FILE NAME: Union Carbide (UC)

DATE: 1932

DOC#: UC001

DOCUMENT DESCRIPTION: Transactions of the National Safety Council - Dust in Industry congested lanes, exposure in priority lanes was about 18% less for those in carpools, 28% less for those in high-occupancy vehicles (e.g., vanpools), and 61% less for those in express buses. These differences

Faster vehicles created more air turbulence, which may have helped to disperse pollutants surrounding vehicles in priority lanes. Furthermore, these differences existed even though the priority lanes were often

lanes, differences in exposure also could have been caused by differences in vehicle type and ventilation, both of which were not controlled.

on standardized routes that included a freeway carpool lane in Los Angeles. One vehicle used the carpool lane and the other the unrestricted lanes. Each vehicle repeatedly drove its route for both the morning and

outside of each vehicle. Because the vehicles had different air exchange rates, comparisons of external CO levels (measured at the base of the windshield) are appropriate. Based on these measurements, the

vehicle in the carpool lane (2.8 ppm). For a hypothetical 40-km commute, exposure in the noncarpool lane (measured in parts per million-minutes) was estimated to be 187% greater than exposure in the

commute, because they are exposed to lower CO concentrations and spend less time commuting in heavy traffic. However, the study did not account for the extra time to collect nonfamily members of a carpool.

literature. However, Flachsbart (1995a) developed a series of statistical models to predict passenger cabin exposure to CO based on trip variables for a 6.2-km Honolulu artery divided into three links. Based on

variables: (1) the ambient CO concentration, (2) the second-link travel time, and (3) either the travel time, vehicle speed, or CO emission factor for the third link. The models showed that the vehicle's travel time

passenger cabin exposure to CO on the third link because of mathematical relationships among these three predictor variables.

4.5.2 Federal and State Policies Affecting Temporal Trends in Exposure

Studies show significant decreasing trends in population exposure to CO concentrations from

[illegible]

poisoning, and another is based on direct measurements of passenger cabin exposure to CO concentrations from traffic emissions. Table 4-7 summarizes data on these indicators from several U.S. studies and [illegible]

shows the federal and California tailpipe CO emission standards by model year for comparison. In Table 4-7, the net mean CO concentration value represents the microenvironmental component of total

concentration, as recorded simultaneously at a fixed-site monitor.

Based on death certificate reports compiled by the National Center for Health Statistics, Cobb and Etzel (1991) reported statistics on the annual rate of unintentional deaths from CO poisoning in the United

[illegible] in 1988. Motor vehicle exhaust gas accounted for 6,552 deaths or 56.7% of the total 11,547 unintentional deaths occurring during the 10-year period. The highest death rates per 100,000 persons

1932

TRANSACTIONS

National Safety Council

Incorporated

TWENTY-FIRST ANNUAL SAFETY CONGRESS

Washington, D. C.

October 3 to October 7, 1932

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J. M. Woltz, Youngstown Sheet & Tube Company.

its personnel and the uniform high caliber of its work, the Bureau's laboratories at Pittsburgh seem the logical place for such certification to be done. The manufacturer of protective equipment welcomes definite specifications he can meet, no matter how rigorous, and expects to pay the testing bill whether his equipment is passed or rejected. No private testing laboratory would be expected to undertake this type of work without charging the manufacturer a fee adequate to give the laboratory a reasonable profit. The Bureau's fees in the past, for this type of work, have been modest, but the funds reverted to the U. S. Treasury, and not to the Bureau's laboratory. Unless an absurd and wholly unnecessary hardship is to be placed upon the Bureau, it should be permitted to do such work on a cost, or pay-as-you-go, basis.

General Discussion

Chairman Greenburg after delivery of the papers invited discussion, which was lengthy and spirited. This may be summarized as follows:

Dr. H. K. Pancoast, Philadelphia, pointed out that while X-ray presents the best method of observing changes in the lungs and also for determination of their incapacity, most examinations are not thorough. This point is frequently overlooked. Expert evidence is very important in making a diagnosis and grading incapacity.

The point made by Dr. Russell, of the advisability of special boards to decide the physical status of employees exposed to silica hazards, was also emphasized by Dr. W. J. McConnell, Metropolitan Life Insurance Company, New York City. In this connection Commissioner R. G. Knutson, Wisconsin Industrial Commission, spoke of the difficulties experienced in handling compensation cases. He suggested amendments to the occupational disease laws in various states for the complete coverage of occupational diseases, so that claims can be decided by the commissions rather than by common law. The conflict of testimony by so-called experts appearing before the commissions is sometimes remarkable. In some cases a final decision has been necessarily withheld until after an autopsy. John Roach, Deputy Commissioner of Labor, New Jersey, advocated the appointment of a Medical Board to be paid by the State whose opinion in compensation cases should be final.

There is a great difference of opinion about these cases, said Chairman Greenburg; the compensation commissions differ, the doctors differ, and on the other hand, industrialists have not been alert to the situation; but they can do a great deal in the future. Compensation Boards in the past have been somewhat arbitrary in their decisions. Some time ago I suggested in Connecticut that the commission should be made up of a lawyer, a physician specialist, and an engineer; but this suggestion did not meet with very much favor.

Asked to outline how silicosis cases are handled in Canada, Dr. J. G. Cunningham, Toronto, Ontario, said: Our laws define the terms silicosis and tuberculosis, and they further define the industries and occupations affected, but they refer to mining especially. The cases come from the individual physicians and are referred to the silicosis board. When the claim is received, the board examines the records and the claimants, to see if the regulations of exposure have been complied with; if so, the claimant is personally referred to the silicosis board; two or three of the members examine the case personally, and then each case is decided by all three members of the board. The claim is then referred back to the compensation board.

Two other points of interest occur to me, he said further: first, we have had a number of stone cutters with 15 years exposure to limestone, contacting tuberculosis, but in every case the occupational history showed that they previously had cut sandstone; second, in an extensive examination of workers exposed to silica dust and alkaline powders, reports in the literature have shown the rapid development of silicosis, but in our experience an examination of two small groups with similar exposure has shown only a small amount of fibrosis. The importance of exposure to coal dust also has not yet been sufficiently realized.

Dr. J. P. Leal, U. S. Public Health Service, Washington, D. C., emphasized the point made by Professor Drinker concerning the use of masks, that the minimum pressure necessary to operate such a mask should be used, that a decision should be made as to what this is, and that we should be sure that pulmonary excursion does not operate against appreciable pressure and against proper and continuous lung ventilation.

It is important to find some workable protective device, said Mr. Roach, that will protect workers in sixty or seventy different industries where the exposure exists. It is possible that in laboratories a well made apparatus will work fairly well, but in the various industries workers are found who have sharp and irregular features, and many times a mask or respirator will not work on these faces as on other workers with round, smooth features. The protective device thus becomes a menace rather than a help. We are also very much concerned whether the filter is satisfactory and will properly strain out the particles.

It has been mentioned, said Dr. Russell, that some limestone and sandstone workers have had silicosis. We must remember that granite workers and others have shown the presence of silicosis, although they have not been directly exposed, and other workers beside cutters have shown the presence of silicosis, all of these cases being due to previous occupational exposure involving silica hazards. Recently we had a case of a man with silicosis and tuberculosis, his job having been loading coal (not a real silicosis exposure), but previously he had been a gold miner. He is now 50 years old, has tuberculosis, and three of his five children also give positive tuberculin reactions, which is against the usual conception that tuberculosis from silicosis is transmissible.

Professor Drinker said: I have been asked whether I consider a respirator a good protection if no other apparatus is available. My answer is that it would not be. In a high concentration of dust, if the respirator is functioning properly, it should reduce the amount of dust breathed. But a respirator is not really an eight-hour day apparatus. In other processes, however, where the work is intermittent and a workman is not obliged to wear his respirator continuously, it should function as an efficient protective apparatus.

WEDNESDAY MORNING SESSION

October 5, 1932

For the record of this joint session of delegates of the Industrial Health Section with the Chemical Section, see page 166 of this volume.

WEDNESDAY AFTERNOON SESSION

October 5, 1932

Chairman Greenburg, on the opening of this session, called for the report of the Nominating Committee and officers were chosen as follows:

For Chairman, Dr. R. G. Leland, American Medical Association, Chicago.
Vice-Chairman, Dr. W. R. Redden, American Red Cross, New York City.
Secretary, Dr. C. O. Sappington, Chicago.

Chairman Greenburg then introduced the first speaker.

injurious and are, therefore, removed from the sample. After proper dilution, the contents of the graduated flask are thoroughly shaken so that a uniform suspension is obtained, and two portions of about one cubic centimeter are removed with a pipette to just fill two Sedgwick-Rafter counting cells. The cells are allowed to stand at least 20 minutes and the dust particles are then counted by means of a microscope.

The microscope with an Abbe condenser is provided with an eyepiece micrometer, a 16-millimeter objective and a 7.X eyepiece. The eyepiece micrometer has a large square engraved on it, and this square is divided into 100 squares, one of which is further divided into 25 smaller squares. The proper tube length of the microscope is determined by calibration with a stage micrometer, so that a side of the large square of the eyepiece covers 1 millimeter (1,000 microns).

