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T- 8/3 for 8/4 mtg. w CPB

Inter-Office Correspondence

DATE: July 8, 1987

TO: C. P. Blahous

FROM: W. B. Graybill

LOC: 36 West

SUBJECT: Lake Charles Derivatives Plant - Blood QAT

CONFIDENTIAL

As I mentioned in a recent phone conversation, the abnormal liver function study being conducted at Lake Charles is proceeding. The Quality Action Team has developed the attached approach.

We need Dr. Carl Myers and Zeb Bell to be involved as much as they can. At least, we want their critique of the approach. This study as I understand it will be reportable to EPA (TSCA 8(d)) and may precipitate an OSHA inspection or a NIOSH Health Hazard Evaluation.

Specifically, Dr. Hollinger, consultant, will be meeting with the QAT at Lake Charles July 17 and this would be a good interface opportunity. In any case, J. C. Delgado will keep Carl and Zeb updated.

W. B. Graybill

/yra

Attachment

c: R. Rompala/J. Cafaro
R. E. Williams

SL 042842

CHEMICALS PPG **CONFIDENTIAL** INTEROFFICE / LAKE CHARLES

TO Distribution DATE June 16, 1987

FROM R. J. McCorquodale SUBJECT Blood QAT

Minutes: 6/11/87

Attendance:
Murry Davis Jon Shepherd
J. C. Delgado R. J. McCorquodale
Lamar White

ITEMS:

1.) Monitoring Activity -
As soon as possible - Jon Shepherd will coordinate with Jim Rock and Lamar White to determine the specific jobs of the 42 employees identified under the current study as having abnormal enzymes. (6/26/87)
Once the job identification is complete, McCorquodale will request from the lab that 10 eight hour TWA samples be obtained per job. A minimum of 5 to be "off hours" (evenings - graveyards - weekends). This activity to be complete by end of July. Data to be sent to J. C. Delgado in G.O.

2.) Control Group -
To commence after beginning of Plant Communication. (Item 3).
Murry Davis to coordinate with Field Supervision the determination of 100 employees to serve as a "control group" for liver enzyme study.
A.) Must have never worked in Derivatives (assignment).
B.) Ratio of Operations, Maintenance, Shipping and Supervision to match ratio in the original 42.
C.) Questionnaire to be completed when sample drawn.

J.C. & Murry to determine ratio.
J.C. & Murry to draft questionnaire with input from Dr. Looney.

3.) Communication -
The use of a video tape as a communication tool in attempting to relieve hourly (and salary) concerns regarding liver enzymes was accepted. Video tape to have four components:
A.) Introduction - John Fike
B.) Question Answer Session - McCorquodale - Looney
C.) Procedure Discussion - McCorquodale
D.) Labor Policy - Chuck Bellon

Via brainstorming, a list of questions for Dr. Looney was prepared. McCorquodale to work up a consolidation for review by QAT. June 26th. (Original list attached)

McCorquodale to arrange video-tape session once questions (and answers) are reviewed and accepted. This project has a must do priority.

4.) Vinyl Institute -
Members were given a draft of questions to be posed to Vinyl Institute. Comments, revisions, etc., to be in Lamar White's hand by June 18th. Lamar to handle all VI activity.

5.) Policy -
Lamar prepared a guide broken into 3 parts for the QAT to work from -
A.) Basis of Policy
B.) Goals of New Policy
C.) Elements of New Policy

A.) Basis - General consensus reached in this area. McCorquodale to rewrite and distribute for review.

B.) Goals - Same as A Above.

C.) Elements - This item had several areas which require input and review. General agreement reached.
1.) Policy statement - McCorquodale to draft as a composite of items A & B above.
2.) Protocol - Agreement that no action or policy would be effective unless a health consideration protocol be drafted which specifically directs the plant physician in dealing with "abnormal" blood enzyme results. A meeting will be scheduled with Drs. Looney, Meyers, and Hollinger plus J. C. Delgado and as many QAT members as feasible. J. C. will draft a guideline for development of the protocol and distribute it in advance of the meeting. J. C. will also coordinate scheduling of the meeting.
3.) Once the Protocol is finalized, it will be utilized to prepare a proposal for treatment of employees relative to job assignments and other labor concerns.

