

Public Responsibility in Asbestos- Associated Diseases*

Prepared by Hans Walli, Chairman,
Margaret R. Becklake, and Roger Mitchell
*This position paper was adopted by the ATS
Board of Directors, March 1982.*

Diagnosis and evaluation of impairment in asbestos-related cases are discussed in this paper. For more information on evaluation refer to the 1982 ATS Statement "Evaluation of Impairment/Disability Secondary to Respiratory Disease" (Am Rev Respir Dis 1982; 126:945-951).

PLAINTIFF'S EXHIBIT

SWB-66

The American Thoracic Society and American Lung Association are pleased to have this opportunity to provide input in the deliberations of this Committee concerning one of the major occupational health issues faced by our society. We represent a professional society composed of chest physicians and biomedical scientists, who investigate the causes of and work toward the prevention of lung diseases, as well as public volunteers committed to reducing the burden of lung disease in communities around the country.

At the outset, we would like to emphasize our conviction that, as with many other occupationally induced disorders, the asbestos-associated diseases are best dealt with by prevention through control of exposures to airborne concentrations of asbestos dust. Monetary awards can never compensate individuals for loss of health, or their relatives for loss of life, nor can any compensation scheme provide the adequate disincentive for industry which would lead to the prevention of these conditions; this is due in large part to the long latency period between relevant exposure and clinical manifestations of these diseases. Recognizing, however, that past exposures have produced these conditions, we are committed to the provision of just resolution of claims by injured workers. We have testified previously that it is our belief that disease-specific approaches to federal compensation legislation are not optimal in reaching the objective of equitable and timely awards for all workers who develop diseases as a consequence of their employment. The inadequacies of the black lung legislation have received considerable attention and have been the subject of periodic controversy, often focusing on questions of cost effectiveness and equity. Thus we regret the extension of a fragmentary ap-

proach to the over-all burden of occupationally-induced lung disease implicit in the passage of further legislation dealing with the conditions caused by exposure to one specific material. Nevertheless, we recognize that there may well be overwhelming public and economic pressure making it necessary to consider seriously legislation dealing specifically with the asbestos-associated diseases. Therefore, in spite of our reservations, we are anxious to provide our views on how this problem might be approached.

Much has been written and said recently concerning the inadequacy of the present system in meeting the needs of individuals who have developed asbestos-associated diseases. We are in full agreement with this assessment. In this context, tort litigation has been shown to be inequitable, costly, and markedly unjust in the distribution of resources, a high proportion of awards going to individuals in whom evidence of disease cannot be demonstrated. Indeed one of the main deficiencies in this approach is that it distorts medical evidence, calling, for instance, for "proof" when in fact medical diagnosis is more often hypothesis, i.e., the best available explanation given the facts about a case. Other deficiencies are the failure to rely on objective medical evidence in individual cases, as in mass settlements, and the fact that in the assessment of individual cases medical experts may be chosen not for their expertise and objectivity but because their testimony will support one side or the other. Given the nature of medical diagnosis, the facts about a case are frequently open to more than one interpretation. We are mindful also of the projections of the future burden of such litigation affecting all segments of our society. Similarly, we feel that the state compensation systems have often dealt poorly with asbestos and other workplace-associated diseases, and we have testified previously in regard to our view that a uniform federal system of occupational lung disease com-

pensation should be developed. We have reviewed, with disappointment and considerable reservation, the draft bills that have been proposed, since it is our opinion that they have not dealt adequately with medical criteria for the conditions to be compensated.

Our testimony on an approach to the compensation of asbestos-associated diseases is predicated on the belief that public policy in this area should be based on scientific information. The known asbestos-associated diseases all have been shown to be dose-related, and we are persuaded by the evidence that there are differences in biologic activity of asbestos related to fiber type and process. While this is not the appropriate forum for a comprehensive discussion of these or other related scientific issues, it seems reasonable, however, to suggest that the scientific data base can and should be used in the decision-making process as the means of assessing the likelihood that the disease is due to exposure, particularly for conditions which also occur in the general population in the absence of asbestos exposure. While we readily recognize, however, that many of the decisions made in the clinical setting concerning individual cases lack precision, informed medical opinions most often lead to reasonable conclusions. So it is with many clinical decisions.

The following, in our view, are the necessary elements of a more equitable and workable system of compensating the injured worker who has been exposed to asbestos. In the individual case, the major medical issues to be decided are diagnosis, causation, and impairment. The process of reaching a diagnosis depends upon sound medical practice irrespective of the underlying cause of disease. Determining the most likely cause will usually depend on assessing the levels of exposure to known causative agents; this will be based on epidemiologic studies of occupationally exposed populations. The assessment of impairment will depend pri-

* Testimony of the American Thoracic Society and the American Lung Association submitted to the Senate Subcommittee on Labor

Asbestos-Associated Diseases — — — — —

marily on evaluation of disturbance in lung function. Ultimately guidelines must be established to facilitate this decision-making process, and these must be the subject of continuing review in light of emerging scientific evidence. We strongly suggest that these guidelines not be written into the law because of the dynamic nature of scientific knowledge. The legal system must accept the uncertainties of diagnosis, which invariably depends upon assessment of medical probabilities.

