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Waukegan
January 4, 1971
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H. M. Jackson - GHQ New York PO 91

RE: STANDARD PROCEDURE FOR WORK RESTRICTIONS AND COUNSELING OF PNEUMOCONIOSIS CASES

I appreciate yours and Cliff's desire to assist me in developing the proper format for the Manual of Standard Practices, however in reviewing the revised procedure as submitted in your letter of December 22, 1970 I find that very little of the original intent of the Standard Procedure is retained. For example one of the most striking features was your change from "Procedure for Work Restrictions and Counseling of Pneumoconiosis Cases" to that of "Procedure for Establishing Work Restrictions and Counseling Employees with Pulmonary Impairments". We are in fact talking about, and I think the standard should be specific, in stating pneumoconiosis cases. We are not talking about pulmonary impairment. I do not believe that there is any need to be ambiguous in this respect. Many of these cases, diagnosed sufficiently early, will not have any evidence of pulmonary impairment. They certainly are not to be confused with non-occupational diseases involving pulmonary impairment such as: emphysema, bronchiectasis, asthma, postoperative and posttraumatic lung changes, etc. We are talking about pulmonary fibrosis of occupational origin and I believe we must be specific in this regard.

I am most anxious to let the procedure as outlined in my letter of 10/29/70 to those locations that now have pneumoconiosis cases of record, be given a trial, as was approved by Mr. Burnett and the Policy Committee Task Force. Until proved otherwise, rather than embark on a totally new procedure, I would like to see a system with more than fifteen years of actual use and extremely satisfactory results, be given an opportunity of further success. Further, I am not persuaded that any great problem in advising employees of their diagnosis, after job approval is determined, will occur because of the lack of knowledge of actual job situations by the consulting physicians. More than 70% of all of our pneumoconiosis cases are at either the Manville or the Waukegan locations, where of course we have full time J-M physicians. If Toronto and Pittsburg locations are included, where well qualified part-time physicians who are quite familiar with problems, are available, then more than 78% of our cases are covered. Further, the advantage to the physician to be able to reassure the employee that although, he is a pneumoconiosis case, his prognosis based on no further exposure is optimistic, is of great value in the difficult duty of advising an employee/patient he has pneumoconiosis. However, more than this, the primary reason that this procedure was set forth in this sequence was that it alerted the employees supervision that the employee would be advised and therefore precluded the potentially difficult situation of an employee returning to his department following counseling and advising his supervision that a job change for him was indicated by the physician, without his department having any preparation for this information.

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RE: STANDARD PROCEDURE FOR WORK RESTRICTIONS AND COUNSELING OF PNEUMOCONIOSIS CASES

There are several other points in your suggested Standard Practices that I would like to comment upon. For one, in the counseling of the employees it is mentioned, "and review the employees chest x-ray with him". This I think should not be a specific part of the Standard Practice, but left entirely, to the discretion of the physician involved with the counseling. Many will, as I have, find it is very helpful in advising the patient of his condition to use x-ray films. However, it must be recognized that perhaps somewhere between 95 & 99% of patients in general having x-ray films taken, never see their x-rays. It is not a common procedure with physicians to show patients their x-rays. In our situation it may be that the counseling physician does not in fact have the x-rays in his possession, but that they are on file at the local hospital, or in some other institution rather than in his office, or the company medical department. Next I would comment that putting in the Standard Practices that the physician will conduct his counseling in a manner that will assure that the employee understands his physical condition is unnecessary, it being understood that the physician will use whatever methods are appropriate to that particular patient, to acquaint that individual with his diagnosis.

I further believe that the formula for determining the acceptability of the employee/patient's job is far better set forth in the original suggestions that you made, that I incorporated in my recommendations of 10/29/70.

In summary it would be my desire Hugh, that we follow the original approval by Mr. Burnett in giving the proposed procedures a trial of actual usage to see what modifications should be made, if any. There is one immediate addition that I found quite practical and that is that as part of the physicians original implementation of restrictions, that he will indicate on that whether or not a respirator can be worn by the individual patient/employee in question. We will undoubtedly wish to have further discussions on this subject, however, I can only emphasis that I am particularly impressed with a system that has shown itself not only practical in application, but has resulted in a rapport between the company and the patient/employees significantly better than in most of our plant and mine locations since its implementation more than 15 years ago.

T. H. DAVISON, M.D.

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