No. 12-70535

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PEABODY COAL CO.,
Petitioners
v.
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,UNITED STATES DEPARTMENT OF LABOR
and
ROBERT DALE OPP,
Respondents

On Petition for Review of a Final Order
of the Benefits Review Board

BRIEF FOR THE FEDERAL RESPONDENT

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

BRIEF FOR THE FEDERAL RESPONDENT

STATEMENT OF JURISDICTION

This case involves a claim filed by Robert Dale Opp in 2000 for benefits under the Black Lung Benefits Act (BLBA), 30 U.S.C. §§ 901-944. Opp died in August 2002, and his surviving spouse, Ruth Ann Opp, continues to pursue his claim on behalf of the estate.

After various administrative proceedings, Administrative Law Judge Stuart A. Levin issued a decision on April 27, 2010, awarding benefits to Opp and ordering Peabody Coal Company, Opp's former coal mine employer, to pay them. Record Excerpt (RE) 16.[1] Peabody appealed this decision to the Benefits Review Board (BRB) on April 30, 2010. CCR 97-100. The BRB had jurisdiction over this appeal because section 21(a) of the Longshore and Harbor Workers' Compensation Act (Longshore Act), 33 U.S.C. § 921(a), as incorporated by 30 U.S.C. § 932(a), allows an aggrieved party thirty days to appeal an ALJ's decision to the BRB.

The BRB affirmed the ALJ's decision on May 16, 2011, RE 8, and denied Peabody's timely motion for reconsideration on December 22, 2011. RE 7. This Court then docketed Peabody's petition for review on February 21, 2012. RE 1. The Court has jurisdiction over Peabody's petition because section 21(c) of the Longshore Act, 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

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[1] Documents contained in the petitioner's excerpts of record (primarily the decisions below) are cited as "RE." Documents not reproduced in the excerpts of record but identified and paginated in the Index of Documents in the Certified Case Record (CCR), RE 3-6, are cited to the CCR Index. Because the CCR Index does not provide separate entries or page numbers for the exhibits admitted by the ALJ, the Director cites to their original exhibit number. "DX," "EX," and "CX" respectively refer to Director's Exhibits, Employer's Exhibits, and Claimant's Exhibits.

of appeals in which the injury occurred.[2] *See also* 20 C.F.R. § 802.406 (timely motion for reconsideration tolls the sixty-day appeal period). The injury, within the meaning of section 21(c), arose in Montana, within this Court's territorial jurisdiction.[3] 33 U.S.C. § 921(c).

STATEMENT OF THE ISSUES

1. Does the Administrative Procedure Act forbid an ALJ from discounting expert testimony in a BLBA case that contradicts the Department of Labor's evaluation of scientific and medical literature in the preamble to the BLBA's implementing regulations?

2. Are the ALJ's assessments of the conflicting expert testimony and ultimate decision awarding BLBA benefits to Opp supported by substantial evidence?

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[2] Although Peabody's appeal was docketed on the 61st day after the Board decision, the sixtieth day, February 20, 2012, was a legal holiday, thus making the appeal timely.

[3] Although Opp first worked as a coal miner in Illinois and Missouri, states within the jurisdictional boundaries of the United States Court of Appeals for the Seventh and Eighth Circuits, Opp's most recent exposure occurred in Montana. DX 3. When a claimant is exposed to coal dust in more than one circuit, section 21(c) does not specify which forum is the proper one. 33 U.S.C. § 921(c). Thus, Peabody's selection of this Court is permissible as Montana was one location of Opp's occupational exposure to coal mine dust. *Hon v. Director, OWCP*, 699 F.2d 441, 443-44 (8th Cir. 1983) ("appeal lies in any circuit in which the claimant worked and was exposed to the danger, prior to the manifestation of the injury"); *Consol. Coal Co. v. Chubb*, 741 F.2d 968, 970-71 (7th Cir. 1984) (same).

STATEMENT OF THE CASE

1. Legal framework

Former coal miners who are totally disabled by pneumoconiosis, a respiratory or pulmonary impairment arising out of coal mine employment, are entitled to BLBA benefits. 30 U.S.C. § 901(a). It is undisputed that claimant/respondent Robert Opp suffers from chronic obstructive pulmonary disease (COPD) that totally disables him from performing his former work as a miner.[4] The disputed issue in this case is whether Opp's disabling COPD is "legal pneumoconiosis" as defined by 20 C.F.R. § 718.201.

a. Regulatory provisions

Compensable pneumoconiosis takes two forms, "clinical" and "legal." 20 C.F.R. § 718.201(a). "Clinical pneumoconiosis" refers to a cluster of diseases recognized by the medical community as fibrotic reactions of lung tissue to the

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[4] Chronic obstructive pulmonary disease, commonly abbreviated "COPD," is a lung disease characterized by airflow obstruction. The Merck Manual at 568 (17th ed. 1999). COPD "includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema, and asthma." 65 Fed. Reg. 79939 (Dec. 20, 2000). The medical experts variously described or categorized Opp's COPD as, *e.g.*, diffuse, focal, centriacinar, or bullous emphysema, and chronic bronchitis. RE 202; CX 1; EX 1; 2; 4; 5 at 12, 14; 6 at 10, 22; 8 at 24; 9 at 6, 15. For the reader's convenience, this brief generally replaces these various terms with the umbrella category, COPD.

"permanent deposition of substantial amounts of particulate matter in the lungs." 20 C.F.R. § 718.201(a)(1); *see also Eastover Mining Co. v. Williams*, 338 F.3d 501, 509 (6th Cir. 2003) ("Clinical or medical pneumoconiosis is a lung disease caused by fibrotic reaction of the lung tissue to inhaled dust that is generally visible on chest x-ray films." (citing *Usery v. Turner-Elkhorn Mining Co.,* 428 U.S. 1, 7 (1976)). This cluster of diseases includes, but is not limited to, "coal workers' pneumoconiosis" as that term is commonly used by doctors. 20 C.F.R. § 718.201(a)(1). Clinical pneumoconiosis is generally diagnosed by chest x-ray, biopsy or autopsy. 20 C.F.R. §§ 718.102, 718.106, 718.202(a)(1)-(2).

"Legal pneumoconiosis" refers to "any chronic lung disease or impairment . . . arising out of coal mine employment" and specifically includes "any chronic restrictive or obstructive pulmonary disease" with such causation. 20 C.F.R. § 718.201(a)(2); *see Eastover Mining*, 338 F.3d at 509 ("Legal pneumoconiosis includes all lung diseases meeting the regulatory definition of any lung disease that is significantly related to, or aggravated by, exposure to coal dust."); *Richardson v. Director, OWCP*, 94 F.3d 164, 166 n. 2 (4th Cir. 1996) ("COPD, if it arises out of coal-mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis."). A disease arises out of coal mine employment if it is "significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R.

§ 718.201(b). Moreover, pneumoconiosis is "recognized as a latent and progressive disease which may first become detectable only after cessation of coal mine dust exposure." 20 C.F.R. § 718.201(c).

b. Background to the inclusion of certain obstructive pulmonary disease in the definition of pneumoconiosis (20 C.F.R. § 718.201(a)(2))

The BLBA defines pneumoconiosis broadly as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). This definition is the source of the concept of "legal" pneumoconiosis, and the original implementing regulation at 20 C.F.R. § 718.201 (1999) mimicked the statute's language. *See Eastover Mining Co. v. Williams* 338 F.3d 501, 509 (6th Cir. 2003) (describing pneumoconiosis under section 718.201(1999)).

As these provisions were applied over the years, there was much litigation over exactly what type of lung disease might be considered to have arisen out of coal mine employment. While there was no dispute (or very little) in the medical community that chronic restrictive lung disease could arise from coal mine employment and therefore be designated as legal pneumoconiosis, there arguably was a question whether chronic obstructive disease could. Certain physicians reported in various black lung cases that coal dust exposure never causes chronic obstructive lung disease; consequently, in their view, a miner's COPD could never

meet the definition of legal pneumoconiosis.