The large square of the eyepiece micrometer, therefore, encloses the dust in an area of one square millimeter, and since the counting cell is one millimeter deep, all the dust suspended in one cubic millimeter of the sample is under the ruled field. All particles visually less than 10 microns in longest diameter in one quarter of the field are counted at five points on the cell, namely, near the four corners and the center.

Two cells of each dust sample are counted and the average of 10 counts is obtained. Control counts are subtracted from the average sample counts, giving finally, average net counts of the number of particles which are then calculated in terms of particles per cubic foot of air sampled.

Having determined the concentration of dust particles less than 10 microns in diameter in a given atmosphere, it is also necessary to obtain information regarding the mineral composition of the dust before any evaluation of the health hazard can be made.

In general it may be said that the harmfulness of a quartz containing dust is usually in direct proportion to its free-silica (SiO_2) content. It is, therefore, necessary to distinguish between "free silica", that is the silica that occurs as quartz, and "combined silica", or the silica that is combined with other elements in the various silicate minerals. It should be borne in mind, therefore, that the total silica reported in the customary chemical analysis is no measure of the amount of free silica.

The quartz content of fine dusts is usually determined by a combination of petrographic and chemical methods. Each dust presents individual problems and no individual technique applies to all dusts regardless of their composition. Those interested in this problem should consult Reprint No. 1560 of the Public Health Reports, February 24, 1933, entitled "The Quantitative Determination of Quartz (free silica) in Dusts" by Adolph Knopf, Professor of Physical Geology, Yale University, and Consultant, United States Public Health Service.

Discussion of Dust Problems

By DR. LEONARD GREENBURG

Yale University, New Haven, Conn.

The speaker said in part: On the technical side of this problem you have been presented with two excellent papers by Mr. Jones and Dr. Meiter. There is little that I should add from this point of view. Perhaps the most valuable contribution that I can make is to present to you my own personal view of the broader administrative aspects of this problem gained as a result of many years of close contact. In order to do this, let us analyze the problem in its simplest terms.

We may begin by agreeing that pulmonary fibrosis results from the inhalation of certain dusts in known concentration over a sufficient period of time. This fact has been demonstrated repeatedly by means of industrial, laboratory and pathological studies. On this simple fact, I take it, there is complete agreement.

Such legitimate cases of disabling pulmonary fibrosis are held in many states to be the responsibility of the employer. Further, a perusal of the compensation laws makes it evident that there exists a decided trend in the direction of broadening the compensation acts throughout the Union for we find from time to time that additional states are being added to the list of those holding silicosis to be a compensable disease. We would certainly be blinding ourselves to the facts were we not to admit the existence of this trend in social legislation. It should be pointed out here that this is a very wholesome and desirable state of affairs. The insurance principle has justified its existence in spreading the burden of ill fortune over a long period of freedom from catastrophe and surely in the case of industrial accidents it has freed us from the deplorable state of affairs in existence prior to 1912. In the case of the occupational diseases we may hope for equally satisfactory results.

Nevertheless, compensation insurance is not the complete solution of the problem at hand.

The only adequate means of avoiding the burden of silicosis is by the prevention of this disease. All other methods do not touch the crux of the problem and they carry in their wake a vast amount of litigation, illness, and a large financial burden on industry. If what we have agreed upon to this point is true it is obvious that industry must prevent the dissemination of dust in the workroom air by such adequate engineering techniques as are available; or in certain cases where this is not possible industry must provide, and force the worker to use, such means of personal protection as will adequately safeguard him against the inhalation of dust. It is only by these means that we can guarantee a future free of disabling pulmonary disease due to dust inhalation.

In spite of the very best efforts of industry to solve this problem there will undoubtedly be a certain number of cases brought to the courts and presented as legitimate cases of silicosis. While some of these are true cases of silicosis others, I have been informed, are not, but are designed merely as a means of obtaining funds from industry. A consideration of such cases brings us logically to the second part of the present discussion. What is the ideal method of handling compensation cases with reference to occupational disease and more particularly silicosis?

If we examine the development of the compensation acts we find that a technique designed primarily to adjudicate cases of industrial accidents has by degrees been given jurisdiction over occupational diseases. In fact, in some states diseases are regarded as injuries so that they may be brought within the scope of the original compensation acts. But on close examination it becomes apparent that diseases are far more difficult to adjudicate than are the ordinary injuries arising in industry. They present many technical facets and often require a detailed knowledge of this particular branch of medicine with which the average commissioner is very often unfamiliar. As a result we find in practice that the Court is presented with highly technical evidence by experts for the plaintiff and for the defendant which is very difficult if not impossible to satisfactorily evaluate. Often the commissioner is caught between the conflicting views of such witnesses and is not provided with his own experts to aid him in arriving at the real scientific background of the problem at hand.

What we really need is a strengthening of the technical side of the compensation acts to keep pace with the increased factual understanding regarding the occupational diseases. This does not merely refer to the Courts themselves but should begin with the promulgation of accurately worded compensation acts which clearly define the diseases for which compensation is to be paid. Compensation commissioners should be assisted by boards of technical experts composed of engineers appointed by the deans of the various engineering schools and of physicians appointed by the deans of the recognized medical schools. The engineers selected should have a very complete knowledge of factory conditions and the field of ventilation, and the physicians should be experts in the field of industrial hygiene and occupational disease. It is only with the aid of such highly specialized boards, or their equivalents, that the compensation commissioners may be able to do complete justice to both sides in these highly technical cases. It is the belief of the speaker that employers and employees alike would benefit greatly from the establishment and use of such boards. In order to hasten the establishment of this system employers are justified in appealing to their legislatures with this end in view; certainly such a legitimate demand should receive the hearty support of all concerned.

Frequently one is asked, what should be done with those claims which are based on little or no real evidence of injury to the worker but which are merely reared by some very enterprising attorney? Such claims are, I have been told, becoming very common of late and constitute a real problem to industry. It is obvious that the compensation advisory boards suggested earlier will, as soon as they are formed, serve the future as a healthy bulwark against this type of baseless claim and I venture to predict that few such cases would be favorably acted upon by a board of real experts in this field. At the present time factory officials should employ the very best legal talent available and should reinforce such legal talent with technical and medical experts thoroughly versed in the field of silicosis. Many cases have been lost by a failure to bring to bear the requsite technical aid required to prove the non-existence of a hazard. Here is an excellent example of a case in which money may be saved in the end by increased expenditures.

We now arrive at the final steps in the control of this problem, the physical and X-ray examination of the worker. Every factory should have pre-employment and routine post-examinations. It seems obvious that the burden of the health of the worker should not be placed on the plant without the privilege of the pre-employment examination. How can industry be legitimately expected to hire a worker "in the blind" as to his or her physical condition and then a day later be expected to shoulder the burden of the worker's health? By repeated physical examinations it is possible to discern the faint early deviations from normal health if any take place. In this manner the employer would be forewarned very early if any workmen showed lung changes suggestive of early silicosis. The routine industrial health examination on a broad scale throughout the major portion of American industry would constitute a public health procedure of major significance. By its means a very large proportion of the population would be aided in the prevention of the degenerative diseases of middle life which today constitutes such a real menace.

ADJOURNMENT

Falls of Persons

THURSDAY AFTERNOON SESSION

October 5, 1933

The special session devoted to discussion of problems arising through falls of persons was called to order by W. S. Paine, manager, Engineering and Inspection Department, Aetna Life Insurance Company, Hartford, Connecticut, who presided. Chairman Paine welcomed the delegates and immediately introduced the first speaker.

Ladder Accidents and Their Prevention

By F. L. HURLBUTT

Manager, Patent Scaffolding Co., Chicago, Illinois

The speaker said in part: In discussing ladder accidents, let us divide our subject into three divisions: (1) selection; (2) care or maintenance; and (3) proper use.

I can think of no piece of plant equipment in which there is the opportunity to buy either safety or accidents that there is in ladders. Basically, no ladder is better than the poorest piece of stock used in its construction. Only well seasoned, straight-grained woods should be used. For extension and string ladders, the rails should be of spruce, Douglas fir, Norway pine or long leaf yellow pine. Because the last named is somewhat heavier, it is not as desirable as the others. Rungs of oak, ash or hickory are by far the best, and here grain is all important. To assure straight grain, the best rungs are hand split in distinction to the ordinary machine turned rung.

The sectional size of side rails must vary with the length of the ladder, and likewise the diameter of the rungs must vary with the width of the ladder between the side rails. But in no case should the diameter of the rung be less than 1¼ inches, nor the tenon less than ⅞ inches. A genuine safety measure on extension ladders is the use of automatic locks, instead of the old fashioned gravity locks. All hardware should be of malleable iron or mild steel. No cast iron fittings should be permitted.

Much discussion has been indulged in over the question of whether rung tenons should extend fully to the side rails or only to within a quarter of an inch. My experience is that where the tenons do not go all the way through the rails, such ladders retain their rigidity better and do not get wobbly as soon as ladders which have the rails completely bored through. Also, moisture is less likely to get at the tenon of the rung and cause rot.

Membership Committee Chairman—R. A. Chaffin, Continental Steel Corp., Kokomo, Indiana.

Railway Car Builders Committee Chairman—P. J. Brand, Pullman Car & Manufacturing Corp., Pullman, Chicago, Ill.

