CONFIDENTIAL

May 10, 1957

Meeting held at Manville, N. J., on May 1, 1957.

Present: Dr. Kenneth Smith — H. M. Jackson
Dr. D. T. DuBow — C. L. Sheckler
Dr. E. D. Merrill

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Dr. Smith speaking:

I would like to suggest, Dave, that we consider certain types of cases in which, when a man comes up at the time of a periodic examination, and he has a suspected occupational disease, we put that aside and we have a conference on that case and see what the implications are and what can be done about it before we say 'early silicosis' or something.

Basically, I'd like to say there are really five types of cases we would like to have put aside at the time of regular periodic examination. First is the recognized occupational disease case - the person whom you have recognized for some time as having first stage asbestosis; the suspected occupational disease case, about which you are not sure; the tuberculosis case, whether active or inactive; the non-occupational pulmonary conditions such as the chest deformity, the unresolved pneumonia or other conditions which might result in a no-dust restriction or some medical restriction ...

(Discussion)

I will explain what we should do. Let me first outline the types of cases we want to set aside: the recognized - the suspected - the tuberculosis - the non-occupational pulmonary disease - and the case that is in litigation, for instance, the case in which a Formal Petition is filed. The case is pulled out and set aside, and you may have a special little conference with Cliff about what is in the records, or we may have a full-fledged conference. Those are the types of cases.

Now the procedure would be, at the time of periodic examination, to record all the physical examination findings, every bit of evidence that you have picked up, all signs and symptoms and things like that. But if you find, on examining a man's Xray, that he has a very early fine nodulation through the lung fields which was not present before, don't put anything in the record about that. Just pull the Xray and his file, and put these in a special drawer - call it a 'conference drawer' or whatever you want to. Do not make any record of the Xray findings or anything in the file at that time. You will see the reason for this as we develop this thing. So that you will know at a later date why you have pulled this case aside, I think it might be advisable to take a little memo pad and write, in your own handwriting, (but not dictated and then typed), a little note as to why you have pulled this Xray aside and want to use it at the conference .. such as, 'Note: 3 plus linear exaggeration' - 'Note: Fine nodulation' - 'Note: Shadow left lower lobe' .. and just clip that to the Xray. At the time of the conference, that will be removed and destroyed, so that we will have nothing in our records as to a diagnosis up to this point. That is the purpose.

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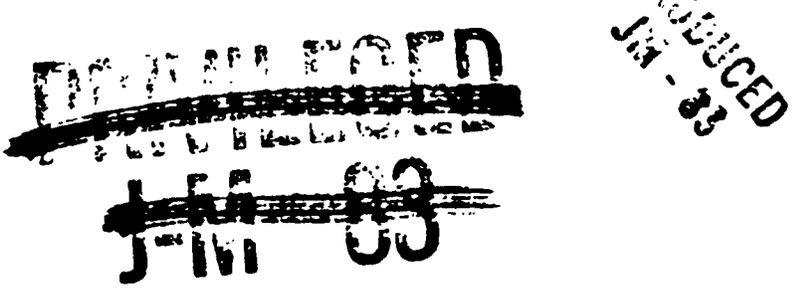
Now, what we thought we should do, because of all the necessity of recording medical facts which are essential for the medical program and essential for all good preventive medicine, but also because of this peculiar legislation that we have in New Jersey - that if we put down an impression today we can be damned for it at a future date - we thought we would suggest having a conference on these questionable cases, and will set them aside. I don't know how many there will be, but we will have to get the frequency of the conferences according to the number of cases, but suppose we say once a month. Hugh and I will come over from New York on the Asa Packer, and we'll set that day aside for a conference for the five of us.

And the first case will come up ... you've got early changes in a suspected O. D. case, in the Xray. We go back and review the Xrays together, and Cliff will have the personnel file there - (it's quite onerous to have the S-54 type of occupational history drawn up on every one of these cases until we catch up with them). For the immediate future, he will have the personnel file there, and he can relate the man's potential exposure of past occupations with any Xray changes, and we will come to a verbal diagnosis as a result.