These doctors provided such opinions despite the fact that courts of appeals accepted that COPD may be considered legal pneumoconiosis (if arising out of coal mine employment). *See, e.g., Peabody Coal Co. v. Holskey*, 888 F.2d 440, 442 (6th Cir. 1989); *see also Bradberry v. Director, OWCP*, 117 F.3d 1361, 1368 (11th Cir. 1997); *Richardson v. Director, OWCP*, 94 F.3d 164, 166 n.2 (4th Cir. 1996); *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 315 (3d Cir. 1995); *Freeman United Coal Mining Co. v. Director, OWCP*, 957 F.2d 302, 303 (7th Cir. 1992); *Consol. Coal Co. v. Hage*, 908 F.2d 393, 395 (8th Cir. 1990); 65 Fed. Reg. 79,943-44 (Dec. 20, 2000) (additional case citations provided).

To avoid inconsistent results and claim-by-claim review of the issue, the Department in 1997 proposed changing the regulation to prevent the categorical rejection of coal dust exposure as a possible cause of COPD. *See* 62 Fed. Reg. 3343 (Jan. 22, 1997); *see also* 65 Fed. Reg. 79,938 (Dec. 20, 2000). The proposed rule provided that:

> "Legal pneumoconiosis" includes any chronic disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any <u>chronic</u> restrictive or <u>obstructive pulmonary disease</u> arising out of coal mine employment.

62 Fed. Reg. 3376 (Jan. 22, 1997) (emphasis added).

The proposed change resulted in both favorable and unfavorable comments. 64 Fed. Reg. 54,978-79 (Oct. 8, 1999); 65 Fed. Reg. 79,937-44 (Dec. 20, 2000).

Individuals providing unfavorable comments asserted that chronic obstructive pulmonary disease - in particular, emphysema - does not arise from coal dust exposure, or at least not unless the miner had complicated pneumoconiosis.[5] *See* 65 Fed. Reg. 79,937-44 (Dec. 20, 2000). In support, they argued that the scientific studies relied upon by the Department in the proposed rule were not valid or were misinterpreted, and that any obstruction resulting from coal dust exposure was not "clinically significant." *Id.*[6]

The regulatory preamble to the final rule in painstaking detail addresses these unfavorable comments and presents and assesses the medical and scientific literature supporting the Department's contrary conclusion that exposure to coal mine dust can cause COPD. 65 Fed. Reg. at 79937-45 (Dec. 20, 2000). Moreover, the preamble addresses the medical literature on the interrelationship between coal dust exposure and smoking as causes of COPD, crediting studies finding the risks of smoking and dust exposure to be additive. *Id.* at 79939-41.

Of particular significance in reaching these conclusions, the preamble

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[5] "Complicated" pneumoconiosis, sometimes referred to as progressive massive fibrosis or severe fibrosis, is a severe form of coal workers' pneumoconiosis. A miner suffering from that disease is irrebuttably presumed to be totally disabled by it. 30 U.S.C. § 921(c)(3); 20 C.F.R. § 718.304; *Gray v. SLC Coal Co.*, 176 F.3d 382, 386 (6th Cir. 1999).

[6] As detailed below, Peabody's experts raise these same objections. *Infra* at 17-22.

identifies the Department's reliance on a comprehensive study by the National Institute for Occupational Safety and Health (NIOSH). *Id*. at 79939, 79943; Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 62 Fed. Reg. 3338, 3343 (Jan. 22, 1997) (citing National Institute for Occupational Safety and Health, *Criteria for a Recommended Standard: Occupational Exposure to Respirable Coal Mine Dust* § 4.2.2. *et seq*. (1995)).[7] NIOSH, the statutory scientific advisor to the black lung benefits program, 30 U.S.C. § 902(f)(1)(D), and an expert in the analysis of occupational disease research, reviewed the Department's proposed revisions and concluded that "NIOSH scientific analysis supports the proposed definitional changes."

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[7] In April 2011, 16 years after publication of its original *Criteria*, NIOSH released Current Intelligence Bulletin 64, *Coal Mine Dust Exposure and Associated Health Outcomes, A Review of Information Published Since 1995* (2011). As its title indicates, the purpose of the Bulletin was to "update the information on coal mine dust exposures and associated health effects from 1995 to the present." *Id* at iii. One of the main conclusions drawn from the review of new information was that the "new findings strengthen [the] conclusions and recommendations" [reached in the original 1995 publication]. *Id*. at 5. Among other findings, the Bulletin confirms the dust-related effects on chronic airway obstruction, including emphysema, as well as the similar effects on COPD caused by smoking and dust exposure. *Id*. at 23-24. A draft of Bulletin 64 was made available for notice and comment, 75 Fed. Reg. 52355 (August 25, 2010), and the National Mining Association submitted largely unfavorable comments, criticizing *inter alia* the science underlying a connection between coal dust exposure and the development of COPD. Both Bulletin 64 and the 1995 *Criteria* are respectively available on the NIOSH website at http://www.cdc.gov/niosh/docs/2011-172/ and http://www.cdc.gov/niosh/docs/95-106/.

Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 64 Fed. Reg. 54966, 54979 (Oct. 8, 1999).

In regards to the unfavorable comments, the Department rejected, point-by-point, the criticisms leveled at the scientific studies it relied on. 65 Fed. Reg. 79,938-43. With regard to emphysema in particular, the Department noted :

> Drs. Fino and Bahl find no scientific support that clinically significant emphysema exists in coal miners without progressive massive fibrosis [*i.e.*, complicated pneumoconiosis]. . . . but the available pathologic evidence is to the contrary. . . . Centrilobular emphysema (the predominant type observed) was significantly more common among the coal workers.

65 Fed. Reg. 79,941 (study and rulemaking record citations omitted). Thus, the Department concluded that "[c]ontrary to the commenters' argument, then, the record does contain overwhelming scientific and medical evidence demonstrating that the coal mine dust exposure can cause obstructive lung disease." 65 Fed. Reg. 79,944.

The proposed rule became effective January 19, 2001, and is codified at 20 C.F.R. § 718.201(a). The Department gave the provision retroactive effect (*i.e.*, made it applicable to all claims pending on the January 19, 2001, effective date) because the changes were consistent with prior court decisions, all of which accepted that legal pneumoconiosis may include COPD. The revised definition of pneumoconiosis was upheld both as to substance and retroactive effect. *Nat'l Mining Ass'n v. Dep't of Labor*, 292 F.3d. 849, 869 (D.C. Cir. 2002); *see also*

Nat'l Mining Ass'n v. Dep't of Labor, 160 F.Supp 2d 47, 72-73 (D.D.C. 2001), *aff'd and rev'd in part*, 292 F.3d 849 (rejecting challenge to DOL's authority to define pneumoconiosis).

In the litigation challenging the definition of pneumoconiosis, the National Mining Association *conceded* that the record compiled in the preamble supported the premise that "obstructive lung disease *may* be caused by mining exposure and can contribute to a miner's disability." *NMA*, 292 F.3d at 862.

2. Course of the proceedings below.

Robert Opp filed his claim for federal black lung benefits in 2000, which was initially awarded by the district director. DX 1, 36. After a formal hearing, RE 122, ALJ Donald B. Jarvis denied the claim. RE 102. On appeal, the Benefits Review Board vacated the decision and remanded for further consideration. RE 96. ALJ Stuart A. Levin (the ALJ) awarded benefits on remand, RE 85, but the Board again vacated and remanded. RE 75. The ALJ then denied benefits, RE 55, but the Board vacated the denial and remanded. RE 48. The ALJ then awarded benefits on April 27, 2010, RE 16, and the Board affirmed the award on May 16, 2011. RE 8. On December 22, 2011, the Board denied Peabody's timely motion for reconsideration. RE 7. Peabody then petitioned this Court for review. RE 1.

