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ASBESTOS: MIXED DUST AND FELA ISSUES

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WEDNESDAY, FEBRUARY 2, 2005

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Arlen Specter, Chairman of the Committee, presiding.

Present: Senators Specter, Hatch, Grassley, Cornyn, Coburn, Leahy, Feinstein, Durbin, and Carper (ex officio).

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Chairman SPECTER. Good morning, ladies and gentlemen. The Judiciary Committee will now proceed.

This hearing will deal with the proposed legislation on asbestos. We will take up two subjects, although I hope the issue on the Federal Employers Liability Act will be largely resolved.

Our principal concern this morning is on the issue of disease caused by asbestos contrasted with disease caused by silicosis or other airborne particles. We are moving along on what I still hope and project will be a very early timetable.

As you all know, a draft bill has been circulated. There have been agreements on many of the contested issues as a result of very extensive meetings held among the stakeholders presided over by Judge Becker, former Chief Judge of the Court of Appeals for the Third Circuit, who is with us today. On issues where understandably we cannot find consensus and agreement, decisions have been made on what is viewed as an equitable and appropriate handling of the issue.

The matter of asbestos versus silicon is a challenging one, and our preliminary findings are that it is possible to distinguish in almost all cases what is caused by asbestos and what is caused by silicon. And we want to refine that even further to see how we can define that in legislative terms so that individuals who are suffering from both silicosis as well as asbestosis are not precluded from having claims for their silicosis ailments, but that we do not have people who have been compensated for asbestosis go back and have a second recovery which is unjustified. This is a very knotty problem, and it could be enormously problemsome for any proposed legislation. But that is what we are working on.

The draft bill was submitted some time ago. A few remaining blanks will be inserted as promptly as we can work them through, with the proposed bill to be filed of record.

With respect to the issue on the Federal Employers Liability Act, there has been a concern that those in workmen's compensation not be treated better and people in FELA not be treated worse, that there be an equality. And there have been many, many, many discussions, which is characteristic of what we have done generally. And the parties are again reportedly very close to an agreement, and I am informed that if there is ultimately no agreement, there is an agreement that the bill should provide for language that within a certain time frame the issue would be submitted to compulsory arbitration, which would be a good resolution with the parties agreeing to that kind of conclusion. So we are moving ahead.

We have very good attendance today, and with that statement of three and a half minutes, I am going to yield to my distinguished Ranking Member, Senator Leahy.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Senator LEAHY. Thank you, Mr. Chairman. And I also commend you for starting on time, which is a nice way to do things here. And I commend you for holding the hearings. We have tried very hard in the last 2 years to get a bipartisan consensus on this issue. I was talking to Judge Becker on the way in, and I commended him, as both Senator Specter and I have. His work on this has been herculean, and I think it is one of the reasons why we are this far along. He also said the various stakeholders have worked diligently with him, and I think that is why we are so close to an agreement on many of the aspects of the national trust fund to fairly compensate victims of asbestos exposure.

I am worried that it appears that some special interests are trying to limit their liability in cases not related to asbestos through a last-minute and I believe overly broad provision that could jeopardize years of work by both Republicans and Democrats trying to develop an asbestos trust fund.

Despite its title, I am afraid that the latest draft would dramatically alter the proof requirements and recovery rights within the tort system for "any personal injury claim attributable to exposure to airborne dust, fibre, or minerals." I put a chart up which shows this.

The chart shows the relevant language from the latest asbestos draft. This sort of 11th hour provision was not in the bill reported by this Committee last Congress or in the substitute bill considered by the full Senate last year. It is not limited to so-called mixed dust. It appears to cover hundreds and perhaps thousands of injuries caused by airborne substances other than asbestos, including silicosis, black lung disease, even lead poisoning. That is overreaching.

The Leahy-Hatch medical criteria adopted unanimously by this Committee in the last Congress and agreed to by all the stakeholders addressed only asbestos-related injuries. The purpose of this legislation has always been to address compensation for asbestos victims, not to provide compensation for injuries caused by other material. As a matter of fact, I am glad to see Dr. Laura Welch here for an encore performance before this Committee. She provided insightful testimony and critical assistance with the de-

velopment of the Leahy-Hatch medical standards for compensating asbestos-related disease that we crafted in the last Congress.

It is clear to me that requiring victims to prove that asbestos was not a cause of their injuries in court would preempt State law. It would shift the burden of proving defenses to plaintiffs and greatly expand the scope of liability protection for corporations without adding a balancing or corresponding method of compensation for additional victims.

Now, remember, we are taking away people's rights to jury trials in this legislation. In doing that, we should always balance—if you are taking away rights, you have got to balance that with having other rights given to them.

Both my grandfathers, my Irish grandfather and my Italian grandfather, worked as stone cutters in the granite quarries of Vermont. Both suffered from silicosis because of the workplace exposures to stone dust. One of my grandfathers I never knew because he died at the age of 35 from that.

Now, they did not have asbestos-related disease, so they would not have qualified for compensation under the proposed trust fund. And under this language, they would have faced unprecedented legal hurdles to recover any compensation in a court of law. It is not fair, and I do not find it acceptable.

Now, the biggest danger to enacting bipartisan asbestos legislation is over-reaching by some interests for immunity from lawsuits brought by victims with legitimate injuries caused by silica or other substances. So I hope those who are pushing this overly broad sort of last-minute—I hate to call it a Christmas tree, maybe Christmas present might be better—legislation will step back and realize that we are trying—let's not kill the greater good by some last-minute, special interest legislation.

The second issue we are addressing today should be easier to resolve in a fair manner. FELA, the Federal Employers Liability Act, is a unique statute. It has provided workers' compensation benefits for railroad workers and provided compensation tort law for injuries to railroad workers such as asbestosis. The latest asbestos draft bill overrides FELA for victims of asbestos exposure. But by preempting FELA, the proposal also eliminates the railroad workers' compensation program, even though all other workers' compensation programs remain intact in the bill. I think we can change that because it would not be fair.

I commend the representatives of the railroad workers for coming to the table to bargain in good faith for special awards under the proposed trust fund. I hope the representatives of the railroads will do the same.

I look forward to working with the Chairman, and I want to commend him again for the enormous amount of time and effort he has put into this, and Senator Feinstein and other members of the Committee and the stakeholders. We can resolve these efforts. We can bring about a solution.

Mr. Chairman, I will put the rest of my statement in the record. This was somewhat long, but I wanted people to understand that we are getting so many calls in my office from all the stakeholders, and I wanted them to know just where I was. And, of course, Sen-

ator Hatch and I worked so hard on this last year to get the medical criteria in there.

Thank you.

[The prepared statement of Senator Leahy appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Senator Leahy. When you talk about hard work on this bill, it applies far and wide, with what Senator Hatch and you did last year in originating the idea of the trust fund, which after a lot of analysis, is, in my judgment, the only way we are going to move toward a solution here. And we have had very lengthy hearings, and Senator Feinstein has been in the forefront last year and again this year. She and I sat—she is considering a bill of her own or perhaps we will work a bill out. The legislative process here I think is all going to—I am optimistic it will all come together in the end. How we will parse it through and how we will work it through remains yet to be seen, and that is precisely what we are doing.

Again, I think the number of meetings where Judge Becker has presided are now 38 in number, in addition to many, many individual meetings and calls on a continuing and constant basis. During the league championship game in Philadelphia a week ago Sunday, Judge Becker was working on Sunday calling some of the witnesses who are on this panel. And I was not totally cooperative while the game was in play, but a little during half-time and a little during a break. And I will tell you that Judge Becker handed me the cell phone after talking to some of these people while McNabb was running, and I declined—and not respectfully. I just declined.

Well, we have asked the stakeholders to produce witnesses today. We have offered two slots for AFL–CIO. They felt that our lead witness would be their spokesperson on this issue, and she is Dr. Laura Welch, Medical Director for the Center to Protect Worker Rights, a research and development institute affiliated with the building and construction trades of AFL–CIO. She has held faculty positions at Yale, George Washington University, is the author of over 50 peer-reviewed publications and technical reports in the field of occupational and environmental medicine. She has many years of experience in medical surveillance programs for asbestos. Dr. Welch received her medical degree from the State University of New York at Stony Brook in 1978 and a bachelor's from Swarthmore College in 1974.

We have, as is our custom, established a 5-minute rule which we would ask you to observe, and there will be time to amplify your views during the question-and-answer period. And I think it best to start with 5-minute rounds among the members so that people get at least a chance to ask without waiting throughout the entire morning. But we will have multiple rounds, and we will be here as long as any member has questions and as long as any panelists have something that they want to add.

So you are the lead-off, Dr. Welch. Thank you for joining us and the floor is yours.

STATEMENT OF LAURA WELCH, M.D., MEDICAL DIRECTOR, CENTER TO PROTECT WORKER RIGHTS, SILVER SPRING, MARYLAND

Dr. WELCH. Thank you very much for the opportunity to appear here, and as everyone has heard already, I had the honor of assisting the Senate in developing the medical criteria going into this legislation. So I will have some comments on how I think this Section 403 integrates with that. But I understand that the main concern is that cases of asbestosis would also be filed as injury due to other dust, such as silica. I really do not think that is a problem. Asbestosis and silicosis really are different diseases, and they are separable from each other based on the history of exposure, the chest X-ray, and pulmonary function testing.

I was able to read Dr. Epstein's testimony before coming here this morning, and he is going to discuss it in more detail. So I am just going to defer to him to describe how silicosis and asbestosis are different. But really, the history is different, the X-ray is different, the pulmonary function tests are different. They are really fairly easy to separate.

Senator Leahy has already pointed out but I want to re-emphasize that the medical criteria for this fund were designed to identify and compensate workers or individuals with asbestos-related diseases. And I think a lot of work went into the development of criteria that do not compensate for diseases that are not related to asbestos. The X-ray and pulmonary function test criteria that are in the bill identify asbestosis and the pleural disease caused by asbestos. And, in addition, the medical criteria require a physician statement that asbestos was a substantial contributing cause to the disease that is being put forth for compensation and excluding other, more likely causes of that pulmonary condition. So essentially the medical report will say this is asbestosis and that the physician has considered other cases such as silicosis and is not a more likely cause.

So it is really set up so an applicant has to have significant lung disease with impairment caused by asbestos to be compensated under the fund. So we are not going to be seeing other diseases like silicosis being compensated under this fund.

So in some ways, this term that has been used of "mixed dust disease," and I wanted to just state that the textbook definition of mixed dust pneumoconiosis has nothing to do with asbestos. Mixed dust pneumoconiosis is caused by simultaneous exposure to crystalline and silica and other dusts, like iron oxides, coal, and graphite. So asbestosis and silicosis together are not mixed dust disease. And I know that the other doctors on the panel are going to talk about how likely that is to occur. There may be some that have both diseases, but that is really very rare.

Now, let me make a couple comments on the specific language of the bill. The language was up there a little while ago, but it states that, "To proceed with a civil suit for a disease attributable to an airborne, dust, fibre, or mineral, the claimant must prove that their functional impairment was not caused by exposure to asbestos." And as a physician, I think that is an impossible statement to respond to. I cannot swear exposure to asbestos made no contribution to a person's lung disease. Almost everyone who has lung

disease in this country from silica or from anything else will have had some exposure to asbestos, and the bill would require me to say there was no contribution from that.

I can make an affirmative statement that this is asbestosis, that asbestos is a substantial contributing cause, that it is the primary cause, that the disease is another disease. But to say there was absolutely no physiologic contribution at all from asbestos is really not medically possible. So I have a lot of concern with that particular language.

In addition, the scope of the diseases and exposures covered by the term "personal injury claim attributable to exposure to airborne dust, fibre, or minerals," I started to make a list, and that term "mineral" alone encompasses over 500 different substances. It includes all metals and metal compounds. So there is a range of lung diseases that would be impacted by that language. In addition to asbestosis and silicosis, it would include chronic beryllium disease, asthma that is caused by wood dust or other dusts, cotton dust disease, coal workers' pneumoconiosis. There is a list as an appendix to my written testimony that goes through that in more detail.

And then, in addition, minerals cause diseases that are not lung disease: lead poisoning, mercury causes kidney disease, arsenic causes neurologic injury, chromates cause contact dermatitis. It is a very long list. So any person with a personal injury claim, for example, lead poisoning, would have to submit the evidence required in 403, even though the disease of lead poisoning has nothing to do with asbestos exposure and might not even need a chest X-ray for diagnosis. And when I was making my list of other conditions and exposures, I would say that the language could cover personal injury claims for medical malpractice as well because there are metals that are used as therapeutic drugs. Lithium, for example, is used to treat bipolar disorder. Platinum is a cancer chemotherapeutic that is used for a lot of different agents. And I do not think the intent of this legislation was to reach out into other areas that are not even product liability. But the way I read it, it would.

Chairman SPECTER. Dr. Welch, your time is up. Could you summarize, please?

Dr. WELCH. Okay. The only other point I wanted to make was everybody has had exposure to asbestos who was alive in the 1970's. There is asbestos in everyone's lungs. So the requirement that if you had asbestos exposure you come under this bill would include an untold number of people. So I would agree with Senator Leahy's initial comments. My impression is that the range of diseases, conditions, exposures that are included under this language is way too broad, and trying to solve a problem of this combined asbestosis and silicosis that as a physician specializing in the field I do not see presents a problem.

So thank you very much, and I could answer questions.

[The prepared statement of Dr. Welch appears as a submission for the record.]

Chairman SPECTER. Thank you, Dr. Welch. We will be coming back to you for questions, which will give you an opportunity to amplify your testimony.

Our second witness is Mr. Michael Martin from the law firm of Maloney, Martin and Mitchell in Houston. For 15 years, he has been a specialist in environmental toxic torts after his father was diagnosed with asbestosis. He represented families suffering from occupational diseases—silicosis, asbestosis, and many others. He has been a member of the Texas State Legislature, was twice named Texas Monthly's 10 Best Legislators, law degree from South Texas College in 1985, and a bachelor's from the University of Texas in 1982.

Thank you for joining us, Mr. Martin, and we look forward to your testimony.

STATEMENT OF MICHAEL B. MARTIN, MALONEY, MARTIN AND MITCHELL, L.L.P., HOUSTON, TEXAS

Mr. MARTIN. Thank you, Mr. Chairman, and it is an honor and a privilege to be before you here today. I find it ironic, actually, that I am standing here or sitting here before you talking about silicosis when this august body declared war on silicosis in 1932 when the disaster surrounding silicosis first hit this country. And here we are in 2005 still talking about the issue.

I have spent a large part of my legal career specializing primarily in silicosis cases. I really do not do much other types of occupational lung disease cases. And some of my clients that are currently active and on file and have cases are individuals who are truly sick at young ages. My client Rafael Martinez is a victim of a bilateral lung transplant at the age of 32. My client Rick Mahar in Washington is a victim of a bilateral lung transplant at the age of 42. These gentlemen have had their lungs taken out of their body, and hyalinized silicotic nodules and conglomeration of silicotic nodules were found as a product as a result of their employment as sandblasters, which involves very intense exposure to silica dusts.

But it cannot be said in looking at the pathology of those gentlemen, which we have and can confirm, that there is not some asbestos in their lungs because as Dr. Churg, who I think everyone on the panel is familiar with, as noted in his book, "The Pathology of Occupational Lung Disease," over the past 50 years some 50 million workers were exposed to asbestos, and if you add to that the general environmental exposure to asbestos, everyone in this room can qualify as a person who was exposed to asbestos.

No doubt Mr. Mahar and Mr. Martinez, two people who suffer from acute silicosis and are victims of a rapidly progressive disease that caused their lung transplantations, certainly had asbestos in their lungs, but they did not have asbestosis.

And as I look at Section 402 or 403(a), as provided and demonstrated before the Committee, the primary problem I see from a pleading practice as a lawyer is that it requires me as a lawyer representing a silicosis victim on claims that are substantially smaller in number across the country than asbestos cases, it requires me to plead a negative. It requires me to plead that something does not exist. If I file a pleading for acute silicosis or accelerated silicosis or chronic silicosis, that should be dispositive. If I file a pleading for berylliosis or if I file a pleading for hard metal lung

disease, all of which are diseases caused by other minerals or heavy metals, that should be dispositive.

But what this language does is shifts the burden of proof to me to prove that something does not exist, and then requires me to say that my client was never exposed to asbestos, which I probably can never do if you take Dr. Churg's opinion on its word that most workers in the workplaces across the country and in the industrial environment have been exposed to asbestos.

So this double-negative scenario that the language presents under 403(a) is very problematic, and it creates this risk: It creates the risk of throwing a person like Rick Mahar, a victim of a bilateral lung transplant, into the Asbestos Trust, where he does not belong, where he would not get compensation, and for his family, his future is in great question. And to throw him into a trust would potentially delay the resolution of his claim and ultimately result in the extinguishment of his claim because that trust is not designed to provide him a remedy. Moreover, those companies that are potentially responsible for creating the trust are not responsible for causing his disease. So there is a fundamental unfairness on both sides if you include silica, silica-related claims, mineral dust claim in the same breath with asbestos, which has been a ubiquitous substance involving high numbers and large numbers of litigation.

In summary, Mr. Chair, I think it is important that we look at this language very carefully and identify the fact that it shifts the burden inappropriately, and it creates the risk that clients who are truly ill from silicosis or other serious lung diseases not associated with asbestos will have their remedies extinguished and not have any recourse at all to secure and provide some security for the future of their families and themselves.

With respect, we would hope that 403(a) be relooked at in terms of narrowing its scope and application.

[The prepared statement of Mr. Martin appears as a submission for the record.]

Chairman SPECTER. Thank you, Mr. Martin.

For the record, it should be noted that Senator Grassley and Senator Hatch have departed for a Finance Committee hearing. Senator Grassley is Chairman and Senator Hatch is the senior member. And thank you for your testimony, Mr. Martin. We will be coming back to you to utilize your experience to see if you have some ideas as to how we can insert the legislative language. You have had experience in the field and as a legislator as to how we do it, how we separate them out to be sure that people who have disease from silica can collect but not collect it twice.

Our third witness is Dr. David Weill from the University of Colorado Health Sciences Center in Denver, Associate Professor of Medicine, Associate Director of the Lung Transplant Program, diagnosed and treated numerous patients with asbestosis or silicosis, and is a certified so-called B reader. He has recently been involved in reviewing such matters and lawsuits, a medical degree from Tulane, and a bachelor's also from Tulane.

Thank you for joining us, Dr. Weill, and the floor is yours.

STATEMENT OF DAVID WEILL, M.D., ASSOCIATE PROFESSOR, DIVISION OF PULMONARY AND CRITICAL CARE MEDICINE, UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER, DENVER, COLORADO

Dr. WEILL. Senator Specter, Senator Leahy, and members of the Judiciary Committee, thank you for the opportunity to testify before you about silicosis and asbestosis. I am board certified in internal medicine and pulmonary medicine and have diagnosed and treated silicosis and asbestosis patients. Last spring, I was invited to serve as a visiting professor in Beijing, China, where I saw hundreds of cases of asbestosis and silicosis, and many of these cases were very advanced. The Chinese experience, of course, was sobering and far different from what I have seen in the United States, where genuine cases of these diseases are, fortunately, quite rare.

It is critical to understand that asbestosis and silicosis are very distinct diseases. They are not easily confused in practice, and it is very rare for one person to have both diseases.

There are several different types of silicosis, but in the United States today, chronic simple silicosis is the most common form. It is characterized by rounded nodules, like tiny marbles, found principally in the upper lobes of the lungs. In its lower grade forms, simple silicosis usually does not result in respiratory impairment, although it may progress over time. When progression does occur, it tends to be slow and depends on several factors, most importantly whether or not exposure continues.

If there is respiratory impairment, it typically is restrictive or involves both restriction and obstruction. Unlike silicosis, which is characterized by the presence of small nodules in the lungs, asbestosis involves fibrosis in the area of the lungs where oxygen exchange takes place. Asbestosis can result in both a restrictive pattern of disease—effectively a reduction in the lung volume—and interference with the gas exchange process. From a pathologic, radiographic, and clinical perspective, asbestosis and silicosis are very distinct diseases.

It is theoretically possible for one person to have both diseases, but in my clinical experience in the United States, I have never seen a case like this. Even in China, where I saw workers with jobs involving high exposure to asbestos and silica, I did not see anyone or review the chest X-rays of anyone who had both silicosis and asbestosis.

I would now like to talk about the recent increase in silica litigation. In the last few years, I have reviewed numerous diagnoses in the ongoing Texas MDL concerning silicosis liability. Almost invariably these cases have involved alleged simple chronic silicosis in low perfusion categories where there is no significant respiratory impairment due to silica exposure.

From a medical standpoint, it is puzzling to see so many ostensible silicosis cases in such a short period of time. Although the statistical evidence is imperfect, few would question the proposition that industrial dust control mechanisms have made silicosis much less common today than it was a generation ago. This conclusion is supported by reviews of death certificates undertaken by NIOSH, which reports that "Over the past several decades, silicosis mortality has declined from well over 1,000 deaths annually in the late

1960's to fewer than 200 pre year in the late 1990's." This decline should be associated with fewer and fewer silica lawsuits. Instead, my experience is that silica lawsuits are sharply increasing.

I have several observations about this:

First, nearly all of the litigation diagnoses come not from treating physicians, but from screening companies that provide their diagnostic services to plaintiffs' law firms.

Second, among the 3- to 400 silicosis claims I have reviewed, only two involve actual silicosis.

Third, many of the silicosis plaintiffs whose films I have reviewed have also been diagnosed by plaintiff experts, at one time or another, with asbestosis. In most of these cases, the plaintiff was X-rayed twice. The first X-ray was taken typically as part of an asbestosis screening conducted several years ago and resulted in the conclusion that the plaintiff had abnormalities consistent with asbestosis. Subsequently, the plaintiff returned for a second X-ray and a new silicosis diagnosis was based on the second film which, in all instances, was very similar to the first film. Silicosis was not mentioned in the first report and asbestosis wasn't mentioned in the second report.

In other cases, the claimant was X-rayed only once, yet received two different diagnoses based on the same film. This must be litigation driven because there is no medical explanation for it.

There are real cases of silicosis, but the majority of silicosis diagnoses I have seen in litigation are simply not valid. As a physician, I find this very concerning. The current rise in silicosis lawsuits cannot be explained medically. Most of these claims have involved workers who originally filed asbestosis claims, but it is exceedingly rare for a patient to have both diseases.

As based on characteristic chest X-ray findings and other clinical factors, it should not be difficult for a doctor to distinguish between these two conditions. Genuine confusion in a medical setting would be rare.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Weill appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Dr. Weill.

Our next witness is Professor Lester Brickman, from the Benjamin Cardozo School of Law, Yeshiva University of New York. His expertise includes administrative alternatives to mass tort litigation, a member of the New York State Bar Association Committee on Professional Ethics, the Committee of Professional Responsibility of the New York Bar. He has been consulted for the United States Office of Education, the National Science Foundation, Council on Legal Education for Professional Responsibility, master of law degree from Yale, a law degree from Florida and bachelor's from Carnegie Mellon.

Thank you for being with us today, Professor Brickman, and we look forward to your testimony.

STATEMENT OF LESTER BRICKMAN, PROFESSOR OF LAW, BENJAMIN N. CARDOZO LAW SCHOOL OF YESHIVA UNIVERSITY, NEW YORK, NEW YORK

Mr. BRICKMAN. Thank you, Mr. Chairman, Senator Leahy, in his absence, and Members of the Committee.

