no evidence of respiratory crackles, but the treatment records (which he

[10] Black lung is a disease "arising out of coal mine employment" and includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 718.201(b).

supposedly reviewed) show otherwise. *Compare* A.387, 449 *with* A.260, 285. His report indicates Mr. Gregory had no impairment of oxygen gas exchange at rest, but he testified at deposition that there was a "mild impairment or inefficiency" at rest. *Compare* A.386 *with* A.444. Perhaps most glaring of all, Dr. Tuteur's table of "the totality of available pulmonary function data" omits *all* of the FVC results and the FEV-1/FVC ratios. *See* A.388. These numbers are fundamental to understanding Mr. Gregory's lung condition, and it is unclear to what extent Dr. Tuteur considered them.[11] Given these inaccuracies in Dr. Tuteur's opinion, Pen Coal's championing of it because he "reviewed many more" records than Dr. Stark rings hollow to say the least.

Nor is Dr. Tuteur's opinion as clear as Pen Coal asserts. While at times he opines that tracheomalacia is the sole cause of Mr. Gregory's problems, he also retreats from that categorical view, expressing "the safe answer . . .that a *major*

[11] Pulmonary function tests, also called spirometry, "measure the degree to which breathing is obstructed." *See Yauk v. Director, OWCP*, 912 F.2d 192, 196 n.2 (8th Cir. 1989). These tests measure data such as the volume of air that a miner can expel in one second after taking a full breath (forced expiratory volume in one second, or FEV1), the total volume of air that a miner can expel after a full breath (forced vital capacity, or FVC), and the ratio between those two data points. *See* Occupational Safety and Health Administration, U.S. Department of Labor, Spirometry Testing in Occupational Health Programs: Best Practices for Healthcare Professionals, at 1-2 (2013), available at https://www.osha.gov/Publications/OSHA3637.pdf. Pulmonary function tests resulting in certain values established in the regulations are evidence of total disability in BLBA claims. *See* 20 C.F.R. § 718.204(b)(2)(i); 20 C.F.R. Part 718 Appendix B.

part of this phenotype is due to the tracheomalacia and the placement of the stent and its sequelae, and *far less likely* to be contributed to by the inhalation of coalmine dust." *Compare* A.455 *with* A.454 (emphasis added). Given Dr. Tuteur's "safe answer," the ALJ reasonably believed that Dr. Tuteur "entertained the possibility that Claimant's obstruction was not entirely caused by the tracheal stent." A.68; *see Midland Coal v. Shores*, 358 F.3d 486, 492-93 (7th Cir. 2004) (stating an ALJ's reasonable interpretation of a doctor's statement satisfies substantial evidence review even though other interpretations may be possible). Once Dr. Tuteur's opinion is understood as leaving open the possibility of additional causes besides tracheomalacia, his rejection of coal mine dust exposure simply cannot stand. *See Harman Mining*, 678 F.3d at 313 (stating an ALJ may discredit a doctor whose opinion is inconsistent with findings in the preamble).

D. The ALJ properly gave less weight to Dr. Crisalli's opinion

Pen Coal finally argues that the ALJ improperly gave less weight to Dr. Crisalli's opinion. The ALJ based this decision on the fact that Dr. Crisalli was the only doctor who did not believe Mr. Gregory has a restrictive lung condition. A.67. Substantial evidence supports the ALJ's determination.

Dr. Crisalli recognized that some of Mr. Gregory's pulmonary function tests suggested a restrictive defect. A.327, 329. However, Dr. Crisalli believed those test results were not valid. (*Id*.) Accordingly, he did not diagnose a restrictive

condition. Instead, he concluded that Mr. Gregory's pulmonary capacity "is well within normal limits, tending to rule out a restrictive defect." A.301. Despite Pen Coal's claims to the contrary, Pet'r Br. 35-36, Dr. Crisalli never "amended his opinion" after reviewing additional test results. Rather, Dr. Crisalli repeated his belief that the test results were not valid. A.329.

Dr. Crisalli's failure to diagnose a restrictive condition, despite the overwhelming evidence that Mr. Gregory has one, is relevant in that it suggests Dr. Crisalli did not have a complete understanding of Mr. Gregory's lung condition. In fact, Dr. Crisalli was entirely mistaken in believing Mr. Gregory had no pulmonary abnormality whatsoever. A.334. The Board and this Court have held that an ALJ may legitimately assign less weight to a medical opinion that presents an incomplete picture of the miner's health. *Stark v. Director*, 9 Black Lung Rep. 1-36, 1986 WL 66226 (DOL Ben. Rev. Bd. 1986); *Eastern Associated Coal Corp. v. Director*, 79 Fed. App'x 581, (4th Cir. 2003) (unpublished) ("[I]t was not inappropriate for the ALJ to accord less weight to an opinion premised on incomplete information."). Similarly, it makes little sense to credit Dr. Crisalli's opinion regarding the cause of Mr. Gregory's totally disabling respiratory impairment when he mistakenly believes Mr. Gregory has no respiratory impairment at all. *See Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 116 (4th Cir.

1995) (stating doctor's opinion "can carry little weight" regarding the cause of disability when he mistakenly finds no pneumoconiosis).

Ultimately, this is a case of conflicting medical opinions, a so-called "battle of the experts." *Mingo Logan Coal Co. v. Owens*, 724 F.3d 550, 558 (4th Cir. 2013). It is the role of the ALJ – not the appellate court – to resolve that battle. *Id.* Accordingly, the Court should affirm the ALJ's findings.

II. If the Court Finds the ALJ's Decision Unsupported by Substantial Evidence, the Case Should be Remanded for Proper Application of the Fifteen-year Presumption and its New Implementing Regulation

The fifteen-year presumption is invoked if a miner (1) "was employed for fifteen or more years in one or more underground coal mines" or in surface mines with conditions "substantially similar to conditions in an underground mine" and (2) suffers from "a totally disabling respiratory or pulmonary impairment[.]" 30 U.S.C. § 921(c)(4).[12] In September 2013, shortly after the ALJ issued his decision, the Department amended 20 C.F.R. § 718.305, the regulation addressing the

[12] Congress restored the fifteen-year presumption in section 1556 of the Affordable Care Act, and made it applicable to claims filed after January 1, 2005, and pending on or after March 23, 2010, the ACA's enactment date. Pub. L. No. 111-148, § 1556, 124 Stat. 119, 260 (2010). When applicable, there is a rebuttable presumption that the miner "is totally disabled due to pneumoconiosis[.]" *Id*; *see also* 20 C.F.R. § 718.305(c). The party opposing entitlement may then rebut the presumption by proving that either the miner did or does not have clinical and legal pneumoconiosis, or the miner's pneumoconiosis played no part in his pulmonary disability. 20 C.F.R. § 718.305(d).

presumption.[13] That amended section states in part that a surface mine is "substantially similar" to an underground mine if the miner was "regularly exposed to coal-mine dust while working there." 20 C.F.R. § 718.305(b)(2). Although promulgated after the ALJ's decision in this case, the revised regulation applies to this claim. 20 C.F.R. § 718.305(a).

The ALJ here declined to invoke the fifteen-year presumption, despite finding total respiratory disability, because he believed Mr. Gregory failed to establish that the conditions he encountered as an above-ground miner were substantially similar to those underground. A.30. In particular, the ALJ faulted Mr. Gregory for failing to go "into great detail regarding the actual amount of dust he encountered." *Id*. Under amended section 718.305, however, such a showing is unnecessary.[14] Mr. Gregory only needs to show that he was "regularly exposed to coal-mine dust." 20 C.F.R. § 718.305(b)(2); *see also Antelope Coal Co. v. Goodin*, 743 F.3d 1331, 1342 (10th Cir. 2014); *Central Ohio Coal Co. v. Director, Office of Workers' Compensation Programs*, 762 F.3d 483, 489 (6th Cir. 2014).

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[13] The revised regulation does not change the law, but merely reaffirms the Department's longstanding interpretation of 30 U.S.C. § 921(c)(4). *See Central Ohio Coal Co. v. Director, Office of Workers' Compensation Programs*, 762 F.3d 483, 489 (6th Cir. 2014); *Antelope Coal Co./Rio Tinto Energy Am. v. Goodin*, 743 F.3d 1331, 1342 (10th Cir. 2014).

[14] Mr. Gregory raised this issue before the Board, which declined to consider it because it affirmed the ALJ's award without applying the presumption. A.78 n.9.

The Director believes Mr. Gregory's testimony may be sufficient to satisfy this requirement. A.18, 20-21, 23; *see also* A.1 (indicating "much dust exposure" in his benefits application). Because the ALJ did not have the opportunity to apply this standard, any remand should include instructions for the ALJ to reconsider invocation of the presumption under the governing regulatory standard.[15]

[15] The coal industry continues to mount legal challenges to the "substantial similarity" provision. *See Premium Coal Co. v. Director, OWCP*, No. 14-3719 (6th Cir.) (response briefs filed January 29, 2014). Given the current posture of the instant case – on appeal of an award on other grounds – it is premature to raise and address these legal issues.

CONCLUSION

The decision below should be affirmed.

Respectfully submitted,

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ADDENDUM
Summary of Record Evidence of Dr. Stark's Treatment

1996

4/30/96 Dr. Stark examined Mr. Gregory, noted severe restrictive disease and ordered pulmonary function tests (PFTs), spirometry and lung volume tests, fluoroscopy. A.274-75.

5/24/96 PFTs, spirometry, and lung volume tests ordered by Dr. Stark were conducted. A.247-49.

Chest x-ray and fluoroscopy ordered by Dr. Stark were conducted, read by Robert Davis, who noted rib fractures, clear lungs. A.148.

6/25/96 Dr. Stark examined Mr. Gregory, noted central wheeze in lungs and suggested possible tracheomalacia. A.273.

Dr. Stark ordered blood work. A.107.

7/31/96 Dr. Stark conducted pulmonary exercise test. A.121-31.

Dr. Stark requested stress test, performed by Dr. Paulus. A.98.)

Dr. Stark referred Mr. Gregory to Dr. Bush for a cardiology procedure. A.132.

8/6/96 Dr. Stark examined Mr. Gregory and reviewed the test results, noted that the results were consistent with tracheomalacia. Dr. Stark ordered videofluoroscopy of trachea. A.273.

8/28/96 Videofluoroscopy ordered by Dr. Stark was conducted by Robert Davis, who concluded that Mr. Gregory did not have tracheomalacia. A.147.

9/25/96 Dr. Stark examined Mr. Gregory, noted "coarse wheeze" in lungs, discussed videofluoroscopy results. Dr. Stark believed the test was not conducted properly and again expressed opinion of tracheomalacia. A.272.

Dr. Stark conducted fiberoptic bronchoscopy, found dynamic tracheal collapse. A.103-04.

9/30/96 Dr. Stark examined Mr. Gregory, discussed having CT scan done. A.271.

10/8/96 CT thorax scan ordered by Dr. Stark was conducted by Robert Davis, who noted healed rib fractures, noncalcified 3x4 mm nodule in upper left lobe, most likely a granuloma. A.146.

11/8/96 Dr. Stark examined Mr. Gregory, noted upper airway obstruction due to tracheal collapse. A.270.

1997

7/3/97 Dr. Stark examined Mr. Gregory, noted that pulmonary nodule was stable. A.270.

Dr. Stark read x-ray, noted old rib fractures, calcified pulmonary nodules, one measuring 4-5 mm. A.145.

9/9/97 Dr. Stark examined Mr. Gregory, noted slight wheeze in lungs. A.269.

10/23/97 Dr. Stark examined Mr. Gregory, who reported that use of inhaler was helping. A.268.

1998

2/13/98 Dr. Stark examined Mr. Gregory, who reported that his breathing was getting worse. Dr. Stark noted a coarse wheeze in lungs. A.266.

Dr. Stark requested bloodwork. A.115-16.)

Dr. Stark read x-ray, noting calcified granulomas, old fractures, no significant changes since last reading. A.144.

3/16/98 Dr. Stark conducted spirometry and lung volume tests. A.229-31.

3/24/98 Dr. Stark examined Mr. Gregory, who reported that he was "breathing worse." Dr. Stark noted tracheomalacia. A.267.

Dr. Stark requested bloodwork. A.113-14.

4/21/98 Dr. Stark examined Mr. Gregory, who was experiencing shortness of breath. Dr. Stark noted dynamic airway collapse, severe tracheomalacia. Dr. Stark and Mr. Gregory discussed possible insertion of stent, risk of stent migration and airway obstruction. They decided to try the stent. A.174-75.

Dr. Stark inserted a silastic stent, in the hope that it would help with airway obstruction. A.177-78.

4/22/98 Stark ordered x-ray, read by Paul Stemkowski, who noted "chronic atelectatic or fibrotic changes" bilaterally in the lungs, old healed rib fractures. A.143.

5/13/98 Dr. Stark examined Mr. Gregory, who reported slightly better breathing since the stent was inserted, but he felt a "tickling" in the throat. Dr. Stark noted tracheomalacia. A.265.

7/15/98 Dr. Stark examined Mr. Gregory, who reported improved breathing and cough. Dr. Stark noted tracheomalacia. A.264.

10/22/98 Dr. Stark examined Mr. Gregory, who reported that his breathing was much better than before the stent. A.263.

1999

1/12/99 Dr. Stark examined Mr. Gregory, who reported coughing up yellow mucus. Dr. Stark diagnosed bronchitis. A.263.

Dr. Stark interpreted an x-ray, noting old rib fractures, the stent, "chronic pleural change" and possible bibasilar compression and/or atelectasis [collapsing lung]. A.142.

2/11/99 Dr. Stark examined Mr. Gregory, who reported producing yellow mucus "all the time." Dr. Stark noted chronic bronchitis, the tracheal stent. A.262.

2/20/99 Dr. Stark requested bloodwork. A.217-18.

3/16/99 Dr. Stark conducted spirometry and lung volume tests, finding "borderline restrictive ventilator deficit." A.164-66.

4/8/99 Dr. Stark examined Mr. Gregory, noted tracheomalacia. A.262.

7/1/99 Dr. Stark examined Mr. Gregory, who reported "breathing worse." Dr. Stark noted bibasilar crackles, tracheomalacia, and bronchitis possibly due to stent irritation. They discussed removing the stent. A.260.

Dr. Stark interpreted an x-ray, noted granulomas, markings bilaterally, healed rib fractures. A.141.

7/26/99 Mr. Gregory was admitted to hospital. Dr. Stark's evaluation at intake noted that the silastic stent was not working well and had moved, that Mr. Gregory had developed increasing shortness of breath over the past few months, along with increased productive cough. Dr. Stark admitted Mr. Gregory to remove the stent. He noted tracheomalacia and chronic bronchitis. A.171-72.

Dr. Stark requested x-ray reading by Chun Kim. A.139.

Dr. Stark removed the silastic stent. A.167.

7/28/99 Dr. Stark requested a bronchoscopy, which was conducted by Chun Kim. A.140.

Dr. Stark inserted a wire mesh stent, noted tracheal malacia. A.169-70.

7/29/99 Dr. Stark requested x-ray reading by James Carrico. A.138.

Dr. Stark completed discharge summary, noted that Mr. Gregory was "well known" to his practice for management of tracheomalacia. Dr. Stark also diagnosed chronic obstructive pulmonary disease, acute exacerbation. A.158-59.

Home care instructions given to Mr. Gregory noted obstructive chronic bronchitis. A.160.

8/16/99 Dr. Stark examined Mr. Gregory, who reported coughing much less. Dr. Stark noted tracheomalacia. A.261.

8/25/99 Dr. Stark conducted nocturnal oximetry test. A.161-63.

09/23/99 Dr. Stark examined Mr. Gregory, who reported that his cough had improved since the stent replacement. Dr. Stark noted tracheomalacia, breathing stable. A.258.

2000

3/29/2000 Dr. Stark examined Mr. Gregory, noted tracheomalacia, "breathing fair." A.258.

12/12/2000 Dr. Stark examined Mr. Gregory, who reported continued productive cough. Dr. Stark noted tracheomalacia. A.259.

2002

01/07/02 Dr. Stark examined Mr. Gregory, noted cough, tracheomalacia, obesity. A.257.

04/29/02 Dr. Stark examined Mr. Gregory, noted tracheomalacia, obesity. A.256.

10/18/02 Dr. Stark examined Mr. Gregory, who reporting fair breathing, cough with yellow to white mucus. Dr. Stark noted tracheomalacia and "RAD" [reactive airways disease]. A.254.

2004

03/24/04 Dr. Stark examined Mr. Gregory, noted tracheomalacia. A.255.

2005

10/14/05 Dr. Stark ordered bloodwork. A.105-06.

10/25/05 Dr. Stark examined Mr. Gregory, noted chronic bronchitis, tracheomalacia, obesity. A.295.

11/1/05 Dr. Stark completed a form indicating Mr. Gregory has occupational lung disease caused by coal mine employment. Dr. Stark explained that Mr. Gregory has tracheomalacia, that he collapses his trachea

with cough, and that his chronic dust exposure has caused an industrial bronchitis which worsens his condition. A.296.

2007

10/10/07 Dr. Stark examined Mr. Gregory, who reported that his breathing may be slightly worse but his cough has improved. Dr. Gregory noted that the tracheomalacia was stable. A.251.

2008

10/8/08 Dr. Stark ordered spirometry & lung volume tests. A.117-18.

11/4/08 Dr. Stark examined Mr. Gregory, who reported that his breathing was about the same but that he coughed up lots of yellow mucus. Dr. Stark noted tracheomalacia, restrictive lung disease, and chronic bronchitis. A.278.

12/16/08 Dr. Stark examined Mr. Gregory, who reported continued productive cough. Dr. Stark noted restrictive lung disease, obesity, tracheomalacia. A.279.

2009

12/15/09 Dr. Stark examined Mr. Gregory, who reported that his breathing was about the same, with minimal cough and yellowish mucus. Dr. Stark heard crackles [breathing noises] in the bases of lungs, noted tracheomalacia. A.285.

2011

1/24/11 Dr. Stark examined Mr. Gregory, who was breathing about the same but continued to complain about a productive cough. Dr. Stark noted tracheomalacia, obesity, and restrictive lung disease (RLD). A.284.

11/29/11 Mr. Gregory testified that he was seeing Dr. Stark every three months. A.26.

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I certify that this brief is proportionally spaced using Times New Roman 14-point typeface, and contains 8,537 words.

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CERTIFICATE OF SERVICE

I certify that, due to inclement weather on February 17, 2015, the Director's brief was filed and served electronically on February 18, 2015, using the Court's CM/ECF system, with hard copies mailed, to the Court and the following attorneys:

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