STATEMENT OF THE FACTS

1. Opp's work and smoking histories.

Opp worked as a coal miner for thirty-nine years, from 1950 to 1989. RE 105. Opp's last coal mining job consisted of operating an end loader, driving a truck, operating a caterpillar, loading holes, loading topsoil, loading rocks, and painting. RE 138. He described his work environment as dusty to "real bad." RE 138-39, 141, 142. Opp smoked cigarettes from approximately 1948 until 2000, although he testified that "a lot of times" he would quit for "six or seven months at a time." RE 105, 150-51. Opp smoked between one-half to one and one-half packs per day. *Id.* Opp testified that he began having breathing problems in 1994 or 1995. RE 34.

2. The relevant medical evidence.[8]

This appeal centers on the ALJ's evaluation of testimony by six medical experts: Dr. James, who testified that Opp's COPD arose, in part, out of his coal

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[8] Because only the etiology of Opp's totally disabling COPD is at issue on appeal, most of the medical evidence is not directly relevant. Thus, the results of various x-ray readings, which are primarily used to diagnose clinical pneumoconiosis, and pulmonary function and arterial blood gas tests, which are primarily used to determine whether a claimant is totally disabled, are not discussed except to the extent they are relied on in a physician's narrative opinion. *See* 20 C.F.R. §§ 718.201, 718.202(a)(1).

mine employment; Dr. Anderson, who also stated that Opp's dust exposure contributed to his COPD; and Drs. Repsher, Fino, Tuteur, and Renn, who attributed Opp's COPD solely to smoking.

a. Dr. James

Dr. David James examined Opp in April 2000.[9] DX 11, 12. Dr. James recorded a thirty-nine year coal mine employment history; Opp's complaints and symptoms; family and medical histories; and a fifty-two year smoking history of up to a pack and a half per day. He conducted medical testing – a chest x-ray, and ventilatory and arterial blood gas tests – and reported that although the chest x-ray was negative for pneumoconiosis, the pulmonary function test results revealed "severe airflow obstruction," and the arterial blood gas study results demonstrated "normal arterial saturation at rest with significant desaturation with exercise."[10]

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[9] This examination was provided by the Department to fulfill its statutory duty to provide a claimant-miner with "an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation." 30 U.S.C. § 923(b).

[10] A pulmonary function (or ventilatory) test is one measure of a miner's pulmonary capacity. The test measures three values: the FEV1 (forced expiratory volume), the FVC (forced vital capacity), and the MVV (maximum voluntary ventilation). The FEV1 value measures the amount of air exhaled in one second on maximum effort. It is expressed in terms of liters per second. Obtaining a FVC value requires the miner to take a deep breath and then exhale as rapidly and forcibly as possible. The FEV value is taken from the first second of the FVC exercise. The MVV value measures the maximum volume of air that can be moved by the miner's respiratory apparatus in one minute, and is expressed in

(continued…)

Based on these results, his physical examination, and Opp's occupational and smoking histories, Dr. James diagnosed coal workers' pneumoconiosis, COPD, and exercise-induced desaturation of oxygen. He attributed the pneumoconiosis to coal dust exposure, the COPD to dust exposure and smoking, and the arterial desaturation to pneumoconiosis and COPD. Dr. James concluded that Opp's "chronic exposure to coal mine dust is a contributing factor to his total disability and severe respiratory impairment."

Dr. James elaborated on and provided further support for his diagnoses in a supplemental report, DX 12, and in testimony before the ALJ and at deposition. RE 168-206, 217-228. Dr. James explained that since first examining Opp, he had reviewed additional evidence, including CT scans, x-rays readings, as well as tests performed by Peabody's doctors and Opp's treatment records. RE 173-74; DX 12. Dr. James continued to believe based on these test results and the magnitude of Opp's coal dust exposure and cigarette smoking history that both exposures

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(…continued)

liters. *See Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1138 nn. 6, 7 (7th Cir. 1988); 20 C.F.R. § 718.103; 20 C.F.R. Part 718 App. B.

Arterial blood gas tests "are performed to detect an impairment in the process of alveolar gas exchange." 20 C.F.R. § 718.105(a). The defect primarily manifests "as a fall in arterial oxygen tension either at rest or during exercise." *Id.* "[A]lveolar gas" refers to "the gas in the alveoli of the lungs, where gaseous exchange with the capillary blood takes place." Dorland's at 756. Alveoli are the "small saclike structures" in the lungs. *Id.* at 55, 1070.

"played a significant role in causing Mr. Opp's respiratory disease and impairment."

As further support, Dr. James relied on a number of scientific studies concluding that "chronic coal mine dust exposure can cause airflow obstruction, even in miners who have x-rays that do not show evidence of fibrotic disease," RE 182-83, DX 12; that coal dust exposure can cause emphysema, RE 183-86, 188-90, 192, which comports with his diagnosis of diffuse, bollous, and centriacinar emphysema related to coal dust exposure, RE 210-02, 227-28; and that the effects of coal dust exposure and smoking are additive.[11] RE 199-200. On this last point, Dr. James explained that Opp's pulmonary problems were more severe than the average person's with a similar smoking history, and consequently "we have two agents that have been associated with development of [COPD], and we have, in Mr. Opp's case, a level of impairment more than we would expect as we reviewed solely from his cigarette smoking." RE 200.

Regarding the partial reversibility of his impairment following administration of a bronchodilator on Opp's pulmonary function tests, Dr. James testified that it did not refute his opinion because "a significant minority of

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[11] The Department relied on many of these same studies in the preamble. *Compare* DX 12 p. 3 *with* 65 Fed. Reg. 79939 (Oxman study), 79939 (Attfield study); RE 183-185 with 65 Fed. Reg. 79938-39, 943 (NIOSH *Criteria*).

individuals who have been found to have [COPD] purely from smoking can also have a change after a bronchodilator.[12] The mechanism and the pathophysiology as we understand from coal mine dust-induced [COPD] probably has many similarities." RE 196. Moreover, Dr. James noted that Opp was still severely impaired following the use of a bronchodilator and that partial reversibility was consistent with pneumoconiosis. RE 198. Finally, he described the progression of Opp's COPD as consistent with pneumoconiosis based on the "level of severity," and "the experience with other types of exposures that cause [COPD] and that they have been found to progress." RE 198-99.

b. Dr. Anderson

In his May 18, 2001 report, Dr. William Anderson stated he was Opp's treating physician and opined that Opp was suffering from "end stage emphysematous [COPD]." CX 1. He relied on Opp's history of thirty-nine years of coal mine employment to conclude that his coal dust exposure "most probably is a contributing factor in his [COPD] due to his severe disease at a relatively young age [68 years old at the time]. This is more than one would expect in a smoker[.]"

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[12] A bronchodilator is "an agent that causes expansion of the lumina of the air passages of the lungs." Dorland's Illustrated Medical Dictionary at 253 (30th ed. 2003). A lumen (the singular of lumina), in turn, is "the cavity or channel within a tube or tubular organ." *Id*. at 1069.

Dr. Anderson found it "reasonable to assume that his COPD is caused by factors other than tobacco smoking, although that definitely must be considered a contributing factor." He stated that he had made his diagnosis "antidotally[.]" [*sic*].

In his March 18, 2002 report, Dr. Anderson reiterated that "Mr. Opp's emphysema is at least to some extent related to pneumoconiosis." CX 2.

c. Dr. Repsher

Dr. Lawrence Repsher examined Opp in October 2000 at Peabody's request. DX 33. He recorded a 40.5-year coal mine employment history and a fifty-year smoking history of up to one and one-half packs per day; Opp's complaints and symptoms; his medical and family histories; a chest x-ray reading; ventilatory and arterial blood gas test results; and an electrocardiogram. Dr. Repsher concluded that Opp did not have pneumoconiosis, citing the negative x-ray and the absence of a restrictive impairment. He explained, "The inhalation of coal dust does not cause individually measureable nor clinically significant airways obstruction. Rather, inhalation of coal dust does cause a statistically significant, but quantitatively insignificant airways obstruction, which is usually present within six to twelve months of beginning work in a coal mine and does not progress."[13] He continued,

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[13] Although according to Dr. Repsher, coal dust inhalation does not cause an (continued…)

"Coal workers['] pneumoconiosis, when clinically significant, is primarily a restrictive disease that may have some obstructive features." Dr. Repsher diagnosed totally disabling COPD unrelated to coal dust exposure, with "marked hyperinflation and bullous emphysema, neither of which are seen in coal workers['] pneumoconiosis."