Members at Large—

L. S. Adams, Hubbard Steel Foundry, East Chicago, Ind.
C. M. Allen, The American Rolling Mill Co., Middletown, Ohio.
J. A. Coltrin, National Radiator Corp., Johnstown, Pa.
H. M. Croghan, Inland Steel Co., Indiana Harbor, Ind.
G. A. Davis, Illinois Steel Co., Chicago, Ill.
John P. Eib, Illinois Steel Co., Joliet, Ill.
E. A. Ellis, Wheeling Steel Corp., Wheeling, W. Va.
W. T. Filmer, The Youngstown Sheet & Tube Co., Youngstown, Ohio.
A. C. Gibson, Spang, Chalfant & Co., Inc., Pittsburgh, Pa.
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W. J. Ireland, Kohler Co., Kohler, Wis.
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F. A. Lauerman, Republic Steel Corp., South Chicago, Ill.
T. H. McKenney, Illinois Steel Co., South Chicago, Ill.
D. V. Medalie, Interlake Iron Corp., Chicago, Ill.
W. E. Megraw, H. H. Robertson Co., Pittsburgh, Pa.
Robert L. Schmitt, Louisville Car Wheel & Railway Supply Co., Louisville, Ky.
J. K. Stafford, Mississippi Valley Structural Steel Co., Decatur, Ill.
J. M. Woltz, The Youngstown Sheet & Tube Co., Youngstown, Ohio.

Health Hazards in the Foundry

By CAREY P. McCORD, M.D.

Medical Director, The Industrial Health Conservancy Laboratories, Cincinnati, Ohio

The speaker said in part: Over and over again it seems necessary to restate in many guises such well established foundry fundamentals as the following:

1. Excessive heat is a hazard common to all foundries.

2. Excessive heat means high loss of valuable chlorides from the body and calls for replacement. The use of salinized drinking water is now better established as desirable than ever before. More rather than less salt is advocated for the normal foundry worker exposed to high temperatures.

3. Molten metal emits chemical rays at times harmful to the eyes. Goggles fitted with glass barring these rays prove their worth to the workmen in many plants.

4. Metal fume fever fortunately is fleeting in its known effects, but no less is real. It is more often found where zinc enters the metal mix.

5. Sudden and extreme variations in temperature may be the lot of foundry workers—notably so in winter. The body makes adjustments to these quick changes with admirable facility. No less, these burdens are conducive to respiratory diseases, including pneumonia. Pneumonia reaches highest frequency among foundry men.

6. Lead poisoning is far from rare in the foundry.

7. Carbon monoxide may be found in harmful quantities.

8. Antimony, nickel, cadmium, manganese, phosphorus, arsenic, and sulphur may on occasion find their way into the crucible and thus make possible the development of ill health traceable to such causes.

9. In core making, many binders have led to skin diseases.

10. If metal grinding, polishing and buffing constitute a part of the foundry's activities, a long list of additional hazards may be cited, ranging from the action of chrome polishing materials to tenovitis from the drag of the buffing wheel.

11. Last, but foremost, is the hazard of dust. At the present moment concern over health hazards in the foundry may be divided in the ratio of 99 per cent for dusty lung diseases and 1 per cent for all others combined. While this disproportion may not be warranted, it appears desirable that I devote the major portion of my comments to selected items related to dusts and the diseases produced by dusts.

Confronted with any new and outstanding hazard in industry, the tendency is to exaggerate the requirements for control. This notably was true when benzol first came into wide industrial application. Now the conditions under which benzol may with safety be used are so well delineated that where these conditions are provided benzol poisoning is unknown. A similar course is predictable for the silica hazard in foundries.

As the major problems connected with dusty lung diseases and their causations become harnessed by the specialist, opportunity is provided for the consideration of many secondary aspects of dust and dusty lung diseases. I propose now to comment on five of these slightly less significant matters—important in my opinion to the employment manager, the safety engineer, and the plant physician.

1. How shall the foundry operator protect himself against cases of dusty lung diseases originating in other plants?

Many foundry operators are faced with suits or other form of claims that undoubtedly are related to previous employment in other foundries or other dusty trades. Since silicosis may require and usually does require many years for its development to the point of disability, it naturally follows, by way of example, that 16 years of previous foundry exposure is more blamable in the causation of silicosis than two years of similar exposure in present employment. Yet the present employer is likely to find himself saddled with full responsibility.

Lately I have had opportunity to examine well made film negatives of applicants for work, without admitted previous exposure in industry. These persons were found to live and drive on dusty country roads made of flint. Approximately 50 per cent of these young adults presented sufficient involvement in their films to be rated as "suspicious" in relation to pneumoconiosis. Given a few months exposure in a foundry anyone might hold himself eligible for claims against his employer alleging dusty lung disease.

The answer to the problem is definite. Every prospective employee for any dusty portion of a foundry should be x-rayed by a competent maker and interpreter of chest films. For the good of the prospective workman and for the good of the operator, any applicant exhibiting any x-ray evidences of any degree of involvement resulting from the action of dusts or the presence of other pulmonary pathology in well established degree, should be denied employment in any dusty exposure. Expensive as x-rays may be, they are likely to prove one of the most economic steps that may be taken in these days of wholesale litigation, synthetic testimony, unskilled physicians, and plaintiff-prone juries.

2. What shall be done with the workers known to possess dusty lungs?

In late months many employers in dusty trades have procured routine x-ray examinations of all employees. Out of every hundred undisabled men, properly examined, a fair percentage is likely to present some degree of clear-cut pneumoconiosis. What is to be done with such men? Many are not disabled. Some are outstandingly hale and hearty. Shall they be told of their state? Many are likely to develop mental quirks and neuroses. Some will take an unfair advantage of the employer through claims. A small consensus of mature and fair-minded opinions as to appropriate action for this very time may be epitomized as follows:

Seek to eliminate further exposure to the dust hazard. Do not apprize any undisabled workman of his condition. Make repeated x-ray examinations at about six months intervals. If advancement of the condition appears, then take action suited to the individual case. Otherwise keep these men at some work.

3. Are negroes more susceptible to dusty lung diseases than whites?

I know of no large series of cases arising under identical conditions in this country among whites and negroes that prove the negro to be more readily involved by dusty lung diseases. The negro is more susceptible to tuberculosis than his white fellow workman. His housing is likely to be on a lower plane. His exposure to tuberculosis is prone to be greater than in the case of the average white man. On account of this background, the negro at this time is rated as a greater risk in the foundry than whites under conditions of equal exposure.

4. How necessary are dust counts in detecting hazardous work points in a plant?

The dust counter has established itself as the best available yardstick for the determination of different quantities of dust in the atmosphere. Like so many instruments in its class, the dust sampler and counter has been glorified far beyond its real merits. Opportunities for errors are legion. Legal standards based on present dust counting methods are utterly futile. Notwithstanding many pitfalls, however, the dust counter is a most valuable instrument. It finds its greatest usefulness in discriminating between much dust and little dust; improving the efficacy of preventive measures and devices; in the determination of the carriage of fine dust into non-dusty departments; in the detection of unsuspected dusty work points.

5. In litigation what medical defense may be involved?

Without presuming any qualifications in the domain of law, the plant physician, the safety engineer or the employment manager may be called upon to furnish attorneys all possible information in preparation for trials. Below I am listing a number of items that are in prospective use or have been used in various instances:

(a) Denial of the existence of dusty lung disease: Recently in the examination of a sample of 202 films of men exposed and unexposed to dust, one was singled out as exceptionally free of even usual amounts of fibrosis. This film was examined as an unknown, as were all others. Later it was pointed out that the workman from whom this film was made was a litigant demanding a large sum of money on account of an alleged silicosis. Similarly, about four out of every five litigants alleging dusty lung disease are in fact free of such diseases. The claims are spurious and may be proved so by appropriate examinations carried out by qualified investigators.

(b) The denial of disability or prospective disability: A large number of workmen whose lungs show some signs of dusty action are not incapacitated and no proof exists that real disability is an early prospect.

(c) The denial of neglect: Many of the true cases of dusty lung disease have been developing over long periods of years such as 15, 25 or 40. Since the medical profession has professed scant knowledge of these diseases during these periods, it is unreasonable to believe that the industrialists could have possessed more. Inevitably it follow that operators of dusty industries may not be presumed to have possessed earlier and greater information of these occupational diseases than physicians, industrial hygienists, state health departments, state factory inspectors, and other agencies devoted to health conservation. No industrialist may be charged with neglect for failure to supply protection against an insidious disease unknown or little known to the medical profession. Even at this time the average physician possesses the most meager information as to these conditions.

(d) The origin of the dusty lung disease in previous employment: Manifesting it is unjust that a few weeks of employment in some one foundry should be held responsible for a well established dusty lung disease when antedating this employment, there have been years of exposure to similar work in other plants.

(e) The origin of the dusty lung disease from causes other than industrial employment: In some localities over the country it seems probable that sufficient dust may arise from roads, farm work, etc., to induce characteristic involvement of the lungs.