I welcome the Committee's interest in addressing a critical issue in the proposed FAIR Act. As proposed, the FAIR Act would preclude claimants with asbestos-related conditions from bypassing the National Asbestos Compensation Program and filing ostensible silica claims in State and Federal courts, seeking recovery for what is, in reality, the asbestos-related condition or, even worse, filing a claim with the program and then seeking additional money for the same medical condition by pursuing silica claims in court.

Without this provision, the same entrepreneurial lawyers and their allies who brought us the elephantine mass of asbestos claims will simply continue the litigation under another name. Indeed, this is already happening. A Federal MDL proceeding in Texas on silicosis is overseeing over 10,000 silicosis claims. As the chart being shown illustrates, over 60 percent of these silica claimants have previously filed asbestos claims with the Manville Trust. One would expect a similar result for silica lawsuits pending in other jurisdictions. Let me explain what is going on.

First, the very consideration of asbestos litigation by the Congress is motivating lawyers to switch to silicosis. Today, you have already heard doctors testify that there is no medical explanation for the recent and rapid increase in silicosis claims. Indeed, there is a broad consensus and the statistics indicate that the incidence of silicosis is decreasing. Yet, when the Congress started to focus seriously on asbestos litigation reform, entrepreneurial lawyers and their allied mass screening enterprises began to shift to the manufacturer of silica lawsuits. Now, here are some astounding figures.

For 26 years, until 2001, a major silica defendant faced as few as zero and as many as a few hundred claims a year. In the next few years, in the most recent few years, as legislation began to be seriously considered by the Congress, claims shot up into the thousands, reaching as many as 20,000, as the chart shows. That your serious consideration of asbestos litigation stimulated this sharp rise in silica claims is not merely conjecture on my part. Heath Mason, the co-owner of the mass screening entity, N&M, has testified that the Hatch bill was bad for his asbestos business, but good for his silicosis because "it gets lawyers to have to change gears on what they think is going to work."

As one asbestos silica attorney ventured, "Why reinvent the wheel?"

These mass screenings are manufacturing silica claims at a rate never seen before.

Second, the silicosis claims are being brought in the same relatively few "magic" jurisdictions where asbestosis claims have been brought. As the current chart shows, Texas and Mississippi account for the vast majority of silicosis claims. For one defendant, they account for 90 percent of the claims filed against it.

Third, advertisements routinely list screenings for both asbestos and silica. Note, the advertisement for a May 2002 screening, with states in capital letters. Well, first, you have the billboard that

reads, "Have you been tested? Asbestos/Silica Disease Screening." And now you have the advertisement reading, "Asbestosis, mesothelioma, cancer, lung cancer or silicosis."

Fourth, in using the same advertisements, the same screening companies, the same carefully selected B readers in the silica cases that they have used in nonmalignant asbestos cases, the lawyers are retreading their prior asbestos diagnoses into silica diagnoses for the same alleged injuries.

So it is not surprising, as I mentioned before, that approximately 60 percent of silica plaintiffs in the silica MDL have received two diagnostic reports—one for asbestosis and one for silicosis. Dual diagnosing, as we have heard, occurs in various ways. Dr. William Oaks, for example, issued one report where he interpreted the X-ray as consistent with silicosis and without pleural plaques and in the other report, written on the same day, with regard to the same X-ray, interpreted as consistent with asbestosis.

With dual diagnoses, lawyers can get two claims for the price of one or perhaps for a modest add-on. Heath Mason testified that his screening company pays one of his doctors $50 extra to write a second diagnostic report for silicosis based upon the same tests the doctors relied upon to diagnose asbestosis

Chairman SPECTER. Professor Brickman, your time is up. Could you summarize it.

Mr. BRICKMAN. Yes, I will. Thank you.

The FAIR Act, Mr. Chairman, should close this loophole. I understand that this is not a silica bill, and I do not expect that it will deal with pure silica claims, but it should not be possible to evade the National Asbestos Compensation Program by means of the entrepreneurial, if not fraudulent, conduct that I have described.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Brickman appears as a submission for the record.]

Chairman SPECTER. Thank you, Professor Brickman.

We will turn now to Dr. Theodore Rodman, retired pulmonary physician who developed an expertise in occupationally related drug diseases early in his career. He began his career at the University of Pennsylvania Medical School and recently retired as a professor of medicine at Temple. He has examined and participated in the care of hundreds of patients with asbestos-related lung diseases and reviewed X-rays on thousands of such patients. He is a member of numerous professional organizations, such as the American Thoracic Society, the American college of Chest Physicians, and the American Federation for Clinical Research, an M.D. from Penn and a bachelor's from Dickinson Law School.

Thank you for coming to Washington today, Dr. Rodman, to give us the benefit of your expertise.

STATEMENT OF THEODORE RODMAN, M.D., RETIRED PROFESSOR OF MEDICINE, ARDMORE, PENNSYLVANIA

Dr. RODMAN. Thank you very much, Mr. Specter, for giving me the opportunity to address the Judiciary Committee. Somehow or other I got the wrong understanding that the statement could be as long as 10 minutes. So I am certain that I will be cut off by you. Much of what I have to say is repetitive of what Dr. Weill had said.

And although I have never met nor spoken to Dr. Weill, I endorse his statement in its entirety and would adopt it as my own.

I am a 77-year-old pulmonary physician who retired about 4 years ago. After about 50 years of practice, teaching and research, I ended my career as a professor of medicine at Temple University Medical School. I began my medical career at the University of Pennsylvania Medical School and was on its faculty for a number of years.

Early in my career, I developed an interest in occupational lung diseases. In the following half-century, I examined and participated in the care of hundreds of such patients. I have reviewed X-ray studies on thousands of such patients. By virtue of its industrial base, the Delaware Valley, with its shipyards, power plants, oil refineries and manufacturing facilities, has had no shortage of patients with occupationally related lung disease. The commonest exposure by far was to asbestos in shipyard and construction industry workers. We also saw many who had been exposed to silica, primarily those who worked in mines, quarries, tunnels, and foundries. Of the hundreds whom I examined, I can remember only one or two who gave a clear-cut history of significant occupational exposure to both asbestos and silica—not surprising, considering the disparity in occupations in which asbestos and silica exposure occur.

Among the thousands of chest X-rays, which I reviewed in asbestos- and silica-exposed individuals, I cannot remember a single chest X-ray which showed clear-cut findings of both asbestos exposure and silica exposure.

During the decades of the 1970's, 1980's and 1990's, in connection with the asbestos litigation, I evaluated a large number of litigants. Not one of them had medical records suggesting a history of significant silica exposure. I found evidence of asbestos-related changes in many. I found no evidence of silica-related changes in any. I found no evidence in the reports of any physician, whether retained by the plaintiff or the defendants, that concluded that the patient had silica-related changes.

On the basis of this personal experience, I have concluded that both asbestos- and silica-related changes and disease are common, but rarely occur in the same patient. The medical literature and textbooks with which I am familiar are consistent with my conclusion.

In contrast, when we took care of the anthracite coal miners, combined occupational lung disease was seen commonly in the same patient. These miners were exposed to both coal dust, producing coal workers' pneumoconiosis, black lung, and silica, from drilling into stone, producing silicosis.

The changes of both occupational lung diseases were readily apparent. This combination was, and still is, known as mixed-dust pneumoconiosis. It is seen rarely in patients with asbestos-related disease because they are rarely exposed to silica.

At this point, I was going to show a number of color illustrations, but I think that would be time-consuming, and I will postpone that hopefully for later.

In conclusion, my experience in the asbestos litigation in the Philadelphia area has created in me the impression that the plain-

tiffs' attorneys had assembled a small collection of medical experts who were willing to perceive on chest X-rays and testify that asbestos changes were present when, in fact, none was. This impression was recently supported by a carefully controlled research study done at Johns Hopkins Medical School, in which review of these X-rays by a panel of impartial expert pulmonary radiologists confirmed the absence of asbestos-related changes in the vast majority of these X-rays.

I have been told that there has been a dramatic increase in the United States in the number of silica injury lawsuits, many initiated on behalf of plaintiffs who had previously received monetary awards for asbestos-related injuries. Based upon my experience that asbestos-related disease and silicosis very uncommonly occur in the same individual, and based upon my observations in the asbestos litigation in the Philadelphia area, I strongly recommend that medical evaluation for litigation purposes of such litigants should be done by an impartial group of physicians, free of any vested monetary interest in finding silicosis present or absent. This medical evaluation should include a careful review of all available prior medical records and X-rays.

I have finished what I have to say.

[The prepared statement of Dr. Rodman appears as a submission for the record.]

Chairman SPECTER. Thank you, Dr. Rodman. We gave you a little extra time because of the confusion in information which you received.

We turn now to our final witness on this panel, Dr. Paul Epstein, clinical professor of medicine at the University of Pennsylvania, board certified with a specialty in internal medicine and a subspecialty in pulmonary diseases.

He spent a large portion of his career studying occupational lung disease and is certified at the National Institute of Occupational Health Safety, NIOSH, by its highest qualification rating as a so-called B reader of chest X-rays, people who have been occupationally been exposed to potentially toxic dust, such as asbestos, silica and coal dust. Over the past 30 years, he has personally examined 17,000 individuals who have been exposed to these substances. His medical degree is from Tufts and his bachelor's from Princeton.

Thank you for joining us, Dr. Epstein, and we look forward to your testimony.

STATEMENT OF PAUL E. EPSTEIN, M.D., CLINICAL PROFESSOR OF MEDICINE, CHIEF, PULMONARY AND CRITICAL CARE MEDICINE, PENN MEDICINE AT RADNOR, RADNOR, PENNSYLVANIA

Dr. EPSTEIN. Thank you, Chairman Specter, and thank you, Senator Leahy and other Members of the Committee. I appreciate your asking me to testify today.

I would like to describe a little about the diagnosis of dust-related diseases of the lung. When an individual inhales certain types of potentially toxic dust, the lung may react by developing some scar tissue. This combination of the presence of dust in the lung, the development of scar tissue, is known by the medical name

pneumoconiosis. There are several different kinds of pneumoconiosis, and the most common are asbestosis and silicosis.

Both asbestosis and silicosis are caused by long-term inhalation and retention of particular kinds of dust in the lung. Although each of these diseases requires a substantial amount of dust retention, a longer and more consistent daily exposure to silica dust is required in order to produce silicosis than the amount of asbestos needed to produce asbestosis.

Lung diseases like asbestosis and silicosis are both characterized by scar tissue formation and take a long time to develop after the initial exposure. The time lapse between exposure and the onset of lung disease related to that exposure is called the latency period. And for both asbestos and silica exposure the latency period is at least 20 years.

There is an individual susceptibility to the scar-producing effects of both asbestos and silica, so that if two individuals work side-by-side, one may develop the disease while the other may not. While both diseases share common factors, such as dust inhalation, scar tissue formation and a long latency period, each of them has a very different clinical appearance and can be recognized easily by their relatively distinct patterns of abnormality on the chest X-ray.

For instance, asbestosis produces linear, streaky or feathery patterns on the chest X-ray, predominantly in the lower portions of the lung. This pattern of asbestos-related scar formation is almost always accompanied by patches of thickening of the membrane that covers the outer surface of the lung. These thickened patches are known as pleural plaques or pleural thickening. Frequently, the pleural plaques caused by asbestos exposure contain calcium that can be seen on the chest X-ray.

Silicosis has quite a different appearance on the chest X-ray. In this disease, the deposits of scar tissue occur in a distinct, rounded, nodular pattern, similar to the appearance of buckshot, and they are predominantly at the top of the lung rather than at the bottom of the lung. The rounded nodules of silicosis are not accompanied by pleural plaques or by pleural thickening. In other words, the X-ray appearance of these two dust-related diseases are vastly different.

Abnormalities on breathing tests are also somewhat different in people who have asbestosis as compared with those who have silicosis. In asbestos, the characteristic changes cause a restriction of the amount of air that can fit inside the lungs, and there is a decrease in the efficiency of the lung tissue in taking up oxygen. These changes occur relatively early in the evolution of asbestosis, even when chest X-ray abnormalities are mild.

On the other hand, people with silicosis often have no abnormalities on their breathing tests until the rounded nodules proliferate in great numbers and become larger in size. At that point, the volume of air in the lungs may decrease, and there may be a decrease in the person's ability to exhale air rapidly from the lungs.

When people have both diseases, that is, both asbestosis and silicosis, the characteristic clinical and X-ray manifestations are each discernible as separate features and the diagnosis of dual disease processes can be made with relative ease.

Over the course of the last 30 years, I have personally examined approximately 17,000 individuals who have been occupationally exposed to asbestos. These workers have held many different jobs, including those of shipyard workers, oil refinery employees, construction workers, steel mill employees, chemical workers, insulators, electricians, painters and riggers, to name a few.

Additionally, I have evaluated many workers who are occupationally exposed primarily to silica, including coal miners, sandblasters, stone quarry workers, glass makers and refractory brick manufacturers. A large number of these workers were exposed to both silica and asbestos.

While it is theoretically possible to have combined disease consisting of asbestosis and silicosis, it has been my clinical experience that the overwhelming majority of patients I have seen with asbestos-related disease have no evidence of silicosis. In fact, I can recall no more than about a dozen or so individuals who have had combined asbestosis and silicosis. And these were people who had substantial occupational exposure to silica, often in jobs that were separate from their subsequent jobs that involved exposure to asbestos.

Chairman SPECTER. Dr. Epstein, your time is over. Could you summarize, please.

Dr. EPSTEIN. Yes. For this reason, it is my professional opinion that the dual occurrence of asbestosis and silicosis is a clinical rarity.

Thank you.

[The prepared statement of Dr. Epstein appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Dr. Epstein.

Mr. Martin, you have been in the field. You have been a legislator. You think we can improve the formulation of a statute. What suggestion would you give us?

Mr. MARTIN. I do think you can improve it, and this is what I would suggest. I think, in looking at 403, what you have to do is move away from the idea that a plaintiff has to require to prove a negative. I would suggest, as a solution to that, the issue of disclosure; that what a plaintiff should do under the circumstances the distinguished members of the panel have related to today, where there are retreads or double filings, is that a plaintiff should disclosure that up front. If he has already filed an asbestos claim, that should be disclosed, and that should be the point from which you legally then move.

If a client walks into my office and he says, "Well, I have already filed a claim for asbestos," my radar is going to go up because I agree with the panel that it is rare. I have had two cases involving asbestos and silicosis together in my entire career. And so I think one of the other questions that you have to look at in that disclosure is did these men who are attempting to file an additional claim for silicosis, what was their actual exposure at the workplace and did they really have exposure to silica? In those two instances, the two gentlemen sandblasted, which involved intense exposure to silica, resulting in their contraction of silicosis, and then later they were assigned to another job where the had to cut couplings for asbestos insulation on pipe, and they did both for several years.

Chairman SPECTER. Dr. Epstein, you say that the medical determination is clear-cut on the X-rays?

Dr. EPSTEIN. Yes, it is.

Chairman SPECTER. So why should there be a problem of someone who has collected from asbestos exposure, asbestosis, mesothelioma, being able to collect from silicosis if he or she has not actually been exposed to silica, if the evidence is conclusive as to what is the cause?

Dr. EPSTEIN. First of all, these are very rare, overlapping diseases. I think that part of the answer to that question is that the individual with asbestosis is probably more commonly impaired severely by that type of abnormality than is the person who has silicosis. The number of people who have silicosis at the present—

Chairman SPECTER. If someone has collected from the Asbestos Fund, and he makes a claim for silicon exposure, and you take a look at the X-rays, and except in these very, very rare cases, it is demonstrated that he suffered from asbestos, then isn't he precluded from collecting from this silicon claim?

Dr. EPSTEIN. Yes.

Chairman SPECTER. Professor Brickman, what is so complicated about defeating, you used the term "entrepreneurial" in a pretty heavily pejorative, derisive comment, some entrepreneurial activity is still regarded as legitimate in our society, but where you have an array of experts here—Dr. Welch, from AFL–CIO, and Dr. Epstein, Dr. Rodman, Dr. Weill—and you could look at the X-rays and tell. They come in and make a claim for exposure to silica, and the X-rays give you the facts. So what is the problem?

Mr. BRICKMAN. In part, Mr. Chairman, 403 I think is being misrepresented. It does not say that you have to show you have—

Chairman SPECTER. Never mind 403. Answer my question. What is the problem? You come in and make a claim for silica, and the X-rays show it is asbestos. Are you not ruled out automatically?

Mr. BRICKMAN. I am not speaking to the content of 403. So I do not claim any expertise in terms of the language. I do not see a problem in the way in which the implementation would occur. You do not require negation of exposure. You require negation of the cause of impairment, and that is a critical difference that I think would explain why the testimony against the provision really does not meet the test.

If you claim impairment, then you must show that the impairment was not caused by asbestos. The medical testimony this morning is quite clear that the diagnosis of asbestosis is a reliable medical diagnosis when done by reliable medical experts.

Chairman SPECTER. My red light went on during the middle of your answer, and I adhere meticulously to the time limits, so that I can ask my colleagues to do the same.

Senator Leahy?

Senator LEAHY. Thank you, Mr. Chairman. I assume that there will be the ability to file follow-up questions with some of them.

Chairman SPECTER. By all means, sure.

Senator LEAHY. Dr. Welch, after I started this process, about 2½ years ago now, held the first Committee hearing on asbestos litigation, all of the medical testimony we have had, including yours, has involved asbestos exposure only. The Leahy-Hatch medical criteria

in the bill, is designed to apply to asbestos disease only, they do not apply to silica diseases. Now, I understand from your testimony today that there is no basis in medicine for the concern of some of the business community that asbestos claims could be transformed into claims for diseases caused by other dusts, asbestosis, silicosis, other dust diseases, different ones that can be differentiated upon pulmonary exams, X-rays and so on. Now, if that is correct, diseases causes by exposure to non-asbestos-related dust, fiber and minerals, would not meet the asbestos medical criteria you helped the Committee draft a couple years ago. Am I correct in that?

Dr. WELCH. That is correct.

Senator LEAHY. The latest draft Asbestos Bill requires victims of silica exposure, other airborne dust, fibres or minerals, to submit medical evidence that proves asbestos exposure did not cause their injury, basically proving a negative. If a non-asbestos victim could not meet this high evidentiary standing in court, then my understanding, they would be barred from suit, and they would be precluded from receiving any recovery in the trust fund.

Dr. WELCH. That is correct, because their disease would not meet the criteria under the trust fund, so they would not get compensation in the trust fund. But this languages seems to me to say they could not get compensation anywhere else either unless they could prove all these negatives, which in my opinion you really could not do. So they cannot be compensated under the trust fund because they do not have asbestosis, but they cannot go anywhere else either.

Senator LEAHY. Some of the testimony today has been that people of a certain generation are going to have, including myself, are going to have some level of asbestos in their lungs from an unknown source, is that correct?

Dr. WELCH. Correct.

Senator LEAHY. I love the expression "those of a certain age," and now that I am 64, I understand it better.

So would a doctor be able to determine that asbestos exposure absolutely did not cause a patient's impairment?

Dr. WELCH. I do not think he could say that.

Senator LEAHY. Mr. Martin, you have been a legislator too, as the Chairman has pointed out. I do not have all my questions with a celestial tone with it. But I am concerned that preemption of silica claims in this bill could leave silica victims, like my own grandfathers, without any remedy in court or the Asbestos Trust Fund. After all, we are taking away a right to jury here. Now, you have represented people exposed to silica for more than two decades I think you said in your testimony. During that time, have you ever been asked to prove that another airborne substance did not cause your client's injury during those 20 years?

Mr. MARTIN. No, never. It has never become an issue. And I plead what I plead, and I have to prove what I plead. Either I meet my burden of proof or I do not. It is as simple as that, and that is the way the legal system has worked since the Founding Fathers wrote the Constitution.

Senator LEAHY. In fact that sort of suggests my next question. I mean are you aware of any other area of law where victims are

required to plead and prove the substance other than the one alleged in the complaint was not a causal factor in their injuries?

Mr. MARTIN. No, I am not, and it is nonsensical to have to prove something that should not even be relevant at trial because it is not part of what is being argued or pled as the injury in question.

Senator LEAHY. I understand from some of the business community that they are concerned that victims would be allowed to double dip, receive double recovery unless we include this expansive language in the draft. This so-called mixed-dust language in the latest bill does not preclude double recovery because nothing in the language hinges on whether a victim has recovered from the Asbestos Trust Fund. It seems simply to create an unprecedented shift in the burden of proving defense for claims outside the scope of asbestos. I have not tried any cases for a long time, but am I correct in that?

Mr. MARTIN. Yes, I think you are, and I think the problem is, is that I do not think the language does solve the problem of double dipping or double recovery. I think it just attempts to preclude a greater number of victims who are not in the asbestos world and exposed to other dusts and other minerals, many of which I provided pictures of in my testimony. So I think the problem is, is that by including everybody in this group, you are stripping rights of a certain group of people, whereas there might be a narrow way you could craft this thing to deal with the double-dipping issue.

Senator LEAHY. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Leahy.

Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman.

I think we can all agree that the Asbestos Trust Fund is designed to compensate people who are sick as a result of asbestos-related disease, and is not designed to compensate people for exposure to other carcinogens or create other medical problems. That is one of the reasons why I have concerns, for example, about a provision that is currently in the bill to compensate for colorectal cancer.

Dr. Epstein, are you aware of any medical justification for tying the inhalation of asbestos fibres to colorectal cancer?

Dr. EPSTEIN. There have been a number of articles in the medical literature that have suggested that colorectal cancer is associated with asbestos exposure. I personally have gone over the literature in detail. That is not my opinion. But there is opinion within the medical literature that says that that is correct.

Senator CORNYN. I admit that my understanding of the human anatomy is pretty elementary, but the idea that you can inhale an asbestos fibre and end up with cancer in your rectum or in your colon seems pretty far-fetched.

Dr. EPSTEIN. It does if you think of it as being inhaled. But frequently what happens is that the asbestos is inhaled in the lung, it is coughed up and is then swallowed. But in my opinion, that is not a valid cause of colorectal cancer.

Senator CORNYN. Thank you for explaining that. That had not occurred to me.

Professor Brickman, I know that you have talked to us a little bit about the abuses of mass screening of people who claim to have asbestos-related or silica-related disease. This bill, as currently

written, provides up to $600 million for screening of potential claimants to the asbestos fund. Does that cause you any concerns, or how can we make this bill as strong as possible to prevent the kind of abuses that we see here demonstrated on your chart, where we hear from the medical experts that it is clear when somebody has silica-related disease as opposed to asbestos-related disease, but you have people here apparently claiming both?

Mr. BRICKMAN. Senator Cornyn, as you know, I have written extensively on the subject of asbestos litigation and have focused on asbestos screenings, writing a fairly substantial law review article on it, in which I describe the entrepreneurial model, which I would depict as reality rather than characterize it in any other way. That article sets forth what I see is occurring in asbestos litigation. And what I see now occurring in silicosis litigation: the same B-readers, the ones that the Manville Trust professional staff referred to generically as "Dr. Bogus," are being hired by the same plaintiff lawyers, in some cases some new plaintiff lawyers, by the same screening entities, the same kind of false witness memories being implanted to generate witness testimony. These are the facts that I empirically support in my written statement.

I believe you have the same thing going on now with silicosis litigation as occurs in the asbestos litigation. You have the phenomenon of the retreading of claims, which I have described in far more detail in my prepared statement, and what you also have now which is in anticipation of the possible passage of the FAIR Act is the bypass procedure, and this is not a medical cardiological process. The bypass procedure is where somebody who would otherwise claim 1/0 asbestosis who is unimpaired and who, under the FAIR Act will not get compensation, instead will claim 1/0 silicosis, because the same B reader, at the same time he reads the X-ray fills out two forms, 1/0 asbestosis, 1/0 silicosis. Or in the second model, the same X-ray is read as 1/0 asbestosis, and then two, three, 4 years later by that same B reader or a different B reader is read as 1/0 silicosis, because it saves money not to have to take a second X-ray.

