OH

Shell Oil Company

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PLAINTIFF'S EXHIBIT
SH-698

October 13, 1987

J. E. McKinley, M.D.
Wood River Manufacturing Complex
Medical Department
P. O. Box 262
Wood River, IL 62095

SUBJECT: THE ROLE OF THE SHELL PHYSICIAN IN
THE SHELL OCCUPATIONAL HEALTH PROGRAM

Dear Dr. McKinley:

You will recall that in recent conversations you have suggested that I put some policy/guidelines in writing. I have done so (attached), and I hope the points are clearly made and that this document will assist in developing the kind of program we want for Wood River.

Pursuant to a conversation with Mr. Bagley, I am copying him for information.

I hope we can get things moving at a rapid pace. If you need further help let me know.

Corporate Medical is planning a consultation visit to Wood River in late November or early December to review progress and recommend staffing needs.

Very truly yours,

R. E. Joyner, M.D.
Corporate Medical Director

Attachment

cc: J. K. Bagley
A. D. Ditmar

LAM 018718

CP8728501

DPMC-12341

THE ROLE OF THE SHELL PHYSICIAN
IN THE
SHELL OCCUPATIONAL HEALTH PROGRAM

I. TREATMENT OF OCCUPATIONAL DISEASE AND INJURY

The Shell physician should institute and monitor therapy only for those ill or injured employees who continue to work at full or restricted duty. He should not assume medical treatment responsibility for those employees who are off work (at home or in the hospital) and under care of other physicians. (In fact, because of the terms of our malpractice insurance coverage, he should not appear to significantly influence or direct a course of treatment decided upon by the treating physician unless such course is deemed to be clearly unacceptable medical practice.)

The clinical progress of employees hospitalized with occupational conditions however, should be followed at appropriate intervals so that management may be kept informed and the Shell physician can observe appropriateness of treatment.

When treating employees who are at work, the Shell physician should monitor progress closely and refer to a specialist at the earliest indication that improvement is not occurring at a normally-expected rate.

Corporate Medical guidelines on the use of therapeutic narcotics in the workplace (attached) should be followed.

II. ACCIDENT STATISTICS AND OSHA RECORD KEEPING

Shell physicians should be guided by the AOMA Code of Ethical Conduct (attached) and a recent communication from the Occupational Practice Committee of the AOMA which states "Under no circumstances should consideration of accident statistics or any other conflict of interest cause the physician to deliver any other than what he considers an optimal treatment regimen for the individual patient. Not only would this be indefensible behavior from an ethical standpoint, it will also be deleterious to the accident prevention effort."

To attain optimal personal effectiveness and productivity, the Shell physician must establish and maintain a high level of professional credibility with our employees. Part of the ongoing validation of the Shell physician and the Shell medical program comes from the local community of physicians who are the personal physicians of our employees. Their opinions of the Shell physician and Shell's medical programs are communicated in both direct and subtle ways to our employees. Thus, the

employee's personal physician is a key player in maintaining the respect with which our physicians are viewed and, consequently, their effectiveness as a useful resource for both the employee and the Company.

The Shell physician's relations with community physicians must, therefore, be of the highest ethical and professional standard. He cannot maintain respect if he is perceived as a supplicant who wheedles the treating doctor to return an employee to duty in cases in which the primary reason for the return is to produce a cosmetic effect on accident statistics or record keeping.

The Shell physician however, should keep in mind at all times that an important part of his job is to assist in assuring early return-to-work of disabled employees (and, secondarily, to create whatever favorable outcome he can reasonably effect upon accident statistics). His primary duty, then, is to discuss problem cases with outside physicians, advise them of the nature and availability of restricted work, and negotiate an arrangement as favorable as possible to the well-being of the employee and the wishes of the company. Professionalism demands that this normally be done one time only for a given set of circumstances. The treating physician, now aware of Shell's interests, is the final decision-maker, and rightly so, since he has the ultimate medical responsibility. Shell cannot absolve him of that responsibility, nor should we try, since such efforts might involve us in needless liability.