(f) The actual quantity of dust present in an industry is below any reasonable threshold of probable production of damage: The mere fact that an industry or department is classified as a dusty operation is not in itself proof of the possibility of development of pneumoconiosis. The nature and extent of protective devices may fully exculpate the plant as a practical hazard. Dust count methods have certain undeniable limitations, but this form of testing along with tests of the efficacy of ventilating apparatus may be utilized on occasion wholly to eliminate any justification for contention that the air dustiness prevails.

(g) Diseases other than pneumoconiosis fully may account for abnormal state in the lungs, or other chest contents: At least ten other diseases may so stimulate pneumoconiosis as to permit confusion and error. Among others are fungus diseases, tuberculosis, especially disseminated tuberculosis, cancer, syphilis, pleurisy with calcifications, certain types of unresolved pneumonia. In addition, claims are known to have arisen alleging pneumoconiosis when in fact the pathology centered about such unrelated conditions as aneurysm, mediastinal tumor, anaphylactic asthma, valvular heart disease, etc.

(h) Silica is not a poison: In some states claims at law must be based upon acts applicable only to poisonous substances. What constitutes a poison is a matter of definition. At the present time, the best thought as to the action of silica within the lungs is unfavorable to acceptation of it as a poison. Primarily, silica action is physical rather than chemical.

(k) Pneumoconiosis does not constitute an accidental injury: In some instances it has been contended that dusty lung states are accidental injuries. Such specious arguments ordinarily are put forth in effort to obtain compensation in political states where no provisions are made for occupational diseases. To the contrary, every valid concept prompts a recognition of the pneumoconiosis and occupational diseases.

These several defense items are of course not set out as having any element of the panacea. However, on occasion some one or more may play a helpful part in defeating some of the cases now pending, richly deserving defeat.

WHEREAS, there is such pressing need for prompt executive action to put these measures into effect and stop these needless tragedies;

THEREFORE BE IT RESOLVED: That the National Safety Council respectfully urges the President of the United States to call the Governors of the several States into conference as early in the new year as practicable, to lay before them the seriousness of the situation, the remedies which have been developed for correcting these conditions and the necessity for prompt and united action in all the States to adopt and more energetically carry on an effective program for the protection of life and limb on our streets and highways.

By formal motion, and by a rising vote, the entire audience of delegates and guests approved this action of the Council Executive Committee.

Following this, Lt.-Col. Reninger read the following letter received from the President of the United States:

THE WHITE HOUSE
WASHINGTON

September 27, 1934

My dear Mr. Long:

I wish to extend to the members of the National Safety Council, in session at the twenty-third Annual Safety Conference, my most cordial greetings and my heartiest good wishes for the success of your endeavors.

The fact that you are concerning yourselves with saving life, that you are keeping in view human values and personal security commends your program to the entire country.

I am greatly impressed and pleased with the constructive steps already taken toward the elimination of accidents, especially highway disasters, which, because avoidable, are doubly tragic. This is a problem which we must attack with the utmost energy and persistence. Ultimately we may expect to reach the solution of highway safety, provided complete cooperation on the part of all citizens is given to concerted efforts of groups such as yours. At present the rising toll of fatalities on roads and city thoroughfares indicates in a manner all too grim that we are still far from the goal.

American automotive developments and our unequalled system of highway communications which have given signal contributions to our convenience, pleasure, and commerce, must not be permitted to devolve into instruments of death and disaster.

I assure you of my keen personal interest in your efforts and commend your splendid program to induce cooperation among every citizen in our nation with the movement looking to the prevention of needless fatalities—a drain upon our most precious natural resource which must be ended.

Very sincerely yours,

FRANKLIN D. ROOSEVELT.

Mr. John E. Long,
President, National Safety Council,
c/o Cleveland Hotel,
Cleveland, Ohio.

President John E. Long then arose and introduced Mr. Harold G. Hoffman, Commissioner of Motor Vehicles of New Jersey, who presided as Toastmaster. His witty introduction of the speaker of the evening, Dr. John L. Davis, of New York City, was highly appreciated by the big audience; and was only surpassed, perhaps, by the brilliant address of Dr. Davis, himself.

Dr. Davis was listed in the program to speak on "The Spirit of America." Despite this handicap, he seized the opportunity to present a highly popular monologue—so popular in fact that his success mounted steadily throughout the evening; and it was readily agreed, after an hilarious session, that no banquet of the Council had approached this for many a year.

ADJOURNMENT

TWENTY-THIRD ANNUAL SAFETY CONGRESS
NATIONAL SAFETY COUNCIL

Dust in Industry

FRIDAY AFTERNOON SESSION

October 5, 1934

The session devoted to a discussion of Dust in Industry was called to order by Dr. E. G. Meiter, Director, Industrial Hygiene Laboratory, Employers Mutual Liability Insurance Co., Milwaukee, who presided. Dr. Meiter briefly welcomed the delegates and then introduced the first speaker.

Types of Dust That Cause Occupational Diseases

By LEROY U. GARDNER, M.D.

Director, Saranac Laboratory for the Study of Tuberculosis, of the Edward L. Trudeau Foundation, Saranac Lake, N. Y.

The speaker said in part: Experience has demonstrated that the lung tissues can tolerate very large amounts of most kinds of foreign dust particles without serious interference with function. The lung may be intensely pigmented by colored dusts with no evidence that respiration is impaired. But dusts composed, in whole or in part, of silica have been shown to be dangerous because they stimulate the growth of the connective tissues of the lungs and bring about the formation of scar tissue. This destroys the normal elasticity of the organ which is necessary for respiration and it thickens the delicate membranes so that a free interchange of gasses is impeded. Fortunately, these results only follow the prolonged inhalation of very large quantities of silica.

Experiments have demonstrated that the injection of silica into the tissues of animals kills the cells where the substance lodges and excites an inflammation. When healing takes place a very dense and characteristic kind of scar tissue forms. Most non-siliceous dusts produce no inflammation and very little scar. It has been shown that such changes do not follow the injection of silica unless the particles are very fine, three microns or less in diameter, and unless enough of them localize in one area. With larger particles the rate of reaction is so slow that little change occurs within a year. As a general rule, the finer the particles, the more rapid the cellular response. The reaction to fine silica begins within four or five hours and it continues for a period of years.

If the silica is combined with bases in the form of silicates, it rarely produces such active and progressive changes. The silicate of magnesium, asbestos, does cause the formation of scar tissue in experimental animals and in the human lung, but most other silicates are not generally recognized as irritating. Recently it has been claimed that a hydrated silicate of aluminum and potassium, called sericite, is responsible for most of the cases of silicosis. This silicate, a transformed feldspar, is often associated with quartz and it has been identified in the lungs of persons suffering from silicosis. However, at least two types of sericite have failed to excite significant changes when injected into animals. Experiments with this substance are still in progress. Kaolin, an alumino-silicate of potash, has also produced quite characteristic changes in the lungs of rabbits. But our present knowledge does not permit us to assume that silicates as a class will produce serious tissue damage.

Most observers now believe that uncombined silica, or quartz, is poisonous to the tissues because it is slowly dissolved in the fluids of the body. Certainly the majority of the experimental observations suggest a chemical injury, but it is difficult to understand how enough of such an insoluble substance as quartz could be dissolved within eight hours to produce a well marked, acute inflammation. If solubility were the only factor one should discover a more active response after the injection of the more readily soluble silicates, but such is not the case. Formerly it was held that silica produced its effect mechanically. The hard sharp quartz particles were believed to abraid the lung surfaces and excite the formation of scar tissue as a manifestation of healing. This theory is no longer tenable for when animals are injected with other hard, sharp particles like diamond, carborundum or aluminum oxide, there is no inflammation and practically no formation of scar tissue. Ultimately it may be shown that the irritation of silica is due to some unrecognized property possibly related to its atomic structure.

When quartz particles are inhaled they produce three specific effects which are not excited by any other type of dust yet studied. They alter the behavior of the pulmonary phagocytes; they stimulate the formation of circumscribed nodules of scar tissue; and they subsequently increase the susceptibility of the lung to infection, especially tuberculous infection

Phagocytes that ingest too many quartz particles are killed by this irritating substance. As the cells die they liberate their burden and several new phagocytes come out to take it up again. By a repetition of this process enough phagocytes accumulate so that many of them ingest only a few particles. Under such circumstances the stimulus is not strong enough to kill but merely accelerates the motility of the cells. They naturally tend to leave the air spaces, enter the lymphatic vessels and accumulate in the lymph nodes. This process becomes more rapid under the influence of the irritating silica and very considerable numbers of particles are consequently localized in the nodes.

After six or eight years the quartz in the nodes has caused a marked overgrowth of the fibrous elements in these structures. Ultimately the reaction develops to such an extent that the node is entirely replaced by a mass of coarse, glassy scar tissue fibres, often several times as large as the original node. Such nodules encroach upon and compress the lymphatic vessels. The drainage system of the lung is choked and effective removal of subsequently inhaled dust is gradually diminished. Dust now accumulates around the lymph vessels and sheets of scar tissue develop in this location.

These preliminary changes do not constitute the disease, silicosis; they involve only the lymphatic system. The respiratory tissues are not appreciably affected. In good stereo X-ray films these preliminary changes may be visualized as a thickening and beading of the shadows cast by the blood vessels together with a widening of the shadow of the root of the lung. The blood vessels are thickened because the most important lymphatic vessels course through their walls. The beading is due to the minute nodules of silicotic scar tissue in the lymph nodes within the lung. The root shadow is widened because of the silicotic reaction in the lymph nodes in this location.