This is the reality that the Committee needs to deal with in terms of drafting language. If the bypass works, then the defendant community that is paying the $140 billion will have to pay tens of billions more again for what would have been asbestosis claims, but are now being dressed up as silicosis claims.

Senator CORNYN. I see my time has expired. I will wait till my next round. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Cornyn.

Senator Feinstein?

Senator FEINSTEIN. Mr. Chairman, actually, this is one of the most informative panels I have heard on the issue, so I want to just thank everybody. Obviously, you all know what you are talking about, so it is very much appreciated.

Let me just ask a couple of questions just to cement this. I guess everybody agrees that asbestosis and silicosis are easily distinguishable. Does anybody not agree to that?

[No response.]

Senator FEINSTEIN. Are there any other asbestos-related diseases that could be confused with silica-related diseases?

Dr. Epstein?

Dr. EPSTEIN. If I may answer that, the answer to that question is no. They are really quite separate diseases.

Senator FEINSTEIN. Anybody differ with that? Dr. Welch?

Dr. WELCH. Well, asbestosis definitely causes lung cancer, and there is some information that silica is a cause of lung cancer, but I do not think it is really relevant to this issue because then you would be having to say that, that you are manufacturing claims of lung cancer in a different jurisdiction. But just to be precise, they both can cause that. Not mesothelioma, however. That is uniquely due to asbestos.

Senator FEINSTEIN. As one who has worked on this issue, and I know the Chairman knows this, and I know Judge Becker knows it too, this is a huge issue. It is really a potential deal-breaker. It is very hard to solve. I would like to ask that each one of you kind of look at the language and come up with some recommendations for us. I particularly think that we do have to prevent dual claiming. I do not know how you would work sanctions for fraud, but I certainly think dual claiming. I think disclosure that was mentioned today, that a claimant would disclose dual claims. I think the occupational history is important to be in the bill so that when you evaluate it, that is in the bill.

My own view is, as we have discussed, Mr. Chairman, that Dr. Rodman was one that did at the end of his written testimony present a possible solution and it is really a medical screening panel. How you set that panel up to really avoid a huge bureaucracy I think is a problem, but I think some of these criteria are important to include in that.

I am very concerned by the growth in silica cases in court now. I do not know how you prevent someone from going to court. Assuming we can make the clear distinction of what the Asbestos Trust would apply to, I do not know how you say to others, "You do not have any remedy." Does anyone have a suggestion there?

Mr. BRICKMAN. Senator Feinstein, if I may, what we have involved here is the economics of mass litigation. The purpose is not to prevent somebody from going to court. Because of the economics of mass litigation, the cost to a defendant to prove that somebody claiming silicosis actually has something that would come under the compensation program and therefore would not be eligible, would be several thousand dollars. It could be three, four, five, six, seven thousand dollars. You multiply that by 10,000, 20,000, 30,000 claimants and you being to see the dimensions of the problem. What you need therefore is to have a procedural device so that the court can dismiss the claim very early on before there are large expenses incurred. That way the plaintiff gets his day in court, but the defendant does not have to spend $10,000 to prove that he really comes under the compensation program and should not get a silicosis award.

Senator FEINSTEIN. What would that process be?

Mr. BRICKMAN. I can provide language I think that would—it is similar to what is being suggested now, but I could certainly provide language procedurally that would accomplish that.

Senator FEINSTEIN. See, I have a problem with this language because I agree that the plaintiff should not have to prove a negative

and it seems to me that this is meant to be for people who are sick, therefore medical criteria are important, therefore a medical screening panel as a deciding point with some references I think is important. I mean what really complicates this is the dramatic growth of silica cases now in court. If you have any further comments, I would very much like to hear them.

Mr. MARTIN. Senator, if I may, I mean when I first started handling silicosis cases it was kind of like boutique litigation. I mean there were not but 150 cases on file in Texas I think back in the 1980's all together amongst five or six firms.

I think the key, as opposed to a medical panel, which might be a little too bureaucratic and costly, I think the key is disclosure. If someone has filed a previous asbestos claim and is coming back into the litigation system, they ought to be able to have to show a good reason for doing that. This language does the opposite. It creates a situation where a victim who has not been in the litigation system, but who has a very debilitating disease such as silicosis or hard metal lung disease, has got to prove that he is not guilty before he even gets to prove his own case.

So I think to look at it from the other perspective, from that perspective, and say these guys up here, maybe they ought to be disclosing that they had a previous lawsuit on file as the trigger point for something else happening to perhaps address Professor Brickman's concern about the cost and the burden that is placed on the litigation system.

Mr. BRICKMAN. May I briefly respond? Disclosure is a necessary but not a sufficient response because that does not—I fully agree that disclosure should be part of the bill, but it is not sufficient because it does not deal with the economic costs imposed on a defendant to prove that this is a national program case that is, that it falls under the FAIR Act, and not one that should be eligible in the tort system.

Senator FEINSTEIN. So what would you do?

Mr. BRICKMAN. I would provide the Committee with language, which I will go back to my office and draft, that I think will deal with that procedural problem of creating an early dismissal process before all of the costs need to be incurred.

Senator FEINSTEIN. Thank you. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Feinstein.

Senator Coburn?

Senator COBURN. Thank you, Mr. Chairman.

And thank each of you for your testimony. I had a good time late last night reading it because we did not have a 48-rule with which I had the time to do it.

I have just a couple of comments. No. 1, as a practicing physician the difference between the restrictive and obstructive patterns seen in these two diseases is not uncommon at all. We see it all the time. There are mixed disease patterns.

My question to each of you is how many times have you seen true clinical silicosis and true clinical asbestosis in non-smokers? Anybody ever seen that?

Dr. WEILL. Senator, are you talking about those two diseases in one patient?

Senator COBURN. In the same patient at the same time.

Dr. WEILL. I have never seen it.

Senator COBURN. Anybody here ever seen, in a non-smoker, true clinical asbestosis and true clinical silicosis?

Dr. WELCH. But I think the testimony was even in the smoker, people do not see them combined, so smoking is not that relevant.

Senator COBURN. I understand, but I am asking specifically about non-smokers?

Dr. RODMAN. I have no recollection, Senator, of having seen it, but theoretically it is possible, and therefore it almost certainly has occurred on occasion.

Senator COBURN. Okay. Now take away the smoking restriction, how often has this panel seen active clinical disease manifested both by chest X-ray and pulmonary function tests and diffusion capacity of the lung, how many times have you seen that in your entire careers in this panel?

Dr. EPSTEIN. Very rarely. I've seen maybe a couple of such cases.

Dr. RODMAN. The same response, I have never. I have no recollection, but I am 77 years old.

[Laughter.]

Senator COBURN. I use that excuse all the time, doctor. I am 40-years-old and I have never seen it.

Mr. MARTIN. I have had two clients.

Senator COBURN. With clinically proven, medically documented pleural plaques and pulmonary nodules—

Mr. MARTIN. Yes. And the distinguishing factor is that along with that, they had specific job histories that involved intense exposure to silica and asbestos both.

Senator COBURN. Dr. Welch?

Dr. WELCH. Yes. I would agree, I have not seen a combined case of the two. I would also want to point out, an occupational history is really important.

Senator COBURN. I agree.

Dr. WELCH. And that is a major criteria in differentiating the two, as well as the X-ray.

Senator COBURN. Dr. Welch, would you do me a favor? I read your resume a moment ago. Would you, after this, give to the Committee, if we may, your references on small-cell, large-cell, adenocarcinoma of the lung related to asbestosis for me so I can review that?

Dr. WELCH. Sure. Actually there was a paper just published this month that is very helpful in asbestos lung cancer.

Senator COBURN. Thank you very much. I would love to have that.

So I just want to make the point, you know, the old adage I was taught when I was in business is "greed conquers all technologic difficulty," and what we are seeing in the personal injury case is that, as the Congress moved to consider asbestosis, the technologic difficulty was to get somebody to read an X-ray a different way for money so that a different claim could be made. We need to not shy away from that. That is what this is all about.

This is about making sure people who have true injury get true compensation and that that compensation goes to the people who are injured more than it goes to the trial bar. And we need to not shy away from trying to be very rigorous in placing demands that

false claims cannot be made out of this asbestos trust and then turned around and turned into something else, because what I see coming is us sitting down to have a silicosis trust, and I do not think we are that very far away. So I believe it is important that people who are injured are compensated, and I want them compensated. But I want us to be real clear about the game that is going on in this country today in the courts that does not have anything to do with my patient's true injury, but has everything to do with how you manipulate the system.

Dr. Welch?

Dr. WELCH. If I could comment on that. I mean I think that there is a difference between the burden of disease in this country from asbestos and from silica. If there are claims that are not silicosis, do not have an impairment, do not have the occupational history, that is a problem. But the asbestos claims that have come forward in this country, the vast majority of them are people who are really sick, mesothelioma, lung cancer. I just want to remind people, the reason there is an asbestos problem, asbestos disease and this bill, is because so many people were exposed and so many people were sick, not because plaintiff lawyers made up bad cases. We would not be creating a billion dollar trust fund if there was not illness out there.

So I am just afraid that the discussion begins to seem like, oh, the whole problem—that you would have to have a silicosis bill because there are bad claims. I mean we have an asbestos bill because people are sick.

Senator COBURN. I do not deny that we have an asbestos bill because people are sick, but I also would not deny the fact that a lot of people have claimed asbestosis when clinically they do not have it, and are seeking compensation for an injury based on exposure, when there is no true injury there. And I think the data will show that true in lots of the claimants.

Mr. BRICKMAN. If I may add, Senator, the vast majority of asbestos claims, claims of disease from exposure to asbestos that have been brought in this country, there have been 850,000 claimants. Each one sues 60, 70, 80 different companies. So you can do the math. The vast majority of those claimants have no medical illness caused by asbestos as recognized by medical science. At least 500,000, maybe 600,000 of those claimants do not have an illness. They have sued in the system. They generate $50,000, $60,000 $70,000 it used to be $100,000 worth of payments made, of which they get about half and the lawyer takes about half for fees and expenses. So I would take issue with Dr. Welch's characterization. I call it Senator, diagnosing for dollars.

Senator COBURN. It also is a reflection on my profession as well for not standing up for what is true and diagnosing for dollars.

Chairman SPECTER. Thank you, Senator Coburn.

Dr. Welch, how would you solve the problem? How would you structure the system to compensate the asbestos victims who are truly sick, and be sure that the so-called double dipping does not occur?

Dr. WELCH. Well, I am neither a lawyer nor a legislator, so my opinion is—

Chairman SPECTER. Puts you in a pretty good position.

[Laughter.]

Dr. WELCH.—somewhat maybe uninformed. But what I hear is the problem is people are filing claims for silicosis who do not have silicosis, that lawyers may be manufacturing claims just based on an X-ray. And if you were to examine that case at all, if anyone were to examine that case from a distance even, they are probably unlikely to have an exposure to silica that is sufficient to cause disease, and the X-ray may not be characteristic.

So from my point of view, if people are paying those claims, that is the problem, and if people are not paying those claims, they will go away. So I do not quite see why you have to craft this legislation. I do not like to think that cases go into court that you could just file any case and you get paid on it, and that is the kind of implication that the testimony is giving, that these claims that clearly are not silicosis are getting paid. So I do not know how you would solve that in the language.

I think Mr. Martin had a good suggestion, that you identify the people who have an asbestos claim, because once you have asbestosis—and this bill does not compensate all the people who applied to Manville Trust. I mean it is more narrow. It is people with impairment. It is not junk cases. I mean this bill does not compensate junk cases. So if people have been compensated under this bill, given the criteria that are there, for most of them it is likely they do not have silicosis, and so they would have to affirmatively prove they have something else to go forward. The burden on those people would probably need to be higher, because as we are saying, we do not expect a lot of combined disease.

Chairman SPECTER. Mr. Martin, you talked about identification of having made an asbestos claim preliminarily. How would you follow up on that in subsequent litigation for somebody who tries to collect on silicosis where there really is no bona fide basis?

Mr. MARTIN. You craft it this way. A plaintiff who has filed a previous asbestos suit would have to disclose that in his pleadings up front. Then in order to overcome a presumption of preemption under the bill, he would have to rebut that presumption by establishing that silica is truly a significant contributing cause of the disease.

Chairman SPECTER. Are you starting to deal with a negative there, proof of a negative?

Mr. MARTIN. Yes, but it is predicated on disclosure, you see.

Chairman SPECTER. Your proof of a negative is different from the other proof of—

Mr. MARTIN. Well, I do not want to be inconsistent, Senator, I truly do not in terms of my criticism of proving a negative. But the issue here is disclosure. If an individual has previously filed an asbestos lawsuit, he should disclose that. That should be the first step. And then some way, whether you create a presumption or not is maybe not the best way to craft it because I am just kind of thinking out loud and brainstorming. Some way, if he truly does have an asbestos disease—and I think everybody on the panel agrees that that would be a very rare instance—that there be some mechanism where he would be able to prove that this is a significant cause, but otherwise, he has to deal with the issue that he has already filed this old suit here.

I think that is where you start from, as opposed to starting from somebody who never filed a lawsuit before for asbestos.

Chairman SPECTER. So there would be a provision in our Federal bill which would impose a disclosure requirement on a plaintiff who sues in some other forum at some other time, and the Federal legislation would deal with a presumption to impact on litigation in some other court, in some other forum, which relates to silica?

Mr. MARTIN. Something along those lines. I am thinking in generalities as opposed to specific language, but it is triggered off disclosure that someone knows that a previous lawsuit for asbestos was filed. Then, you can craft some language that would attempt to deal with Professor Brickman's concern about letting this thing generate too much cost too quickly and being able to address it earlier. I do not know whether that would be through a presumption or some other language. I would have to sit down and craft it.

Chairman SPECTER. It is not going to be dealt with in a summary fashion. It is not going to be dealt with until there is an examination of the proofs, the X-ray. My red light just went on, but it does not apply to answers—only to questions.

[Laughter.]

Mr. MARTIN. I think you are exactly right. There has to be some medical threshold involved there in order to meet that—once that disclosure is made, there has to be some medical threshold established that silica or hard-metal lung disease or cobalt exposure or something else is involved.

Chairman SPECTER. Senator Feinstein?

Senator FEINSTEIN. Clearly, there is a problem. If you go from 2002, with 3,500 cases, to 2003, with 22,000 cases, you have a net gain of cases of 17,000 in a year which indicates to me that something is afoot. I would like to hear from both Professor Brickman and Dr. Epstein. They both seem to have some reaction to Dr. Welch not to be adversarial, but to hopefully come up with a solution here.

Mr. BRICKMAN. Well, one possible solution or, perhaps that is too strong a word, resolution for the silicosis epidemic would be to stop consideration of the FAIR Act. That would reduce the pressure on plaintiff lawyers to retread their cases.

Senator FEINSTEIN. Do you mean just drop an asbestos bill—just forget it?

Mr. BRICKMAN. I predict you would have fewer silicosis claims if you dropped the FAIR Act because that is the reality. This is an entrepreneurial venture, and is a function of the profitability of the claiming process. How much does it cost to generate a claim? It generally costs somewhere about $1,000 to $1,500 for a plaintiff's lawyer to generate a claim. That is through a screening process. Then, it is a question of how much do you get in return for putting that claim in, and that is a function of how many § 524 (g) trusts are being created and what they pay, what solvent defendants are paying and so on.

So the reality is, I mean, as I have testified, and I think there is a considerable volume of evidence on this point, that the silicosis epidemic occurs in perhaps one, maybe two places only—the courts and maybe Dr. Welch's office. But in the Mayo Clinic, in hospitals around the country, in pulmonologists' offices, you do not see sili-

cosis. You only see it in certain courts. There is a disconnect between medical science and what is happening in certain courts, and that disconnect is a mirror image of what has happened with asbestosis claiming, with nonmalignant asbestosis claiming. It is deja vu all over again.

Senator FEINSTEIN. Since you mentioned Dr. Welch's name, would you like to respond to that or do you just want to avoid it?

Dr. WELCH. Well, I am going to ignore the insult, but I do want to say we did spend a lot of time when this bill was starting talking about what claims were, what diseases were, their projections of diseases. And of the asbestos claims, there are a lot of claims that are made for people who are not impaired, and so when you talk about these numbers of claims—but in terms of dollars paid out, it is primarily paid to people with impairment and people with cancer. We are still seeing 2,500 mesotheliomas, most of which are caused by asbestos, every year in this country, a lot of lung cancers.

So the burden of disease—I just want to make it clear—that there are people with asbestos-related disease who are impaired, sick and dying from it. If there are a lot of junk claims as well, my understanding is most of those claims wed not be compensated under this trust because they would not have any impairment. And once someone has an abnormal X-ray, an occupational history and impairment, they are beginning to meet the criteria that would fit under this bill, depending on what their occupational history is.

So you can sort of have both. You can have a lot of junk, but people are not getting compensated for that.

Senator FEINSTEIN. Dr. Epstein and then Dr. Rodman.

Dr. EPSTEIN. I think that there is less of a disparity between Dr. Welch's opinion and mine, certainly about impairment. I would like to point out that probably all of the physicians in this room understand that in order to have silicosis, in order to develop that disease, you have to have a large amount of exposure to silica. This is not a whiff of silica. This is a lot of silica over a long period of time.

Now, the Congress has experience in dealing with this type of problem before. In fact, the Federal Coal Mine, Health and Safety Act did deal with the problem of who comes through the door. And the way the Congress decided to act in the past was that there had to be a certain provable amount of exposure in order to get in the door and be compensated under that act. I think that that may be one of the ways of dealing with this problem, at least have some threshold beyond which an individual can claim silicosis.

Senator FEINSTEIN. Thank you.

Dr. Rodman?

Dr. RODMAN. I have a very strong personal conviction that we are skirting around a very big and important issue, and that is the presence of a few bad apples or—

Senator FEINSTEIN. Turn on your microphone, please.

Dr. RODMAN. My personal conviction is that a major problem that we have not yet addressed directly is the presence of some bad apples in the legal profession and perhaps more bad apples in the medical profession. As long as there are doctors who, on paper, are well qualified, who are willing to read a chest X-ray which they

once said showed signs of asbestosis and re-read it or read a second X-ray on the same patient which does not differ significantly, as showing silicotic changes, I do not think the law will have sufficiently addressed this problem.

Senator FEINSTEIN. Thank you.

Thank you, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Feinstein.

Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman.

As I understand the language that is on the board up here and the process, if someone has a claim of asbestos-related exposure or injury, we are in the process the proposal is to create a $140-billion fund, which is a no-fault, nonadversarial process by which they can be compensated for their asbestos disease. That is the goal. But if they do have asbestos-related disease and they file a lawsuit after that fund is created, then the court could, and should, say you are in the wrong place. You should not be in court. You should be filing your claim against the fund.

So it just makes good sense to me to say that there ought to be some threshold to show that your disease is not related to asbestos if you file a subsequent civil lawsuit. And from what I hear of the medical experts here all arrayed is that ought to be relatively easy for a well-qualified physician to do, to read an X-ray and distinguish between silicosis-related disease and asbestos-related disease.

Would you agree or disagree or have I missed something, Dr. Epstein?

Dr. EPSTEIN. I would agree with that.

Senator CORNYN. Dr. Rodman?

Dr. RODMAN. I would agree, except that my experience has been that many X-rays that I read as showing no signs of asbestos-related changes were differently read by other physicians whose credentials on paper were good and who did see asbestos-related changes when I think none were present. And I think this was—

Senator CORNYN. That is the scandal you alluded to in some parts of the medical profession and even legal profession as well. Unfortunately, we are always going to have unscrupulous people who occasionally will take advantage of the situation.

Dr. WEILL. Senator, may I make one comment?

Senator CORNYN. Doctor? Yes, sir.

Dr. WEILL. I think one way to deal with the unscrupulous nature of some of the B readers out there—

Senator CORNYN. Let me ask you, please, will you tell me whether you agree or disagree that it ought to be relatively easy on the X-ray to distinguish between asbestos- and silicosis-related disease so you could make this sort of showing relatively straightforward.

Dr. WEILL. Yes. In an ideal world, and certainly in the clinical setting, it is easy. However, in the world in which we live, I think because of some unscrupulous B readers, we are in situation where, if your entry into the system is simply to get a B read on an X-ray that is abnormal, that is too low of a threshold. And I think what we ought to do is what some countries in Europe that I visited do is set up panels. I know that may be bureaucratically

difficult to do and cumbersome, but it really helps validate the system and validate the diagnosis.

Senator CORNYN. Our time is a little short. I wanted to ask Mr. Martin, you and Professor Brickman had a discussion about disclosure and whether that would be adequate.

First of all, let me ask you are you involved in this multi-district litigation in Corpus Christi, where these duplicative claims have been made?

Mr. MARTIN. I have one case there. I have never filed a duplicative case in my career. And that one case involves a man with massive conglomeration in the upper lobes with cavitation.

Senator CORNYN. So you are aware at least of the occurrence of people making silica-related claims who have previously made claims for asbestos.

Mr. MARTIN. And that is the concern. And I think the point that you hit on—

Senator CORNYN. My time is short, so let me just get to what I am trying to ask, and we will give you a chance to answer as long as the Chairman does not cut you off.

But will you agree with me, Mr. Martin, that if someone, the disclosure might potentially be a problem, number one, for the lawyer whose client does not tell them the truth, the whole truth and nothing but the truth or perhaps the lawyer, an unscrupulous lawyer, and unfortunately there are bad apples among the legal profession as we all know who does not disclose it, but right now is it not a standard part of basic pretrial discovery in very silica claim, in every asbestos claim, to ask have you filed a lawsuit, have you made claims previously for any personal injury and that sort of thing?

So how would an additional disclosure requirement get us to where we need to be in order to separate and distinguish between these two types of claims?

Mr. MARTIN. The answer to your question is, yes. In terms of the discovery process, it must be disclosed and is typically disclosed.

Senator CORNYN. But, apparently, that discovery process did not reveal, in this instance, and in the story reported in the New York Times related to this whole what appears to be a scandal, where people have made asbestos claims or silica claims and not disclosed—they have either failed to, they have not been asked, they have been asked or they have not told the truth or something has gone wrong. So how do we get over that hurdle?

Mr. MARTIN. Well, I suspect if that is happening that there is a Federal district judge down in Corpus Christi who is going to start knocking some heads off because those are serious problems in court, when you are not being truthful and up-front in answering interrogatories.

But I do think disclosure is the key to—what I am worried about is the fact that I have never filed one of these subsequent lawsuits. I have got a group of guys who are truly sick from independent illnesses, which these men have seen on occasion in their own offices, and I do not want them to be completely precluded because there is a group of people who filed second lawsuits. And this language precludes them from seeking that remedy, and that is the issue of concern.

Chairman SPECTER. Thank you, Senator Cornyn.

In Corpus Christi, they do not knock heads together, they knock them off?

[Laughter.]

Mr. MARTIN. Yes. We are close to the ocean, and we can just knock them right off into the Gulf.

Senator CORNYN. And then they really get tough, Mr. Chairman.

Chairman SPECTER. Well, Senator Cornyn, of course, is an expert at being a Texas Senator, and having been on the Supreme Court and the attorney general, but there appears to be somewhat different standards of conduct, as we are having it described, with two sets of X-rays simultaneously, different markings.

