PLAINTIFF'S EXHIBIT
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CONGRESS OF THE UNITED STATES

HOUSE OF REPRESENTATIVES

COMMITTEE ON EDUCATION AND LABOR

SUBCOMMITTEE ON LABOR STANDARDS

HEARING ON THE EXISTENCE OF ASBESTOS-RELATED DISEASES IN AMERICAN INDUSTRY AND THE MANNER AND ADEQUACY WITH WHICH THE VICTIMS OF THESE OCCUPATIONAL DISEASES ARE PRESENTLY COMPENSATED.

STATEMENT BY: HILTON C. LEWINSOHN

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TRUMBULL, CONNECTICUT

MAY 1, 1979

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My name is Hilton C. Lewinsohn. I am Corporate Medical Director for Raybestos-Manhattan, Inc., which is headquartered in Trumbull, Connecticut. I have been engaged in this capacity since October, 1976, prior to which I was Chief Medical Officer to TBA Industrial Products Company Limited in Rochdale, Lancashire, England, and Medical Advisor to the Turner and Newall group of companies. I was employed as a Pneumoconiosis Medical Officer in the Ministry of Pensions and National Insurance (now the Department of Health and Social Security) from 1963 to 1966, which provided me with further special experience and training in the field of occupational lung disease and the assessment of disability resulting therefrom. The curriculum vitae which is attached hereto as Appendix I lists my academic achievements, affiliations and publications.

I should like to present this statement in three sections, namely:

A. Asbestos and health - the matter in perspective,
B. The diagnosis of asbestos-related disease,
C. Assessment of Disability and Bill H.R.2740.

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SECTION A

In Section A, which is accompanied by an itemized bibliography, I have attempted to summarize the main clinical features of the asbestos-related diseases and to point out some of the important features of these diseases. The points which are stressed in this section are:

1. Asbestos is a generic term referring to all the asbestiform varieties of various minerals.
2. The recognition that asbestos caused asbestosis dates back to the 1930's.
3. All varieties of asbestos can cause asbestosis.
4. It is difficult to diagnose asbestosis in the early stages of the condition; it is easier to do so as the diagnostic criteria referred to become more clearly defined in the late stages of the disease.
5. It is not possible to diagnose asbestosis using any single test and it is necessary to consider all the findings in relation to the history of exposure. Exposure includes not only dust level, but also length of time of exposure.
6. Asbestosis is dose-related and should be preventable by means of adequate dust controls.
7. Not all industries or all occupations produced asbestosis cases in the same proportion of the labor force, because, obviously, some processes are dustier than others, some industries were able to control their operations, while others did not.
8. Lung cancer associated with asbestosis has been shown by epidemiologic studies to be related to occupational exposure. In view of the overwhelming effect of the tobacco habit in the general population

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it is not possible to accept that lung cancer in an asbestos worker without asbestosis is necessarily due to the dust exposure. The possibility exists that in a cigarette smoker, whether exposed to asbestos or not, lung cancer would have occurred because of the tobacco habit, irrespective of any possible exposure to asbestos.

9. Mesothelioma of the pleura or peritoneum is frequently associated with exposure to asbestos. The amphibole varieties of asbestos, crocidolite and amosite, are thought to be most likely to be associated with it.

10. There is evidence that mesothelioma may occur as the result of exposure to other fibrous minerals and that asbestos, therefore, is not always the cause. It is essential to obtain a meticulous history and to prove asbestos exposure as other stigmata, such as asbestosis, may not be present in these cases.

SECTION B

Section B is accompaniedby a bibliography and attempts to define the diagnostic features of the asbestos-related diseases for the purpose of deciding whether or not they are occupational in origin in any given person.

1. Asbestosis is defined as a type of diffuse interstitial pulmonary fibrosis which does not have a specific histological pattern to distinguish it from interstitial fibrosis resulting from othe causes, but which occurs in association with a history of exposure to the commonly used varieties of asbestiform minerals and may be characterized by the presence of asbestos bodies and asbestos fibers in the lungs greatly in excess of those seen in the general population.

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2. The diagnosis of asbestosis depends upon:

   a. History of past exposure to asbestos dust

   b. Clinical signs and symptoms

   c. Chest radiographs taken serially over a period of time

   d. Tests of lung function taken serially over a period of time.