The Shell physician, therefore, should not be asked or expected to make repeated contacts with treating physicians because of arbitrary record keeping rules or deadlines. Such behavior is unprofessional and will damage our position in the medical community and with our employees.

The Shell physician must be prepared to stand firmly against the possibility of ill-founded pressuring to take some action in a case solely because of a statistic, when that action is not in the best interest of the employee-patient.

III. PREGNANCY RESTRICTIONS

When faced with the ticklish problem of pregnancy restrictions, the Shell physician should act in generally the same manner as outlined above. Pregnancy cases can be very difficult to resolve and may, at times, require several dialogues with the outside physician. When, however, a good faith effort has been made with the employee's physician to provide responsible restrictions and when the employee's physician will not agree, the disposition of the case should become a management decision, using the Shell physician's opinion as a resource for that decision-making exercise.

IV. IN-PLANT MEDICAL EMERGENCY RESPONSE

Shell Medical Department personnel should be prepared to respond promptly to the scene of any medical emergency in order to initiate proper medical treatment at the earliest possible moment. The practice of remaining in the Medical Department while an outside ambulance is called for a patient cannot be condoned. Skilled medical care and the patient must be joined together as rapidly as possible, using whatever method is the fastest.

The Deer Park Manufacturing Complex has developed a model response system which is regarded as extremely effective and which should be instituted as soon as possible at Wood River.

V. AMBULANCE CASES

During his in-plant work hours, the Shell physician should normally see and evaluate any patient being evacuated from the Plant by ambulance with the exception of those deemed by a well-trained ambulance crew to be in a critical, life-threatening condition. The reasons for this are:

(a) The Shell physician should have as much first-hand knowledge of the injury as possible, in order to advise management as appropriate, and to influence the institution of the best available medical care.

(b) On occasions, it may become clear to the Shell physician that evacuation/hospitalization is not necessary and that a less heroic line of treatment can be initiated.

(c) An incident could occur where the evacuated employee dies subsequent to evacuation having not been seen by a Shell doctor or a nurse despite the fact that Shell doctors and nurses were on site and on duty. The public relations repercussions of such an incident could be extremely embarrassing and the legal implications possibly disastrous.

Implementation of this policy can be easily executed through development of a clear understanding between the ambulance authority and the Shell Medical Department.

VI. NURSING SERVICES

There should be no question of where the nurse's professional responsibility and accountability should reside; it should be with the physician. The Shell Occupational Health Program manual clearly states this policy: "In locations with full-time physicians, the occupational health nurse should report administratively and professionally to the

location physician." The fact that the full-time physician is there on a contract should not alter this recommendation. Any other arrangements which could create a conflict of allegiance or proper conduct in a nurse's mind is unprofessional and could damage our respect from employees and possibly expose us to liability. Nurses are also included in Shell's malpractice coverage, and that coverage is based on the normal assumption that a nurse acts under the orders of a physician.

VII. WORKERS COMPENSATION ADMINISTRATION

The majority of this activity should reside with the Employee Relations/Industrial Relations function, especially those activities which raise the likelihood of confrontational relationships between the employee and the Medical Department. Such activities could lead the employee to believe that the Shell physician is a policeman (or a truant officer), and that he is the czar who controls the workers comp benefits. That belief is patently detrimental to the mission of the Medical Department and should be scrupulously guarded against. Trust and respect for the medical function cannot occur in such a climate.

The role of the Shell physician is defined in the Shell Occupational Health manual (Physicians Services, section Df).

> "Should possess sufficient expertise to advise and assist Management in the fields of sanitation, safety, Workmen's Compensation, and governmental health regulations."

The Shell physician can play a valuable role with a low profile, and that should be the objective of the planners of this function. Specifically, his role includes:

For all cases:

1. Insures that the employee receives optimal immediate and follow-up medical care.

2. Prepares the initial accident report on each first aid case (First Report of Injury).

3. Maintain close communications with all injured employees, especially in lost-time cases.

On a case-by-case (exception) basis:

1. Makes necessary contacts with treating physicians to obtain opinions and ascertain injured employee status.

2. Arranges for special medical exams in appropriate cases (i.e., second-opinion medical examinations).

3. Furnishes opinions (ad hoc) on progress, treatment, validity of claim, and degree of disability and prognosis.

Does not suggest or approve settlement amounts

Should not be involved in clerical aspects of Workers Comp administration.

Nurses in Medical Department should not be used as Workers Comp clerks.

Must maintain medical confidentiality of all medical information unrelated to claim.

10/13/87

bc: C. E. Ross, D.O.
R. S. Marnoy, M.D., M.P.H.
D. E. Miller, M.D.
S. A. Bergman, M.D.
S. R. Cowles, M.D.
B. J. Kern, M.D.

rom: DP29AJT9--VM29 Date and time 02/05/92 10:54:03
To: DP29ES9 --VM29 E. SHEPPER DP29KJM9--VM29 K. J. MOORE
DP29MLB9--VM29 M. L. BRAXTON

From: AJT29
Subject: Applicability of New Surveillance Protocols
I talked to Dr Sally Cowles yesterday afternoon. During the conversation I asked whether/when/how the new protocols are/would be in effect. She said that a set of copies had been handed out at a Nurses' meeting sometime last year, and that she considers the revisions to have been in effect since then even though there may not have been any announcement or cover letter stating so.
Ariel J Thomann MD

E N D O F N O T E

From: DP29AJT9--VM29 Date and time 10/25/91 13:39:23
To: HO78LCW --VM36 L. C. WADDELL HO78LCW --VM36 L. C. WADDELL
HO78LCW --VM36 L. C. WADDELL

From: ajt29
Subject: Revised Surveillance Protocols from Corporate
Clyde: This is being forwarded to you as a question mark: we have discussed the new protocols to some extent, but we still do not know whether they:
(1) are in effect already, and if so since when, as we have received no notification to that effect, or
(2) are final but not yet effective (if not, when will they be official)
We'll appreciate clarification that will allow us to plan our priorities.
Thanks
Ariel J Thomann MD
*** Forwarding note from DP29AJT9--VM29 09/26/91 14:10 ***
To: DP29ES9 --VM29 E. SHEPPER DP29KJM9--VM29 K. J. MOORE
DP29MLB9--VM29 M. L. BRAXTON

From: ajt29
Subject: Revised Surveillance Protocols from Corporate
1. On 23 Sep I had questions about an employee who declared "claustrophobia" on his Respirator Questionnaire. I tried to reach Dr Waddell re. how/how far to pursue the "should be evaluated" clause of the "Proposed Revision" of 1989 vintage I was using as guidance. In Clyde's absence I was referred to R Deetjen RN; she was most helpful in FAXing me a copy of the protocol she has, and also offered to send me a set of others for my own use. The FAX version arrived with ate Sep 91; it has minimal changes from the previous one but my original query is still unanswered.
2. Late yesterday I received the rest of the materials. I now realize that it is a full set of Surveillance Protocols (minus Noise Exposure?!. Almost all are dated Jan 91. Almost all are presumably final (not "Proposed revisions").
3. My quick preliminary review of the first three (Asbestos, Benzene, and brand new Fire Brigade / Emergency Response) indicates there are changes in all I looked at. In-depth study may reveal more substantial changes yet.
4. I requested Martha to make copies (full set for Exec, and at least one copy for review by the appropriate Action Person for individual protocols). We may need to spend some time analyzing what changes we need to implement, and when.
Ariel J Thomann MD

cc: DP29ES9 --VM29 E. SHEPPER DP29KJM9--VM29 K. J. MOORE
DP29MLB9--VM29 M. L. BRAXTON

E N D O F N O T E

LAM 018726

Memo:
The forwarding "cover letter" was shown first to Dr. Shepper as "printscreen" of draft — he approved it as implementation of matter discid yet. @ Exec ↓

Med Dept - Asbestos -