If we come to a verbal diagnosis and an agreement as to what is in the film and what could be done, I would like to suggest this procedure for the disposal of cases:

Suppose that we sit down in conference, and you have an early suspected occupational disease ... early silicosis - there is fine nodulation ... and we all say, 'Yes, he did not have it in the previous film, but he's got something today'. Then it is up to Cliff and his group to review the working environment. We have our Industrial Hygiene technician now, and all the dust counting procedures, and they will investigate everything on the man's present job to see if these changes could be due to his present exposure.

Now, there are two alternatives that will result from that: If the man in his present job has no exposure, but has some Xray changes, - the job today has no toxic materials in it, and there are no dust counts to indicate anything could be the cause of the Xray change, we must assume then that these changes were due to a previous exposure or some other condition. We will record at that time in the man's medical file - (you will do this) - the type of shadow that you see. If there is a fine nodulation present in all lung fields, just record the type of shadow you see, where it is and how extensive it is, with no diagnosis. I mean, do not say 'fine nodulation typical of early silicosis'. That is, we have not decided that it can be early silicosis because we have not identified any exposures - we are just describing an Xray shadow. We will note that the Xray changes are not due to the man's present exposure, which is ruled out through Cliff. We have noted the Xray changes - we have ruled out any exposure in his present job - so we record the type of shadow and the fact that shadows are not due to the present working conditions of the man. After the conference, when we have



made a verbal diagnosis, then we ask Cliff to go out and survey the man's job area, and then he comes back and tells you 'I am sorry, there is nothing in this man's environment that could account for those shadows', and you record the type of shadow you see without making a diagnosis. You record the fact that the changes in the Xray are not due to his present job, and then, we do not tell the man anything about that. He just goes on like that. No dust restriction or medical restriction is given to the man or to the company. That's our responsibility, to care for the man and to protect management.

The other thing is the case which we think is suspected occupational disease. Cliff goes out into the plant - his crew goes out - and they survey the work environment and find that the man is working in a potential dust hazard. In other words, he is working somewhere like in a silica exposure which might be the cause of his present Xray changes. Then, the procedure is for Cliff to discuss this with the Plant Manager, identifying the job but not the man, (we still have not identified the man and any disease in any way). Cliff will say, 'At the cut-off saw, or the lathe, or something like that, in Transite Pipe, you have people in trouble, Mr. Plant Manager. Find out how that exposure can be eliminated at that job - what they can do by changing working methods - what can they do by controlling the dust at its source - how fast can it be done - and how much is it going to cost? This is the discussion with the Plant Manager. They can then institute the task team approach to control the hazard.

At that point, everything is still ethical. We have not identified a man with a disease without the man's knowing it. We have not indicated anything in our medical records which can say 'this is early silicosis' and which later can incriminate us if our diagnosis is wrong. But we have set in motion the wheels to elimination of the hazard to an employee or employees.

And then what we want to do is to put a bring-up on that file for later action. As soon as this has been identified as a potential exposure, Cliff comes back to you, and tells you there is a potential exposure and we are going to try to do something about it. You put a bring-up on the file for three months or six months. Now, obviously, nothing is going to happen to the man in that short time. Any disease that he may have started is not going to progress markedly because of the present exposure with our materials as we know them today. So the two of you talk together, and you put a bring-up on the file for three months or six, whichever is necessary, but, just make sure the bring-up is for another conference to talk about what has been done. In the meantime, the Industrial Hygiene people are watching to see what the Plant Manager is doing, and if they are trying to control a dust source, Cliff will know about that because they will be wanting more dust counts to see if they have controlled the source or if they have not.

The bring-up is put on the man's file, and you two discuss it with Cliff, and if the result is, that in a short time, because of ventilation or working methods, you can control the hazard so that the man is in no trouble, you can put down the Xray shadows - and I don't think it is advisable at that time to tell the man the diagnosis. It is the same as the first case, in which you have identified an Xray change and the man is not in any potential dangerous source which will harm his health.

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The other side of the coin is that if they have not done anything in the Plant, then we've got to sit down with the Plant Manager and the division people at a special conference and say 'Listen, this man is going to be told that he should not work in this area, he has a medical restriction, and this is what it is going to mean to you in dollars and cents and trouble, and trial and tribulation'. That's a special thing we will have to decide in this group ourselves, if, after a reasonable time, nothing has been done by the plant production people.