The structure of a workable system should first include a national panel of experts to develop and periodically modify guidelines and criteria for the adjudication of claims for asbestos-associated diseases. Secondly, there should be regional panels that would, of course, include health professionals knowledgeable in occupational lung diseases and that would be responsible for the case-by-case determinations. Finally, a mechanism must be developed to make possible an appeal of the medical decision rendered by the regional panel.

While the selection of both the national and regional panels, and the development of an appeals system, should be dealt with in the legislation, the details of these aspects are beyond the scope of our testimony, although a few brief comments seem appropriate. The national panel of experts should consist of highly experienced and respected members of the biomedical community. They should be selected from outside the government, and be maximally immune to short-term political influences. Similar considerations should determine the selection of the regional compensation panels.

Recognizing the importance of the guidelines, which are the responsibility of the national expert panel, we have appended to this statement an outline of what we consider to be a reasonable set of guidelines concerning the asbestos-associated diseases based on present knowledge.

All of the diseases which have resulted from asbestos exposure in the workplace have serious consequences to health and may impair function and reduce longevity with their implicit personal tragedy. For the individuals at risk because of past exposure to asbestos dust, public responsibility is to insure that those who are injured receive the necessary support and assistance. This has not always been the case. The blame for this must be shared by elements of the legal and medical system, as well as segments of management and labor. The system outlined in this testimony attempts to maximize rationality and equity. We have every expectation that the Congress will respond appropriately to this difficult challenge.

Proposed Guidelines for Case Evaluation Based on Assessment of Evidence Available March 1983

The case evaluation process involves establishing the presence of disease (diagnosis), its cause, and the extent of its functional effect on the individual (impairment).

I. Diagnosis and Determination of Cause

A. Asbestosis

Asbestosis is a pneumoconiosis defined as diffuse fibrosis of the lungs caused by asbestos exposure. Its features include rales (crackles), breathlessness, finger clubbing, lung function abnormalities (usually reduced volumes and impaired gas exchange), radiographic changes (irregular and linear opacities), and histopathologic demonstration of fibrosis with tissue fiber identification. The first four of these are non-specific; changes on the X-ray and pathologic tissue examination have increasing, but by no means absolute, specificity. Individually, these are not sufficient to make a diagnosis; in combination, the diagnosis depends upon weighing probabilities and assessing the evidence *in toto*, an important component of which is estimation of past exposure. In practice, the diagnosis is usually established on radiographic and exposure evidence. An expert committee of the College of American Pathologists and the National Institute for Occupational Safety and Health has recently developed guidelines for the pathologic diagnosis of asbestos-associated disease. When lung tissue is available for histopathologic examination, a diagnosis of asbestosis depends minimally upon the demonstration of discrete foci of fibrosis in the walls of respiratory bronchioles associated with accumulations of asbestos bodies (light microscopy). Additional findings are diffuse interstitial pneumonia and fibrosis. Neither fibrosis nor asbestos bodies alone is sufficient for the histopathologic diagnosis of asbestosis.

B. Nonmalignant Pleural Effects

These include pleural effusions, focal hyaline thickening (plaques) and diffuse pleural fibrosis. Plaques indicate exposure, not disease, because they do not cause symptoms or functional impairment. Attributability is assessed on the basis of an exposure history and the absence of other causal factors.

C. Lung Cancer

The diagnosis of lung cancer in asbestos-exposed individuals is no different than in other clinical settings. In population studies of various occupational groups, evidence of asbestosis has been found when

excess lung cancer risk is demonstrated for comparable levels of exposure. In the individual case of lung cancer, the cause can not be determined precisely. For this reason, the judgment must take into account length, intensity and character of exposure, evidence of other asbestos-associated diseases, and smoking history.

D. Malignant Mesothelioma

The primary issue is valid diagnosis. This diagnosis generally cannot be established clinically, radiographically, with pleural fluid examination, or with limited biopsy tissue. Since the potential for misdiagnosis is considerable, adequate tissue specimens should be examined by pathologists experienced and expert in the diagnosis of this tumor (e.g., mesothelioma panels). When the diagnosis has been established, a history of exposure, even if short, is sufficient for a judgment of causation.

II. Assessment of Impairment

This follows the establishment of an asbestos-associated disease. In cases of extensive asbestosis or extensive pleural fibrosis, reference should be made to criteria for impairment in restrictive disorders outlined in the ATS Statement on Evaluation of Impairment/Disability Secondary to Respiratory Disease (1). Use will be made of pulmonary function tests and exercise performance testing when necessary. Regional panels will be responsible for periodic updating of impairment level.

1. ATS Statement on Evaluation of Impairment/Disability Secondary to Respiratory Disease. *Am Rev Respir Dis* 1982; 126:945-951.

Chapter News

MTS Makes Home Care Outcome Manual Available

Outcome criteria for home health care agencies on the subjects of obstructive lung disease, restrictive lung disease, infantile apnea, pediatric and adult asthma, and lung cancer are now available from the Massachusetts Thoracic Society.

Home Health Care Outcome Criteria Volumes I and II define appropriate home health care procedures and includes third-party payer documentation instructions. For more information contact Colleen McComas, Massachusetts Thoracic Society, 263 Summer Street, Boston, Massachusetts 02210, (617)426-8330.