RJM/fb

Attachments:

1. Basis of New Policy
2. Concerns With Current Policy
3. Goals of New Policy

Distribution:

QAT Members
John Fike
Chuck Bellon
J. C. Delgado ✓
Dr. R. C. Looney

SL 042844

GOALS OF NEW POLICY

1. Protect employee health.

2. Establish a consistent and equitable procedure that meets the prime goal and minimizes corporate liability.

3. Assures open communication.

4. Incorporates all monitoring results.

5. Addresses employees' economic concerns in conjunction with conservative medical objectives.

BASIS OF POLICY

1. Employee health is the prime concern and objective.

2. Federal regulations will be met.

3. Corporate liability will be minimized.

4. A protocol directing action will be adhered to which assures consistent application of sound medical judgement.

5. Management will apply equitable treatment to employees based on the best medical guidelines available.

PROBLEMS WITH OUR CURRENT POLICY

1. USES NON-SPECIFIC SCREENING TEST TO MAKE PASS/FAIL DECISIONS.

2. THERE HAS BEEN ESSENTIALLY NO FOLLOW-UP ON CASES WHERE SCREENING TEST INDICATED A PROBLEM.

3. DOES NOT CORRELATE PERSONNEL MONITORING HISTORY WITH INSTANTS OF ABNORMALITY.

4. DOES NOT INSTITUTE PERSONNEL MONITORING TO DETERMINE IF EXPOSURE IS A POSSIBLE CAUSE OF ABNORMAL CASES.

5. NO EVALUATION IS MADE OF NUMEROUS POSSIBLE OTHER CAUSES OF ABNORMALITIES.

6. DOES NOT ALLOW MEDICAL JUDGEMENT, BUT INSTEAD PLAYS A NUMBERS GAME.

7. MAKES THE MOST INCRIMINATING AND MOST COSTLY COURSE OF ACTION THE FIRST CHOICE OF IN CASES OF ABNORMALITY.

8. DOES NOT ALLOW FOR THE EXPECTED VARIATION IN THE TEST RESULTS DUE TO ANALYTICAL VARIATION NOR INDIVIDUAL DIFFERENCES.

9. DOES NOT REALLY CONSIDER WORKER HEALTH AS THE PRIMARY OBJECTIVE.

10. PUTS THE CORPORATION IN THE WORST POSSIBLE SITUATION FROM A LIABILITY VIEWPOINT.

11. DOES NOT PROVIDE A MEANS OF DEALING WITH REOCCURRENCES OF ABNORMALITIES.

12. DOES NOT UTILIZE A DOCTOR'S JUDGEMENT AND COLLECTION OF ALL NECESSARY FACTS TO MAKE DIAGNOSIS AND RECOMMENDATION ON CONTINUED WORK ASSIGNMENT.

13. DOES NOT PROVIDE A FAIR TREATMENT OF OUR #1 ASSET.

QUESTIONS

1. What are we "looking" for when we draw blood? (i.e., not VCM, EDC, etc.)
2. What is an enzyme?
3. How often are blood tests done?
4. What enzymes do you look for?
5. What role do enzymes play in the body?
6. Are these enzymes normally monitored by private physicians when treating patients?
7. Who do you run these blood tests on - A, B, C, or all?
8. How do we tell when and how much exposure an employee gets?
9. Can I see my medical records and/or get a copy?
10. Why do we wait 3 weeks/3 months before retesting an employee?
11. Why do laboratories have different "normal" ranges?
12. Why does PPG use different labs?
13. Does the government know about this?
14. Have we talked with "experts" about our "problem" (concerns)?
15. Has anyone checked the validity of the lab results from the 3 different labs used (PPG, National Health, Path Lab)?
16. After years of working in Plant B - with possible liver enzyme elevations - what <u>is</u> going to happen to me?
17. Can a person's enzymes be caused by household cleaner, aerosols, etc., that contain ClCH.
18. Why did we start running these tests?
19. Why do we restrict people from working in Plant B?

20. When did we begin monitoring employee's blood?

21. Has anyone at Lake Charles ever developed a disease due to organics exposure?

22. Is there any correlation between air monitoring and blood monitoring?

23. What does "exposure" mean (how can you get exposed) (breathing, ingestion, skin)?

24. What is the treatment, if any, for diseases caused by toxic chemicals?

25. Here lately, more people are being restricted from Plant B than in the past. Why, what has changed?

26. Is it effecting my health to work in Plant B?

27. What is the experience in other plants (local and PPG) - do they have this problem?

28. Some of the people that have been removed and returned to Plant B have been told to stop drinking, lose weight, and other things - they did this and cleared up. Were you able to decide if that is what caused their enzyme changes?

29. What other things besides organics in Plant B can cause these changes?

30. Why have some people been taken out of B immediately and some haven't?

31. Is there a level above the "normal" that is considered "room for analytical error" and/or do these normal ranges apply to everybody?

32. Do some people normally have slightly "elevated/abnormal" enzyme levels?

33. If I am taking medication that is suspected to cause liver effects, should I stop taking it before I am tested?

34. Where do "normal" values for enzymes come from?

35. What do elevations in enzyme levels mean?

36. What is the function of the liver?

37. What causes enzyme levels to be elevated?

38. Do we have vinyl, EDC, etc., in our blood?

39. If I have a "high" enzyme - am I sick, i.e., cancer, AIDS, other?

40. If a person is exposed to "organics", how long does it take to affect the liver, or show up in enzyme tests?