The other type of case -- we've gone over the suspected occupational disease, the recognized occupational disease -- then, the tuberculosis case. If you pick up an active tuberculosis case, your procedure today as I understand it is to refer the man to the Somerset County T. B. Association or his family doctor. And at that time I think you should tell Cliff ...

(Discussion)

I think the follow-up of contacts is absolutely necessary. I think the method of doing it should be thought out a bit. I think because of the potential liability associated with that in which, because of recent ruling in New Jersey Courts, if I come down with T. B. and I am working beside you and I give it to you, you have an occupational disease - that's recognized today in New Jersey - so, because of that potential, I think that Cliff is the logical contact for you as soon as you've identified a case of active tuberculosis. Go to Cliff and say 'This man has active T.B. - get a list of all the contacts so that we can survey them and prevent further trouble'. Then, when you have the list, sit down and review the file of each man. For instance, if you have eight or ten people who are contacts of one known case, and you call them all in for examination within two or three days, they are going to be quite a bit disturbed. So, I think the thing that would be advisable would be to see when the man's last examination was - if he had an examination two months ago and his Xrays were clear, obviously there's no point in having another Xray today, because, goodness knows how long this active case has been developing, how long he has had a chance to spread the T.B. Put a bring-up on this man for two months hence - or one month - or four months.

(Discussion)

Whether it is one week or three months will depend on when the last examination was. The longest period would be three months.

(Discussion)

Family and social contacts are not our responsibility. That's the responsibility of the County T.B.

Your procedure as you have it today is to call up the contacts, depending on the date of the last examination, at intervals, but you will not allow three months to elapse from the diagnosis of the active case till the last contact has been checked. You will recall every contact at approximately three month periods for the first year, and six month periods for the second year, checking Xrays and sputum and change of patch tests. In other words, if a man has a positive patch test, that's it; but if he has a negative patch test, you keep patch testing at each recall to see if there are changes.

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(Discussion)

If you do routine patch tests on all negative reactors at the time that you do the re-check Xray, that would be in order.

(Discussion)

Well, I think it would be advisable to get all the names of contacts and discuss everything with Cliff, and don't worry about Ed Legge or employment or anybody else like that. That's because of the legal implications.

(Discussion)

Well, the point I mean is, I was in Midge's office this morning when Ed Legge came in and said that in Midge's absence yesterday, and Cliff's absence, you went over to him.

(Discussion)

It isn't that urgent.

(Discussion)

After the procedure for the disposal of an active case, the procedure for the disposal of an inactive which you pick up at the periodic examination - maybe you've noticed it several times, in the past. But I would say that from now on the procedure for inactive T.B. cases should be reviewed in conference just the same as the procedure for the suspected o.d. that was outlined awhile ago -- putting the thing aside for conference, talking about it, telling Cliff 'Here's a man that should have a job restriction - look at his environment' -- and Cliff looks at that and comes back ..

(Discussion)

I think, because of the very, very bad reputation that the green card and no-dust restriction has developed in the minds of the plant people, that we should stop completely.

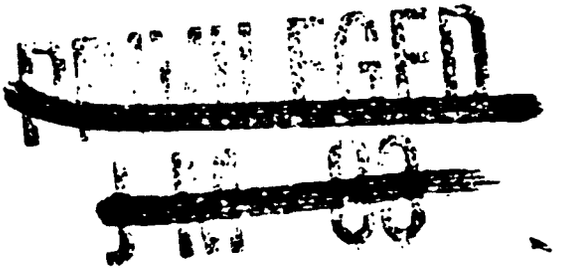
(Discussion)

We are in a position as a group, then, to take the responsibility of protecting the man from being harmed and protecting the company from a financial liability. And I think this group right here is a lot better equipped in our thinking than having the Plant Managers and their supervisors take over some of that responsibility, because their judgment in disease control is not as good as ours. Their judgment is superior in production methods, to ours, and if they will leave the disease and financial liability control to our judgment as a group, it will work better.