In a supplemental report, EX 3, and at deposition, Dr. Repsher reiterated his core beliefs that "pneumoconiosis, when clinically significant, is primarily a restrictive disease;" that "the inhalation of coal dust does not cause individually measureable nor clinically significant airways obstruction;" and therefore "since the component that could be related to inhalation of coal mine dust is too small to be measured in an individual, it cannot then be a significant factor in Mr. Opp's disabling COPD." Indeed, at deposition, Dr. Repsher went even further, claiming that "the coal mine dust literature" did not reveal a single case of coal dust exposure causing "clinically significant COPD" in a miner who never smoked. EX 9 at 13.

Dr. Repsher found Dr. James's contrary opinion flawed, alleging Dr. James

(…continued)
'individually measureable" or "clinically significant" obstruction, he also stated that it was possible for a pure obstructive impairment to be caused by coal dust exposure. EX 3; EX 8 at 11-13, 22. He does not rectify these two seemingly contradictory positions.

misunderstood the medical literature. EX 9 at 14. He described one study, relied on by Dr. James (and cited in the preamble), as "hopelessly inaccurate, systematically underestimating the degree of dust that was in the mines. And it's the old story: Garbage in, garbage out." *Id*. at 15. He likewise criticized and found unsupportive other scientific studies that Dr. James (and NIOSH and the preamble) relied on. EX 9 at 22-23, 48-50. At bottom, Dr. Repsher admitted that his basic disagreement with Dr. James was whether the scientific literature "shows a clinically significant effect of coal mine dust on COPD and emphysema." EX 9 at 30.

d. Dr. Fino

Dr. Gregory Fino reviewed the medical record for his September 5, 2001 report. EX 4. Based on a CT scan reading, he diagnosed bullous emphysema, "a classic pattern that one would expect as a result of cigarette smoking." Like Dr. Repsher, Dr. Fino admitted the possibility of a coal-dust-induced obstructive impairment "in a susceptible individual," EX 4, EX 5 at 8, but applying a formula allegedly measuring expected loss of lung function due to coal dust exposure, he opined that any impact on lung function from legal pneumoconiosis (if present) "would be a negligible decline" even with *39 years* of coal mine employment, and "would make no change whatsoever in [Opp's] overall impairment or disability." Dr. Fino noted an improvement in Opp's pulmonary impairment following

administration of a bronchodilator, which he opined was inconsistent with pneumoconiosis. He concluded that even if Opp had pneumoconiosis, his COPD would still be entirely due to smoking.

At deposition, Dr. Fino reiterated that Opp suffered from diffuse emphysema with bullae, resulting in "[v]ery severe obstruction." EX 5 at 12, 14. Because the CT scans and x-ray readings were negative for pneumoconiosis, Dr. Fino opined that Opp's emphysema was entirely due to smoking. EX 5 at 20-21.

e. Dr. Tuteur

Dr. Peter Tuteur reviewed the medical record for his July 30, 2001 report. EX 1. Like Drs. Repsher and Fino, Dr. Tuteur opined that Opp suffered from a total respiratory disability that was due entirely to smoking. Dr. Tuteur described Opp's symptoms and clinical findings as "quintessentially characteristic of [COPD]," but atypical for pneumoconiosis because the impairment was obstructive in nature, not restrictive, and partially reversible following the use of a bronchodilator. Dr. Tuteur further disputed two medical studies relied upon by Dr. James (and cited in the preamble), associating coal dust exposure with obstructive disease, criticizing them as "epidemiologic," and stating that even the "better of the two" studies was "highly flawed." Nonetheless, Dr. Tuteur acknowledged a less than 1% chance of measureable airflow obstruction in miners without x-ray evidence of pneumoconiosis.

At deposition, Dr. Tuteur reiterated his findings and continued to criticize the various medical studies relied on by Dr. James, NIOSH, and/or cited in the preamble. EX 6 at 24-25, 28-33, 35-37. He neatly summed up his view: "There's no credible evidence in the literature to indicate that coal mine dust inhalation acts additively or synergistically with the chronic inhalation of tobacco smoke to promote chronic obstructive pulmonary disease." EX 6 at 34.

f. Dr. Renn

Dr. Joseph Renn reviewed the medical record for his August 10, 2001 report. EX 2. He diagnosed "chronic bronchitis with an asthmatic component and pulmonary emphysema," all a result of tobacco smoking rather than exposure to coal mine dust. He also stated that Opp's respiratory impairment was totally disabling.

Dr. Renn confirmed his diagnoses at deposition. EX 9. He explained that exposure to coal mine dust did not contribute to Opp's COPD because his symptoms appeared after his exposure ceased. EX 9 at 13, 16. He further stated that Opp had diffuse and bullous emphysema, which he associated with tobacco smoke but not coal dust exposure, because coal dust can cause focal emphysema only, and only when clinical pneumoconiosis is also present. EX 9 at 41. Thus, he opined "in the absence of medical coal workers['] pneumoconiosis, in this particular case, there is also no legal pneumoconiosis because there is no

contribution to the overall emphysema." *Id.* Finally, in regards to the medical literature finding a relationship between coal dust exposure and obstructive pulmonary disease, he stated that a critical review of the literature shows nothing more than a scientific, *i.e.*, statistical, loss, not a clinically-significant decline. EX 9 at 43-48. That said, he also admitted the possibility of an obstructive impairment caused by coal dust exposure apart from clinical pneumoconiosis, *i.e.*, x-ray evidence of the disease.

3. **Summary of the decisions below**

a. ALJ Denial, May 29, 2003

ALJ Jarvis found that Opp worked as a coal miner for thirty-nine years and suffered from a totally disabling pulmonary impairment. RE 105, 120. He denied the claim, however, because Opp failed to establish either clinical or legal pneumoconiosis. He found the x-ray readings uniformly negative for pneumoconiosis and Dr. James's diagnosis of pneumoconiosis outweighed by the contrary opinions of Drs. Repsher, Tuteur, Fino, and Renn. RE 117-119.

b. Benefits Review Board Remand, May 27, 2004

The Board vacated the denial, finding that ALJ Jarvis had failed to consider Dr. Anderson's opinion diagnosing pneumoconiosis. RE 98. Additionally, the Board held that ALJ Jarvis had failed to fully consider Dr. James's opinion. It accordingly remanded the case for further consideration. RE 97, 99-101.

c. ALJ Award, May 2, 2005

On remand, ALJ Levin credited the diagnoses of legal pneumoconiosis by Drs. Anderson and James and discounted the contrary opinions from Drs. Repsher, Tuteur, Renn, and Fino. He noted that the doctors' disagreement regarding the scientific literature on the relationship between coal mine dust exposure and obstructive impairments, but found "a plain reading of the studies" supported Dr. James's opinion. RE 92. He also determined that Drs. Repsher, Fino, Tuteur, and Renn had improperly based their opinions that Opp's COPD was due entirely to smoking on the absence of clinical pneumoconiosis, in particular the absence of positive x-ray readings. RE 93. He also rejected Dr. Tuteur's opinion that the partial reversibility after administration of a bronchodilator supported a diagnosis of smoking-related COPD, citing Dr. Fino's statement that most of Opp's impairment was not reversible. *Id*. Having credited Dr. James's opinion that Opp's COPD was related to his smoking and coal dust exposure over the contrary opinions, the ALJ awarded benefits.

d. Benefits Review Board Remand, June 29, 2006

The Board again vacated the ALJ's decision. The Board held that the ALJ had failed to determine whether the opinions regarding pneumoconiosis from Drs. James and Anderson were sufficiently definitive and reasoned to be accorded probative value. RE 79-80. Next, the Board held that the ALJ had erred in finding