If still more dust is inhaled it can no longer be effectively carried off through the lymph vessels. The phagocytes now carry it into the walls of the air spaces. Often the cells group themselves in nodules but sometimes they are scattered. In these locations the silica again stimulates the formation of scar tissue. The result is a general thickening of the septa between the spaces and nodulation throughout the functional portion of the lung. This change seriously interferes with function as interchange of gas cannot take place through the thickened walls of the air spaces and the tissues lose their normal elasticity. Less involved air spaces dilate and their walls stretch, producing the condition known as emphysema, which is also incompatible with effective respiration.

With the formation of silicotic nodules in the functioning parts of the lung the disease, silicosis, is said to begin. On the X-ray film such nodules cast clear cut, round shadows. As they increase in number and size they blot out the formerly accentuated linear shadows of the blood vessels. In a well marked case both lung fields may be thickly seeded with hundreds of such sharply defined, rounded, nodular shadows. Where there is emphysema, often at the bases, no markings are visible and the film appears black.

The condition of silicosis is a progressive one and it continues to develop after a man has left his dusty occupation. Serious results only follow, however, when he leaves with many nodules in the lung tissue itself. As such nodules increase in size they replace important functional elements. Obviously the continued growth of only a few nodules situated in the lymphatic system could have little effect other than to increase the obstruction already present.

The serious part of silicosis is its frequent complication by tuberculosis. This may arise from reactivation of a pre-existant latent infection or it may result from a new infection from without. The danger of infection increases with the amount of silicosis present. The course of the infection in the silicotic is usually chronic and it often fails to produce characteristic symptoms for months or years after its onset. Many times it is accidentally discovered in routine X-ray examination of groups of active workmen. However, evidences of disability are much more marked in silicotic individuals with infection than in those with uncomplicated disease. Occasionally tuberculosis may run a very acute course in the silicotic subject but this is also true in other persons. The cause of the susceptibility of the silicotic lung to tuberculosis is not perfectly understood, but it would seem that the action of the silica on the tissues creates a medium favorable for the growth of the bacteria. The tubercle bacilli multiply and a slowly progressive tissue reaction ensues, but the usual clinical symptoms of tuberculosis are often held in abeyance for a long time because the chances for absorption of poisonous products of infection are minimized by the obstructed lymphatic system. It is also possible that some of these poisons may be absorbed on the silica particles, as Cummins has suggested. Ultimately the infection gains the upper hand, symptoms develop and death from tuberculosis ensues.

The only other type of dust which is generally recognized as a cause of severe pulmonary injury is asbestos, a silicate of magnesium. This substance is fibrous in character and is more readily soluble than quartz. Apparently the protective upper respiratory mechanisms seem inadequate to prevent the inhalation of many such fibres and even quite long ones may penetrate into the finer bronchial tubes. These structures have irregularities in their walls which seem to hold the fibrous dusts. In this location the asbestos particles are surrounded and ingested by phagocytes. The cells do not seem to be particularly irritated for they are not especially numerous nor do they migrate rapidly into clumps as in the case of phagocytes dealing with quartz. Apparently most of them carry their burden of asbestos fragments directly into the walls of the tubes in which they lie. The mildly irritating dust sets up a proliferation of the connective tissue cells in the walls resulting in collar-like thickening of the tubes. Contraction of the new connective tissue narrows or closes the tube and thereby shuts off the ingress of air to the more peripheral air spaces. These spaces then collapse, a condition known as atelectasis. This in itself is a cause of fibrosis or scarring of lung tissue. The result is a fibrosis of numerous relatively small areas in the lung due to the collar-like constricting fibrosis about many small terminal bronchial tubes. The lymphatic system seems to play little part in disposing of asbestos dust and very insignificant amounts of this dust are found in the lymph nodes.

Not a few cases of asbestosis die of tuberculosis or bronchopneumonia but the prevalence of the former infection is probably much less common than in silicosis. Surveys of large groups of asbestos workers fail to reveal such a high incidence of tuberculosis as found in similar studies on silica workers

The inhalation of unusual amounts of non-siliceous dusts apparently fails to produce significant alterations in the lung. It is of course possible that injurious ones may ultimately be discovered, but none are recognized today. The non-siliceous particles enter the lung and are ingested by phagocytes as in the case of quartz. The cells are not stimulated to move very rapidly and as a consequence many of them remain within the air spaces for a long time. Some, particularly those containing relatively few particles, make their way into the lymphatic system and accumulate in the lymph nodes. In sufficient concentration, or perhaps because they are mixed with small amounts of silica, they set up a low grade, non-progressive chronic inflammation. But this reaction results only in a little thickening in the lymph nodes and about the lymphatic vessels. The lung tissue may be variously pigmented, black from coal or red from iron, but there is no formation of scar tissue that interferes with function. The susceptibility to tuberculosis of the person with such pigmentation is not increased but it is apparently quite definite that pneumonia is unduly prevalent in coal miners and that chronic bronchitis results from the inhalation of cement. The X-ray films of men working in non-siliceous dusts shows either nothing at all or a more or less marked accentuation of the linear shadows cast by the blood vessels. This, of course, is due to the chronic inflammatory changes about the lymphatic trunks in walls of blood vessels.

The effects of mixtures of free silica and non-siliceous materials are less clearly defined and should receive more serious attention. It would seem unwise to assume, as has been done in the past, that the non-siliceous substances serve only as inert diluents and that only the quartz component of a dust is of significance. Experimental and clinical data are accumulating which suggest that at least some other dusts may materially modify the action of quartz, both in its capacity to produce nodular fibrosis in the lungs and to increase the susceptibility to tuberculosis. For example, animals inhaling heavy concentrations of a mixture of equal parts of pure silica and hematite dust for eight hours a day over a period of 14 months have shown not even the slightest indication of nodule formation in the lung, whereas pure quartz dust, inhaled for only two hours a day, produces definite nodulation. It also seems to be true that animals inhaling such a mixture are much less susceptible to tuberculosis than those exposed to pure quartz. In the case of the human iron miner, some lungs show definite silicotic nodulation, others only a very few nodules and many no nodules at all. All exhibit heavy deposits of iron particles with a cellular connective tissue reaction. When these findings can be correlated with chemical analysis of the lung tissues and the approximate amount of rock work which these miners have performed, some relationship between the exposure to silica and the fibrous nodule formation may be established. Tuberculosis in these iron miners is apparently less prevalent and much less severe than in men exposed to pure silica. What has been said of iron miners is also probably true of foundry workers and coal miners. It is generally accepted that men in the latter occupation have less tuberculosis than the average for the age period; Cummins believes that they have the infection but that it is so atypical and benign in its manifestations that it escapes diagnosis.

Mention should also be made of mixed dusts like certain slates and granite containing large amounts of free silica in combination with silicates. Experimentally these substances behave atypically and do not produce nodular fibrosis unless there is complicating infection. The same may also be true in human beings. Unquestionably such dusts are capable of producing typical silicotic nodules and they predispose to tuberculosis. From a theoretical standpoint they should receive much more intensive study to clarify our views on the whole subject. At the present time it appears that the action of their quartz component is modified and partially neutralized by the other substances which they contain.

Using Exhaust Systems and Respiratory Equipment To Protect Workers Exposed to Dust

By STUART W. GURNEY and DAVID S. BEYER

Liberty Mutual Insurance Company, Boston

The speaker said in part: A number of our states have had references to dust elimination in their labor laws for a good many years, but no state has as yet thoroughly enforced these laws. The codes of five states which we investigated provide that grinding, buffing and polishing wheels should be exhausted, although two of the states exempt from these provisions wheels on which water is used.

This seems ill-advised, since a study of wet and dry grinding in Connecticut by Winslow and Greenburg has shown that the application of water does not by any means eliminate the dust hazard.

It may be remarked that, with everything else equal, a high static suction will give a higher velocity at the point of origin of the dust, fume or gas than a low one; but this alone is not a measure of the effectiveness of any exhaust system. Wisconsin has adopted the principle of specifying a limit to the number of dust particles of respirable size per cubic foot of air. After all, this is what we are primarily interested in, to keep the dust contamination down to a point where it will not be harmful.

These variations and conflicting provisions in state codes merely reflect the general lack of authoritative standards. It is accordingly fortunate that definite steps are now being taken by the American Standards Association to develop the proper basis for such codes. There are two committees working on this problem; the Ventilation Code Committee, sponsored by the American Society of Heating & Ventilating Engineers, and the Exhaust Code Committee, sponsored by the International Association of Industrial Accident Boards and Commissions. It is also arranged to appoint sub-committees to take up five specific subjects: Abrasive cleaning, chromium plating, granite cutting, rock drilling, and spray coating. In addition, a Sub-Committee on Fundamental Principles of Design and Operation and Maintenance of Exhaust Systems will be appointed.

The two most important considerations in an effective exhaust system are: 1. Velocity of air flow; 2. Arrangement of the inlets (from the standpoint of nearness to the dust source, shape, etc.).