I think it would be very useful for the Committee to hear Judge Becker, some views from Judge Becker. I have asked him if he would care to make a few comments at this point.

Let us turn to Judge Becker.

Judge BECKER. Thank you, Senator.

I think I share Senator Feinstein's comments that this has been an extraordinarily useful hearing. I think we have learned a lot from the experts. My sense is that this problem is soluble by drafting. I think there are certainly flaws in Section 403 of the discussion bill. I do not think it made it clear enough that the intention for discussion purposes was that the preemption would only be for those who qualified for the Asbestos Fund. There not a Catch 22 to put anybody in limbo or in no man's land.

And I think the testimony also makes clear that you cannot rule out any possible contributing factor because of the widespread exposure in the Nation's population to asbestos. I think, however, that some other adjectives like "significant" or "substantial," that it be some significant factor or even a minor factor. In other words, it would have to be more than a minor factor in order to rule out—

Senator FEINSTEIN. Mr. Chairman, would you just allow me one thing?

Could it be primary—primarily?

Judge BECKER. It could be primarily. I mean, that would be one possible solution, Senator Feinstein. I know that was in an earlier draft of yours. But the question that everybody is fighting about is who has got the burden of proof. Everybody talks about not proving a negative.

The problem there, I mean, what we are talking about here is preempting—and this is the overarching issue here—we are talking about preempting cases that are going to be brought in State court. There is no doubt, I mean, what we are saying because these cases, if anybody is going to bring, has a legitimate silica claim, they are going to bring it in State court.

So we are talking about the Congress of the United States preempting—some are going to say this is a kind of tort reform. Does the Congress have the power to do this? Plainly, the Congress has the power to do this. This is the grand daddy of all tort reform bills in terms of abolishing asbestos litigation in State court. But what it would be doing, and plainly the power of the Congress, it is in the Commerce Clause to do so, is regulating practice in State court. I think not only can you do it, but it needs to be done. Among the

things that need to be talked about are disclosure, the question of burden of proof.

But from the point of view of the defense community, the thing that they are upset about, and this is what Professor Brickman was stressing, is defense costs. Because as Dr. Welch says, well, okay, nobody is going to pay these cases, the problem that the defense community has brought to us is, well, if a lawyer has got a thousand of these cases, and they have to defend them, even if it costs $500 or $1,000 to defend each one, that is a big hunk of change.

So, therefore, there has to be some threshold limitation. One of the threshold limitations, as I think might be considered and has not been mentioned here this morning, although the medical basis has been mentioned for it, and we have talked a lot about the unimpaired, is to preempt any claim in State court that is not impaired. In terms of this bill, that would be at least Level III in the medical criteria. Level I, where you get medical monitoring, where you do not get paid anything, those claims arguably could be preempted, and the question is whether or not the medical criteria fit, even though the medical criteria in the bill are different. There is asbestos and silica disease. In terms of the criteria for Level III, with respect to the degree of restriction, and I have them here, and I will not burden the Committee by reading them, but it is 80 percent of lung capacity in certain tests and so forth.

To the extent that this has been described to us this morning, both silica and asbestos are interstitial lung diseases which have the same kind of sequelae, the shoe would fit, and, therefore, you could limit. And another thing that could be considered, in addition to the disclosure, in addition to the idea of a medical panel, and some kind of screening panel. You could, also, and I think we could fiddle with the burden of proof I think language, and I would welcome the opportunity to have my thirty-ninth meeting, thirty-nine steps—I do not know. It was a movie someplace or another, or a book—I would be willing to have my thirty-ninth meeting, and sooner rather than later, like this afternoon or over lunch. You have got everybody here. Let us get everybody in a room, and we do not leave them out—I have the Metroliner schedule, the Night Owl I think is 2 a.m. We will get them tickets on the Night Owl, and we will lock them in a room until we get something worked out. I think we can work something out.

Chairman SPECTER. Judge Becker, that is—

Judge BECKER. I think this combination would work.

Chairman SPECTER. That is an excellent idea.

So why don't we move on to Panel two now, and let us have a designation of those who are going to move from this proceeding to a drafting proceeding.

Panel two is Mr. Paul Hoferer and Mr. Donald Griffin.

Before panel one leaves, let me thank all of you very much for coming. You have already received a number of accolades for your very helpful testimony, and we do appreciate your coming long distances and leaving your professional activities to be in Washington today to provide this testimony. So thank you all very much, and some of you have drafting assignments to be completed after you leave here today.

Mr. Paul Hoferer is Vice President and General Counsel of the Burlington Northern and Santa Fe Railroad. He began working there as a switchman in Kansas City during the summer while in high school, and then spent 3 years in the U.S. Army, including Vietnam and began his career with the Santa Fe law department in Topeka, Kansas, as a trial attorney.

In the year 2000, he received the Paul C. Garrett Award for Meritorious Service to the Association of Railroad General Claims Conference. He has a business degree from Central Missouri State University and a law degree from Washburn University School of Law.

In a sense, I worked for the Santa Fe years ago delivering bills of lading in Wichita at the age of 11.

Thank you for joining us, Mr. Hoferer, and we look forward to your testimony.

STATEMENT OF PAUL HOFERER, VICE PRESIDENT AND GENERAL COUNSEL, BNSF RAILWAY COMPANY, FORT WORTH, TEXAS, ON BEHALF OF THE ASSOCIATION OF AMERICAN RAILROADS

Mr. HOFERER. Thank you very much, Mr. Chairman, members of the Senate Committee. Good morning. As Senator Specter said, my name is Paul Hoferer. I am the Vice President and General Counsel of the BNSF Railway Company, headquartered in Forth Worth, Texas.

My background has given me a rather unique view of both sides of this issue because I worked 7 years as a railroad switchman while I was attending college and law school. As a switchman, I was a member of a national railroad union. I also spent 20 years after law school working as a trial attorney litigating FELA cases, and I am currently responsible for managing the litigation at BNSF Railway Company.

First of all, I want to thank the Committee for the opportunity to present the views of the members of the Association of American Railroads concerning this asbestos act.

The AAR members primarily have two concerns. The first one is the treatment of the asbestos claims under the Federal Employers Liability Act, which we call the FELA, and the second is the potential for claimants to subvert the Act's intent by converting asbestos claims into ones that allege injury for other airborne substances.

Railroads neither manufactured nor distributed asbestos, and had stopped significant use of it by the steam era in the 1950's, roughly 50-some years ago. Despite this, we have been named as defendants in numerous lawsuits brought under the FELA. The FELA covers only rail employees and was enacted in 1908, prior to the State worker's compensation laws to cover employees injured in other industries. That is what the State worker's compensation bills were passed for.

The proposed legislation would cover all asbestos-related injuries, including those which might otherwise have been brought under the FELA. That is as it should be. There is no justification for treating asbestos claims brought by railroad workers any differently than claims brought by other workers in the industries.

Railroad labor has concerns and protested, claiming its members would be treated unfairly. That is not the case. All asbestos claim-

ants, not just railroad claimants, would lose their ability to file any civil litigation and instead would be compensated by the fund.

Rail labor also claims that its members would likely receive less total compensation than other workers because its members would have recourse only to the fund, while employees in other industries would also have a remedy under the worker's compensation laws.

That concern is addressed in the most recent draft of your legislation. It grants railroad employees an additional payment which would be equal to any reduction in benefits that they would have been entitled to if they were covered by State worker's compensation laws. I believe that amendment is one that Judge Becker proposed.

Rail labor says that this isn't enough. Instead, they want to receive additional payments equal to the historic FELA payments for asbestos claims, in addition to the fund. Although the fund is designed to substitute for all tort claims, under rail labor's plan rail employees would be entitled to two payments that are a substitute for tort recoveries or litigation and would include payments to uninjured workers—something the Act seeks to eliminate.

The AAR believes this is unwarranted. Under the tort system, including the FELA, plaintiffs are entitled to only one full recovery for their injury. Indeed, if an asbestos claimant who also sues other defendants, he or she is not entitled to collect multiple, full recoveries. Any settlement with one defendant is offset currently by the FELA settlement.

Having said that, the railroads are negotiating, as was mentioned earlier by the Senator, with rail labor over this issue in an attempt to reach a compromise so that labor can support this legislation. We, too, hope to reach a compromise in this matter. However, our willingness to negotiate is predicated on one condition, that no additional compensation or contribution be made from the railroads to the fund for a special FELA adjustment.

There are several other important elements we think have to be incorporated in any effort to add an FELA special adjustment to this Act. The adjustment must reflect only net FELA payout. I think there was a comment earlier that roughly half of the money does not go to the claimant; it goes to the attorneys and the cost of litigation. Any FELA adjustment will be treated the same way the bill treats worker's compensation. It should be based on objective medical criteria, and no FELA lawsuit should be allowed while the law is passed.

Finally, one brief comment about mixed dust. We too are concerned about the Act's elimination of asbestos lawsuits, and it could be illusory because of the concerns previously expressed. The concern is that the plaintiff will seek recovery from the fund, while at the same time file lawsuits alleging respiratory injury caused by exposure to substances other than asbestos.

I think Professor Brickman and Dr. Weill both mentioned this and covered it more than adequately. I do want to say, though, that we believe that the proposed legislation will represent a fair means of addressing the asbestos lawsuit crisis only if it effectively prevents claimants from controverting asbestos claims into other types of claims.

I stand ready for any questions.

[The prepared statement of Mr. Hoferer appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Mr. Hoferer.

We turn now to Mr. Donald Griffin, who has been a very regular attendee at our stakeholders meetings. He is the Director of Strategic Coordination and Research for the Brotherhood of Maintenance of Way Employees Division of the International Brotherhood of Teamsters, which represents railroad employees primarily engaged in the construction and maintenance of railroad tracks, bridges and other structures.

Prior to his arrival at BMWED in 1996, he was with the law firm of Hyshaw, Mahoney and Clark, here in Washington. He has a law degree from Rutgers, in 1987, and bachelor's degree from the University of California, in 1972.

Thank you for your steadfast attendance at 38 meetings and we look forward to your testimony here today.

STATEMENT OF DONALD F. GRIFFIN, DIRECTOR OF STRATEGIC COORDINATION AND RESEARCH, BROTHERHOOD OF MAINTENANCE OF WAY EMPLOYEES DIVISION, INTERNATIONAL BROTHERHOOD OF TEAMSTERS, WASHINGTON, D.C.

Mr. GRIFFIN. Thank you, Mr. Chairman. On behalf of rail labor, I would like to thank you and Judge Becker and Senator Leahy for all of the hard work you have done here to try to get the parties to reach some sort of understanding on the FELA issue.

Mr. Chairman, I am here today on behalf of all of the rail labor unions within the AFL–CIO, and I speak to you on a matter of great importance to the men and women who are members of those unions.

To know someone suffering from deadly asbestos disease, as I do, and most people who work on the railroad do, is to know that, first and foremost, any legislation in this area must treat the sick and injured fairly. The proposed bill does not treat railroad workers fairly because it takes away a railroad worker's Federal statutory right.

Under this bill, a railroad worker may not bring a claim under the Federal Employers Liability Act, otherwise called FELA, for an asbestos-related injury or illness on the job. All other workers retain full rights to bring claims for asbestos-related injuries or illnesses under State or Federal laws with regard to their specific employers.

I must emphasize that rail labor believes there is no compelling reason to take away rail workers' rights under FELA. Asbestos claims under FELA have not clogged the courts, do not unfairly delay compensation due injury rail workers, and, importantly, do not threaten economic health of the Nation's railroads.

Nevertheless, at the urging of the Chairman and Senator Leahy, rail labor has made a proposal for an adjustment that would fairly compensate railroad workers for their unique loss of worker's compensation benefits provided under FELA. Our proposal is Appendix A to my written testimony submitted to this Committee.

Rail labor's proposal is simple. It follows a pattern used by Congress since 1926 to legislate matters affecting rail labor and rail

management: have labor and management negotiate a mutually satisfactory result. Our proposal provides that labor and management will negotiate quickly to create a fair adjustment to trust fund values for injured rail workers.

If the parties cannot reach agreement, the dispute will be sent to a neutral party to provide a final and binding resolution of the entire dispute. Our goal is to provide a special adjustment to injured rail workers that both labor and management agree is fair—nothing more.

The FELA adjustment contained in the draft bill which is supported by rail management is unfair because most injured rail workers would not receive it. To receive rail management's proposal, the claimant must also apply for an occupational disability payment from the Railroad Retirement Board. What this means, in practice, is that a claimant cannot apply for rail management's proposed adjustment unless he or she has 20 years of service on the railroad. According to the Railroad Retirement Board, over half of the workers in its system do not have 20 years of service. So those employees cannot receive this adjustment.

In addition to the 20-year service requirement, a railroad worker must have a current connection to the industry when or she applies, meaning the employee must be working in the industry. That means a railroad worker with 20 years' service, but who has moved to another non-railroad employer cannot receive the adjustment.

Additionally, all retired railroad workers are ineligible for the adjustment because they lack a current connection. This last point is especially significant because of the long latency periods between asbestos exposure and the manifestation of asbestos-related injury. What this means is that over half of active employees cannot receive the adjustment and all retired railroad workers are ineligible, as well. Under FELA, all of these employees would be eligible to file a claim for an injury against the railroad. Rail labor submits that an adjustment that is not available to the overwhelming majority of potential beneficiaries because they either lack the required railroad service or have worked so long they are retired is unfair.

Finally, I have listened carefully to Mr. Hoferer's testimony today and read his prepared remarks, and wish to make the following brief comment. Rail labor is delighted that rail management has taken up our more than year-old invitation to sit down and work this dispute out through negotiation. Rail labor views the railroads' comments today as affirmation of the soundness of our proposal for a negotiated special adjustment.

In conclusion, rail labor's preferred position would be the preservation of injured railroad workers' rights under FELA. However, if that is not possible, rail labor respectfully requests this Committee to adopt rail labor's proposal for an FELA adjustment.

Thank you very much.

[The prepared statement of Mr. Griffin appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Mr. Griffin.

Mr. Hoferer, there is a statement at pages 8 and 11 of your prepared testimony that, quote, "There should be no continuation of FELA suits after enactment of [asbestos fairness] legislation."

I take it that your real meaning there is that there are to be no more asbestos-related lawsuits.

Mr. HOFERER. That is correct, yes.

Chairman SPECTER. What we are dealing with here is to try to be sure that the rail workers are treated the same as workers generally under State workmen's laws, so that where there is extra compensation or however that treatment is made that the rail workers would be treated the same way.

Is that essentially correct, Mr. Griffin?

Mr. GRIFFIN. That is essentially correct, given that FELA operates substantially different than worker's comp in that it is a tort-based system. But that is the goal.

Chairman SPECTER. Well, we have striven mightily to do that. It seemed to Judge Becker and me at the outset that it was not all that complicated, but it certainly has been. So I am delighted, and I compliment you both on your negotiations and your efforts in good faith to solve the problem. I compliment you even more on agreeing to binding arbitration, if you can't come to an agreement, because I believe that will provide a legislative solution.

I believe that that will effectively take this issue off the table, and I see the group of stakeholders, four in number, who have been at 38 meetings nodding in the affirmative, and I do not think it necessary to encumber the record any further.

With 2 minutes and 55 seconds left, I yield to you, Senator Cornyn.

Senator CORNYN. Does that means I can have the extra two minutes.

Chairman SPECTER. You may.

Senator CORNYN. If I can have that and my 5 minutes, I don't expect to ask a lot of questions, but I do want to say that I think our goal is, both when we talk about silica-related disease and other diseases and how we treat the trust fund, to accomplish two goals.

One is to make sure that the fund is actually successful and compensates asbestos-related disease and people who are actually suffering from that disease. There is also, I think, a related goal of making sure that we sweep in all asbestos claims into the fund, both to maintain the viability of the fund and the size of the fund, but also to make sure that we don't have dual tracks, one under the fund and then one in the tort system, because, frankly, I am reminded from Judge Becker's comments that he said this is tort reform. I have heard it referred to as scandal reform, and I think that really is what we are engaged in. Frankly, there is a consensus that the current system does not operate fairly.

The other principle, I think, that is important is that someone be compensated once for a single, indivisible injury, a basic sort of legal principle. Now, in the workers' comp, and I trust also the FELA area, I would like your comment first, Mr. Griffin.

If you are successful in an FELA lawsuit and you subsequently sue an asbestos manufacturer for the asbestos exposure, then does the FELA claimant—does the plaintiff there have any obligation to offset or to repay to allow that FELA claim to be subrogated to the third-party lawsuit?

Mr. GRIFFIN. Senator, unfortunately I am not one who has normally handled FELA cases. It is my understanding that there may well be an offset. Very often, a plaintiff will bring an action against the railroad only. Some bring actions against both the railroads and manufacturers.

I know railroads have the right, after an FELA judgment against them, to go after third parties on joint and several tort liability theories.

Senator CORNYN. Well, you are not suggesting, Mr. Griffin, that we ought to carve out FELA cases and allow those to proceed and then also permit individuals who are claiming asbestos-related impairment to sue under the trust fund or make a claim under the trust fund for the same indivisible injury, are you?

Mr. GRIFFIN. No. This is actually an asbestos injury. Since the bill as proposed takes away the railroad worker's rights under FELA to bring a claim under FELA for the asbestos-related injury, any recovery for that injury will come from the trust fund and any special adjustment that would accrue to railroad workers. That is the sole source of recovery for the asbestos injury under this bill.

Senator CORNYN. Well, I would say that we ought to have two goals here. One is to make sure that we get as many asbestos-related claims into the fund as we possible can, because there are all sorts of groups and individuals who are trying to get the best deal they can for their group or interest. But, unfortunately, it has the concomitant effect of diluting the likelihood of success of the trust fund itself, and I think we all are interested in making sure that the trust fund actually works.

Mr. Hoferer, can you comment on those two issues, both including everybody into the fund in order to maintain the viability of the fund, and then also the idea of dual compensation or what we used to call double-dipping?

Mr. HOFERER. Sure, I will be happy to. Let me say first of all, a couple of years ago there was a United States Supreme Court decision, *Ayers* v. *Norfolk Southern*, and what it basically did was it allowed some FELA asbestos claimants who were suing the railroad to recover for all of the asbestos exposure caused by prior employers or other parties. The railroad had to pay one hundred percent of that because the Supreme Court said that under the FELA law contribution was not divisible and they had to pay all of the damages, which was a very expensive case.

Under the current proposed legislation, what you have is the ability for everyone to be treated equally. We want the rail employees to be treated the same as anyone else in any industry.

I think the way to do that is to have this measured by the worker's compensation standard. I say that because I believe there is some confusion in talking about this whole subject. The FELA is a lawsuit tort-related matter that is conducted in a courtroom. It has elements of damages that are not covered in worker's compensation. It is a whole different thing.

That is why if the suggestion is that you get to collect under the fund and under the FELA, you are really collecting twice. Even if it is the average, you are collecting twice what the lawsuit damages would be.

Now, on the other hand, you have a situation where the rail workers have a lot of other benefits that are not tied up with the FELA. Mr. Griffin mentioned one of them, the occupational disability annuity. We know that about 98 percent of the people that apply for it have it granted to them. Now, that is for active employees.

We have total disability. That also is available to them. It is the Social Security equivalent. The occupational disability annuity is unique. No other workers in the United States have anything like that. It doesn't exist under Social Security. Then we have sickness benefits. We have the continuing medical benefits if the employee is an active employee. And, of course, they get Medicare if they are retired. So these are all benefits that are in addition to the FELA.

The other thing I would say that is important here is the vast majority of the rail employees who have filed for asbestos claims are retirees, and the reason is quite simple. The true, significant asbestos exposure ended in the 1950s with the steam-era locomotives. You can do the math. You are talking about people that are going to be in their 70s.

I hope that addresses some of your concerns.

Senator CORNYN. Thank you.

Chairman SPECTER. Thank you very much, Senator Cornyn.

We are joined here by Senator Carper, who is a prospective cosponsor of the draft legislation, and in that light we invite him to make a comment.

Senator CARPER. Mr. Chairman, thanks very, very much to you. I want to say something about Seema Singh, the young woman sitting right behind you, and say how much we have enjoyed working with her and other members of the staff of this Committee and the people that are represented in this room and that are watching today. You are well served by her as a member of your staff.

I enjoyed riding down on the train this morning, as I do many mornings. I come from Delaware on the train, and had the good fortune this morning of sitting across the table from a fellow whose picture was in the New York Times business pages, with yours, and that is Judge Becker.

Chairman SPECTER. Odd, he didn't mention it when he spoke.

Senator CARPER. He mentioned he has known you for 53 years, Mr. Chairman—53 years. He told some great stories to everybody on the train about you—no, not really.

Chairman SPECTER. Well, in that event, you can go ahead.

[Laughter.]

Senator CARPER. I want to say to Judge Becker, God bless you. Thank you for the time and energy and intellect that you have put into this. If we end with a bill, in no small measure the credit will be yours.

Mr. Chairman, I am encouraged by hearing rail management and rail labor sit at the same table and say this is one they think they can work out, and that they are determined to do that, and if they can't hammer it out, to turn to binding arbitration. I want to commend you. That is the kind of spirit that we need to be able to resolve some other difficult issues on this bill.

People have asked me do I think in the end this is going to be a partisan bill or not. I certainly hope not. I certainly hope we have

a bipartisan bill, maybe a consensus bill. That could be the triumph of man's hope over experience, but I don't know that it needs to be.

I know the Chairman has done a huge amount of work on this and has a strong and abiding interest in this issue and coming to a fair resolution, as does Senator Leahy, as does Senator Feinstein, who has put enormous effort into this. I hope, in the end, that the bill that emerges from this Committee will be something very much like a consensus and we will end up with 75 or 80 people voting for it on the floor, and maybe convincing our friends in the House that the better part of valor here is to maybe side with the Senate on this one.

I commend you for your efforts. I look forward to continuing to work with you and hope to be a cosponsor in the near future. Thanks, Mr. Chairman.

Chairman SPECTER. Well, thank you very much, Senator Carper, for those kind comments.

Thank you, Mr. Griffin and Mr. Hoferer.

Mr. GRIFFIN. Thank you.

Mr. HOFERER. Thank you, Senator.

Chairman SPECTER. I think this has been a very useful hearing and we are going to plod ahead to try to get this all done.

Mr. HOFERER. Good luck to you, sir.

Chairman SPECTER. That concludes the hearing.

[Whereupon, at 11:45 a.m., the Committee was adjourned.]

[Questions and answers and submissions for the record follow.]

[Additional material is being retained in the Committee files.]

QUESTION AND ANSWER

Senator Coburn
Follow-up Document Request for Dr. Laura Stewart Welch:

Please provide the Committee with your references on small-cell and large-cell adenocarcinoma of the lung related to asbestosis. Please include the paper that you mentioned in the hearing that was just published this month on asbestos-related lung cancer.

Asbestos, Asbestosis and Lung Cancer

All major types of lung cancer are caused by asbestos. Numerous studies show that there is a dose-response relationship between exposure to asbestos and the risk of lung cancer, with increasing exposure leading to increasing risk of disease. Workers with asbestosis have a higher risk of lung cancer than asbestos exposed workers without asbestosis, but in this case the asbestosis may simply be a surrogate measure of exposure; significant asbestos exposure is required to cause asbestosis.