Dr. James's opinion better supported by scientific literature because the ALJ had improperly reviewed the scientific studies himself and had improperly substituted his interpretation for that of the doctors. RE 81. Finally, the Board found that the ALJ erred in finding that Drs. Repsher, Fino, Tuteur, and Renn had based their opinions solely on the absence of clinical pneumoconiosis: "Drs. Repsher, Tuteur, Renn and Fino provided detailed explanations for their opinions which the [ALJ] failed to adequately consider." RE 82 (footnote omitted). Accordingly, the Board remanded the claim for further consideration.

e. ALJ Denial, January 30, 2008

The ALJ interpreted the prior Board decisions as requiring a finding that Drs. James's and Anderson's opinions were neither well-documented nor well-reasoned and thus not credible. RE 62-63, 71. He further believed that the Board had necessarily found the contrary opinions from Drs. Repsher, Tuteur, Fino, and Renn to be supported by "detailed explanations" and credible. RE 73. Based on this understanding of the Board's latest decision, the ALJ denied benefits. RE 55-73.

f. Benefits Review Board Remand, February 24, 2009

The Board vacated the ALJ's decision a third time. The Board held that the ALJ had erred in finding that the Board had ruled on the credibility of the conflicting medical opinions and remanded the case for the ALJ to reconsider

whether the opinions were reasoned under section 718.202(a)(4). RE 51-52. The Board also held (apparently backtracking from its 2006 decision) that the ALJ "is permitted to review the medical literature admitted into the record for the purposes of determining whether Dr. James has accurately characterized the literature and whether the criticisms that employer's experts have raised concerning the studies have merit." RE 52 (footnote omitted).

g. ALJ Award, April 27, 2010

The ALJ ruled that Drs. Anderson's and James's opinions that Opp's COPD was due to smoking and coal dust exposure were both reasoned and documented. RE 20-24. He found that Dr. Anderson had reasonably based his opinion on the symptoms he treated, the severity of the disease at such a young age (age 68), the extent of the disability being greater than one would expect to find in a smoker, the pulmonary function study results, and a CT scan showing moderate COPD. RE 20-21. Similarly, Dr. James's opinion was supported by the miner's history, his symptoms, the results of a pulmonary function study, the doctor's explanation that coal mine dust exposure can cause obstructive disease even in the absence of positive x-ray readings, and the fact that Opp was "clearly more impaired" than most patients with just a smoking history." RE 22. Moreover, the ALJ observed that Dr. James had relied on medical literature documenting "a significant contributing role of coal mine dust exposure in chronic obstructive pulmonary

disease" as well as "an additive effect for patients with coal dust exposure and cigarette smoking." *Id*; RE 26.

The ALJ then engaged in an exhaustive review of the medical literature. RE 26-28. He first determined that Dr. James had "accurately characterized the studies' findings and conclusions." RE 28. He then addressed the criticisms of the studies leveled by Peabody's experts, which, the ALJ recognized, were the same objections that the mining industry had raised in the rulemaking proceedings. RE 24-38. The ALJ accordingly looked to the preamble to see how the Department had dealt with these criticisms. *Id*.

The ALJ accepted the Department's assessment of the medical literature and rejection of the mining industry's criticisms of it. In particular, the ALJ agreed that the opinions from Drs. Repsher, Tuteur, Fino, and Renn (that coal dust exposure causes a "statistically relevant but not clinically relevant" obstructive pulmonary impairment, RE 32) were, as the Department had determined, contrary to "the prevailing view of the medical community or the substantial weight of the medical and scientific literature." RE 32; *see also* RE 33. Moreover, the ALJ found that Drs. Renn and Repsher had improperly discounted a study involving underground miners because they believed that Opp, as a surface miner, had less exposure to coal dust, which was contrary to the ALJ's determination that Opp's exposure was "substantially similar" to that of an underground miner. RE 35.

Furthermore, the ALJ rejected all four doctors' reliance on "the need for x-ray confirmation of fibrosis or pneumoconosis [which] was expressly addressed and rejected by the Department in its rulemaking proceeding." RE 36-37. And the ALJ observed that the Department had found an additive effect between cigarette smoking and coal dust exposure, a finding that Drs. Renn and Tuteur disagreed with. RE 37-38. Last, the ALJ discounted Dr. Repsher's opinion - that COPD due to coal dust exposure does not progress after the first year of exposure - as contrary to the preamble and judicial precedent. RE 38. In sum, the ALJ accorded the opinions "diminished weight" because "the Department has determined that criticisms of [the medical studies on which Dr. James relied] are insufficient to undermine the study's findings that coal dust exposure can cause a clinically significant respiratory or pulmonary impairment." RE 33, 34.

Besides concluding that Peabody's experts' criticism of the medical literature was unfounded, the ALJ found other reasons for according their opinions less weight. Dr. Renn's opinion was unreasoned because he expected to see a "relative reduction" in total lung capacity in COPD caused by coal dust exposure, but failed to explain the extent of this reduction or how it would be differentiated from the effects of smoking. RE 38. Similarly, he found fault with Dr. Fino's opinion for failing to discuss the effects of coal dust exposure on Opp's diffuse emphysema, and for stating that a miner's emphysema increases with the extent of

his pneumoconiosis, a position rejected in the regulatory preamble "as contrary to the medical and scientific evidence." RE 39. Moreover, the ALJ rejected Dr. Tuteur's explanation that Opp's partially reversible impairment indicated COPD solely due to smoking. *Id.* The ALJ observed that even after using a bronchodilator, Opp remained totally disabled: "It . . . appears, as Dr. James concluded, that the miner's respiratory ailment was the product of more than one disabling process, a partially reversible component, and a fixed irreversible component." RE 39-40.

The ALJ thus credited Dr. James's pneumoconiosis diagnosis as the most credible opinion in the record. RE 40. Weighing all the evidence together, the ALJ determined that Drs. Anderson and James offered reasoned and documented opinions that smoking and coal dust exposure contributed to Opp's "severe progressive" COPD. RE 40-41. Conversely, he found, for the reasons above, that the contrary opinions of Peabody's experts were entitled to "little evidentiary weight." RE 41. He thus determined that Opp had established the presence of legal pneumoconiosis. RE 41.

Finally, the ALJ determined that Opp's legal pneumoconiosis arose out of coal mine employment, RE 42, and that it contributed to his undisputed total pulmonary disability. RE 43-46. The ALJ again credited Drs. Anderson's and James's diagnosis that coal dust exposure was a contributing factor to his COPD,

RE 45, while rejecting the contrary opinions from Drs. Repsher, Tuteur, Fino, and Renn as "neither well-reasoned nor well-documented." RE 43-44.

The ALJ ordered Peabody to pay benefits from January 1, 2000, to August 31, 2002, the month before Opp's death. RE 46.

h. Benefits Review Board Affirmance, May 16, 2011

The Board affirmed the award of benefits. The Board held that the ALJ had acted within his discretion in crediting as well-reasoned and documented Drs. Anderson's and James's diagnoses of legal pneumoconiosis and total disability due to pneumoconiosis. RE 11-13. The ALJ had permissibly found that these physicians' opinions were consistent with their underlying data and adequately explained how the data supported their conclusions. RE 11. Further, the Board held that the ALJ "acted within his discretion in concluding that, in significant part, the opinions expressed by employer's experts were rejected by the DOL in the comments in the preamble to the amended definition of pneumoconiosis set forth in 20 C.F.R. § 718.201" and thus, the ALJ had "rationally found that Dr. James's interpretation of the medical literature was entitled to greater weight than the interpretations advanced by Drs. Fino, Repsher, Tuteur, and Renn." RE 12-13.

Additionally, the Board affirmed the ALJ's findings that Dr. Fino had failed to address the diffuse emphysema diagnosed by Dr. James; that the Department had rejected Dr. Fino's opinion that coal dust-related emphysema increases as

pneumoconiosis increases; and that Drs. Tuteur and Renn did not fully address whether Opp's coal dust exposure contributed to his fixed and disabling pulmonary impairment. RE 13, 14. The Board thus affirmed the award of benefits.