Many an installation that is otherwise all right fails to remove the dust successfully merely because there is not enough air being drawn through the system. In a series of tests that were conducted under actual working conditions by Theodore F. Hatch, Department of Industrial Hygiene, Harvard School of Public Health a machine used in dressing stone was employed, and it was noted that with an air flow through the hood of 230 cubic feet per minute, there were over one hundred million dust particles in the surrounding air. When the air flow was increased to a little over 250 cubic feet per minute, the dust concentration had dropped to forty million, a marked improvement. As the air flow was further increased, the drop in dust concentration was relatively slower, and it took a volume of about 380 cubic feet per minute to bring the dust concentration down to ten or fifteen million particles per cubic foot, which was considered reasonably safe for this type of dust.

It is accordingly possible sometimes to take an installation that is not satisfactory and, if the remainder of the system is well designed, by merely speeding up the blower or adding a larger one, to bring about the desired results.

Another very important consideration is to get the inlets of the exhaust system as close as possible to the source of the dust. The drop in efficiency as we get further away from the inlet is really surprising to one who has not studied the principles involved. It should be remembered that if we have the open end of an exhaust pipe or air duct in operation, the air tends to flow in from all sides, even from behind the opening. As we move away from the end of the pipe, the velocity drops very rapidly, so that even at a distance of five inches from the hood the velocity may be less than 10 per cent of that right at the hood inlet. This is the most important consideration to keep in mind and one which is frequently lost sight of in designing exhaust systems. It is not uncommon to see an exhaust inlet a few inches in diameter with which the person making the installation hoped to draw dust from a distance of several feet, but the air flow even a foot or two away from the entrance to the inlet may be negligible.

Still another important consideration having to do with the design of the inlet, is the addition of a flange. The effect of this flange is to cut down the air that would flow in from behind the opening, thus drawing it nearly all from the front. Thus the efficiency of the system is substantially increased and the scope of the exhaust extended appreciably, without increasing the power consumption or otherwise adding to the expense of keeping up the system.

There are also other considerations of perhaps lesser importance. For example, air cannot be "pulled" from a distance by merely directing an exhaust pipe toward the point in question, but it can be "pushed" or blown, directionally, for a considerable distance. This principle may be used advantageously in directing the dust toward the opening of the exhaust inlet and thus getting the desired results with a lower exhaust velocity and power consumption than would be required if suction alone were depended upon. This principle has been applied effectively in drilling material containing asbestos, where the exhaust inlet is placed at one side of the drill and a small air jet at the opposite side of the drill, blowing across the table, turns the particles that would fly out from this side and directs them back into the exhaust system. It is also being applied to foundry shake-out work.

Other considerations in designing exhaust systems include the elimination of unnecessary bends or curves, the provision of clean-out doors, and the proper construction of joints. Where there is a general ventilating installation and one or more exhaust systems, care must be taken to see that they do not conflict with each other.

After an exhaust system has been installed it should be tested by taking actual dust counts to see that the dust is really being cut down to the desired point, and such counts should be taken at intervals after the installation has been made, to see that it is still functioning properly.

The fact that the dust particles that cause the trouble are so small that they are invisible under ordinary conditions (less than 10 microns or 1/2500th of an inch in diameter) often makes it hard to convince the practical plant manager that there is any dust present; it also makes it impossible to tell, without the use of special instruments, whether the completed exhaust system is actually removing the dust.

It might seem like an insult to one's intelligence to say that after an exhaust system has once been installed it should be maintained in good operating condition. However, the numerous cases one encounters in the plants where this obvious necessity is not carried out, indicates that it is really one of the major considerations in connection with the elimination of dust or fumes. Cases are not unknown where the blower has in some manner become reversed so that the air is being ejected and diffusing the dust, rather than drawing it in; other instances where the efficiency of the system has been lowered or its value nullified by clogging up, disconnection or wearing out of the piping, etc., are all too common.

One concern, of which the writers have knowledge, has a "U" tube permanently installed in one of its main exhaust systems so that the foreman or safety man can tell at a glance whether there are any changes that would indicate a break-down in the system. All such installations should have regular inspections by some competent person as a routine part of their upkeep.

It will be sufficient here to discuss respiratory equipment very briefly. The simplest form of this equipment is the filter respirator. Such respirators have a definite value for temporary use such as sweeping up, cleaning out bins, shoveling materials, etc., but they require careful fitting and constant supervision to see that they are being properly used.

It is our opinion, after watching the sincere efforts in a number of plants to enforce the use of these respirators, that it is rather impracticable to require them to be used on full-time operation. One notices the men, under these conditions, surreptitiously pushing the respirator aside and gasping in free air like a fish out of water. Certainly, if they are to be used any considerable length of time, frequent rest periods should be allowed where the men can get out into the free air for a few minutes refreshment.

There are also the large air-fed helmets, with which most of us are familiar used for sandblasting, etc., which have been carried to a high state of perfection for the purposes to which they are adapted.

We believe, however, that much more use could be made advantageously of the type of apparatus that lies midway between the filter respirator and the air-fed helmet, namely, the light, air-fed respirator which covers the nose and mouth and leaves the rest of the face exposed. With a light hose attachment, this device offers considerable freedom of movement, and if air outlets were supplied so the hose could be quickly transferred from one outlet to another it would seem to be practicable to use them over a considerable area. They afford the advantages of a pure air supply without excessive weight and without the restriction to breathing that is imposed by the filter respirator.

The Medical Supervision of Workers Exposed to Dust

By W. J. McCONNELL, M.D.

Assistant Medical Director, Metropolitan Life Insurance Co., New York City

The speaker said in part: The harmfulness of dusts varies widely in accordance with the physical and chemical natures of each individual substance. Certain dusts are soluble or slightly soluble in the body fluids and their harmful effects are proportional to the toxicity of the compounds formed. Lead, mercury, and arsenic are examples of poisonous dust. Other dusts exert their harmful effects locally on the skin and mucous membranes and through irritation to the respiratory passages. Chronic acid and alkalies are examples. Attention recently has been called to the probably harmful effect of dusts arising from radio-active ores. A fourth group of dusts which are insoluble or very difficultly soluble in the body fluids may initiate harmful pathological lung conditions. These may be subdivided into non-fibrosis and fibrosis producing dusts. The organic dusts, mainly the vegetable fibers, such as cotton, jute, hemp, etc., are non-fibrosis-producing dusts. The fibrosis producing dusts are limited, so far as we have evidence, to a few of the inorganic mineral dusts, such as free silica, crystalline silicon, quartz, and certain combined silicates. Of the fibrosis producing dusts, those having a high percentage of free silica are admittedly the most important because exposure over a period of years to such dusts distinctly predisposes the individual to tuberculosis.

The effectiveness of dust control measures in preventing diseases produced by dusts can be determined only by careful physical examination of the workers so exposed under the guidance of competent medical supervision. The benefits which accrue to the employer and employee, alike, as a result of the physical examination of all applicants for employment, as well as periodical examination of those already engaged, would indicate very careful consideration by industry of a program for control of sickness. Such a procedure protects the employer from engaging an applicant already physically or mentally impaired who later may claim disability for a condition either not associated with employment or contracted during a previous employment. The applicant's physical and mental condition is established and by keeping record of his subsequent illnesses and accidents, the question of responsibility for injuries and sickness need never arise.

The applicant is protected from engaging in work for which he is physically ill adapted which, if undertaken, might easily bring about serious impairment of his health. For example, an applicant with an arrested tuberculosis who seeks work in a certain dusty occupation, if allowed to engage in such work might readily convert an inactive tuberculosis into an active one; thereby endangering life or at least seriously impairing the applicant's future efficiency and earning capacity. Whereas the same applicant if assigned to a position that involves no such exposure, might be expected to continue for years as a useful and productive workman. The examination of applicants for employment likewise protects those that are already employed from the risks of communicable diseases such as tuberculosis and various acute respiratory and other infections being introduced into their midst by a new applicant.

Many of the younger individuals who seek employment have never before received a thorough physical examination and consequently are unaware of the defects from which they suffer. As a result of physical examinations, many defects are located which may be removed or corrected before they have caused irreparable damage, thereby increasing the efficiency of the worker and often averting definite and finally chronic diseases. Furthermore, incipient tuberculosis, unsuspected diseases of the heart, kidneys, and a host of other diseases of a similar nature, are discovered and the applicant referred for proper medical care and treatment which otherwise might have been postponed until too late.

Of even more importance than the initial physical examination of applicants is the periodic examination and care of old employees by an industry. Such a procedure serves to check the efficiency of preventive measures designed to prevent occupational diseases. It offers the most effective way of controlling the health of large groups of workers by discovering early not only occupational diseases, but many other conditions that go undiscovered until the worker is acutely ill or becomes disabled. If the various contagious conditions go unrecognized others become infected, thereby causing serious economic loss, as well as endangering the health of a group of individuals.

The information obtained from physical examinations affords the medical supervisor the opportunity to make certain that employees are engaged in suitable work out of which they are getting maximum results, to correct the effects of undue exposure to harmful environmental conditions, and generally to lessen all occupational hazards. As a public health measure, it is impossible to over-estimate the value of periodic examinations in establishing interest in sickness prevention.

The set-up of a proper program for medical control of workers exposed to dust depends upon the number of employees involved and individual plant conditions. A series of articles under the title of "The Medical Department Manual" by Dr. Hart E. Fisher, appearing in current numbers of "Industrial Medicine," gives a comprehensive account of the organization and operation of a medical department.