Some express the opinion that clinically diagnosed asbestosis must be present in order to attribute a lung cancer to asbestos exposure. To understand the relationships between asbestos exposure, asbestosis and lung cancer, several important characteristics of radiological detectable asbestosis must be described. One, the likelihood of developing asbestosis increases with the amount of asbestos dust inhaled. Second, workers who smoke have a higher likelihood of developing asbestosis, because of reduced clearance of asbestos from the lung (smoking damages the lungs' defense mechanisms). Third, asbestosis is a disease that generally takes 15 or more years to develop. All three factors also describe the likelihood of developing an asbestos-related cancer: increasing risk with increasing dose, higher risk in a smoker, and a substantial latency between onset of exposure and onset of disease. Therefore it is clear that workers with asbestosis will have a higher risk of lung cancer than workers without asbestosis, on average.

The question at issue is not whether workers with asbestosis have a higher risk of lung cancer than workers without asbestosis, but whether workers without asbestosis have a risk of lung cancer increased above that of the general population. Many well-conducted epidemiological studies support a direct relationship between asbestos exposure and risk of lung cancer, and show an elevated risk of lung cancer in asbestos-exposed workers in general.

An international group developed the Helsinki criteria for attribution of lung cancer in asbestos exposed workers, and concluded that an exposure of 25 fiber-years, or the equivalent exposure using an occupational history, in the absence of any other disease, doubles the risk for lung cancer. Several European countries have established this or a similar level of exposure as the criterion to be used for compensation of a lung cancer in an asbestos exposed worker. The current version of the trust fund requires a number of weighted years of exposure to asbestos, ensuring that only cases of lung cancer with substantial exposure to asbestos are compensated under the fund.

Smoking and asbestos act in concert to cause lung cancer, each multiplying the risk conferred by the other. In a large study of asbestos insulation workers in North America, non-smoking asbestos workers were five times more likely to die from lung cancer, smokers not exposed to asbestos were approximately 10 times more likely to die from lung cancer, and asbestos workers who smoked were more than fifty times more likely to die from lung cancer. Asbestos workers who stopped smoking demonstrated a sharp decrease in lung cancer mortality. Although smoking does increase the risk of lung cancer, this effect does not detract from the risk of lung cancer attributable to asbestos exposures. The risk of lung cancer after exposure to asbestos is related to the amount of asbestos inhaled.

References:

There are a large number of studies that establish asbestos as a cause of lung cancer; those are not included here, except for a reference to an OSHA document that reviewed that literature, a review from the International Agency for Research on Cancer (IARC) and a few of the pertinent Selikoff papers. These remainder of the references focus on the question of whether or not asbestosis is a necessary condition before a lung cancer can be attributed to asbestos exposure. The paper published most recently is the one by Cullen et al.

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SUBMISSIONS FOR THE RECORD

STATEMENT OF LESTER BRICKMAN
PROFESSOR OF LAW, BENJAMIN N. CARDOZO SCHOOL OF LAW
OF YESHIVA UNIVERSITY

BEFORE THE UNITED STATES SENATE COMMITTEE ON THE JUDICIARY
CONCERNING
"ASBESTOS: MIXED DUST AND FELA ISSUES"

February 2, 2005

Mr. Chairman and members of the Committee, I am Lester Brickman, a Professor of Law at the Benjamin N. Cardozo School of Law of Yeshiva University. I thank you for inviting me to speak at this hearing about "Asbestos: Mixed Dust and FELA Issues." For the record, let me indicate that I am not representing any party or other entity with an interest in asbestos litigation or legislation. Moreover, I am not being compensated for my testimony.

For almost fifteen years, I have devoted considerable scholarly effort to the issue of asbestos litigation and more than a decade ago, drafted a proposed administrative alternative to asbestos litigation at the request of a federal executive branch agency. I welcome your interest in addressing a critical issue in the proposed National Asbestos Compensation Program to be created by the Fairness in Asbestos Injury Resolution (FAIR) Act. As proposed, the FAIR Act has a provision that would effectively preclude claimants with asbestos related conditions from bypassing the National Asbestos Compensation Program and filing ostensible silica claims in state and federal courts seeking recovery for what is in reality the asbestos-related condition (or, even worse, filing a claim with the program and then seeking additional money for the same medical condition by pursuing silica claims in court). If this protective provision is eliminated or diluted, the claimants will be able to seek recovery twice against many of the same companies

for the same alleged injury and will encourage continuation of the asbestos litigation scandal under another name.

While the proposed legislation will hopefully bring some finality to the asbestos exposure tragedy and the ensuing asbestos litigation morass, changing the bill to eliminate this protection against double claiming will regrettably open the door to another elephantine mass of mostly baseless litigation. Specifically, it would create a significant danger that the mass filings of non-malignant asbestos claims generated by mass screening companies will be replicated and that asbestos claims will be regenerated as non-malignant silica claims. In fact, lawyers, the mass screening companies they employ, and the comparative handful of B-readers and other doctors they regularly retain, have in anticipation of federal asbestos legislation, already focused on a phenomenon known as "retreading," or turning asbestos claims into silica claims. If given a green light by the deletion of the provision in question, we can anticipate another massive failure of the civil justice system; retreaded silica claims will overwhelm the state and federal courts.

As you are all well aware, asbestos exposure has resulted in a national tragedy. A carcinogenic substance which has resulted in more than 100,000 deaths has been transformed into a malignant enterprise. As with asbestos, excessive silica exposure can also result in serious lung disease and even death. But also, as has been the case with asbestos, baseless claims are mounting exponentially. And, as with asbestos, the tragedy of silica exposure is being transformed into an enormous money making machine in which baseless claims predominate. And, as with asbestos litigation, this will not only deprive those with serious injuries of just compensation but also negatively affect job creation and shareholder value.

My testimony will consist of:

I. QUALIFICATIONS

Over the past fourteen years, I have devoted a substantial amount of time to research on asbestos litigation. Because of my expertise, I was requested by the Administrative Conference of the United States, an executive branch agency of the federal government, to draft a proposed administrative alternative to asbestos litigation and to organize a colloquy to consider and debate that proposal.[1] I have published four articles on asbestos litigation;[2] in these articles, I discuss the nature of asbestos-related disease; the history of asbestos litigation, including the phenomenon of the unimpaired claimant; the rise of an entrepreneurial model including attorney-sponsored mass screenings, the use of a comparative handful of B-readers who regularly over-diagnose x-rays and are induced to do so by substantial financial incentives, the administration of pulmonary function tests by screening enterprises that rarely conform to American Thoracic Society standards, and the use of witness coaching techniques that include the implantation of

[1] Administrative Conference of the United States, Colloquy: *An Administrative Alternative to Tort Litigation To Resolve Asbestos Claims,* October 31, 1991, Transcript at 4.

[2] *The Asbestos Litigation Crisis: Is There A Need For An Administrative Alternative?*, 13 CARDOZO L. REV. 1819 (1992); *The Asbestos Claims Management Act of 1991: A Proposal To The United States Congress*, 13 CARDOZO L. REV. 1891 (1992); *Lawyers' Ethics And Fiduciary Obligation In The Brave New World Of Aggregative Litigation*, 26 WM. & MARY ENVTL. L. & POL'Y REV. 243, 272-98 (2001); *On The Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, 31 PEPP. L. REV. 33 (2004).

false memories; the effective hourly rates generated by contingent-fee-financing of the litigation and the effect of those fees on the litigation; the use and effects of forum selection; the impact of mass consolidations; and the culmination of the litigation in the bankruptcy of many former producers and sellers of asbestos-containing products and the administration of that bankruptcy process. These same issues and facts predominate in the silica litigation.

I have also recently been selected by President Bush to appear with him at "An Asbestos Litigation Conversation," which was held in Macomb County, Michigan, to explain to the audience how asbestos litigation had developed and why it was of critical importance to enact legislation to remove the litigation from the courts.

I append to this Written Statement an Appendix setting forth my qualifications in further detail.

II. OVERVIEW

I do not intend this morning to discuss particular legislative language. Instead, I want to focus on why allowing claimants to recover from the National Asbestos Compensation Program for asbestos-related injuries and then separately to recover through litigation by claiming silica-related injuries would create a clear and present danger. This danger is a function of the same entrepreneurial screening activity that I described in detail in my article "On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality," published by the Pepperdine Law School a year ago.[3] It is the mass conversion of bogus asbestos claims into bogus silica claims by the same plaintiffs' lawyers, screeners and B-readers that have made asbestos litigation into a national scandal. I took note of that occurrence in my law review

article, where I stated that "the developing silicosis litigation phenomenon appears to be an attempt to replicate asbestos litigation and recycle asbestos claims."[4] I have since had an opportunity to focus more specifically on silica litigation and can now report additional findings.

When the Congress started to focus seriously on creating an administrative resolution of asbestos claims, entrepreneurial lawyers and the mass screening enterprises that they spawned began to shift their efforts to the manufacture of silica lawsuits. Currently, these mass screenings are manufacturing silica claims at a rate never seen before. Just as there is a disconnect between medical science and claims of asbestosis, so too with silica claims. Here too, medical science offers no explanation for this by now familiar phenomenon. It can only be explained by the entrepreneurial litigation model. It involves the same process and the same individuals and firms that created entrepreneurial asbestos litigation. Further, and no doubt most troubling for any company which contributes to the National Asbestos Compensation Program, lawyers are using these same screening companies and physicians to morph or "retread" their prior asbestos diagnoses into silica diagnoses for the very same injuries.

These retreaded "asbestos-to-silica" claims must be dealt with by legislation. Silica litigation in key jurisdictions such as Mississippi and parts of Texas already has the hallmarks of a burgeoning mass tort: Mass screenings, mass "diagnoses," mass claims, and coerced mass settlements of mostly bogus claims when courts resort to aggregations to clear their calendars. With thousands of silica cases already clogging the courts, experience with asbestos litigation plainly indicates that we cannot rely entirely on the judicial system to separate the few bona fide

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[3] *See* Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2.
[4] *Id.* at 46-47, n.29.

silica claims from the mass of retreads. What is needed is a mechanism that separates the asbestos claims from genuine silica claims at the outset of a case. Moreover, in light of the numerous claims already retreaded and filed in the tort system, a claimant making a claim against the Compensation Program should be required to fully disclose whether he has previously made a claim involving asbestos exposure or has a medical or laboratory report indicating asbestos-related disease.

III. A LEGAL NOT MEDICAL EPIDEMIC

Only recently has silica litigation exploded. In the first half of 2003 alone, more than 17,000 plaintiffs filed suit.[5] While one company was facing 3,505 claims in 2002, the next year it was facing 22,000 silica claims.[6] Similarly, as of September 2003, one insurer identified 30,000 silica cases brought against its insureds compared to 2,500 cases it had one year earlier.[7] Illustrating this trend is the Federal Silica MDL 1553 ("MDL") that now involves over 10,000 plaintiffs predominately from cases initially filed in the Mississippi state courts and removed to Federal court.[8]

This rise in silica claims in the last few years seems incompatible with observations in the medical literature. I am not a medical doctor, but a few examples from the medical literature

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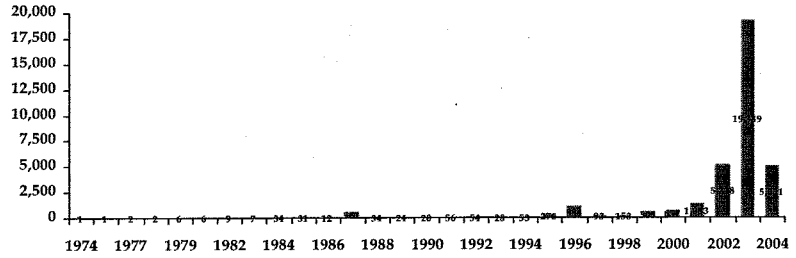
[5] *See* Brief in Support of Joinder and Response of Textron Inc., Norton Company and Siebe North, Inc., in the Motion to Transfer Under 28 U.S.C. § 1407 at 3 (filed July 15, 2003), *In re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).
[6] Susan Warren, *Silicosis Suits Rise Like Dust*, WALL ST. J., Sept. 4, 2003, at B5.
[7] Jonathan Glater, *Suits on Silica Being Compared to Asbestos Cases*, N.Y. TIMES, Sept. 6, 2003, at C1.
[8] Information based upon the number of plaintiffs in Complaints filed in Multidistrict Litigation, MDL Docket No. 1553, U.S. Southern Dist. Texas. *See* Email from Daniel Mulholland to Lester Brickman (February 1, 2005) (on file with the author).

demonstrate the lack of a medical epidemic. From 1950 to 1979, for example, Massachusetts General Hospital reported only 15 cases of silicosis and coal worker's pneumoconiosis.[9] From 1980-1987, the Mayo Clinic found only 10-25 cases of silicosis per year from the approximately 250,000 patients seen annually.[10] Between the two periods of 1969 to 1981 and of 1982 to 2001, the death rate for silicosis had dropped 70%.[11] As one journalist noted, "litigation is rising at the same time deaths from silica are falling . . . ."[12]

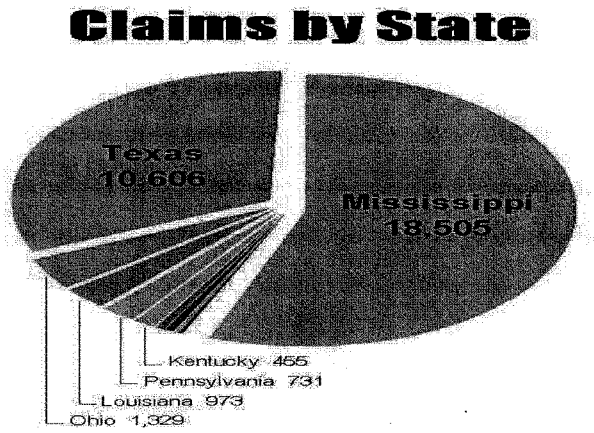
Further, prior to 2001, there had never been a year in which more than 1,000 plaintiffs filed suit for silica related injuries. Yet in 2003 alone, 19,389 plaintiffs filed suit – more than in the previous thirty years combined. The chart below illustrates the silica litigation epidemic.

Silica Claims by Year[13]



[9] Theresa C. McLoud et al., *Chronic Diffuse Infiltrative Lung Disease*, 5(2) CLINICS IN CHEST MED. 329, 339 (June 1984).
[10] RICHARD A. DEREMEE, M.D., CLINICAL PROFILES OF DIFFUSE INTERSTITIAL PULMONARY DISEASE 46 (1990).
[11] M. D. Attfield et al., *Changing Patterns of Pneumoconiosis Mortality – United States, 1968-2000*, 53(28) MORBIDITY & MORTALITY WEEKLY REP. at 627-32 (July 23, 2004), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5328a1.htm.
[12] Jerry Mitchell, *Silica Suits Latest to Hit Miss. Courts*, THE CLARION-LEDGER (Jackson, Miss.), Oct. 19, 2003, at 1A.
[13] This claim information comes from a major silica defendant which has requested that the company name not be disclosed. I am authorized to disclose it to the committee's staff, if necessary.

Further, these claims are being brought in a relatively few jurisdictions as illustrated below. Just as with asbestos, silica claims are largely brought in "magic" jurisdictions such as Mississippi and certain parts of Texas.[14] For example, nearly 90% of claims filed to date against one company were in Mississippi or Texas. [15]



One obvious question is why has there been such a marked increase in silica claims in the last few years when the medical evidence points to a disappearing disease. The answer is simple. It involves the same reasons that account for the hundreds of thousands of non-malignant

[14] *See, e.g.*, Jerry Mitchell, *supra* note 12; Jonathan D. Glater, *supra* note 7; James Doran and Helen Leonard, *Claims surge as US lawyers see silica as the new asbestos*, TIMES (London), Sept. 10 2003, at 4M. For an explanation of the term, "magic jurisdiction," *see* Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2, at 39 n.17.

[15] This claim information comes from a major silica defendant which has requested that the company name not be disclosed. I am authorized to disclose it to the committee's staff, if necessary.

asbestos claims which I describe in my Pepperdine article.[16] It is the application of the entrepreneurial model to silica, beginning with mass screenings sponsored by lawyers who have the economic incentive to convert asbestos claims to silica claims – perhaps motivated by the concern that the asbestos litigation end game has begun. Heath Mason, the co-owner of the mass screening entity N&M, Inc., testified that the reason his company started focusing on silica cases was because of a previous version of the very legislation that is before this Committee:

> Q. With respect to testing that's being done by N&M these days, would you say that N&M is doing more silica testing versus asbestosis or what is the breakdown? . . .
> A. I would say at the particular time that we did those tests we were doing more silica than we were doing asbestos.
> Q. And is that true today?
> A. As of the last month with the Hatch bill, yes, sir, I would say that it is.
> Q. And has the Hatch bill influenced your business?
> A. For sure.
> Q. Has it influenced it in terms of better or worse?
> A. From an asbestos standpoint, I would say worse.
> Q. Has it increased your business for silicotics . . . testing?
> A. I would say what it does is, it gets lawyers to have to change gears on what they think is going to work.[17]

In other words, some asbestos lawyers simply are diversifying their litigation portfolios by using the proven screening machinery already in place. As one silica attorney ventured, "[w]hy reinvent the wheel?"[18]

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[16] *See* Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2.

[17] Deposition Transcript of N&M, Inc., Representative: Charlie Heath Mason at 272-73 (taken July 8, 2003), *Curtis Johnson v. American Optical Corporation* and *James Underwood v. American Optical Corporation* (Cir. Ct. of Copiah County, Mississippi) (Nos. 2002-0030 and 2002-0027).

[18] Susan Warren, *supra* note 6; *see also* Eddie Curran, *Trial lawyers say: If asbestos cases bad, why settle them?*, MOBILE REGISTER, Mar. 28, 2004, *available at* http://www.al.com/specialreport/mobileregister/?asbestos/triallawyers.html ("Testing companies such as Respiratory Testing Services increasingly test for silica and asbestosis at the same time, often diagnosing both diseases, which can lead to separate claims on behalf of the same person.").

Advertisements routinely list screenings for both asbestos and silica. An advertisement for May 31, 2002 screening states in bold letters, "ASBESTOSIS, MESOTHELIOMA CANCER, LUNG CANCER OR SILICOSIS",[19] a billboard in Indiana read, "Have YOU been tested? ASBESTOS/SILICA DISEASE SCREENING",[20] and statements such as, "You may have silicosis and asbestosis at the same time. So, even if you have an asbestos case you should be tested for silicosis."[21]

IV. DUAL DIAGNOSES

The fact that lawyers use certain mass screening companies and a handful of physicians to generate dual diagnoses, one for asbestosis and one for silicosis, is a relatively recent phenomenon. In my Pepperdine law review article,[22] I described an x-ray that a physician had read for which he issued two separate narrative diagnostic reports for the same individual. In one report, he interpreted the x-ray as consistent with silicosis and without pleural plaques or pleural calcification. In the other report, which was written on the same day, he interpreted the same x-ray as consistent with asbestosis with a diaphragmatic plaque on the left.[23] At the time of writing that article, this was the most direct evidence I had that the screening process was generating separate silica and asbestos claims for the same people. Through the discovery done and in progress in the MDL, I have learned that this is not at all a rare event. Quite to the

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[19] *See* Advertisement, POST (Vicksburg, Miss.), May 26, 2002.
[20] *See* Billboard on Indiana Interstate, Nov. 2002.
[21] *See* Frances E. Leon, Jr., "News and Updates," available at http://www.frankleon.com/news.htm (last visited Jan. 30, 2005).
[22] Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2.
[23] Redacted copies of Dr. Walter Oaks' reports are attached.

contrary, the generation of subsequent and even simultaneous diagnoses appears to be quite common.[24]

In fact, it appears that at least 60% of the silica plaintiffs in the MDL also have or had asbestos claims. In the MDL, defendants provided the Manville Personal Injury Settlement Trust (a trust set up for asbestos claims after the Johns-Manville bankruptcy) with a list of the plaintiffs in the MDL. At that time, there were 8,629 silica plaintiffs in the MDL who had provided defendants with enough information to enable the Manville Trust to determine whether the plaintiffs had previously filed an asbestos claim with the Trust.[25] It turns out that 5,174 of the 8,629 plaintiffs, or 60%, had previously filed an asbestos claim with the Manville Trust.[26] One would expect a similar result for silica lawsuits pending in other jurisdictions.

This dual diagnosing phenomenon occurs in various ways. First, it can involve the situation described earlier where a physician interprets an x-ray, but then issues two separate "consistent with" disease diagnostic reports – neither of which refers to the other finding. Diagnosing report A finds that the plaintiff has changes "consistent with asbestosis" with no mention of silicosis. Diagnosing report B finds that the plaintiff has changes "consistent with

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[24]A few anecdotal reports describe the phenomenon. Noah Myers Bufkin of Lucedale, Mississippi was diagnosed with silicosis at a mass screening. He can't say for sure that he has any symptoms – he couldn't finish a stress test but said it might be due to old age. The same screening company diagnosed him as having asbestosis several years ago. He received $10,000 from that suit. *See* Jerry Mitchell, *supra* note 12. Also, Clifford Dees, a former boiler department worker at International Paper Co., has been diagnosed with asbestosis. "Dees was later asked to return to N&M to be tested for silicosis . . . . He was diagnosed with that as well, he said." "Dees has received only about $3,000 for asbestosis, including one check for $45, and nothing yet for silicosis. But . . . he has been told by his lawyers that he can expect considerably more money in years to come." Eddie Curran, *From Checkup to Check*, MOBILE REGISTER, Apr. 4, 2004, *available at* http://www.al.com/specialreport/mobileregister/?asbestos/checkup.html.

[25] When the defendants submitted the list of plaintiffs' names to the Manville Trust, there were 9,309 plaintiffs in the MDL. Of these 9,309 plaintiffs, only 8,629 had produced sufficient information such as social security numbers to enable the Manville Trust to run the match.

silicosis" with no mention of asbestos.[27] Heath Mason of N&M testified that his company pays Dr. Ray Harron $50 extra to write a second diagnostic report for silicosis based upon the same tests the physician relied upon that day to diagnose the individual with asbestosis.[28] Because of the "bargain" it received on Dr. Harron's second report, N&M only charged its law firm customers half price for the bonus silica diagnosis.[29]

Another variation of this dual diagnosis practice involves a physician rendering a single diagnosing report that identifies both silicosis and asbestosis.[30] A third variation involves a physician rendering an asbestosis or silicosis diagnosis based upon an x-ray and then later, the same or another physician, interprets the same or another x-ray and issues another separate diagnosing report but for the other disease.[31]

All of these variations have one common goal: To keep the asbestos-litigation gravy train alive and in many cases require some companies to pay the same individuals twice for the same injuries. It is incumbent on this Committee to report out a bill that will foreclose this double indemnity.

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[26] Email from Jared Garelick, Senior Attorney, Claims Resolution Management Corporation, of the Manville Personal Injury Settlement Trust (January 31, 2005).
[27] *See* Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2, at 47 n.29
[28] Deposition Transcript of N&M, Inc., Representative: Charlie Heath Mason, *supra* note 17, at 152-56.
[29] *Id.*
[30] Redacted copies of Dr. Dominic Gaziano's reports are attached.
[31] Redacted copies of Dr. Ray Harron's and Dr. James Ballard's reports are attached.