So, the inactive, apparently arrested T.B. case, then, would be handled just exactly as the suspected occupational disease case.

(Discussion)

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No recording to be made - a little slip for your own memory refreshment at the time of the conference - 'Note: Shadow left apex'.

(Discussion)

You've got to have some kind of a record. And this is just because of the legal implications in New Jersey today, we want to have a meeting of the minds as to where we want to go when we do put down the impressions on the medical record.

(Discussion)

Let's all agree that we have a fair working knowledge of Xrays and disease today, and set these cases aside to talk among ourselves before we call in any outside consultants, like Dr. Douglas. If we ask him for an off-the-record conference - or what does he think about a certain film - we are inviting a report which is just the same as putting it down on the diagnosis ourselves. Now, if there is a question about a shadow which appears in the left apex, for instance, which was not there last year, and we don't know why, let's put that aside for conference procedure and decide for ourselves what to do about it before we go outside for consultation.

(Discussion)

Whether it is active or inactive, if we suspect that it is an early incipient ...

(Discussion)

I still think that we have to go to our conference here before we go outside. We've got to make up our own minds on what the implications are. It need not delay things at all. If you have a suspected tuberculous lesion on the Xray today, it doesn't mean that you have to wait three weeks for the next conference. You sit down with Cliff immediately, before you record anything in the file and before you make any outside contacts, and you say 'Here is a case of suspected active tuberuclosis'. Then, he goes back over all the occupational record to see whether or not the man had a silica exposure, for instance, which would pre-dispose to this, which then leads into compensation. You've got to fly by the seat of your pants a little bit as you start, but I don't think we should have any outside contact with those fellows until we have made up our own minds as to what all the implications are.

(Discussion)

Cliff is no farther than fifty feet away, and it isn't going to delay the decision more than half an hour - or at the most half a day, to sit down with him and say 'Here is what is happening - we've got this positive sputum from the man - we've got to notify the family doctor, who already has been notified by the State', but for the company's protection we've got to sit down here and see what the implication is before we go outside. I think it's just to let Cliff have a flag on that file so that he can be prepared if there is a past silica exposure. That's the worry. I think it is our responsibility to the company to notify the management representative, Cliff, in this instance, that here is what is happening and if you see anything that might be a liability, start your wheels in motion. Does that cover you, Cliff?

(Discussion)

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And that is not putting any restriction or hiding of any evidence on your work at all.

(Discussion)

You alert Cliff of the findings - he puts a flag on that man's file and then you go and carry out your legal responsibility.

(Discussion)

Going back to the first question that Ed raised, we don't refer a case outside to Dr. Douglas, as we did routinely in the past, for diagnosis of a questionable shadow, until we have come to our own conclusions and understand the implications of the outside referral. For instance, if a man has a recognized early nodulation in his Xrays, which we have known for years, and we have never had a conference on him, then he shows a little coalescent shadow in one apex, - before we send that outside for consultation with Douglas, we have our own conference here which sets in motion the S-54 procedure, because that is probably going to be an occupational disease claim. Certainly as soon as Douglas sees that and says 'Yes, it looks like T.B. but also he has a pneumoconiosis in the background', we want to know that before Douglas, so that we can just quietly file and start gathering our records together, so we will be prepared to pay the claim off immediately, as is our moral responsibility, without having to go to Court.

(Discussion)

What you have been doing in the past was following an apparently inactive tuberculosis on the Xray, and watching the man, and, if the shadow suddenly appears larger when compared with previous Xrays, you suspect activity and you refer the man to Dr. Douglas for an opinion, or, before you refer him, you do some sputum tests and things like that, and then ask Dr. Douglas for an opinion, and the referral of the man for treatment is made at the recommendation of Douglas through the family physician. He is put in an institution through their offices.

Well, what we'd like to do now is - that when you notice this change in the Xray shadow, which makes you suspect activity, you put the file aside for a moment - you're doing your sputum studies and they come back positive - you get hold of Cliff and sit down and review the case with him and say, 'Here is an old T.B. case, it has become active, we are referring it to Douglas for disposal'. At that time, Cliff will discuss with you the man's past work record and whether or not there could be an occupational exposure related to the reactivation of the T.B. I think that's the essence of what we have been talking about the last couple of minutes.