The Board then summarily denied Peabody's motion for reconsideration. RE 7.

SUMMARY OF THE ARGUMENT

Peabody's lead argument is that the ALJ violated the Administrative Procedure Act by discrediting its medical experts on the ground that their opinions contradicted the Department of Labor's evaluation of and conclusions on certain medical and scientific issues expressed in the preamble to the BLBA's implementing regulations. Although during the rulemaking or before the ALJ, Peabody directly challenged the medical literature cited in the preamble, it no longer claims that its roundly discredited views of the literature are correct. Rather, it contends that the ALJ was *forbidden* from even reviewing, let alone adopting, the Department's previous consideration (and rejection) of its experts' views. Peabody produces no authority for this remarkable claim, and four courts of appeals have unsurprisingly rejected it.

Peabody also offers a brief suggestion that the ALJ erred in crediting Dr. James's opinion over the opinions of its experts. Although Peabody's argument is hardly fully formed, the fact remains that credibility determinations are the ALJ's

to make. Perhaps a different fact finder might have interpreted the opinions of Peabody's experts as more consistent with the Department's views and found them to be more persuasive than Dr. James's opinion (and Dr. Anderson's). That, however, does not change the fact that this ALJ's reading of the expert opinions is supported by substantial evidence and should be affirmed.

ARGUMENT

The ALJ's Ruling That Opp Suffered From A Totally Disabling Pulmonary Disease Caused, In Part, By His Exposure To Coal Mine Dust Is In Accord With The APA And Supported By Substantial Evidence.

1. Standard of Review.

Peabody's challenge to the ALJ's reliance on the preamble presents a question of law that is subject to de novo review. *Movsesian v. Victoria Versicherung AG*, 670 F.3d 1067, 1071 (9th Cir. 2012). The Director's interpretation of the BLBA and its implementing regulations is entitled to deference. *Albina Engine & Machine v. Director, OWCP*, 627 F.3d 1293, 1298 (9th Cir. 2010); *Director, OWCP v. Palmer Coking Coal Co.*, 867 F.2d 552, 555 (9th Cir. 1989).

Absent an error of law, the ALJ's findings and conclusions must be affirmed if supported by substantial evidence. *N. Plains Research Council, Inc. v. Surface Trans. Bd.*, 668 F.3d 1067, 1075-76 (9th Cir. 2011). Substantial evidence means evidence that a reasonable mind might accept as adequate to support a conclusion.

Conahan v. Sebelius, 659 F.3d 1246, 1249 (9th Cir. 2011).

2. In considering the credibility of a medical expert's testimony, an ALJ is permitted to consider the preamble to the BLBA's implementing regulations, which provides the Department of Labor's rationale for the regulations and evaluation of the medical and scientific literature on black lung disease.

Peabody's primary argument is that an ALJ cannot discount a medical expert's testimony that is contrary to the Department of Labor's evaluation of relevant scientific and medical issues in the preamble to the BLBA's implementing regulations without violating the Administrative Procedure Act. Pet. Br. at 25-31. Peabody argues that the ALJ arbitrarily created a "consistency with the preamble" rule to diminish the credibility of its physicians and, thus, violated its due process rights and the Administrative Procedure Act, 5 U.S.C. § 556(d). Pet. Br. At 25. But the ALJ created no such rule, and committed no error in considering the preamble when assessing the credibility of the various medical opinions.

It is the ALJ's responsibility to consider the conflicting medical evidence and assign it appropriate weight based on the record as a whole. *See, e.g. Ludwig v. Astrue*, 681 F.3d 1047, 1051 (9th Cir. 2012) (court must uphold ALJ's findings and inferences reasonably drawn from record even when evidence is susceptible to more than one rational interpretation). In this case, there was a wealth of conflicting medical evidence regarding the clinical significance of coal dust exposure on COPD generally and its impact on Opp's COPD specifically. In

concluding that Opp's coal dust exposure did in fact contribute to his COPD, Dr. James relied on many of the same scientific studies cited to and relied on by the Department of Labor in the preamble when it revised the definition of pneumoconiosis to include obstructive diseases. *See* 20 C.F.R. § 718.201(a)(2); RE 27 n.6 (identifying studies relied on by Dr. James). In response, Peabody's experts resurrected the mining industry's criticisms of these studies, which also had been submitted into the rulemaking record. RE 26 n.5 (identifying studies submitted into record by Peabody). Peabody thus squarely placed before the ALJ the validity of these studies, the Department's reliance on them, and the Department's rejection of industry's criticisms - all of which were discussed in great detail in the preamble. 65 Fed. Reg. 79937-45.[14] In short, Peabody cannot now complain that the ALJ acted improperly by resolving the dispute that it put before him in the first place.

Far from being an APA violation, the ALJ's reliance on the preamble to

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[14] Before this Court, Peabody has not challenged the actual medical and scientific findings made by the Department in the rulemaking or the promulgation of the resulting regulations. Nor is there any basis to do so. Indeed, the mining industry, in its facial challenge to the revised definition of pneumoconiosis, ultimately *conceded* that the rulemaking record supported the premise that obstructive lung disease caused by mining exposure "can contribute to a miner's disability. *NMA*, 292 F.3d at 863. The coal company in *Harman Mining Co. v. Director, OWCP*, 678 F.3d 305, 315 n. 3 (4th Cir. 2012) also did not challenge the substance of the preamble. 678 F.3d at 315 n. 3.

evaluate conflicting medical opinions has been uniformly endorsed by the courts of appeals to consider the issue, as well as the Benefits Review Board. *Consol. Coal Co. v. Director, OWCP*, 521 F.3d 723, 726 (7th Cir. 2008) (describing ALJ's "sensible" decision to discredit physician's opinion conflicting with scientific consensus on clinical significance of coal dust-induced COPD, as determined by Department of Labor in preamble); *Harman Mining Co. v. Director, OWCP*, 678 F.3d 305, 314-315 (4th Cir. 2012) ("Although the ALJ did not need to look to the preamble in assessing the credibility of Dr. Fino's views, we conclude that the ALJ was entitled to do so"); *Helen Mining Co. v. Director OWCP*, 650 F.3d 248, 257 (3d Cir. 2011) ("The ALJ's reference to the preamble to the regulations, 65 Fed. Reg. 79941 (Dec. 20, 2000), unquestionably supports the reasonableness of his decision to assign less weight to Dr. Renn's opinion"); *Little David Coal Co. v. Director, OWCP*, __ Fed. 3d Appx. __, 2012 WL 3002609 at *6 (6th Cir. July 23, 2012) (unpublished) ("[I]t was permissible for the ALJ to turn to the preamble for guidance when determining the relative weight to assign two conflicting medical opinions"); *Ethel Groves v. Island Creek Coal Co.*, 2011 WL 2781446 at *3, BRB No. 10-0592 BLA (DOL Ben. Rev. Bd. June 23, 2011) ("an administrative law judge has the discretion to examine whether a physician's reasoning is consistent with the conclusions contained in medical literature and scientific studies relied upon by DOL in drafting the definition of legal pneumoconiosis."). *See also*

Freeman United Coal Mining Co. v. Summers, 272 F.3d 473, 483 n.7 (7th Cir. 2001) ("During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino [denying that coal dust inhalation causes significant obstructive lung disease] and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'" (quoting 65 Fed. Reg. 79,939)).