1. The establishment of a medical department with adequate facilities and medical personnel who have qualified in the field of industrial medicine. A process analysis of all operations in the plant should be made and the medical supervisor should list all possible health hazards and familiarize himself with their physiological effects. If necessary, he should conduct research studies to determine the harmful effects of new substances introduced into plant processes about which little is known. In cooperation with other departments, he should investigate the extent of the hazards and devise measures of control.

2. The routine examination of all applicants for employment. The procedure should include a detailed history of the applicant's previous illnesses and accidents classified under (a) diseases of childhood, (b) general infectious diseases, (c) respiratory diseases, (d) venereal diseases, and (e) accidents and resulting physical defects. A detailed history of previous occupations engaged in is very important. A mere statement of the type of industry in which the applicant was engaged has slight value, if any. The exact duties performed in each occupation should be noted and information ascertained as to the probable length of exposure to hazardous substances. After the history has been taken and a photograph for identification purposes (if part of routine) is made, the applicant should be directed to the examining room where he is instructed to remove his clothing for physical examination. This examination should be made as complete as is considered necessary to determine the applicant's physical condition.

If the applicant has been or will be exposed to dusts which induce lung diseases, an X-ray picture of the chest is an important part of the examination. This part of the examination may be referred to an experienced roentgenologist, as the value of this method of diagnosis depends upon the type of pictures taken and the experience of the reader who interprets them. The examining physician also may need additional information obtained by laboratory analyses of the blood, sputum, and the urine. These aids to diagnosis should be provided or made available when desirable.

3. The rating and placement of applicants. In cooperation with the personnel department, the applicant should be rated and placed, not only on his training and past experiences, but also on his physical and mental abilities to fill vacancies occurring from time to time. The records of his physical and mental examination should be the confidential property of the medical department.

4. Periodical physical examinations. The frequency of periodical examinations necessarily must depend upon individual circumstances according to the need for such examinations as determined by the supervising physician. Where physical examinations are made for the first time, the employees of long standing should be given ample explanation of the benefits of such examinations and be given assurances that their jobs are secure.

5. Provision for the disabled. Employees who develop disabilities during the course of employment should be re-assigned to occupations which will not interfere with or aggravate the disability, or they should be provided for in other ways.

ADJOURNMENT

Fire Prevention

THURSDAY AFTERNOON SESSION

October 4, 1934

The Fire Prevention Session convened in the Statler Hotel with Chairman Harold L. Miner, Manager, Safety and Fire Protection Division, E. I. duPont de Nemours & Co., Wilmington, Delaware, presiding. After briefly welcoming the delegates, Chairman Miner introduced the first speaker.

How Home Fires Are Caused

By R. B. CRISWELL

Ohio Inspection Bureau, Columbus, Ohio

Speaking extemporaneously, Mr. Criswell gave a demonstration of the devices employed and the arguments advanced by himself and other members of the Ohio Inspection Bureau in bringing to the attention of school children the serious hazards of flammable substances in the homes. His object was to inform safety engineers and perhaps others in his audience who might be interested in becoming safety speakers, how to use simple devices in convincing the school children of the necessity for caution to avoid fires and explosions. Each device and method was outlined briefly, but with striking detail, some of the demonstrations being as follows:

A match, still blazing, was thrown carelessly into a small waste basket, as so many persons still continue to do, and the waste paper immediately flared into a dangerous blaze. With a short talk about the forest rangers and their watchfulness in putting out smoldering camp fires in the North Woods, he next carefully broke a match to make sure the match had gone out completely before he tossed it aside. Said he, "Chaperone your matches; they shouldn't go out alone."

A small doll house, wired in similar fashion to a comfortable home, was exhibited, and after an explanation outlining the many light and lamp fixtures coupled with electrical devices, which might be loaded onto the electric circuit in any home, the speaker attached these devices one after another until the fuse blew out; then he used a copper penny to plug the circuit until a fire developed in the attic of the doll house.

Strangely enough, an ordinary fish bowl, with the goldfish swimming about, if exposed in a sunny nook of the living room, with a flimsy curtain in the right spot beside it, or even a flammable rug underneath, can cause a disastrous fire. The circular fish bowl and the water act as a lens to concentrate the sun's rays. This has happened repeatedly, said the speaker.

A pretty little doll, made of pyroxylin, or some other flammable material, has often become ignited in the hand of a child and has burned the child severely before

The Dust Hazards in Industry

By DR. R. R. SAYERS

Medical Officer in Charge, Office of Industrial Hygiene and Sanitation,
United States Public Health Service, Washington, D. C.

The speaker said in part: Realizing the importance of the dust problem in industry, the United States Public Health Service in cooperation with the Bureau of Mines began its first study of the health of workers in dusty trades in 1914, in the mines of Joplin, Missouri; and later, in 1923, the Public Health Service inaugurated a series of dust studies. These later studies were all conducted in the same manner in order to permit as detailed a comparison as possible between the different investigations.

Briefly, these methods of study may be divided as follows: (1) examination to determine the general physical condition of the workers under observation; (2) special physical examination to determine the prevalence of specific diseases of the respiratory system and the lung pathology resulting from exposure to the particular dust hazard; (3) record of the nature and severity of the disabling illnesses; (4) analysis and detailed study of the occupational environment; (5) occupational mortality statistics relating to the specific dust; and (6) autopsies.

The first six intensive investigations carried out by the Service dealt with the health of workers exposed to dusts in a cement plant, granite cutting industry, anthracite and bituminous coal mining, silverware manufacturing plant, cotton cloth manufacturing, and in municipal street sweeping. Brief studies were later conducted in certain slate, granite, marble and talc quarries, while more recently a rather extensive study of the health of anthracite coal miners was completed.

These six dust studies showed that the workers in the granite cutting plants who were exposed to the highest dust concentrations were found to suffer from an excess of pulmonary tuberculosis after 15 years or more of exposure and developed silicosis from 2 to 10 years. In the group exposed to a lesser amount of dust, silicosis developed only after prolonged exposure, with no excess of tuberculosis. It was found that a close relationship existed between the degree of dust exposure and the extent and severity of the pulmonary damage. Anthracite coal miners suffered from dyspnoea and other signs of pneumoconiosis and experienced a high rate of respiratory sickness; in addition, an excessive mortality from influenza-pneumonia and possibly tuberculosis was found. Bituminous coal miners experienced a generalized fibrosis of the lungs and an excess mortality from influenza and pneumonia. Cement workers showed some signs of early pneumoconiosis with an excess of diseases of the upper respiratory tract. On the other hand, workers in the cotton cloth and silverware manufacturing plants and municipal street sweepers were negative for respiratory conditions and other illnesses when compared with the general industrial population.

Rock Drilling. For five years, the United States Bureau of Mines studied lead and zinc miners in the Tri-State District, Oklahoma. The ore here is high in free silica. Of the 7,722 men examined, a group of 1,647, or 21.3 per cent, was definitely diagnosed as having silicosis, not including those diagnosed as having tuberculosis. All the men diagnosed as having first-stage silicosis had worked an average of 13 years, but those men starting in the mines after 40 years of age worked an average of only 8 years.

The work of rock drilling in subway and tunnel construction in New York City is in some respects similar to that of some of the activities in the hard rock mines, at least in so far as the manner in which dust is evolved, the type of dust and the resultant hazard. Recently the result of a study of rock drillers, blasters and excavators was reported by the New York Tuberculosis and Health Association. An examination of 208 rock drillers, blasters and excavators showed that 118, or 57 per cent of the men had silicosis in various stages of progression. The exposure of most of these men (75 per cent) had been for 20 years or more.

Sandblasting. No study of the health of sandblasters has been reported in the United States; however, a study of the dust exposure of sandblasters was recently completed by the United States Public Health Service in cooperation with the

National Safety Council. This investigation indicated that, judged by the nature of the dust and degree of the exposure, a real hazard exists in this occupation. This study also brought out the fact that it is possible to conduct sandblasting with safety, provided properly designed and well maintained equipment is used

Diatomaceous Silica Workers. Most of the data on silicosis have been gathered from studies made both in industry and experimentally on dusts containing free silica in the form of quartz. Such studies have been made in the granite industry, pottery trades, hard rock drilling, etc. There are other free silica minerals in existence that are not crystalline in nature but of an amorphous composition. In Santa Barbara County, California, there exists the largest and purest diatomaceous silica deposit in the world. This substance consists of about 85 per cent free silica. Recently an examination was made of 108 workers selected among those employed less than 1 year, 1 to 2 years, 2 to 5 years, and more than 5 years. All of the workers were Mexican laborers and the examinations consisted of x-ray determinations, social and medical histories, and clinical examinations of the chests. Dust determinations were also made but these were not reported. The outstanding feature revealed by the examination was the splendid physical condition of the men. Eighty-four per cent of the workers were reported in excellent physical condition. It was found that 60 men showed signs of early pneumoconiosis; 15 were in the moderately advanced stage and 6 in the advanced stage. This latter finding was among workers with a history of exposure of more than 5 years.