V. SILICA CLAIMS PROBLEMS

Much of the information that has been discovered in the MDL to date is disturbing to say the least. The MDL currently has over 10,000 plaintiffs.[32] The vast majority of these plaintiffs' lawsuits were the result of litigation-driven mass screenings using a handful of physicians. Very few, if any, of these plaintiffs were ever diagnosed with silicosis by his or her treating physician.[33] As Heath Mason of N&M has explained: "[W]e have no doctor-patient relationship with these people."[34] Instead nearly every plaintiff was diagnosed by the same handful of B-reader physicians used by the lawyers to support the mass filings of non-malignant asbestos claims.[35] Further, only five B-readers were responsible for over 7,000 silicosis diagnoses in the MDL.[36] One of these physicians diagnosed 111 people in a single day; another averaged 75 diagnoses per day, and a third diagnosed 225 plaintiffs on April 19, 2004.[37]

The MDL cases also involve some of the same physicians that have been discredited by previous studies. A study published in *Academic Radiology* casts doubt on the validity of certain physicians' B-reads.[38] In that study, the authors set up a blinded panel of B-readers to interpret 492 chest x-rays previously read by physicians employed by plaintiffs' lawyers. The plaintiffs'

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[32] Information based upon documents produced in Multidistrict Litigation, MDL Docket No. 1553, U.S. Southern Dist. Texas. *See* Email from Daniel Mulholland to Lester Brickman (February 1, 2005) (on file with the author).
[33] Motion to Strike Plaintiffs' Diagnoses, And For Judgment at 5 (filed June 4, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).
[34] Eddie Curran, *Testing Firms Contend They are Not Practicing Medicine*, MOBILE REGISTER, Apr. 4, 2004, *available at* http://www.al.com/specialreport/mobileregister/?asbestos/firms.html.
[35] *See* Supplemental Report of Dr. Joseph N. Gitlin at 10 (filed Nov. 10, 2004), *In re: Owens Corning* (Bankr. D. Del.) (Nos. 00-3837 to 3854); Motion to Strike Plaintiffs' Diagnoses, *supra* note 33 at 5; Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2.
[36] Motion to Strike Plaintiffs' Diagnoses, *supra* note 33, at 5.
[37] *Id.* at 5-6.

doctors had found that 95.9 percent of the x-rays were positive for changes consistent with asbestos.[39] The blinded panel, however, found that only 4.5 percent of the x-rays had changes consistent with asbestosis.[40] One of the subject B-readers in this study has diagnosed at least 2,400 of the plaintiffs in the MDL.[41] Another one is responsible for at least a thousand B-reads in the MDL.[42] Additionally, the Manville Trust conducted an audit of its x-rays and found that the ten B-readers with the highest volume of claims had a failure rate from 34% to 70%.[43] Many of these same B-readers involved in the Manville audit are plaintiffs' B-readers in the MDL as well.[44]

Further, Dr. Gary Friedman issued a report analyzing x-ray reports, pulmonary function tests and other data for a representative sample randomly selected from 22,578 asbestos non-malignant claims submitted to Owens Corning's National Settlement Program.[45] He found that only five B-readers accounted for over 80% of the claims and had findings that were "not consistent with the spectrum of non-malignant asbestos related disease identified within the peer review literature authored by plaintiff's experts or authors deemed authoritative by plaintiff

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[38] Joseph N. Gitlin et al., *Comparison of "B" Readers' Interpretations of Chest Radiographs for Asbestos-Related Changes*, 11 ACAD. RADIOLOGY 843 (Aug. 2004).
[39] *Id.* at 843, 851, 855.
[40] *Id.*
[41] *See* Supplemental Report of Dr. Joseph N. Gitlin, *supra* note 35, at 10; Motion to Strike Plaintiffs' Diagnoses, *supra* note 33, at 5. This physician is Dr. Ray Harron.
[42] *See* Supplemental Report of Dr. Joseph N. Gitlin, *supra* note 35, at 10; Information based upon documents produced in Multidistrict Litigation, MDL Docket No. 1553, U.S. Southern Dist. Texas. This physician is Dr. James Ballard according to discovery records produced to date in the Silica MDL 1553.
[43] *See* Lester Brickman, *On the Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality*, *supra* note 2, at 108.
[44] Affidavit of Patricia Houser, Ex. 42 (filed March 31, 1999), *In Re Manville Personal Injury Settlement Trust Medical Audit Procedure* (E.D and S.D.N.Y.) (Master File No. 98 Civ. 5693); Motion to Strike Plaintiffs' Diagnoses, *supra* note 33, at 5.
[45] Report of Dr. Gary K. Friedman, Prepared for Owens Corning, undated, circa 5/02, "Owens Corning Non-malignant Claim Submissions 1994-1999" (approx.) at 2.

experts."[46] (Emphasis in original). These B-readers included Dr. Harron and Dr. Ballard,[47] who are two of the handful of B-readers who account for most of the cases in the MDL.[48]

The reason the plaintiffs are being diagnosed by the same physicians who diagnosed scores if not hundreds of thousands of plaintiffs in the asbestos litigation is that they are following the same practices and procedures that have been used to generate the massive number of non-malignant asbestos tort claims. Heath Mason of N&M testified that there is no difference between an asbestos and silica screening.[49]

N&M was responsible for screening approximately 6,577 of the plaintiffs, or approximately 65% of the MDL.[50] Over 90% of these plaintiffs were screened in a short period of time, from July 2001 to September 2002.[51] To put the matter in its proper perspective, N&M, which screens for litigation purposes, has found at least 40 times more silicosis cases in just over one year than the Mayo Clinic treated in seven years.[52] Recall that this is the same screening company that its owner testified pays a physician $50 to render a separate silicosis diagnostic report in addition to an asbestos diagnostic report.[53]

This extraordinary accomplishment begins to make more sense when we consider that three physicians who worked for N&M and who together seemingly diagnosed about 3,700 plaintiffs, all later withdrew their silicosis diagnostic reports. Each one testified that N&M had

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[46] *Id.* at 10, 22.
[47] *Id.* at 18-22.
[48] Motion to Strike Plaintiffs' Diagnoses, *supra* note 33, at 5
[49] Deposition Transcript of N&M, Inc., Representative: Charlie Heath Mason, *supra* note 17, at 34.
[50] Information based upon documents produced in Multidistrict Litigation, MDL Docket No. 1553, U.S. Southern Dist. Texas.
[51] *Id.*
[52] *See* DEREMEE, *supra* note 10, at 46.
[53] Deposition Transcript of N&M, Inc., Representative: Charlie Heath Mason, *supra* note 17, at 152-56.

inserted diagnostic and prognostic language into their reports and these physicians refused to adopt that language at the time of their depositions.

Dr. George Martindale withdrew approximately 3,700 purported diagnoses as "overstatements."[54] Although plaintiffs' counsel had submitted reports from Dr. Martindale purporting to be his diagnoses, Dr. Martindale testified that he never intended to make a diagnosis of silicosis on any of the plaintiffs.[55] In fact, Dr. Martindale testified that he did not even know the criteria for diagnosing silicosis.[56] Dr. Martindale testified that he got into the asbestos/silica screening business to supplement his income and was paid $35 a read by N&M.[57]

Dr. Glyn Hilbun testified that he was hired by N&M for $5,000 a day for five days, or $25,000, to do abbreviated physical examinations at certain screenings.[58] He, however, testified that N&M had inserted language on his reports without his knowledge that purported to say that he had diagnosed the plaintiffs with silicosis.[59] To the contrary, Dr. Hilbun testified that he had never diagnosed silicosis in his life.[60]

Dr. Kevin Cooper worked for N&M for what he called "easy money."[61] He also testified that N&M hired him only to do abbreviated physical examinations at certain screenings, but that he had never diagnosed silicosis before and did not intend to diagnose any of the 239 plaintiffs

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[54] Deposition Transcript of George Martindale, M.D. at 103 (taken Oct. 29, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).
[55] *Id.* at 102.
[56] *Id.* at 70.
[57] *Id.* at 20-21, 52.
[58] Deposition Transcript of Glynn Hilbun, M.D. at 27-29, 32-34, and 38 (taken Dec. 20, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).
[59] *Id.* at 19-22, 58-59, 61-62, 89-90.
[60] *Id.* at 19-22.
[61] Deposition Transcript of Kevin Cooper, M.D. at 83, (taken Jan. 4, 2005), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).

for whom N&M had inserted diagnostic language in his reports.[62] Dr. Cooper testified that he signed the reports, but did not read them before signing them because he was a "very, very busy" man.[63]

Upon learning of Dr. Martindale's testimony, the Honorable Judge Janis Graham Jack, who presides over the MDL, stated at a recent hearing that "it's clear this Martindale business is fraudulent"[64] and that there is "a fraudulent problem [here]."[65] Judge Jack realized how these "fraudulent" cases would harm the legitimately sick: "But what happens is, as we all know, is that sometimes the good is thrown in with the bad and it prevents people who really need to go forward with their case from being heard and getting their discovery. And that's why something like this is so crucial to lay to rest."[66] She has now ordered every physician who had diagnosed any of the plaintiffs and at least the screening companies N&M and RTS to appear before her in two weeks, on February 16-18, 2005.[67] There is every reason to believe that the hearing before Judge Jack will bring still more unsavory facts about the silica litigation to light. In truth, silica litigation today is as scandalous as asbestos litigation – it is just smaller.

VI. CONCLUSION

The proposal to remove the bar against dual claiming is a clear and present danger to the efficacy of the proposed National Asbestos Compensation Program. It would constitute nothing less than the granting of an imprimatur to the retreading of asbestos claims into silica claims with

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[62] *Id.* at 83, 114.
[63] *Id.* at 60.
[64] Status Conference Transcript at 36 (Dec. 17, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).
[65] *Id.* at 17.
[66] *Id.* at 24.
[67] Order No. 19 at 2 (issued Dec. 21, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).

dual diagnoses for the same injury. This phenomenon is already occurring in anticipation of the enactment of the FAIR Act. It is brought into being by an entrepreneurial trial bar using mass screeners and a handful of physicians who are not engaged in good faith medical practice, but who are rather "diagnosing for dollars." Unless the provision in question is retained, the retreading of asbestos claims will defeat the very purpose of the National Asbestos Compensation Program, which is to substitute a fair and efficient administrative compensation system for a tort system that is out of control. Indeed, removal of the bar will allow claimants to obtain double recovery against the same defendants for the same injury, or more typically, for no injury at all.

The bill before you should thereafter retain effective provisions to take the profit for the lawyers and screeners out of retreading. I understand that this is not a silica bill, and I do not expect that it will deal with "pure" silica claims. But it should not be possible to evade the National Asbestos Compensation Program by means of the entrepreneurial, if not fraudulent, conduct that I have described.

We cannot rely on the normal workings of the court system to address this problem. As the asbestos experience shows, the normal process of litigation grinds to a halt when tens of thousands of cases are brought in magic jurisdictions. It is critically important to make sure that the asbestos claims masquerading as silica claims are identified and weeded out at the outset of the litigation process.

Finally, given the prevalence of retreading, any initial disclosure must include information on past asbestos claims and medical reports mentioning asbestosis.

Appendix To Written Statement of Lester Brickman
Statement of Qualifications of Lester Brickman
To Testify On The Fairness In Asbestos Injury
Resolution (FAIR) Act

1. I am a professor of law at the Benjamin N. Cardozo School of Law of Yeshiva University and have been teaching courses and seminars on legal ethics and legal profession for almost 40 years.

2. I have published four articles on asbestos litigation: *The Asbestos Litigation Crisis: Is There A Need For An Administrative Alternative?,* 13 Cardozo L. Rev. 1819 (1992); *The Asbestos Claims Management Act of 1991: A Proposal To The United States Congress,* 13 Cardozo L. Rev. 1891 (1992); *Lawyers' Ethics And Fiduciary Obligation In The Brave New World Of Aggregative Litigation,* 26 Wm. & Mary Envtl. L. & Pol'y Rev. 243, 272-98 (2001); *On The Theory Class's Theories of Asbestos Litigation: The Disconnect Between Scholarship and Reality,* 31 Pepp. L. Rev. 33 (2004). In these articles, I discuss the nature of asbestos-related disease; the history of asbestos litigation, including the phenomenon of the unimpaired claimant; the role of contingency fees in the claiming process; the effects of forum selection on the litigation; and the impact of aggregations including mass consolidations and joinders on asbestos litigation. In addition, I am currently working on an article for publication, titled: "Ethical Issues In Asbestos Litigation."

3. I began research on asbestos litigation in 1991. Later that year, I was requested by the Administrative Conference of the United States, an agency that was part of the executive branch of the federal government, to draft a proposed administrative alternative to asbestos litigation and

to organize a colloquy to consider and debate that proposal. As stated by the Chairman of the Administrative Conference:

> [W]e asked Professor Lester Brickman to prepare a paper proposing an administrative claims solution for comment and criticism by the panel, and we look forward to comments by the audience. Let me introduce Professor Brickman, who teaches law at Cardozo Law School, Yeshiva University. He is a leading authority in the area of attorneys fees and has written numerous articles on the subject. Professor Brickman became interested in the subject of asbestos litigation some years ago when he was hired as a consultant by one of the defendants in the asbestos litigation to review contingent fee issues. He has since had the opportunity to extensively review empirical data, case files, and other materials on the subject. Because of his work in this area, we asked Professor Brickman to draft a proposed administrative solution which our panelists have been invited to criticize.

Administrative Conference of the United States, Colloquy: *An Administrative Alternative To Tort Litigation To Resolve Asbestos Claims,* October 31, 1991, Transcript at 4. To participate in the colloquy, I invited: U.S. District Court Judge Jack Weinstein; Deborah Hensler, a senior social scientist at the Rand Civil Justice Institute; Ronald Motley, a leading plaintiffs' attorney; Andrew Berry, a leading defendants' attorney; Howard D. Samuel, President, Industrial Union Department of the AFL-CIO; and Judge G. Mervin Bober, Associate Chief Administrative Law Judge, U.S. Department of Labor.

4. On the basis of the expertise I had developed and the work I did for the Administrative Conference, as well as additional research I undertook which included accessing then unpublished data compiled by the Manville Trust and the Rand Foundation, I published two law review articles in 1992, which are the first two articles listed in ¶ 2. The first one listed is an analysis of asbestos litigation and has been cited by the U.S. Supreme Court, federal courts of appeals, state courts, casebooks and scores of scholarly articles.

5. In the other article generated by the colloquy, I set forth the proposed legislation which I drafted. Under that proposal, all claims of injury due to exposure to asbestos-containing products would be removed from the tort system and channeled to an industry-financed trust fund to pay claims to those injured and impaired by exposure to such products. The proposal included the establishment of an Asbestos Claims Management Board within the Office of Workers Compensation of the U.S. Department of Labor to promulgate medical criteria for eligibility and to create and administer a claims procedure in accordance with the provisions of the proposed act. In preparing the proposal, I consulted other proposals for setting up an administrative process as an alternative to the tort system. In addition, in the article, I analyzed constitutional and policy questions raised by interposing an administrative agency for payment of claims in place of the tort system.

6. Because of my expertise with regard to asbestos litigation, in October 1991, I was also invited to testify before a subcommittee of the Judiciary Committee of the House of Representatives. My prepared remarks were titled: *Effects Of Asbestos Injury Litigation On Federal And State Courts.* I was not retained with regard to that testimony.

7. I devoted approximately 30 pages to asbestos litigation in a 2001 law review article on aggregative litigation which is the third article listed in ¶ 2 above. In preparing this article, I conducted extensive research on asbestos claiming behavior and the resulting impact on asbestos trusts. I examined how typical "exposure only" asbestos cases are developed and processed; the origin of the Manville Trust, the first bankruptcy trust, which was created in the aftermath of the

bankruptcy of the JohnsManville Corporation; the trust distribution procedure ("TDP") which it adopted and which became a model for subsequent asbestos trusts; the Trust's later attempt to develop and apply an audit program to identify and weed out claims which lacked minimally requisite medical documentation and reflected extraordinarily high incidences of misdiagnoses by a handful of B-readers; and conflicts of interest created by plaintiff lawyers' contingency fee arrangements.

8. In that same article, I also examined the recent trend towards aggregating litigations, including asbestos litigation; the enormous financial incentives unleashed by such aggregations; and the effect of those financial incentives on litigation behavior, in particular, the coercive effect on defendants and the perverse effects on the generation of claims because of the incentives for lawyers to recruit new claimants to replenish their "inventories" of claims.

9. In April, 2003, I was invited to be one of fifteen panelists to speak at a symposium on *Asbestos Litigation & Tort Law: Trends, Ethics, and Solutions,* at the Pepperdine Law School. Among the panelists and speakers were the Hon. Alfred Chiantelli, formerly Coordinator of Asbestos Litigation for the San Francisco Superior Court; Professor Roger Cramton of the Cornell Law School; Professor Deborah Hensler of the Stanford Law School, co-author of the RAND Corporation reports on asbestos litigation; Professor Frances McGovern of the Duke University School of Law, Professor George Priest of the Yale Law School, Victor Schwartz, of Shook, Hardy, & Bacon; the Hon. Griffin B. Bell of King & Spalding, and formerly Attorney

General of the United States; Steven Kazan of Kazan, McClain, Edises, Abrams, Fernandez, Lyons & Farrise; and Alan Brayton of Brayton Purcell.

10. In the article that I prepared for the symposium, which was published in January 2004, I analyze asbestos litigation including an extensive empirical description and analysis of attorney-sponsored asbestos screenings and the role that such client recruitment efforts play in the litigation. This included studying the deposition testimony of approximately forty screening company principals, their key employees and the B-readers and other doctors they retained. I address, *inter alia,* the financial incentives that pervade the recruitment process and how those incentives influence: (1) the actions of B-readers and other doctors involved in rendering diagnoses and producing other medical evidence in support of the claimants so recruited; and (2) the administration of pulmonary function tests as further support. On the basis of the documentary evidence I consulted, I was able to reach conclusions with regard to whether asbestos screening companies adhere to American Thoracic Society standards in administering pulmonary function tests and the consequences of their failure to do so. I also considered the efforts of the Manville Trust to amend its Trust Distribution Procedures to implement an audit procedure in response to tens of thousands of asbestos injury claims presented with inadequate medical documentation or with spurious documentation provided by a select few B-readers, whose diagnoses and reports, according to most neutral medical experts and scientists, lack credibility. I also consider how other asbestos trusts have been plagued with similar volumes of abusive claims and why attempts to resolve the inadequacies of the bankruptcy trust distribution procedures have foundered.

11. In June 2003, I was requested by a staff member of this Committee to permit review of parts of my draft article in connection with hearings that were being planned on legislation addressing the asbestos litigation crisis. Senator Jon Kyl of Arizona cited the forthcoming article, with approval, in the Report of the U.S. Senate Committee or of the Judiciary on S.1125.

12. In researching both asbestos litigation and the formation of asbestos bankruptcy trusts, I have focused on the role of financial incentives in: Generating the medical data used in asbestos claiming; determining the structure of the trusts; and the nature of administration of the trusts and their TDPs. I have been aided in this endeavor by my previous teaching and research on the effect of financial incentives, in particular, contingency fees on the tort system. For the past 15 years, I have been teaching a three credit seminar titled: *The Legal Ethics of Legal Fees and Its Effect On the Tort System.* In that seminar, I directly address the effect of fee structures and fee incentives on the tort system, using articles that I have authored and co-authored and the other research I have conducted. To my knowledge, this is the only such course offered in any law school.

13. In May 2004, I testified before the Committee on Judiciary of the Ohio Senate on Ohio H.B. 292, to reform asbestos litigation. I was paid a fee for studying the bill and preparing my testimony.

14. In July 2004, I testified before the subcommittee on Commercial And Administrative Law of the U.S. House of Representatives Committee on the Judiciary on asbestos bankruptcies. I was not retained with regard to that testimony.

15. In the past several years, I have been invited to appear as a panelist or presenter at numerous conferences and programs on asbestos litigation. I have accepted two such invitations. In June 2004, I was a presenting panelist at the HarrisMartin "Conference on Asbestos Allocation: Apportionment Liability In Asbestos Litigation." My topic was "Ethical Issues in Asbestos Litigation." I also was a presenting panelist at the Mealey's National Asbestos Conference in September 2004, and spoke on the failure of asbestos screenings to adhere to a medical model for screening an exposed population.

16. On January 7, 2005, at the invitation of the White House, I appeared with the President in a "town hall" style event in Macomb County Michigan, titled: An "Asbestos Litigation Conversation." The President asked me to address the audience on why the asbestos litigation system was broken and needed a Congressional fix.

Attachments for
Written Statement of Lester Brickman

Lester Brickman Document

1. CV of Lester Brickman

Statistics

2. Pie Chart: At Least 60% of Silica Plaintiffs Have Already Filed Asbestos Claims

Court Document

3. Status Conference Transcript at 17, 24, 36 (Dec. 17, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).

Medical Reports

4. Dr. Dominic Gaziano

5. Dr. James Ballard

6. Dr. Ray Harron

7. Dr. Walter Oaks

Deposition Excerpts

8. George Martindale, M.D. at 20-21, 52, 70, 102-03 (taken Oct. 29, 2004), *In Re: Silica Products Liability Litigation* (S.D. Tex.) (MDL No. 1553).

9. N&M, Inc., Representative: Charlie Heath Mason 34, 152-56, 272-73 (taken July 8, 2003), *Curtis Johnson v. American Optical Corporation* and *James Underwood v. American Optical Corporation* (Cir. Ct. of Copiah County, Mississippi) (Nos. 2002-0030 and 2002-0027).

News Articles

10. Eddie Curran, *From Checkup to Check*, MOBILE REGISTER, Apr. 4, 2004, *available at* http://www.al.com/specialreport/mobileregister/?asbestos/checkup.html.

11. James Doran and Helen Leonard, *Claims surge as US lawyers see silica as the new asbestos*, TIMES (London), Sept. 10 2003, at 4M.

12. Jerry Mitchell, *Silica Suits Latest to Hit Miss. Courts*, THE CLARION-LEDGER (Jackson, Miss.), Oct. 19, 2003, at 1A

13. Jonathan Glater, *Suits on Silica Being Compared to Asbestos Cases*, N.Y. TIMES, Sept. 6, 2003, at C1.

14. Susan Warren, *Silicosis Suits Rise Like Dust*, WALL ST. J., Sept. 4, 2003, at B5.

Asbestos/Silica Advertisement

15. Billboard on Indiana Interstate, Nov. 2002.

STATEMENT OF PAUL E. EPSTEIN, M.D., FACP

Thank you for inviting me to testify before your committee today. My name is Paul Epstein and I am a pulmonary physician and a Clinical Professor of Medicine at the University of Pennsylvania. I have spent a large portion of my career studying occupational lung diseases and taking care of people who have been exposed to a variety of toxic materials at work.

I would like to describe a little about the diagnosis of dust-related diseases of the lung. When an individual inhales certain types of potentially toxic dust, the lung may react by developing scar tissue. This combination of the presence of dust in the lung and the development of scar tissue is known by the medical name, pneumoconiosis.

There are several different types of pneumoconiosis. The most common types are asbestosis and silicosis. Both asbestosis and silicosis are caused by long-term inhalation and retention of each particular kind of dust in the lungs. Although each of these diseases requires a substantial amount of dust retention, a longer and more consistent daily exposure to silica dust is required to produce silicosis than the amount of asbestos needed to produce asbestosis. Lung diseases like asbestosis and silicosis are both characterized by scar tissue formation and take a long time to develop after the initial exposure. The time lapse between exposure and the onset of lung disease related to that exposure is called the latency period and for both asbestos and silica exposure, the latency period is at least 20 years. There is an individual susceptibility to the scar-producing effects of both asbestos and silica so that if two individuals work side-by-side, one may develop the disease while the other may not.