(Discussion)

Let's say this - if you have suspected activity and you are not sure of it, and want Douglas as an expert to give you an opinion, let us postpone the opinion from Douglas until we have exhausted some more of our own investigative efforts. I think that is a case where we might sit down and make up our own minds whether it is active or inactive. And, when we have made up

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our own minds and have told Cliff 'Look, this looks as though it is active - we're convinced of it', we stand on our own two feet and say we want to call in Douglas or someone like that. Cliff knows about it before we do contact him for an assist in diagnosis.

The main point in this whole business is to make up our own minds of what we should do medically and what the implications are in the compensation and legal field before we get anything in the medical records. Referral to Douglas means a report in the medical record, and that's what we just don't want until we know what the implication of that is.

(Discussion)

If you have seen this enlargement of the Xray shadow and you have investigated his sputum and found it to be positive, and then you have told Cliff 'Here is a reactivated case of T.B.', you have to tell the employee and you have to refer him to the County T.B. Association and to Douglas. But I think right there you have got to call in Cliff and tell him before you tell the employee.

We've made up our minds what's going to happen now as far as the employee is concerned - what should be done - he has active T.B. -- but let Cliff know right at that time what the implications are so he can flag that file.

(Discussion)

We need very considered opinion on these questionable cases. The prime consideration is that we are the experts and not Douglas or anybody else. We have to stand on our own two feet and have our little conference about trying to make up our minds before going on the outside. There's no holds barred on getting the best medical opinion in the world as an aid to diagnosis, if we have our conference first before we go anywhere for any reason. I think that's the main thing.

I think we should adopt this procedure, no matter what has been done in the past, what has been recorded in the past, or what has been told the employee in the past .. that we request no opinion from an outside man for the record, or off the cuff, or, as we say, a hospital corridor opinion - what do you think about so and so. Whether or not the man has been told, I wouldn't do it in the future until we have had our conference because, very honestly, I don't think that it is reasonable to expect you two to keep up to date with all the latest changes in compensation legislation. For instance, Hugh mentioned the General Motors case which, I don't know what the story was - but somebody alleged that he got T.B. from the drinking fountain because the other employee drank from the same fountain, and he got an award. I think it is unreasonable to expect you to know about those changes. But that's Cliff's job - and he has to know about these Xray changes that you see so that he can interpret them in terms of what is happening and what judgment has been handed down elsewhere in the State. So that, the only flag we have there is that, every time a question comes up about pulmonary disease, tell him, - either if it is a reactivation of T.B., even if the man has been told in the past that he has an old T.B., even though he may be followed by Dr. Demy or Dr. Stolow or Dr. Douglas or someone else - even though you know that, before the contact is made with the outside man, let Cliff know, because there may be some change in legislation that happened only yesterday that he will know about and can tell you about. It's his job to know that, and it is not reasonable to expect you to know.

(Discussion)

If you have found some, as you say, equivocal changes on the Xray, and you can't say 'Yes, this is due to occupation' - you just don't know what it is ...

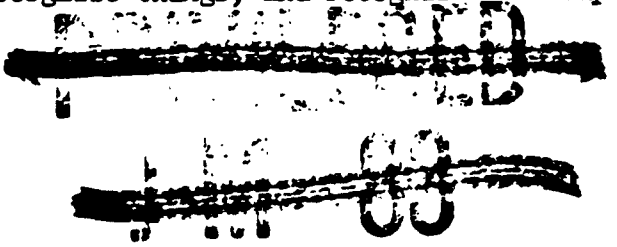
(Discussion)

You've found these Xray changes today, and the man comes tomorrow and says 'What about my Xray?' You say 'We just don't know - we've got to study those Xrays, we've got to refer them to a consultant'. Reassure the man that there isn't anything that's going to worry him. That's the main thing. Don't go into a long harangue or dissertation which may worry the man. If he comes along and asks about the results of his Xray, try to stall off until we have had our conference. And that can be just a 3-man deal, with you two and Cliff, or can be one of our regular ones, but the main thing is to reassure the man that there is no worry whatsoever today.

Then, the environment is investigated, we have our conference, and we may come up with still equivocal changes and say, Goodness knows he has no exposure - those changes may be purely artifact. Let us have another examination in three months and another conference. I think that's another category of case disposal that we should discuss. If we sit down in conference and we say 'Here is this shadow in the Xray, and it may be an artifact - due to the technician pinching the film with the thumb and not leaving the thumb nail mark but the thumb print mark on the apex'. But if there is an artifact, and we can't come up with any definite diagnosis, put it down for recall - another Xray in a day or so, week or so, or a month or so, whatever seems indicated... and another conference to come up with a verbal diagnosis before we start recording or telling.

(Discussion)

The question was, when the man comes to you saying 'Doctor, I've had an Xray outside and my family doctor tells me I have dust in my lungs' - what do we do? If our files show that we have had a conference and have noted these Xray changes and have studied the environment, and we find he has no exposure and we have not told the man, then we can say to the man that it is very interesting that you have had Xrays made outside, we'd like to borrow them and compare them with ours.. thank you for telling us about this.. may we have your permission to go to your doctor and get these? It's just a stalling technique, but that's it. Then, we call him back and say 'We've seen those Xrays, we've studied your environment' and we do everything under the sun to reassure the man that there is no problem there. Say that there are some changes, they have nothing to do whatsoever with his present job, call Cliff in if necessary with the man, bring all the Industrial Hygiene records in and say 'The dust counts have been taken down there, there is no problem whatsoever, you have no worry'. Do everything to reassure the man. That is in the case where we have had a conference and recognize things, and recognize no occupational disease.



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On the other hand, the case that comes in and says "I have had an outside Xray and the doctor says I've got dust in my lungs' - and we have had no conference on that man ... the same stalling, reassuring procedure, thank you very much, may we have permission to get those Xrays ... and get the conference going immediately. And then proceed as outlined before. I think that will summarize what we've talked about in the last couple of minutes.

(Discussion)

We've gone over the disposal of the different types of cases - the known occupational - the suspected occupational - the tuberculosis ... the non-occupational pulmonary disease such as the unresolved pneumonia which we pick up is just the same as the suspected O.D. Let's have a conference on this, see what his job is, is there any exposure there, .. before we put a medical restriction on him. It's the same procedure as before.

I think those are the types of cases we have to set aside.

(Discussion)

On the back-to-work examination in which you have picked up the unresolved pneumonia, you have to make up your mind whether or not he is able to go back to work. I would assume that if he has a resolving pneumonia and has been cleared by his family doctor, for all clinical evidence of this, and he's going back to a non-dusty job, non-hazardous job whatsoever, you might clear him. If your medical judgment says there is no problem involved, no hazard to him in going back to his job, that's o.k. However, if he does have any potential dust hazard in his job, and has this unresolved pneumonia, then you just put a block on him and say 'You are not yet ready to go back to work'. But still, I think that is another case there where it is worth-while just to tell Cliff 'This man has an unresolved pneumonia and is not being allowed to go back to work', and let Cliff put a flag through his records on the man to see what may happen in the future.

(Discussion)

These are general methods of operating in which we can possibly get into trouble, after the advice of our legal people. The first case is where an employee comes along and says 'Please, can I have my Xrays, my doctor wants to look at them'. In some of our plants, we have gone along and said, 'Sure, here are your Xrays, take them to your doctor'. In New Jersey I think we will have to put a slightly different procedure into effect. We have to cooperate with the family doctor at all times; it's a 2-way street. But, legally and ethically, according to the standard of the A.M.A., we should not release those Xrays to the family doctor without the written consent of the employee. We release no information out of the employee's file, of any kind, to anybody, without the written consent of the employee. So, if the employee comes along and says 'Can I have my Xrays, the family doctor wants to see them', explain to him that medical ethics binds us to keep those confidential for him, and we have to have his permission to give them out. That's standard procedure. We wouldn't have any regular release form; just as any employee signs for release of information for an insurance company, to get release of his records. Then we'll say 'Yes, we will send