Dust Hazard in the Granite Quarry Industry. It is a common belief that granite quarrying is not so dangerous an industry as granite cutting in enclosed sheds; quarry work is done outdoors and hence may not be attended with very much dust exposure. However, certain quarry operations require the use of pneumatic tools, which are usually associated with the formation of considerable quantities of dust. It was thought that a study made in a representative granite quarry might cast some light on our problem. Accordingly, a study of a clinico-radiographic nature of 63 quarriers was made and occupational dust exposures were also obtained. The dust determinations show that nearly 38 per cent of the workers (drillers) were exposed to many times the amount of dust considered safe at the present time. Drillers were the only persons showing pathologic lung changes. Half of these workers with an exposure of 5 to 19 years had silicosis, and 4 of the 5 men with more than 20 years of such trade life showed this condition. This study suggests that quarry drillers may experience as high a death rate from pulmonary tuberculosis as do pneumatic-tool workers in granite cutting sheds.

Effect of Inhaled Marble Dust. The pulmonary fibrotic changes due to the inhalation of marble dust appear to be slight in comparison with those caused by stone dust containing a high percentage of silica in the form of quartz. A recent study made by us among marble workers showed that although marble dust, when inhaled in concentrations averaging about 25 million particles per cubic foot of air, produced a mild bilateral, linear fibrosis in a certain number of the 80 men examined, no serious lung changes were noted and there was no disability due to the dust, even after many years of exposure (more than 40 years in some cases). The marble dust under consideration consisted of 98 per cent calcite and 2 per cent dolomite, with no silica present.

Dust Hazard in Abrasive Industry. Artificial abrasives are widely used in industry and for this reason the effect of the inhalation of dusts produced in the manufacture or preparation of these products is of great importance. In 1925, 1929 and again in 1931, Dr. Clark of the Norton Company at Worcester, Mass., made investigations of workers exposed to aluminium oxide and silicon carbide dust produced in the manufacture of grinding wheels, which showed that during a period of 13 years there were proportionately twice as many cases of pulmonary tuberculosis among those working in the abrasive dust departments as in departments where no abrasive dust occurred. In 1931, Kessler, of New Jersey, reported the occurrence of over 100 cases of alleged silicosis in the abrasive powder industry, in which the dust consisted of 99 per cent free silica.

Exposure to Silicate Dust. It has been the belief that the inhalation of dusts composed of silicates (combined silica), in comparison with silica (free silica in the form of quartz), was innocuous. Of recent years many investigators have become cognizant of the hazards of silicate dust exposure. Asbestosis, a fibrosis of the lungs caused by the inhalation of asbestos dust, has already been described both in its clinical and roentgenographic manifestations by investigators in other countries, but to date no studies have been reported in the United States. Cement dust, which contains about 22 per cent combined silica, has been studied, and the effects of the inhalation by workers has been discussed here. In March, 1933, Dreessen, of the United States Public Health Service, reported the results of a study conducted among tremolite talc and slate workers. The slate dust to which these workers were exposed consisted mainly of silicates, there being less than 3 per cent of quartz in the dust. The talc was a hydrous calcium-magnesium silicate, being 45 per cent talc and 45 per cent tremolite, with no quartz present. The results of the study seemed to indicate a relationship between the amount of dust inhaled and the effect of this dust on the lungs of workers.

Statistical Studies. Recently, Lanza and Vane estimated that there are some 500,000 workers engaged in the mining, quarrying and manufacturing industries in this country in which an exposure to silica dust to a harmful degree is entailed. Their analysis of mortality experience of twelve life insurance companies for the period 1915-1926 showed that the actual mortality from respiratory tuberculosis among the silica exposed persons was about three times that of a non-silica dust group. If one considers their data for certain occupations in metal mines and granite and sandstone quarries, occupations known to be exposed to high concentrations of hazardous dusts, then the comparison is more striking, since the actual deaths among these workers was found to be ten times that of the expected deaths. More detailed statistics on occupational mortality as reported by the Registrar-General of England and Wales (1921-1923), and summarized by Britten, show the high rate of 1,886 per 100,000 for tin and copper miners, while the rate for "all occupied and retired males" was only 150. Other occupations with silica exposure showed an excess.

From the evidence just presented concerning the injurious effects produced by the inhalation of certain dusts, it is apparent that a knowledge of the properties of a given dust which determine its capacity to produce pulmonary pathology is essential. Numerous investigations of the industrial dust problem indicate that these properties are the chemical and mineralogical composition of the dust, its concentration in the industrial atmosphere, and its particle size.

In an earlier portion of this discussion evidence was presented which indicated that a close relation existed between morbidity and mortality rates from various respiratory diseases and the exposure to certain dusts in industry. In the study of the dust hazard in the granite cutting industry, it was definitely proved that there is a direct relation between the magnitude of the dust exposure and sickness and death resulting from tuberculosis. It is quite evident, as a result of these studies, that the remedy of the dust evil lies in the effective removal or suppression of the dust to concentration considered safe. However, no set rules may be established for the mechanical protection to be instituted in an attempt to control industrial dust. Specific conditions encountered in a plant will determine the type of protection to be employed.

The protection of workers against certain dusts known to be toxic may at times be accomplished by the substitution of a non-toxic material for the toxic one. One example of such a procedure is the possible use of a metallic or other type of artificial abrasive for sand in the sandblasting process in those operations in which it is not essential to use sand, a substance high in quartz content. Again, the mechanical enclosure of the dust-creating process also serves to protect the worker. An excellent illustration of this type of protection is afforded by the modern sandblast barrel used in the cleaning of small objects. Sometimes it is possible to protect the worker by the substitution of wet for dry processes, as wet drilling instead of dry. In one instance, in the granite cutting study previously mentioned, an operator using a diamond point tool worked the stone wet; the resulting dust amounted to 22 million particles per cubic foot. The same operator was then requested to work the stone dry; as a result, the amount of dust reached the high figure of 45 million particles per cubic foot. In the weaving of asbestos cloth it has been possible to reduce the amount of dust in the air by wet weaving to one-fourth of the amount present when the process is conducted by dry methods. Another example of this procedure in allaying dust is the use of a spray of water in leyner and jack hammer drilling in hard rock, although the new type of Kelly dust trap is now finding much favor for this kind of work.

The Kelly trap consists of a metal chamber designed to enclose the drill steel at the rock surface. No attempt is made to secure a mechanical seal with the rock or between the trap and the drill steel. The dust is removed by an air stream and is carried into an exhaust system connected to the trap. Escape of dust particles through openings between the uneven rock surfaces and the trap is prevented by the air seal produced by the inflowing air. Tests made on this trap under actual working conditions show that the dust concentration at the worker's breathing zone may be kept down to less than 10 million particles per cubic foot with a 60 cubic foot per minute rate of air flow through the hood. This trap is a step forward in the program of dust removal; however, in underground work, such as in mines and subways, there is still the need to solve the problem of compact dust disposal equipment.

In certain cases, such as in the sandblasting of large castings in sandblast rooms, the practical safeguard to the worker is to provide him with a mask or helmet of the positive air pressure type. In the sandblast investigation previously mentioned, it was found that when from 5 to 6 cubic feet of practically dust-free air per minute are supplied to the helmet, the worker receives ideal protection. However, one must always bear in mind that the ultimate criterion of protection should be the dust determination of the air within the helmet during blasting and not the quantity of the air supply itself.

In most dusty processes, however, the most effective means of dust elimination are by the use of properly designed exhaust ventilation systems. Since in many instances it is difficult, costly, and at times an unnecessary procedure to remove all the dust in the vicinity of a worker, we need first to determine the minimum amount of a certain dust which the worker can apparently tolerate with impunity. Such information can be made available by the type of studies carried out by the Public Health Service. For example, in the granite study already referred to, it dust at the breathing level of about 10 million particles per cubic foot (35 per cent free silica).

Studies of dust removal devices used in granite cutting plants at the time this work was conducted showed that a linear velocity of 1,500 feet per minute as measured by an anemometer at the face of the dust-removal hood, would keep the dust at the breathing level to an amount less than 10 million particles per cubic foot.

A word should be said concerning personal respiratory protection against dusts. It has already been shown that in the use of positive pressure respiratory devices in sandblasting, it is important to have a well-designed device supplied with about 6 cubic feet of dust-free air per minute to give full protection to the worker. With reference to respirators of the filter type, there is still much to be accomplished in the design of an efficient and comfortable mask for continuous use. Of great value are standard methods for the testing of the efficiency of respiratory protection devices. Drinker advocates testing a device against the particular dust which the respirator is to encounter, these tests to be made both in the laboratory and under actual industrial conditions. He further suggested that some impartial agency should conduct such tests and certify the devices for industrial use, the work being done on a cost basis. The U. S. Bureau of Mines has prepared such a schedule for testing and approving respirators.

I wish to stress the importance of good housekeeping in the effort to combat the dust hazard. Good housekeeping should not only imply the removal of accumulated dust about a workroom but should also embrace efficient maintenance of dust removal devices and respiratory protective equipment. Systematic inspection of all dust suppression equipment should be an axiomatic principle in every dusty industry rather than the casual attention which it now receives in many instances.

Report of the Nominating Committee

The chairman called for the report of the Nominating Committee at this point, and new officers for the section to serve during the ensuing year were nominated and elected as follows: