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HEALTH SCREENING EXAMINATIONS FOR WORKERS WHO HAVE BEEN EXPOSED TO ASBESTOS

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I appreciate this opportunity to contribute to the discussion of the benefits and costs of carrying out mass screening examinations on individuals who may have been exposed to asbestos in California.

Before proceeding with my testimony, I should tell you something of my background. I am a physician, certified in the specialties of internal medicine, occupational medicine, and industrial hygiene. I spent 22 years, from 1941 through 1963 in the United States Public Health Service. The last eleven of these years were in the Division of Occupational Health, the precursor of the present National Institute for Occupational Safety and Health (NIOSH). After retiring in 1963, as chief of that division, I spent nine years on the faculty of the University of California in Berkeley, teaching and doing research in occupational health. In 1972, I left the University to become a full-time consultant. For the past 10 years, one of my responsibilities has been as medical advisor to the Western States Asbestos Health Plan, which provides medical consultation and services to insulating workers and insulating contractors in 13 western states.

My interest in the prevention and management of asbestos-related diseases began when I was in the Public Health Service. These were the years, from 1952 to 1963, when the association between exposure to commercial asbestos and various forms of cancer was convincingly demonstrated,

* Presented at a hearing of the Senate Select Committee on Maritime Industry, California Legislature, Chaired by Senator Milton Marks, San Francisco, December 12, 1978

first for lung cancer, then for mesothelial tumors and then for several other types of tumors.

In 1964, after I came to California, I began working with Local 16 of the Asbestos Workers Union, to study their exposures to asbestos and their health status. This was supported by a grant from the U. S. Public Health Service. Our study showed that a large proportion of the active and retired members had asbestosis, and that deaths from lung cancer were seven times expected for men who had been in the trade 20 years or more. Measurement of work exposures (these were the first to be done on insulating workers in the U.S. other than those in Navy shipyards) showed that exposures to total dust did not usually exceed those then accepted as standards for asbestos, which were based on counting all dust particles rather than fibers. We also included counts of fibers, using methods that were just being developed, and found that there were very high peak exposures during certain operations, especially mixing of muds, tear-out, and sawing with power tools. These findings, soon confirmed by others, helped support the use of fiber counts for standards, the lowering of permissible levels, and the development of improved work practices. I emphasize these points, because, as my testimony proceeds, you will understand why I feel that primary prevention, by eliminating or reducing exposures, is far more important than medical surveillance in meeting the problem of asbestos disease.

I will describe only briefly the medical portion of our program for the Western States Asbestos Health Plan. In 1966, asbestos workers and contractors in 13 western states set up a supplemental health and welfare fund for occupational health, financed by a contribution of two cents an hour by labor and mangement. This generated about thirty to fifty thousand dollars annually, which supported a joint-management oc-

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cupational health plan. From this a program of periodic physical examinations funded by local health plans has been provided for many local areas in the trade. Since this program is not the major focus of this hearing, I will not describe it in detail. It is mentioned to indicate the experience with physical examinations of heavily-exposed asbestos workers which has influenced my thinking about screening programs. I have records on approximately 1,300 current or former asbestos workers in my files, with chest films on some dating back to 1957. On the average about one-fourth of all those examined have definite evidence of asbestosis, i.e. lung fibrosis, the proportion being determined by how many have had 10, 20 or 30 years in the trade. In all of these examinations, only one case of early operable cancer has been picked up. We do not feel that the program has had a direct impact on the development of functional impairment, disability or cancer, but it has had many indirect benefits. It has provided opportunities to encourage prompt treatment of lung infections, and the cessation of smoking, and to reinforce educational campaigns on work habits. It has provided the worker's personal physician with guidance as to the management of asbestos disease and has provided a permanent file for each man.

The mortality experience of Local 16 in the Bay Area has been disastrous in the past 10 years. Of the last 99 deaths that have occurred, in the years 1967 through 1978, 53 have been from cancer, where about 18 would have been expected; 25 of these were lung cancer, 11 were malignant mesothelioma, six were gastrointestinal tract tumors and 11 were from other sites. So, I do not need to be convinced of the serious effects of heavy exposures to asbestos.

In spite of the foregoing, I cannot recommend a mass screening program for all those who might have been exposed to asbestos at some

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time in the past. The objectives of such a program need to be carefully defined. The effects of deposited asbestos in the lungs are not reversible. An examination program that includes chest film, pulmonary function testing, sputum cytology, and test for occult blood in the stool will probably yield few individuals with definitive asbestosis, and even fewer with evidence of lung cancer, mesothelioma or gastrointestinal tract cancer. I think we should review carefully the experience of pilot programs already carried out, remembering that the test of a program is not the number of positive findings but what can be done to help those with such findings. Those with asbestosis can be given advice as to smoking and treatment of lung infections, which may slightly improve their outlook. Those with evidence of lung cancer, and they will be extremely few, will have their prospects of recovery not much better than if they were diagnosed after having symptoms. Those with mesothelioma will not have their lives prolonged at all. In other words, the reduction of disability and death from asbestos-related disease will probably be almost infinitesimal. The major yield, and this is an intangible, will be in the feeling of relief in those who have been alarmed by the publicity about asbestos diseases, and who receive reports that their chest X-ray films, their pulmonary function tests and their sputum cytology reports are normal. Elimination of non-productive anxiety in such individuals would be the most important return from results of a mass screening program. The legislature will have to decide whether or not this justifies the cost of a major screening program.

Against the benefits described above, one must consider the adverse effects. Support by the state of such a program would indicate its major concern and the publicity required to get maximum voluntary participation

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would generate anxieties in millions of people. This would be fully justified if it saved lives, of course. However, although the risks of asbestos are real, they drop off rapidly as exposures decrease. The incidence figures developed by Dr. Austin, based upon counties where there have been major shipbuilding industries as well as other asbestos plants, suggest that predictions by the Federal government are probably grossly exaggerated.

One must consider the extent to which individuals found with possible or definite asbestosis might become unemployable. Unjust as it may be, the way our current workmens compensation laws are written, no employer could be expected to hire an individual with asbestosis, especially if there is any possibility of further exposure to dusts or other substances that might be construed as aggravating. This is true if asbestosis is actually present. It is equally true if asbestosis has been overdiagnosed, which can occur when inexperienced physicians, who know individuals have been exposed in the past to asbestos, base diagnoses on inadequate evidence. A diagnosis of asbestosis when it is not present can be more damaging to an individual than missing a diagnosis of early asbestosis. An individual can be made unemployable without impairment of function sufficient for compensation. In most states, with a positive report of asbestosis a worker must file for compensation to protect his rights, even though he may not really wish too. With present levels of control, it is almost certainly not necessary for him to quit work with asbestosis or other dusts for medical reasons. Stopping will not significantly affect whether or not he gets lung cancer or mesothelioma. However, if a doctor fails to tell him of positive findings, or even doubtful findings that some over-sensitive doctor later may call positive

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in retrospect, this may be regarded as malpractice. We always tell an individual of the findings in his lungs, but try to put them in perspective so that he can evaluate his choices. Other questions covered briefly:

1) Who is to be screened? Asbestos workers already required to have examinations. Former workers need to be defined. Remember all of us have asbestos in our lungs.

2) Costs.

3) Follow-up.

The foregoing brings me to what I consider the single most important action the California legislature could take with regard to asbestos-related disease, which is to amend worker compensation laws so as to make them appropriate to the problem. When one is dealing with diseases that result from exposures 20 to 40 years prior to the appearance of signs or symptoms, limiting liability to the employer of the last year or last five years makes no sense whatever. This is true for all diseases with long latent periods, such as most occupational carcinogens, but asbestos is the example at hand. There is Federal legislation pending on this subject, and personally, I think it is desirable. But, California should not stand by waiting for Washington to act. It should try to enact realistic legislation, taking care of those whose exposures occurred before it was really known that lung cancer, mesothelioma and bowel tumors could result from asbestos exposures that were measured below the then-operative standards. It should also make provision to compensate for asbestos disease in the immediate families of asbestos workers, who can have exposures from work clothes and household contamination. Compensation plans should not be inhibited by exaggerated predictions of asbestos disease which seem to make fair recompense economically impossible. These predictions will probably not be borne out in fact. Compensation should be based upon evidence of exposure, and proven impairment of function.

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In conclusion, it is my opinion that it would be far preferable to use the m oney required for a mass screening program, of dubious benefit, for a positive program to prevent new exposures and to compensate those who have been harmed by asbestos exposures in the past. They should be properly recompensed for their medical costs, lost earning power, and their pain and suffering. Attempting to do this by litigation on a case-by-case basis or by class action suits is not likely to be equitable either for industry or the worker.

I wish to thank you again for this opportunity to present my views.

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