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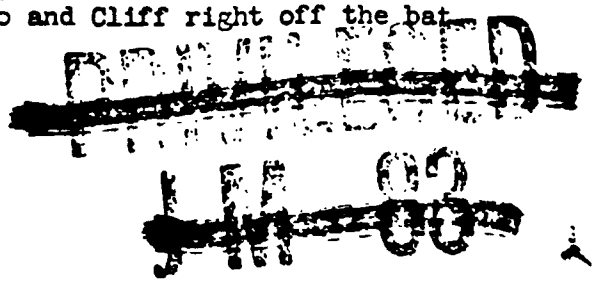
those Xrays along to your doctor.' And that's it .. we will never give them to the employee to take - we will send them. That gives us an opportunity to record the Xray numbers of films and everything in the files (just as when you send an S-54 group on to us) - then Nancy or Ann or somebody records the numbers and sends them by registered mail to the family doctor, or our visiting nurse or our guard will take them to the family doctor.

(Discussion)

I think if you want to be quite ethical there, if the Somerset County nurse comes along and asks if she can borrow the Xrays of any employee, I think you'd agree that, ethically, we have to get the consent of the employee before we release those films. That is, I think, standard code of ethics all the way through. I think the reason for suggesting not giving the Xrays to the employee is to give us an opportunity to review the file to see why they are wanted. Now if it is a recognized case of arrested T.B. in which Douglas wants to check things, we just will follow this procedure of 'Yes, it's perfectly all right, but we want your written permission to send them to Dr. Douglas'. The main thing is to keep the Xrays out of the hands of the employee, so that he will not take those and shop around to three or four different doctors. You may know that Douglas is following this man, but he may have in the back of his mind, 'I am not sure I am getting a fair shake from Douglas or from J-M, so I am going to say I want them for Douglas and I am going over to New Brunswick, to Lieb, or somebody else, and start shopping around with them'. I have seen that happen in my own work, and we want to stop that.

The thing is that if a man comes in and requests Xrays to be taken to his family doctor, we say we shall send them. That may institute a conference procedure before they are sent, that's when you're going to have to play it by ear, to let Cliff know or not, depending on what is in the file. The main thing is to keep them out of the hands of the employee. If you send anything along with the Xrays, I think it should be only the list of the films - I don't think we should say 'This man works in Transite Pipe' - I don't think we should give any interpretation of the films at all - just, 'As requested, here are the films of Anna Luteran, following Xray numbers and dates, please return when you have completed your study'. And that is all there is to it.

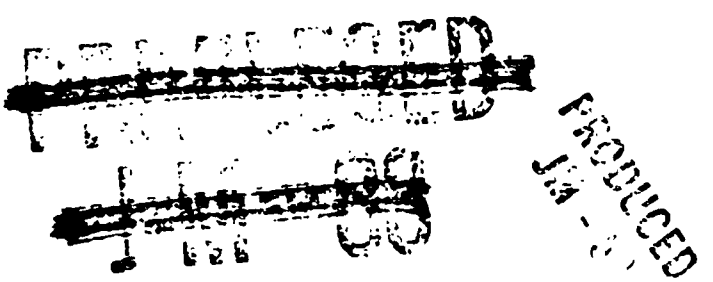
The other thing is that I don't think we should give out any opinion of these films or our diagnosis of them to anybody like the family doctor until we have had a conference about the case itself. Douglas will ask you to borrow these films, you loan them to him, and he can say 'What do you think, is there any dust in there?' We are just going to stall that one until we have finished our conference procedure to come up with a decision as to whether or not we recognize potential occupational disease in that case. If Douglas asks to examine the Xrays, or somebody else asks for them, we'll have to send them by mail, not by the employee. If there is a potential occupational aspect to the thing, there will have to be a special conference between you two and Cliff right off the bat.



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Then, for record purposes, if an outside attorney or someone else calls the Medical Department and asks for information about our employee, either as a result of our examinations he wants a record or impression, we tell him that obviously we cannot divulge the confidential information that is contained in the file without written permission of the employee, and that if the case is in litigation, or litigation is contemplated, he could get this information only through Mr. Clifford Sheckler.

Transcribed by _____
Helen A. Kamm



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