While both diseases share common factors, such as dust inhalation, scar tissue formation and a long latency period, each of them have very different clinical appearances and can be recognized easily by their relatively distinct patterns of abnormality on chest x-rays. For instance, asbestosis produces a linear, streaky, or feathery pattern on the chest x-ray, predominantly in the lower portions of both lungs. This pattern of asbestos-related scar tissue formation is almost always accompanied by patches of thickening of the membrane that covers the outer surface of the lung. These thickened patches are known as pleural plaques or pleural thickening. Frequently, the pleural plaques caused by asbestos exposure contain calcium that can be seen on the chest x-ray.

Silicosis has quite a different appearance on the chest x-ray. In this disease, the deposits of scar tissue occur as distinct, rounded nodules, similar to the appearance of buckshot and they are seen predominantly at the top of the lungs. The rounded nodules of silicosis are not accompanied by pleural plaques or

pleural thickening. In other words, the x-ray appearances of these two dust-related diseases are vastly different.

Abnormalities on breathing tests are also somewhat different in people who have asbestosis as compared to those who have silicosis. In asbestosis, the characteristic changes cause a restriction in the amount of air that can fit inside the lungs and there is a decrease in the efficiency of lung tissue in taking up oxygen. These changes occur relatively early in the evolution of asbestosis, even when chest x-ray abnormalities are mild. On the other hand, people with silicosis often have no abnormalities on their breathing tests until the rounded nodules proliferate in great numbers and become larger in size. At that point, the volume of air in the lungs may decrease and there may be a decrease in the person's ability to exhale air rapidly from the lungs.

When people have both diseases, (that is, both asbestosis and silicosis) the characteristic clinical and x-ray manifestations are each discernible as separate features and the diagnosis of dual disease processes can be made with relative ease.

Over the course of the past 30 years I have personally examined approximately 17,000 individuals who have been occupationally exposed to asbestos. These workers have held many different jobs, including those of shipyard workers, oil refinery employees, construction workers, steel mill employees, chemical workers, insulators, electricians, painters, and riggers, to name a few. Additionally, I have evaluated many workers who were occupationally exposed primarily to silica, including coal miners, sandblasters, stone-quarry workers, glass makers, and refractory brick manufacturers. A large number of these workers were exposed to both silica and asbestos.

While it is theoretically possible to have combined disease consisting of asbestosis and silicosis, it has been my clinical experience that the overwhelming majority of patients I have seen with asbestos-related diseases have had no evidence of silicosis. In fact, I can recall no more than a dozen or so individuals who have had combined asbestosis and silicosis and these were people who had substantial occupational exposure to silica, often in jobs that were separate from their subsequent jobs that involved exposure to asbestos. For this reason, it is my professional opinion that the dual occurrence of asbestosis and silicosis is a clinical rarity.

TESTIMONY OF
DONALD F. GRIFFIN
DIRECTOR OF STRATEGIC COORDINATION & RESEARCH
BROTHERHOOD OF MAINTENANCE OF WAY EMPLOYES DIVISION—
INTERNATIONAL BROTHERHOOD OF TEAMSTERS

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE
FEBRUARY 2, 2005

My name is Don Griffin and I am the Director of Strategic Coordination & Research for the Brotherhood of Maintenance of Way Employes, a Division of the International Brotherhood of Teamsters. Maintenance of way employees build and repair the railroad tracks, bridges and structures on the nation's railroads. I am here representing all of the Railroad Labor Union members of the AFL-CIO as the Chair of the Rail Labor Division's Asbestos Subcommittee.

Senator Specter, Senator Leahy, Rail Labor is pleased to be able to share our views with you. Sadly, in the rail industry, as in many other industries, workers have been exposed to asbestos as part of their job. They have and will continue to pay with their physical well-being, and some with their lives, for simply doing their jobs.

The plight of these hard-working citizens sometimes becomes lost in a welter of competing facts and figures. It is a tragedy that working men and women are becoming sick and are dying from exposure to asbestos. It would be an unbearable tragedy if we added to that burden by forcing them to die in poverty.

To know someone suffering from deadly asbestos disease, as I do, and most people who work on the railroad do, is to know that, first and foremost, any legislation in this area must treat the sick and injured fairly. The proposed bill does not treat railroad workers fairly because it takes away a railroad worker's federal statutory right. Under this bill a railroad worker may not bring a claim under the Federal Employers' Liability Act, otherwise called "FELA," for an asbestos-related injury or illness on the job. All other workers retain full rights to bring claims for asbestos-related injuries or illnesses under state or federal laws with regard to their specific employers

Let me start with a simple fact, recognized by such diverse bodies as the Supreme Court and the Government Accountability Office: FELA is the law that provides compensation to railroad workers who become sick or injured in the course of their railroad employment. This has been the law since 1908. In other words, FELA, is the railroad worker's version of a workers' compensation law. A railroad worker injured on the job uses FELA exclusively to obtain compensation for his or her injuries, because a railroad worker is not eligible for state workers' compensation. This compensation includes sufficient funds to pay for the cost of medical treatment of the asbestos injury or illness.

a proposal that accomplishes the charge given us by the Chairman. We have made a proposal to Senator Specter, Senator Leahy and other Senators that puts railroad workers' compensation claims for asbestos under FELA into an administrative system that does not involve the courts. Our proposal is attached to my testimony as Appendix "A."

Our proposal is simple – Rail Labor and Rail Management will sit down and agree upon a matrix of benefits and eligibility standards for asbestos injuries that would otherwise be covered by FELA, and administration of those standards and benefits are handled the same as others created under the proposed bill. If labor and management cannot agree promptly on the values for the matrix or the eligibility standards, a neutral third party will do so. The simple standard is to make the benefit equal to the amount that the injured rail worker would have received under FELA.

Rail Managements' Proposal

Our proposal stands in stark contrast to the proposal of rail management which would provide railroad workers injured or sickened by asbestos with almost nothing to replace their pre-empted FELA claims.

The proposal of rail management is to deny rail workers entirely the benefits they get under FELA, to eliminate completely workers' compensation for rail workers with asbestos disease. I can only describe as shocking the notion that the workers compensation rights of rail workers should be eliminated by this bill. Shockingly, rail management appears quite satisfied that rail workers are the only workers in America who will have their workers compensation rights eliminated by this bill. That was the case in the legislation in the last Congress and is the effective result of the provision the rail industry is currently proposing.

Rail management has argued that it is okay to strip rail workers injured by asbestos of their workers compensation benefits simply because FELA claims can be presented in court and one of the purposes this bill is to take asbestos cases out of the courts. Rail management then argues that because rail workers get other statutory benefits, asbestos injured rail workers don't need their workers compensation also.

The rail industry proposal contained in the proposed Section 131(b)(4) pretends to replace FELA with an allowance in place of FELA. It is a fig leaf. It is hard to imagine a rail worker who would get a single penny in compensation under the Rail management proposal in return for losing his or her workers compensation.

Under Rail management's proposal, a rail worker must survive a procedural maze of requirements, and then be eligible for railroad occupational disability, which eliminates the vast majority of rail workers. If a rail worker can show that he or she is entitled to occupational disability, the rail industry proposes that the rail worker receive the difference between what the worker would receive under some undefined state workers' compensation program and what the individual would receive under a Railroad Retirement Occupational Disability annuity. However, there is no comparable proposal

in any asbestos legislation that I have seen for workers in the rest of the economy to qualify for a Social Security Disability before they can apply for workers' comp.

Let me provide you a few highlights of the results of the rail management proposal –

- You have to have worked for the railroad for 20 years to be eligible to *apply* for an Occupational Disability. If you have less than 20 years of service, Rail Management's proposal provides nothing. Railroad Retirement Board figures for the year 2002 show that over 90,000 rail workers, about one third of the workforce, have less than *10* years of service in the industry. This group, plus those with between 10 and 20 years of service, get nothing under the proposal.

- You have to be working for the railroad industry at the time of your disability in order to be eligible for Occupational Disability; if you have asbestos disease caused by exposure while you worked for the railroad, but you no longer work for the railroad, because you have changed jobs or retired, you get nothing.

- An Occupational Disability provides an annuity only; there is no coverage for medical costs related to the reason for the disability. Needless to say, the medical costs of a worker with asbestos disease are substantial. Occupational Disability annuity payments averaged $1800 in Fiscal Year 2002 according to the Railroad Retirement Board. Needless to say, that amount is insufficient to cover the cost of medical treatment for the disability and the needs of worker for shelter and food, both for the worker and his/her family. Rail Management's proposal provides rail workers with neither medical insurance for their injuries or illnesses nor cash compensation to purchase that medical care.

- Occupational disability is a benefit under the Railroad Retirement System that is comparable to Social Security disability. Rail workers injured by asbestos exposure may receive an Occupational Disability today if they meet all the eligibility standards, in addition to any FELA settlement or award. To claim that this modest and limited disability program is a complete replacement for losing workers' compensation under FELA, when the injured worker gets it today, along with FELA, is simply a device to deny injured rail workers their workers compensation. I must add that I participated in the negotiations leading to a change in the Occupational Disability standards in 1997 and Rail Management never suggested then that the Occupational Disability annuity should constitute the full compensation accruing to a rail worker suffering an asbestos related injury or illness.

- Many rail employees are retired when the long latency asbestos diseases strike. By definition a retired rail worker is not eligible for Occupational Disability, and he or she gets nothing. In contrast, a retired railroad worker may make a claim under FELA for an asbestos-related injury or illness provided he or she meets the applicable statute of limitations for such a claim, just like a retired worker subject to other workers' compensation laws.

FELA Pre-emption and Collective Bargaining

As I stated earlier, FELA asbestos cases are not part of any asbestos litigation problem. And to throw out FELA for asbestos injuries, a system that works for rail employees, leads us to believe that there is another motive on the part of rail management. This is reinforced by statements from representatives of rail management that they will not save any money under asbestos legislation – their contributions to the Trust Fund will equal or exceed what they expect to pay out for asbestos claims in the future.

Let me suggest what that motive might be. The rail industry has apparently decided that they don't like FELA, a law that has been around since 1908. As part of their collective bargaining demand in the current round of negotiations, they have suggested that if there is not an agreement to change FELA, they will unilaterally seek its repeal by the Congress. We believe this a tactic in that effort, a means to influence collective bargaining. We were pleased to hear Senator Specter say that any effort to eliminate FELA will not have his support, and that he believes that such an effort is ill advised, but the fact remains that the Railroads have made public their opposition to FELA generally.

Mixed Dust

Track workers are exposed to substantial amounts of silica dust while working in and around the stone ballast that supports the track structure. Between 1993 and 1997, NIOSH collected personal samples from 185 track workers employed by CSXT; 15 per cent of those workers' samples exceeded the NIOSH Recommended Exposure Limit (REL) for respirable quartz. Similarly, the Virginia Department of Health requested NIOSH to test Norfolk Southern track workers in Virginia for silica dust exposure following a private physician's report to them that his patient, a 20 year track worker, suffered from severe pneumoconiosis, presumably from silica dust exposure. NIOSH studies in 1991 revealed that 54% of the personal samples exceeded the NIOSH REL for respirable quartz. The NIOSH report on Norfolk Southern concluded that track workers were being overexposed to crystalline silica in the performance of their track maintenance jobs.[1]

These studies highlight how significant the "mixed dust" issue is to railroad workers, particularly maintenance of way workers. Rail Labor fully supports and endorses the comments made by the AFL-CIO's witness on this important issue.

Conclusion

The present bill takes away railroad employees' workers' compensation rights under FELA and places them in a worse position compared to any other workers in the United States who have a claim based upon an asbestos-related injury or illness. Apparently Rail Management believes that its employees should be treated as second class citizens regarding compensation for these injuries or illnesses.

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[1] The NIOSH reports on CSXT and Norfolk Southern are Appendix B to this testimony.

Rail Labor's proposal reluctantly accedes to the removal of railroad employees' right to federal statutory protection and tries to level the playing field for rail workers by restoring to them similar compensation benefits preserved for other workers in this legislation. Moreover, Rail Labor's proposal is consistent with a tradition that extends back to 1926 when the Railway Labor Act was first enacted; that is, legislation affecting railroads and their employees is best accomplished through negotiations between management and labor, and reviewed, amended and adopted by the Congress. Rail Labor's proposal puts the responsibility squarely on labor and management to agree upon a fair replacement for the railroad workers' lost FELA rights and only, as a last resort, puts resolution of that dispute in the hands of a third party for a final and binding resolution.

Mr. Chairman, Senator Leahy and other Committee members, I respectfully request that you include Rail Labor's proposal in this proposed bill. Thank you.

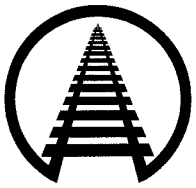
STATEMENT OF

PAUL HOFERER

VICE PRESIDENT AND GENERAL COUNSEL, BNSF RAILWAY

TESTIFYING ON BEHALF OF THE

ASSOCIATION OF AMERICAN RAILROADS



BEFORE THE

U.S. SENATE

COMMITTEE ON THE JUDICIARY

ON

"ASBESTOS: MIXED DUST AND FELA ISSUES"

FEBRUARY 2, 2005

The Association of American Railroads (AAR) is pleased to submit testimony on behalf of the railroad industry on the "Fairness in Asbestos Injury Resolution Act (Act)." AAR will address two issues that are of utmost concern to the railroad industry with respect to this legislation: the treatment of claims under the Federal Employers' Liability Act (FELA), and the need to address the potential for asbestos claimants to circumvent the Act's intent by converting asbestos claims to claims alleging respiratory/pulmonary injury caused by exposure to airborne substances other than asbestos, and thereby continuing to bring claims under the tort system. The first issue is a unique concern of the railroad industry; the second is a concern of many asbestos defendants.

Underlying the Act is an essential, fundamental premise over which there is a broad consensus: that civil lawsuits are no longer an appropriate way to provide compensation to individuals suffering from asbestos-related injuries. In fact, the civil litigation system has created a "crisis" that has been bad for victims of asbestos, bad–and in some cases devastating–for businesses and bad for the nation's economy. The solution offered by the Act would provide those who have been injured by asbestos with quick and sure payment without the need for showing specific defendants to be at fault. A compensation Fund financed by defendants and insurers would replace a system that relies on courtroom battles over theories of product liability or negligence, statutes of limitations, causation, damages and other issues. Compensation from the Fund would be based on sound medical criteria, with the most severely injured receiving the largest payments. The concept behind the Act is to provide compensation to those who are truly ill or injured and to eliminate a system where much of the compensation that is finally paid is siphoned off to transaction costs, primarily attorneys fees, rather than going to the victims of asbestos exposure.

Though railroads did not manufacturer or distribute asbestos, and largely eliminated its use in their operations long ago, they have been named as defendants in numerous lawsuits alleging asbestos-related injuries by the plaintiff. Virtually all of these lawsuits are brought under FELA by current and former employees (historically, largely by former employees). FELA is a federal fault-based statute that was enacted in 1908, at a time before no-fault workers' compensation systems had taken root in this country. FELA covers only railroad employees (and seamen by virtue of the Jones Act). In order to receive compensation for injuries occurring on the job, FELA requires rail workers to sue their employer in state or federal court. Thus, compensation is awarded in a lottery-like manner, with associated litigation costs, and substantial amounts going to lawyers on both sides. The need for both parties to show the other to have been culpable puts unnecessary strain on the relationship between employer and employee.

The Act covers all civil actions seeking recovery for asbestos-related injuries. Civil actions are defined to exclude workers' compensation laws. Under the Act, FELA is not considered to be a workers' compensation law. Thus, claims brought under FELA would be covered by the Act. There is a good reason for this approach. The no-fault workers' compensation system is an entirely different species from the civil litigation system. Workers' compensation laws are administrative systems, that make payment without regard to fault, based on the claimant's wage loss and degree of disability. On the other hand, FELA is a quintessential civil action. FELA has all the attributes of the state-law tort suits which typically serve as the means of seeking compensation for asbestos-related injuries outside the railroad industry, and is characterized by all the uncertainties and problems of the tort system which the Act seeks to eliminate.

Therefore, any legislation which includes as a guiding principle the transfer of asbestos claims resolution out of the traditional tort system, with its attendant costs, and into a system that will fairly and quickly compensate those who are sick, must cover asbestos claims brought under FELA. There is no justification for leaving railroads as the only asbestos defendants still subject to civil lawsuits. In fact, in a recent FELA cases, the U.S. Supreme Court reiterated that the "elephantine mass of asbestos cases . . . defies customary judicial administration and calls for national legislation." Norfolk & Western Ry. Vv. Ayers, 538 U.S. 135, 166 (2003). Congress recognized this early-on and properly determined that, along with all other lawsuits, FELA actions should be preempted by the Act. That debate is long over, and need not, nor should not, be reopened.

Hoping to retain railroad employers as the sole viable defendants in asbestos lawsuits, rail labor protests FELA's inclusion in the Act, complaining that the Act treats its members unfairly. This is not the case. The Act prohibits all asbestos claimants from bringing a civil lawsuit for an asbestos-related injury. All claimants, including rail claimants, would exchange the right to bring suit for the right to receive compensation from the Fund if they meet the Fund's medical criteria.

Nonetheless, rail labor contends that the Act is unfair because non-railroad asbestos claimants (alleging exposure on the job) would have recourse to the Fund, as well as a remedy under applicable state or federal workers' compensation laws, while rail employees would have recourse only to the Fund. Labor has contended that because they will not have recourse to a

workers' compensation remedy, rail workers who suffer a work-related asbestos injury will likely receive less total compensation than other similarly situated non-rail claimants.

A provision was included in a recent draft of the Act that was specifically designed to address this concern. Section 131(b)(4) would have provided an additional payment to rail claimants who could demonstrate that had they been an employee eligible for state workers' compensation, they would have been eligible for an additional payment through workers' compensation. Upon such a showing, rail claimants would be eligible for a payment reflecting the value of that workers' compensation benefit, in addition to the amount they would be entitled to under the Fund. AAR is willing to support this provision as drafted. However, rail labor has rejected this proposal.

Instead, rail labor has insists that, in addition to being entitled to a full payment from the Fund, rail employees asbestos claimants also should be entitled to an adjustment equal to historic FELA asbestos claims payments. As a result, rail claimants would be entitled to two payments as a substitute for tort recoveries. First, they would receive a Fund payment as set forth under section 131(b)(1)–which for seriously ill claimants might be a six and seven figure award. In addition–and, even though the Fund is meant to substitute for all lost tort claims–rail claimants would receive a payment that is calculated to be a surrogate for the FELA award they might have received in the traditional tort system. In addition, some rail claimants would be entitled to a third payment for the same asbestos injury by virtue of their eligibility for an occupational disability benefit under the Railroad Retirement Act, a benefit which now pays approximately

$25,000 a year, and which is not available to individuals who are covered by the Social Security system.

AAR believes that a FELA adjustment is unwarranted because it bestows on rail labor the ability to receive two payments in exchange for the right to bring civil lawsuits. While rail labor asserts that FELA is a workers' compensation right which their members should not be required to forego, the fact is that regardless of how many asbestos defendants they may sue in addition to the employing railroad, under the tort system, plaintiffs are entitled to only one full recovery for an injury. This is a fundamental principle in tort law. See RESTATEMENT (SECOND) OF TORTS §885(3) (1979),[1] and one which applies with respect to actions brought under FELA. See In re Asbestos Litigation, 638 F.Supp. 107, 115 (W.D. Va. 1986)(Restatement of Torts "is the proper measure in a FELA case."); Lucht v. Chesapeake & Ohio Ry., 489 F.Supp. 189, 191 (W.D. Mich. 1980). If a FELA asbestos plaintiff also sues other defendants (e.g., asbestos manufacturers), the plaintiff is not entitled to collect multiple full recoveries. Any settlement with some defendants is offset against a FELA judgment.

For example, in the Ayers case the plaintiffs had also pursued claims against asbestos manufacturers. The trial court reduced the FELA judgments by the amount of the settlements the plaintiffs had received from the manufacturer defendants, an action that was uncontested by the plaintiffs. 538 U.S. at 144. Thus, there absolutely is no principled justification for permitting rail

[1] "A payment by any person made in compensation of a claim for a harm for which others are liable as tortfeasors diminishes the claim against the tortfeasors, at least to the extent of payment made . . ."

claimants to receive two separate, and cumulative, payments meant to duplicate tort recoveries. The payment from the Fund would fully compensate the rail claimant for all lost tort recoveries, including under FELA. Were rail labor to have its way, it is all the other claimants subject to the Act who would be treated inequitably.

Though the railroads believe as a matter of principle that there is no basis for inclusion of a FELA adjustment in the asbestos legislation, they nevertheless are willing to negotiate with rail labor over this issue in an effort to reach a compromise agreement enabling rail labor to support the legislation. However, the willingness to consider this special adjustment is predicated on the fundamental condition that no additional contribution from railroads be required to fund the special adjustment. Railroads already would be required to contribute to the Fund under Tier VII, Section 203(h). Because FELA claims are practically the only asbestos lawsuits brought against railroads, these Tier VII payments–ten million dollars annually in the case of large railroads–are established to represent the railroads' anticipated prospective payout for FELA asbestos claims. Therefore, if an additional payment were required railroads will have paid more than their fair share: in essence, the substantial payments to be made by railroads under Tier VII would be made solely to cover others defendant's claims. AAR has been assured that inclusion of a special FELA adjustment for rail employees will not require additional payment by the railroads–accordingly, the railroads are willing to negotiate with rail labor in reliance on those assurances.

Several other important elements must be incorporated into any effort to add a FELA adjustment to the Act: (1) the adjustment must reflect only net FELA payout; (2) the special FELA

adjustment should be available to rail claimants on the same basis as workers' compensation benefits are available to other Fund claimants; (3) there should be objective medical criteria that must be met before a rail claimant would be entitled to a special FELA adjustment, as well as criteria with respect to the period and duration of railroad employment; and (4) there should be no continuation of FELA suits after enactment of the legislation.

First, in calculating a special FELA adjustment, historical FELA payouts must be adjusted for attorneys fees and other expenses that are paid out of the plaintiff's award. The vast majority of FELA asbestos claimants are represented by attorneys, who typically take, at minimum, a quarter of any settlement or verdict as their fees. The cost of expert witnesses and other litigation expenses further reduces the net amount that the plaintiff receives from any award. These amounts must be deducted when establishing the value of the special FELA adjustment. There is no reason why the Fund should pay rail claimants amounts which previously went into the pockets of FELA plaintiffs lawyers.

Second, regardless of the level of a FELA adjustment, it should be payable under the same conditions that a non-rail claimant would receive workers' compensation benefits. Under section 135(b)(2) of the draft legislation, workers' compensation insurers/employers would not be required to make any additional workers' compensation payments to an asbestos claimant until the amount owed under the workers' compensation statute exceeds the amount of the claimant's award from the Fund. Thus, other claimants only receive workers' compensation benefits to the extent they are greater than the award from the Fund. While this provision may be modified as the legislative process proceeds, any offsets or limits that ultimately apply to a

workers' compensation recovery by other asbestos claimants must be applied equally to the special FELA adjustment. In addition, if a rail claimant is entitled to benefits under a workers' compensation law by virtue of employment outside the rail industry, the FELA adjustment payment should be reduced by the amount of the workers' compensation benefit.

Third, the Act establishes medical criteria that must be met in order for a claimant to be entitled to an award from the Fund. Similarly objective medical criteria should be established in order for a rail claimant to be entitled to a special FELA adjustment award. Otherwise, awarding special FELA adjustments will to become a drawn out and contentious process likely to result in awards to unimpaired claimants.

In addition, specific criteria must be established to determine how long, and for what period of time, a claimant must have worked in rail employment in order to be eligible for the special FELA adjustment. Latency periods are well recognized in asbestos related diseases. It would be unfair to other claimants to award a special FELA adjustment to an employee whose railroad work did not precede by a medically acceptable latency period the development of his asbestos - related disease. Further, a claimant who worked for a minimal amount of time, or after asbestos abatement in rail employment should not be entitled to this special FELA adjustment.