These cases reflect the well-established principle that a reviewing court must generally be at its most deferential when examining an administrative agency's determination of scientific or technical matters within its area of expertise. *See Baltimore Gas & Elec. Co. v. Natural Res.Defense Council*, 462 U.S. 87, 103 (1983); *Marsh v. Oregon Natural Res. Council*, 490 U.S. 360, 377 (1989). The Supreme Court has recognized that this principle applies to the federal black lung program, "a complex and highly technical regulatory program," in which the identification and classification of relevant "criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991); *accord*, *Midland Coal Co. v. Director, OWCP*, 358 F.3d 486, 490 (7th Cir. 2004) ("we see no reason to substitute our scientific judgment, such as it is, for that of the responsible agency," and holding that coal company failed to make required showing that Department's scientific conclusion that pneumoconiosis can be progressive and

latent was not supported by substantial evidence); *Asarco, Inc. v. Occupational Safety and Health Administration*, 746 F.2d 483, 490 (9th Cir. 1984) (court does not second-guess agency's resolution of conflicting, equally-respectable, scientific evidence). Peabody's position - which would positively forbid an ALJ from considering the Department of Labor's evaluation of the scientific literature on black lung disease - turns this well-established principle on its head.

The case Peabody primarily relies upon for its view that the preamble is off limits, *Home Concrete & Supply, LLC v. United States*, 634 F.3d 249 (4th Cir. 2011), stands for nothing of the sort.[15] In *Harman Mining Co.*, the Fourth Circuit addressed this precise point and wasted no words in finding it too dull to hit home: "[*Home Concrete & Supply*] provides a clear example of a regulatory preamble on which any reliance would be problematic. For there we concluded that the preamble *contradicted* the plain statutory language. 634 F.3d at 256-57. For this reason, we properly refused to defer to the IRS's interpretation of the statute contained in the preamble. By contrast, here, the preamble is entirely consistent with the Act and its regulations and simply explains the scientific and medical basis for the regulations." *Harman Mining Co.*, 678 F.3d at 315 n.4. Certainly, the

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[15] *Home Concrete* involved the IRS's attempt to rely on a policy position set forth in the preamble to a regulation to extend the statutorily-set six-year limitations period. 634 F.3d at 257-58.

Fourth Circuit's rejection of Peabody's reading of its case law should lead this Court to reject it as well.

Peabody's reliance on *Wyeth v. Levine*, 555 U.S. 555 (2009), founders on the same shoals. Like *Home Concrete*, the preamble in question in *Wyeth* addressed a legal issue - the preemptive effect of FDA regulations on state law remedies - rather than a scientific or technical one. *Id*. at 577 ("agencies have no special authority to pronounce on pre-emption absent special delegation by Congress"). It was also, again like *Home Concrete*, "at odds with what evidence we have of Congress's purposes" and, to top it off, "revers[ed] the FDA's own longstanding position without providing a reasoned explanation[.]" *Id.* None of these facts are true of the regulatory preamble at issue in this case.

Similarly, Peabody's reliance on *El Comte Para Bienestar de Earlimart v. Warmerdam*, 539 F.3d 1062 (9th Cir. 2008), is misplaced. Peabody accurately quotes *Warmerdam*'s language that "the preamble language should not be considered unless the regulation itself is ambiguous," but omits the Court's qualifying statements:

> [U]nlike the statute's operative part, the preamble does not 'prescribe rights and duties and otherwise declare the legislative will,' nor does it 'enlarge or confer powers on administrative agencies or officers,' but it nevertheless 'may aid in achieving a general understanding of the statute.' *Id*. (internal quotation marks omitted). By analogy, the 'principles governing interpretation of the preamble of a regulation are no different' than those governing statutory interpretation, and thus, '[w]here the enacting or operative parts of a statute are

> unambiguous, the meaning of the statute cannot be controlled by the language in the preamble.' *Id.*

Warmerdam, 539 F.3d at 1070, quoting *Wyoming Outdoor Council v. United States Forest Service*, 165 F.3d 43, 53 (D.C. Cir. 1999). Such is the case here, where section 718.201 unambiguously defines clinical and legal pneumoconiosis, and the preamble to the regulation "simply sets forth the medical and scientific premises relied on by the Department in coming to these conclusions in its regulations." *Harman Mining Co.*, 678 F.3d at 314; *Little David Coal*, 2012 WL 3002609 at *3 (the preamble "simply summarizes the medical and scientific evidence upon which the regulations are founded").[16]

Thus, Peabody is simply wrong that the preamble represents a legislative rule and is therefore subject to the APA's notice and comment requirement. Rather, the preamble provides notice of substantive rules, which are binding and

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[16] Peabody's attempt to dismiss the *Harman Mining* holding as *dicta*, Pet. Br. at 29-30 n.6, is belied by the Court's statement that the operator "disavows any argument that the record fails to offer substantial evidence supporting the ALJ's findings of fact," and Harman's assertion that its appeal presented only questions of law. *Harman Mining Co.*, 678 F.3d at 310. The issue before the *Harman* court, as here, was whether the ALJ could rely on the preamble in weighing the medical evidence. (In fact, the arguments presented by Harman are nearly identical to those presented by Peabody here.) The court made its legal holding evident by specifically affirming the ALJ's decision not to credit Dr. Fino's opinion because it "conflicts with the recognition in the preamble to the 2000 regulations that coal dust can induce obstructive pulmonary disease independent of clinically significant pneumoconiosis." *Harman Mining Co.*, 678 F.3d at 313.

have the force and effect of law. The preamble also addresses comments to the proposed rule. *Harman Mining Co.*, 678 F.3d at 315 (ALJ's citation to the preamble did not "imbue it with the force of law or to transform it into a legislative rule"); *Little David Coal*, 2012 WL 3002609 at *3 ("The preamble does not itself impose any substantive rules or requirements").

Finally, there is no merit to Peabody's contention that the ALJ erred in considering the preamble because it was not part of the record. Both the Fourth and Sixth Circuits have rejected this precise argument. *Harman Mining Co.*, 678 F.3d at 316 ("[T]he APA does not provide that public law documents, like the Act, the regulations, and the preamble, need be made part of the administrative record. Harman cites no authority supporting its contrary view and we have found none"); *Little David Coal*, 2012 WL 3002609 at *3 (the record as a whole included "the DOL regulations, which, in turn, include the preamble"). In any event, even if Peabody is correct that the ALJ violated the APA by taking official notice of the preamble, the company failed to request an opportunity to respond to the ALJ's use of the preamble, as required by the APA. 5 U.S.C. § 556(e) ("When an agency decision rests on official notice of material fact not appearing in the evidence in the record, a party is entitled, *on timely request*, to an opportunity to show to the contrary.") (emphasis added).

3. Substantial evidence supports the ALJ's award of benefits.

In evaluating whether there is substantial evidence to support the ALJ's finding, "'our court will interfere only where the credibility determinations conflict with the clear preponderance of the evidence, or where the determinations are inherently incredible or patently unreasonable.'" *Hawaii Stevedores, Inc. v. Ogawa*, 608 F.3d 642, 648 (9th Cir. 2010), quoting *Todd Pacific Shipyards Corp. v. Director, OWCP*, 914 F.2d 1317, 1321 (9th Cir. 1990). Moreover, "[t]he substantial evidence test for upholding factual findings is 'extremely deferential to the factfinder.' . . . '[O]ur task is not to reweigh the evidence, but only to determine if substantial evidence supports the ALJ's findings.'" *Rhine v. Stevedoring Serv. of Am.*, 596 F.3d 1161, 1165 (9th Cir. 2010), quoting, respectively, *Metro. Stevedoring Co. v. Rambo*, 521 U.S. 121, 149 (1997); *Lockheed Shipbuilding v. Director, OWCP*, 951 F.2d 1143, 1146 (9th Cir. 1991).

In weighing medical evidence, "[j]ust as '[i]t is within the ALJ's prerogative, as finder of fact, to credit a witness's testimony over that of another,' *Duhagon v. Metro. Stevedore Co.*, 169 F.3d 615, 618 (9th Cir. 1999) (per curiam), the ALJ is free to credit a witness's testimony in the face of one party's argument that the witness is not credible." *Hawaii Stevedores, Inc.*, 608 F.3d at 650. Here, the ALJ adequately explained his reasons for crediting Drs. James's and Anderson's opinions over the contrary views from Drs. Repsher, Tuteur, Fino, and

Renn.[17]

a. The ALJ's decision to credit Dr. James's opinion as establishing the presence of legal pneumoconiosis and disability due to pneumoconiosis is supported by substantial evidence.