3. The use of radiography in the medical surveillance of asbestos workers is accepted as invaluable, but a single radiograph, unless compared with earlier films, may be of littel value in diagnosing asbestosis.

4. On current evidence, no single parameter gives a more sensitive indication than any of the others available in all situations. The chest X-ray, when classified on the ILO U/C scale by at least three experienced readers, is probably the most sensitive and specific single index.

5. A definition of lung cancer is suggested for purposes of deciding an asbestos-related etiology. Lung cancer, irrespective of histological type, occurring in an asbestos worker more than 20 years after first exposure with documented evidence of asbestosis diagnosed during life, or discovered post-mortem, should be regarded as being of occupational origin. In the absence of evidence of asbestosis, a history of continuous, uninterrupted exposure to asbestos dust for 20 years or longershould be regarded as confirmatory evidence of hazardous occupational exposure likely to be an etiological factor in the causation of disease. This definition should apply regardless of the fact that work may have ceased many years prior to the diagnosis of this lung cancer.

6. Mesotheliomas very rarely develop in less than 20 years after first exposure, and may be delayed to over 50 years.

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7. In other forms of cancer allegedly related to asbestos exposure, before awarding compensation, it should be established that there is a clear and adequate history of occupational exposure to asbestos dust, and while it may not be possible to describe such expsoure in in terms of dust counts or measured quantities, it should be shown to have been of a continuous and repetitive nature and have been the main occupational activity of the individual.

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C. Assessment of Disability and Bill H. R. 2740

1. As a result of my experience as a Pneumoconiosis Medical Officer in the United Kingdom, I have come to abide by certain definitions of loss of faculty, disability and disablement which are as follows:

Loss of faculty means the total or partial loss of the normal use of organs or parts of the body, or the distruction or impairment of physical or mental functions, (e.g. the power to grip, to walk, to remember, to digest, to hear or to ventilate the lungs).

Disability denotes the specific loss of capacity for any of the ordinary activities of life imposed by the loss of faculty (thus the loss or impairment of the power to grip may involve the inability to hold a tool or operate a machine or play baseball).

Disablement is used to denote the total of the disabilities, that is, the aggregate loss of health, strength and power to enjoy life, and it is on the assessment of this disablement that the level of compensation will be determined.

Thus, exposure to asbestos results in asbestosis which may lead to loss of faculty (e.g. breathlessness on effort) and this imposes various disabilities for work or play (e.g. inability to walk distances or run) which together make up the disablemen resulting from the dust exposure.

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With regard to the Bill itself, I believe that the cause is just, but certain aspects are overstated and will liberalize the dispensation of compensation to include possibly non-occupational illnesses. Should industry or the state compensate persons for the life-style they choose and for their life-habits, such as cigarette smoking? Should not such individuals who multiply the risks involved be asked to ontribute towards the costs of the insurance with which this Bill proposes to provide them?

'Affected person' is too broadly defined in Sec. 102(b) and should only include the reference to occupational exposure.

Panels of medical experts should be established to examine claimants or death claims, similar to the British Pneumoconiosis Medical Panels.

Although a physician may be Board Certified or Board eligible in the fields stated, such a physician may have no special knowledge of occupational lung disease in general or asbestos-related diseases in particular. Unless an expert panel of medical experts is established for the purpose of administration of this act, many unwarranted claims will be incorrectly decided, and, perhaps, some justified claims may even be dismissed.

I would recommend that the Secretary be empowered to appoint physicians competent to decide on the medical facts presented to them and to aportion the percentage of disablement assessed. Only reports on radiographs prepared by a panel of three NIOSH "B" readers should be

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accepted in evidence and strict criteria should be adeopted for interpretation of radiographic findings based upon internationally accepted standards. Each and every claim should be decided by the physicians who should reach agreemant before recommending compensation or rejecting the claim. If it is not possible for them to agree, the claim should be referred to a referee appointed by the Secretary whose decision will be final.

This concludes my statement. Thank you for inviting me to attend these hearings. I trust that my contribution will be of value to this Subcommittee in its further deliberations.

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