

CF 10039 1415

PLAINTIFF'S
EXHIBIT

JM-1996

W. A. Curtner, 2-17

June 4, 1980

Paul Kotin, M.D., 1-06

MEDICAL INFORMATION FOR INSURANCE RENEWAL

There are two elements to your request for information that can be used to convince insurance carriers that the asbestos risk is insurable. One element is the evidence that indicates that asbestos-related diseases are on the decline, and this part is discussed in the enclosed document which examines asbestos-related diseases in general and the biological principles governing them and reviews the medical literature on disease incidence and morbidity and mortality trends. This material can be given directly to insurance companies since it is basic to understanding asbestos-related health risks.

The second element concerns data from Johns-Manville's work experience and the relationship of these data to workers' compensation and third-party cases. This part is the more difficult of the two, and although you have been very specific in the questions you have raised in your memo of May 3, 1980, many of them cannot be answered as precisely as you wish. Consequently I will respond to your questions in this memo and you can then incorporate the information as you see fit in your discussions with insurers.

Under 2(A) in your memo you ask about the declining incidence of asbestos-related disease. Explanation of this and the basis for the statement is included in the separate document. However, you also ask that the statement be quantified. Answers of this type would be mere speculation and as such fraught with dangers. In the medical area the best we can do is speak in trends.

In 2(B) you ask whether "the number of lawsuits is directly related to the number of cases that are medically diagnosed as being asbestos-associated." There is no such direct relationship for a number of reasons. First, the approach in third-party litigation appears to be that of class action. In other words, cases may represent several people or large numbers of people who were employed at the same place, yet not all these individuals in the suit will have asbestos-related disease. A related factor is the clearly documented willingness on the part of some insurance carriers to settle such cases for lesser monies than might be at stake should a case involving a disputed diagnosis proceed to trial. The

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recent verdict in Los Angeles where a jury awarded a plaintiff with nonasbestos-related disease a 1.2 million dollar settlement can only generate a whole new wave of spurious claims.

Second, there is a general trend toward suing for diseases which may be asbestos-related but for the most part are not because they have a multiple etiology, meaning there are a number of factors that can cause these diseases. This does not apply to asbestosis nor entirely to mesothelioma, but it does apply to lung cancer and chronic lung diseases such as emphysema and bronchitis. There are many common causes for gastrointestinal cancer as well. If asbestos exposure does play a role in gastrointestinal cancer, it is minimal.

Third, a number of cases represent stigmata of exposure (pleural thickening, pleural plaques). These stigmata are merely signs of an individual's having been exposed to asbestos; they are not signs of disease.

Even though many of the lawsuits we see do not truly reflect asbestos-related disease, this does not necessarily mean that "the number of medical cases diagnosed as asbestos-related will be no more in 1980 than in previous years." There is a greatly increased awareness among the general public and in the medical community of the potential hazards of excessive exposure to asbestos. The Federal Government, through the National Cancer Institute, has undertaken an extensive educational campaign during the past two years to inform both workers who may have been exposed to asbestos in the past and physicians about possible health effects. Thus, while medical knowledge about asbestos hazards evolved slowly, the accumulated knowledge has been disseminated rapidly during the past five years. As a result, we are seeing some evidence that asbestos-related disease may be overdiagnosed at this time.

Your questions about "a decrease in the number of people exposed to injurious levels of fiber" can be taken two ways: either that there has been a reduction in the number of people working with asbestos or a reduction in exposure levels. I have no figures or even estimates of the current asbestos workforce, but I can demonstrate a reduction in exposure levels at asbestos-using operations. Included in the enclosed paper on asbestos diseases is industrial hygiene data from representative Johns-Manville facilities during the period 1969 to 1979, which very definitely show J-M's progress in reducing levels of airborne fiber in our plants and that we are well under the current OSHA standard of 2 fibers per cubic centimeter of air. These reductions have occurred not only in Johns-Manville but throughout the asbestos industry. The studies of Turner-Newall facilities in England, referred to in the paper, also demonstrate such reductions in exposure levels.

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The rest of the information you seek in item 1(5) cannot be supplied. It is impossible to provide estimates along such lines.

In 2(C) you ask about the projections or estimates of asbestos-related disease. Figures of future disease based on the MCI/NIHMS/NIOSH report on occupational cancer are entirely unsupportable. This is discussed in the attached paper, and copies of J-M's submissions to OSHA on the estimates are included. The data in our response to you show that only a small percentage of future disease cases can be related to asbestos exposure. The estimates by the Federal Government have also been disputed by leading epidemiologists and cancer researchers, as can be seen in the editorial from Lancet and the letter by Sir Richard Doll which are in the separate document.

Pertinent to any discussion of future estimates is the fact that the population exposed in the past to harmful concentrations of asbestos fiber is progressively aging, and many have already died. The aging of the exposed population, therefore, is a confounding factor in another way. Inasmuch as diseases in categories such as cancer increase as a population ages, it is virtually certain that for asbestos-related diseases there will be an irresistible tendency to ascribe these cancers to asbestos exposure.

In answer to your question whether "the claims being made today are due to earlier exposures in much heavier work than the overall experience of J-M's work," the attached paper indicates a reduction in disease. There will still be dusty jobs in these locations, though, and in the early years of these operations, exposure may have been sufficient to produce sporadic cases of asbestos-related disease. When compared with the experience of other J-M plants operating in the 1930's and 1940's, however, the attack rate has been reduced by every criterion. More information in this area will be available by the end of July or early August when Gerald R. Chase completes his biostatistical studies.

I trust this material will be useful to you. You may wish to discuss certain aspects with me in more detail. Please call if you have any questions.