Dr. James diagnosed Opp as totally disabled by a respiratory obstruction caused, in part, by Opp's exposure to coal mine dust. The ALJ permissibly determined that Dr. James provided a reasoned medical opinion, documented by physical examination, pulmonary function and arterial blood gas tests, and medical treatises. RE 19, 40-41, 45. Peabody's only specific allegation of error concerning the ALJ's assessment of Dr. James's report is that the doctor admitted that his opinion was not based on any specific test, and that the medical literature varied concerning the connection between coal dust exposure, emphysema, and pulmonary impairment. Pet. br. at 24. Peabody's argument mischaracterizes Dr. James's opinion and is without merit.

Although candidly acknowledging that "[t]here are no tests that can definitively determine whether Mr. Opp's COPD resulted from his coal mine dust exposure or his cigarette smoking exposure or both," DX 12, Dr. James's opinion

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[17] Peabody has not challenged the ALJ's decision to credit Dr. Anderson's opinion. RE 19-21, 41, 43, and 45. Accordingly, the Court must affirm the ALJ's finding. *Native Village of Hope v. Salazar*, 680 F.3d 1123, 1131 (9th Cir. 2012) (argument not raised in party's brief is waived).

that Opp's COPD was due to both smoking and coal dust exposure was based on a number of factors, not just one test. As the ALJ found, Dr. James relied on Opp's medical, smoking and employment histories, as well as objective test results and the medical literature. RE 21-28. For example, Dr. James testified that the literature showed "that chronic coal mine dust exposure can cause airflow obstruction, even in miners who have x-rays that do not show evidence of fibrotic disease." RE 181-182; *and see* 183-86, 188-90, 192, 193 (discussing medical literature). Moreover, Dr. James explained that although Opp's pulmonary function test results showed some reversibility with bronchodilators, the remaining fixed impairment was disabling and consistent with a coal dust-related condition, as was the progression of his COPD. RE 198-99. And finally, Dr. James testified that Opp's pulmonary impairment was unusually severe if seen in a non-miner with Opp's smoking history, but was consistent with the additive effects of smoking and coal dust exposure. RE 191, 199-200. Because Dr. James's opinion was well-supported and reasoned, it was clearly within the ALJ's discretion to credit.

b. The ALJ rationally discounted the opinions of Peabody's experts.

Conversely, the ALJ permissibly declined to credit the opinions of Drs. Repsher, Fino, Tuteur, and Renn. These doctors all based their opinions in no small part on the common belief that coal dust exposure never or rarely, *i.e.*, less

than 1% of the time, causes a clinically-significant obstructive impairment, RE 31-32, and that x-ray evidence of pneumoconiosis or fibrosis is required before an obstructive impairment, emphysema in particular, may be related to coal dust exposure.[18] RE 35-36. As discussed above, the ALJ permissibly looked to the preamble to determine that these beliefs are incompatible with the medical and scientific underpinnings of the revised definition of pneumoconiosis, 20 C.F.R. § 718.201, and the ALJ therefore reasonably accorded their opinions diminished weight. RE 35-37; 43-44; *Consol. Coal Co.*, 521 F.3d at 726 (affirming ALJ's reliance on the preamble to assess conflicting medical opinions); *Harman Mining*, 678 F.3d 314-315 (same); *Helen Mining Co.*, 650 F.3d at 257 (same); *Little David*

[18] Peabody's experts' lip service to the possibility of "rare" instances of coal-dust induced COPD does not undermine the ALJ's analysis in the least. As the Seventh Circuit explained in regards to an identical opinion from Dr. Tuteur:

> A personal view that [the miner's] condition had to be caused by smoking because miners rarely have clinically significant obstruction from dust . . . would lead to the logical conclusion that Dr. Tuteur categorically excludes obstruction from coal-dust-induced lung disease. . . [T]he Department of Labor reviewed the medical literature on this issue and found that there is a consensus among scientists and researchers that coal dust-induced COPD is clinically significant. This medical authority indicates that non-smoking miners develop moderate and severe obstruction at the same rate as smoking miners. 65 Fed. Reg. 79,938. . . .[H]e did not cite a single article in the medical literature to support his propositions. [The coal company's] only counterargument here is that it is possible to interpret Dr. Tuteur's opinion as being consistent with the proposition that coal dust exposure *can* cause COPD in rare cases. But the Department of Labor report does not indicate that this causality is merely rare."

Consol. Coal Co., 521 F.3d at 726.

Coal Co., 2012 WL 3002609 (same); *see also Freeman United*, 272 F.3d at 483 (affirming ALJ's rejection of Dr. Fino's opinion that coal dust exposure does not cause significant obstructive disease as "not supported by adequate data or sound analysis" and contrary to medical studies cited in the preamble).[19]

Moreover, the ALJ found that the doctors held individual beliefs that conflicted with preamble findings: Drs. Repsher stated that a coal-dust-related obstructive impairment, *i.e.*, legal pneumoconiosis, would not progress after the first year of dust exposure, RE 38; Dr. Fino opined that coal dust-related emphysema increases with the severity of pneumoconiosis, RE 36, 39; and Drs. Tuteur and Renn that coal dust exposure does not act "additively or synergistically" with tobacco smoke, RE 38. The ALJ permissibly accorded their opinions less weight for these reasons as well.

Finally, the ALJ correctly gave less weight to the opinions of Drs. Fino, Renn, and Tuteur for reasons having nothing to do with the preamble. The ALJ

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[19] Although the ALJ relied on the preamble findings, it is also true that these doctors' beliefs conflict with the regulatory definition of coal workers' pneumoconiosis, which recognizes that coal dust exposure can cause or significantly contribute to a purely obstructive pulmonary impairment and that it may exist absent x-ray evidence. 20 C.F.R. §§ 718.201(a)(2), 718.202(a)(4). In addition, Dr. Repsher's belief that a coal-dust-related obstructive impairment would not progress after the first year of dust exposure conflicts with the regulatory definition of pneumoconiosis describing the disease as latent and progressive. 20 C.F.R. § 718.201(a)(2).

declined to credit Dr. Tuteur's opinion because the doctor relied on partially reversible ventilatory test results but failed to explain why the remaining fixed disabling impairment was unrelated to Opp's thirty-nine years of coal dust exposure. RE 39. Likewise unexplained and unreasoned was Dr. Renn's claim that if there were a dust-related impact, there would be a "relative reduction" in total lung capacity; but, as the ALJ found, the extent of this reduction or how the doctor would differentiate it from the effects of smoking was never discussed. RE 38-39. And he found fault with Dr. Fino's opinion for failing to discuss the effects of coal dust exposure on Opp's diffuse emphysema, which Dr. Fino and Dr. James had diagnosed. RE 39; EX 5 at 12. Because it was within the ALJ's discretion to reach these credibility determinations, this Court must affirm.[20]

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[20] Peabody complains that the ALJ misinterpreted its experts' opinions. Pet. Br. at 22-23. But throughout his opinion, the ALJ quoted Peabody's experts and cited directly to their reports and deposition testimony. RE 28-29; 31-40. The fact that Peabody has a different understanding of its experts' views is simply not enough to overturn the ALJ's given this Court's substantial evidence standard of review. *Midland Coal Co.,* 358 F.3d at 492 ("on substantial evidence review we would have to find that the latter interpretation [of the doctor's opinion] was the only permissible one, not that it was one of several").

CONCLUSION

For the foregoing reasons, the Director respectfully requests that the Court affirm the ALJ's award of benefits.

Respectfully submitted,

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STATEMENT OF RELATED CASES

To the Director's knowledge, there are no related cases pending before the Court.

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 9011 words, as counted by Microsoft Office Word 2003.

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CERTIFICATE OF SERVICE

I hereby certify that on August 10, 2012, copies of the Director's brief were served electronically using the Court's CM/ECF system on the Court and the following:

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