Finally, like all other tort actions, FELA claims must be superceded and preempted upon enactment of the bill. The proposals from rail labor contemplate negotiations over the amount of the special FELA adjustment, and promulgation of regulations after enactment, during which time claimants who worked in railroad employment would retain the right to bring FELA

lawsuits. One proposal calls for appointment of a mutually acceptable arbitrator to determine the FELA adjustment benefits if no agreement is reached between rail labor and management. Allowing claimants to continue filing FELA lawsuits simply provides a disincentive for rail labor to agree on the amount of the special FELA adjustment or an acceptable arbitrator. As labor's proposals are structured, claimants can continue to file FELA lawsuits indefinitely, while the Act ostensibly applies to railroads, and the railroads continue to make contributions of millions of dollars each year to the Fund.

With those principles in mind, railroads are willing to work with rail labor, with one important caveat. Railroads are concerned that the Act's elimination of asbestos lawsuits, which is the quid pro quo for payment from the Fund, could be illusory, a concern shared by the business community as a whole. The concern is that while plaintiffs pursue recovery from the Fund, they can simultaneously file lawsuits alleging respiratory injury caused by exposure to substances other than asbestos ("mixed dust"). Certainly, claimants who can prove an asbestos related injury for the purpose of Fund recovery may also suffers from a separate and distinct injury caused by some other exposure, and therefore should be entitled to recover for the separate injury. However, awards from the Fund are designed to constitute a full and fair payment for a specific level of physical injury or impairment, i.e., damage to the claimant's lungs. It is axiomatic that there may be only one recovery for one injury, and claimants should not be permitted to circumvent this principle by alleging different causes of the same injury in different forums.

This is a real, and a very significant, concern. Many of the FELA suits filed against the railroads in which the plaintiff alleges injury from exposure to asbestos also contain allegations of exposure to, or inhalation of, numerous other substances, such a silica and other dusts and fibers. When a railroad settles a FELA asbestos claim today, the railroad generally avoids the potential for multiple seriatim suits for the same injury by obtaining a release for respiratory injury arising from all causes, including asbestos, silica and other fibers, particles and dust. However, when a claimant obtains an award from the Fund, as the Act is currently written, no such releases would be provided to defendants, thus exposing railroads (and all defendants) to the potential for double payment–once to the Fund and again in the lawsuit alleging exposure to other fibers, particles and dust.

Certain members of the FELA plaintiffs' bar actually advised railroads during the pendency of this legislation that if asbestos litigation is precluded through legislation, they simply will refile their inventory of asbestos cases as claims alleging injury caused by exposure to silica or some other substance. Many claimants currently craft their lawsuits so that they can be prosecuted as either asbestos or non-asbestos claims, though the claim seeks compensation for the same injury, by obtaining dual diagnoses.

The proposed legislation represents a fair means of addressing the asbestos lawsuit crisis only if it effectively precludes the continued use of the tort system to seek recovery for injuries that previously were brought as asbestos claims. If claimants can convert their asbestos claims into other claims for the same injury, merely called by a different name, the bill merely saddles American business with only huge financial liabilities to establish the Fund, but no real relief

from the litigation crisis. Thus, only legislation that addresses this serious issue in an effective way can be supported by the railroad industry.

In addition to the key points made above, there is a technical matter that the railroads would like to call to the Committee's attention. Section 131(b)(4)(E) states that

> Nothing in this Act should in any manner be construed to impact or affect the Act of April 22, 1908 (45 U.S.C. 51 et seq.), commonly known as the Federal Employers' Liability Act. This Act is intended to deal solely with asbestos claims and not any other rights possessed by an employee of the railroad industry.

While AAR understands that this provision is intended only to assure rail labor that there is no intent to modify FELA outside the context of the Act, that is not what it states. The first sentence is not an accurate statement, as the Act does affect, in fact it preempts, FELA claims for asbestos. Thus, the sentence should be preceded by the phrase: "Except as otherwise set forth in this Act . . ." The second sentence could be interpreted to exclude the railroads from any provision which addresses mixed dust claims. This would be an unfair, and presumably unintended, result. Therefore, language should be added to make it clear that it is not intended to exclude railroads from the section(s) of the Act which address the mixed dust issue.

Finally, any provisions of the Act addressing the right to remove cases to federal court must state that, for the purposes of the Act, the FELA non-removal provision (28 U.S.C. 1445(a)) is superceded.

Statement of Senator Patrick Leahy
Ranking Member, Senate Judiciary Committee
Hearing On "Asbestos: Mixed Dust and FELA Issues"
February 2, 2005

I commend Chairman Specter for holding this hearing today. In the last two years, bipartisan efforts to find a fair resolution to the asbestos problem have been productive. Judge Edward Becker and the various stakeholders have worked diligently and as a result, today we are very close to an agreement on many aspects of a national trust fund that would fairly compensate victims of asbestos exposure. But now, some special interests are trying to limit their liability on cases not related to asbestos through a last-minute, overly-broad provision that could jeopardize the years of work spent developing a bipartisan asbestos trust fund.

Despite its title, the latest draft of "asbestos" legislation would dramatically alter the proof requirements and recovery rights within the tort system for "any personal injury claim attributable to exposure to airborne dust, fibre, or minerals." This eleventh-hour provision, which was not in the bill reported by this Committee last Congress or in the substitute bill considered by the full Senate last year, is not limited to so-called "mixed dust." It appears to cover hundreds, perhaps thousands, of injuries caused by airborne substances other than asbestos, including silicosis, blacklung disease, and even lead poisoning: Talk about overreaching.

The Leahy-Hatch medical criteria, adopted unanimously by this Committee in the last Congress and agreed to by all the stakeholders, addressed only asbestos-related injuries. The purpose of this legislation has always been to address compensation for asbestos victims -- not to prevent compensation for injuries caused by other materials. Victims of diseases from airborne substances other than asbestos will not be able to qualify for compensation from the trust fund under our bipartisan and consensus medical standards.

I am pleased to see Doctor Laura Welch here today for an encore performance before this Committee. She provided insightful testimony and critical assistance with the development of the Leahy-Hatch medical standards for compensating asbestos-related diseases that we crafted in the last Congress. I thank her for joining us today and look forward to receiving her testimony about non-asbestos related injuries from airborne materials and whether physicians will be able to establish that asbestos was *not* a cause of a victim's injury, which would be required under the latest asbestos proposal.

It is clear to me that requiring victims to prove that asbestos was <u>not</u> a cause of their injuries in court would preempt state law, shift the burden of proving defenses to

plaintiffs and greatly expand the scope of liability protection for corporations without adding a corresponding method of compensation for additional victims. My two grandfathers worked as stonecutters in the granite quarries of Vermont and both suffered from silicosis because of their workplace exposures to stone dust. One of my grandfathers died at the age of 35 because of that exposure.

My grandfathers did not have asbestos-related disease so they would not have qualified for compensation under the proposed trust fund and under the sweeping language in the latest draft bill, they would have faced unprecedented legal hurdles to recover any compensation in a court of law. That is not fair. And it is certainly not acceptable to this Senator.

Let me be clear, the biggest danger to enacting bipartisan asbestos legislation is overreaching by some interests for immunity from lawsuits brought by victims with legitimate injuries caused by silica or other substances. I hope those pushing this overly broad proposal will take a step back and reconsider.

I believe the second issue we are addressing today should be easier to resolve in a fair manner. The Federal Employers' Liability Act or FELA is a unique statute. Since 1908, FELA has provided workers compensation benefits for railroad workers and provided compensation in tort law for injuries to railroad workers, such as asbestos.

The latest asbestos draft bill overrides FELA for victims of asbestos exposure because the proposed trust fund will become their source of compensation. But by preempting FELA, the proposed legislation also eliminates the railroad workers compensation program even though all other workers' compensation programs remain intact under the bill. That is not fair.

If this legislation will eliminate workers compensation benefits for railroad employees, a separate award matrix must be negotiated to compensate these workers for the loss of their workers compensation benefits. That is the fair way to resolve this issue.

I commend the representatives of the railroad workers for coming to the table to bargain in good faith for special awards under the proposed trust fund for FELA-eligible asbestos victims. I hope the representatives of the railroads will soon do the same.

I look forward to working with Chairman Specter, Senator Feinstein, other Members of the Committee, and the stakeholders to resolve these and other important issues in a fair and just manner. We should continue the hard work necessary for us to craft the bipartisan solutions necessary to enact an effective trust fund to fairly compensate asbestos victims.

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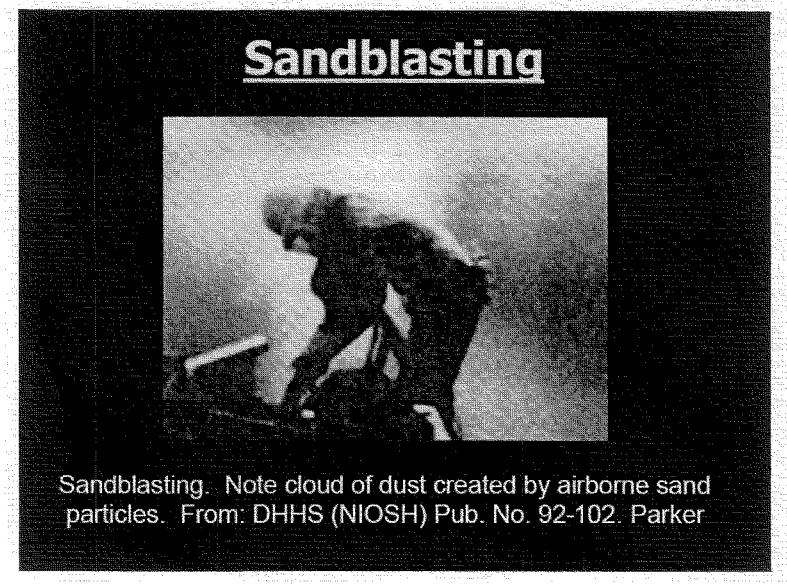
Testimony of Mike Martin
Maloney, Martin & Mitchell, Houston, Texas

Chairman Specter, Senator Leahy and members of the Committee, I want to express my sincere appreciation for being allowed to testify. I am an attorney and former member of the Texas Legislature. I have practiced in the field of environmental toxic tort law for twenty years and have specialized almost exclusively in silicosis and silica-related claims. I have handled approximately 500 silicosis claims over the past 20 years. At the present time, over 60% of my clients have died from silica related illnesses. These cases are tragic to the families who endure the disease. Even worse, the United States Senate held hearings and *"declared war"* on silicosis in 1933 after the Gauley Bridge disaster, an incident in which over 1500 men died from silicosis while digging a railway tunnel in West Virginia. In response to what became a national crisis, the United States Department of Labor, under Secretary of Labor Francis Perkins, produced a film in 1938 in which she declared *"silicosis can and shall be prevented." See, Stop Silicosis, Department of Labor 1938 (restored by National Archives in 1994).*

Despite these declarations generations ago, silicosis still persists. Many have speculated as to why the disease still exists; but one matter is clear, the incidence of the disease has been on the decline, not on the rise. There are fewer silicosis cases in existence today than twenty years ago, although the numbers are still too high. On May 14, 2001 the Occupational Safety & Health Administration announced that its permissible exposure limit for workers was *"insufficient to protect against silicosis." Fed. Reg. Vol 66, p. 25727 (May 14, 2001).* Hopefully, OSHA will develop a standard

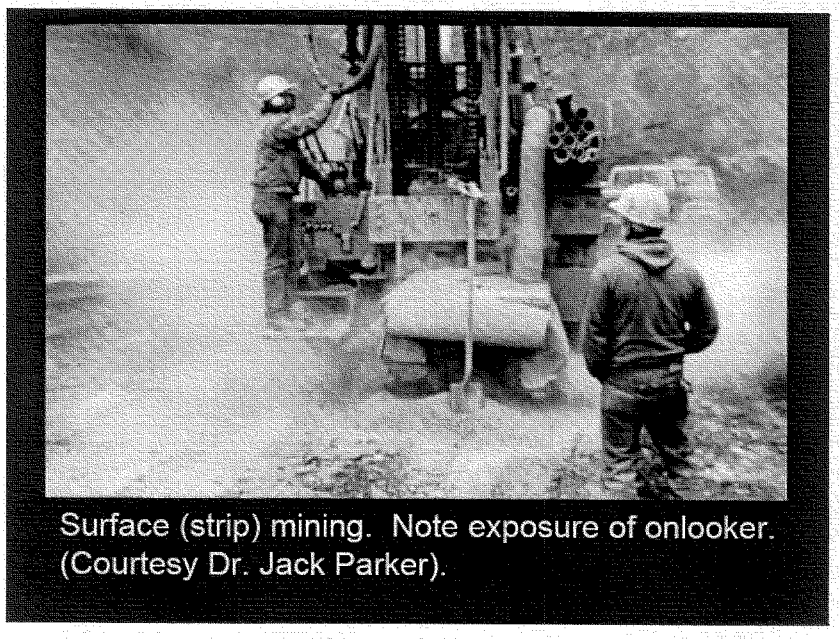
to protect workers from silicosis; a standard which is long overdue in the American workplace.

I.
SILICA AND SILICATE EXPOSURE – A DIFFERENT ANIMAL FROM ASBESTOSIS



Sandblasting produces high levels of silica dust exposure and when inhaled causes silicosis. It also creates exposure to other contaminants such as paint, iron, or other heavy metals, without asbestos exposure. These combinations can cause a variety of other occupational lung illnesses. Because silicosis can be a systemic disorder, it affects more than just the lungs. 25% of silicotics contract tuberculosis or other bacterial infections sometimes difficult to treat. Silicosis can cause connective tissue disorders such as scleroderma, rheumatoid arthritis, kidney

problems, lupus and other mixed connective tissue disorders. ***See Appendix I, comparison between asbestosis and silicosis.***

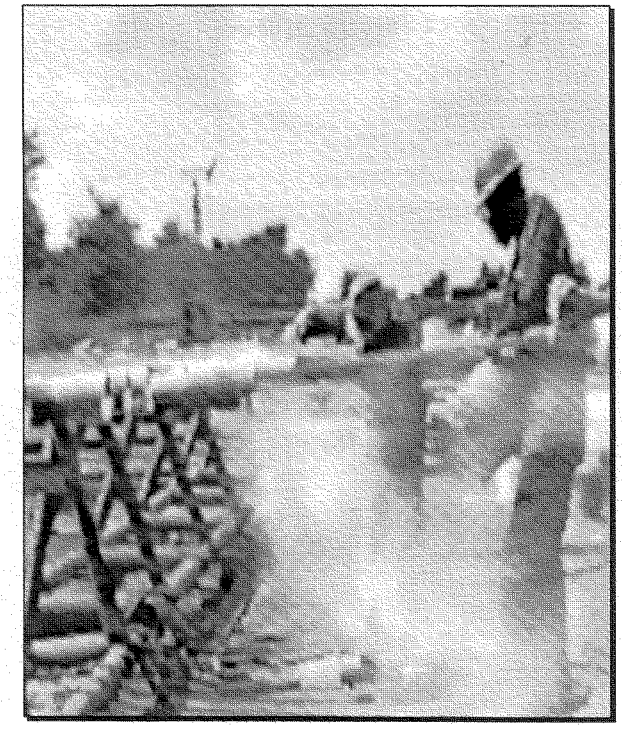


Surface strip mining involves exposure to rock dust which includes silica and a variety of silicates which can all cause lung-scarring, without asbestos exposure. These industries also include rock quarrying, granite and stone cutting. Exposure to silica at higher concentrations can cause three types of silicosis: acute silicosis, accelerated silicosis and chronic silicosis. In 1976, a study of shipyard sandblasters illustrated a range of exposure from 3 to 20 years with an average concentration in the breathing zone of . 8 mg/m3. 50% of the cases were fatal with complicating factors such as tuberculosis and scleroderma. ***See, Ziskind, Weill, Samimi, et al***

"Silicosis in Shipyard Sandblasters" 11 Environmental Research, 237-43 (1976).

Lung transplants have now become an option for individuals suffering from acute and accelerated silicosis.

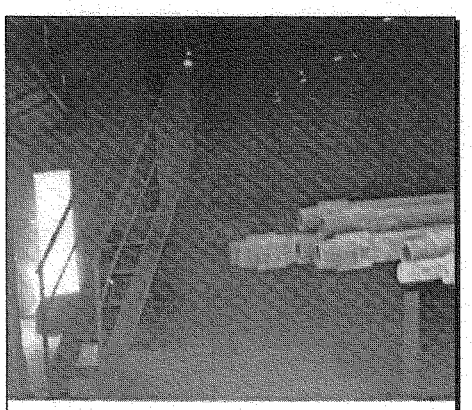
Underground mining and drilling produces classic pneumoconiosis type scaring combining silica and silicates to cause occupational lung scarring. It is highly likely that such a disease will progress. In a study of hard rock miners with 17 to 27 years of exposure at .10 mg/m3, 90% (90 out of 100) of those exposed developed progression of silicosis. *Kreiss & Zhen, "Risk of Silicosis in a Colorado Mining Community" 30 American Journal of Industrial Medicine, 529-39 (1996).*



Industrial pipe cleaning involves exposure to silica containing sodium bentonite which can cause silicosis. Although bentonite is considered a silicate which can also cause pneumoconiosis, silica content in bentonite varies from 1 – 24%. *Brendan, et al, "Silicosis in Wyoming Bentonite Workers" 103 American Review of Respiratory Disease 1 (1973).* Bentonite workers can contract both silicosis or pneumoconiosis. The *National Institute for Occupational Health* lists seventy-two (72) non-asbestos minerals and ores which are associated with human disease from Barite to Zinc. *Occupational Respiratory Diseases, pp. 33-40 (Table 1-32-36) (1986).* None of these minerals contain asbestos.

Not only do these dusts produce a variety of different diseases such as silicosis (silica); these dusts also produce other diseases such as berylliosis (beryllium); hard metal disease (colbalt); siderosis (iron); pneumoconiosis (slate, talc and other "nonasbestos silicates").

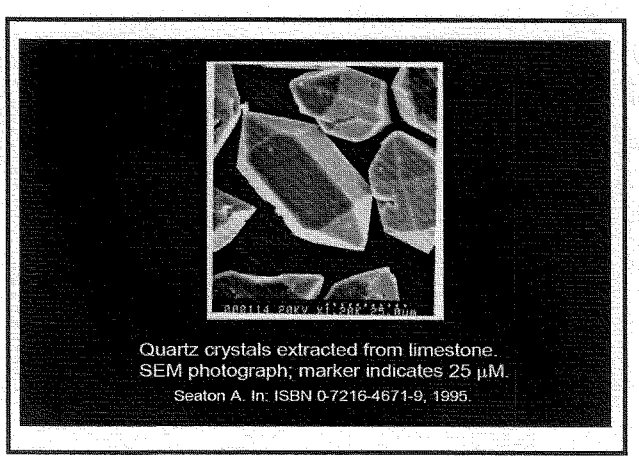
Contraction of either accelerated or acute silicosis often depends largely on dust concentrations at a worksite. Indoor sandblasting operations, where the dust was so thick that the operator could not be seen, as depicted in the below picture, create a dangerous toxic dust environment. Often, even use of respiratory equipment is ineffective to protect the worker from developing a rapidly advancing lung disease. In 1974, the *National Institute for Occupational Safety & Health* recommended that silica sand not be used in sandblasting because the practice was so intrinsically unsafe that there was no way it could be safely performed. *See, Criteria for A Recommended Standard to Crystalline Silica p. 61 (1974).* Unfortunately, OSHA did not act on this recommendation and sand is still used in sandblasting today, representing the primary cause of acute (rapidly progressing) silicosis.



This photo shows pipe being blasted with cabinet door open.

Silicosis results from exposure under circumstances that do not involve asbestos exposure, asbestos production or asbestos application. Sandblasters blast

metal to protect it from rust; foundry workers make sand molds for the making of casts; stone cutters cut granite or other quartz rock; quarry workers crush aggregate rock for road and construction materials; pottery and glass manufacturers use also use sand to make products. All of these occupations involve exposure, in some degree, to crystalline silica or quartz.



The above picture illustrates the electron microscopic image of silica which can cause havoc on the human lungs and the immune system of the body. These silica particles cause a reaction to the immune system by lowering the lung's ability to defend itself from opportunistic infection, a feature dramatically different from asbestosis. Likewise, these quartz particles trigger an immune response in the body. Laboratory studies of sandblasters have demonstrated an increase in the autoimmune response in the body resulting in a variety of systemic ailments relating to connective tissue disease. ***See, American Thoracic Society Adverse Effects of Crystalline Silica Exposure, American Journal of Respiratory and Critical Care Medicine, Vol. 155 (1997).***

II.
THE PLEADING AMD PROOF REQUIREMENTS UNDER THE DRAFT DESTROY THE RIGHTS OF SILICA AND SILICATE VICTIMS FROM PURSUING ANY LEGAL REMEDY.

The current draft attempts to craft, from the preemption language, an exemption for all non-asbestos related occupational diseases. Such a simple declaration that this legislation does not cover any non-asbestos related occupational illness would satisfy this requirement. The need to exclude silica and silicate related claims from this bill is essential to recognize. First, the parties required to fund this legislation are not contributors to other the lung diseases such as silicosis (silica); hard metal lung disease (colbalt); berylliosis (beryllium) or any type of pulmonary fibrosis caused by inhalation of talc, silicates or other mineral substances. It would be unfair to place such a burden on those corporations who did not cause these diseases.

The pleading requirements outlined by Section 403 (a) & (b) extinguish non asbestos diseased victims from pursuing any remedy. The language requires that a non-asbestos claimant make a prima facie showing that he does <u>not</u> suffer any impairment from an asbestos related illness before he can avoid preemption. This burden is unnecessary and exclusionary. If a Plaintiff has not filed a lawsuit for asbestos and is not claiming injury from asbestos exposure, it seems nonsensical that he must plead and prove a negative in order to proceed with litigation. If a claimant does not have an asbestos related illness, his pleadings should clearly state what he does have (i.e. silicosis, berylliosis etc.), not what he does not have. By very definition of the disease pled, asbestos is excluded from the case and preemption does not apply.

The proof requirements of section 403(b)(2)(a) are unrealistic. Section 403(b)(2) is prohibitive because it requires a person to provide a history of "exposure to asbestos." Asbestos is a ubiquitous substance with broad exposure. As noted by Dr. Andrew Churg, Professor of Pathology at the University of British Columbia:

> ***A remarkably large number of individuals, certainly in the millions, have been occupationally exposed to asbestos over the past 50 years. In addition, everyone in the population at large is subject to a much lower exposure from asbestos contamination of ambient air and in some cases asbestos-insulated buildings; the disease causing potential of such exposures is the subject of intense debate.***

Churg & Green, The Pathology of Occupational Lung Disease, p. 277 (2nd ed. 1997). **Therefore, under the logic of the bill's current language, anyone, and perhaps everyone, with asbestos exposure would trigger asbestos preemption, forcing every occupational disease case, of any type, into the asbestos trust, just because someone could identify an occupational exposure to asbestos.**

Forcing all occupational lung diseases into the trust, whether related to asbestosis or not, extinguishes the right of victims to pursue any remedy or compensation. For a man who has just received a bilateral lung transplant from acute silicosis (such as my client Rick Mahar in Washington State), it would be impossible for him to seek remedy for himself and his family. The mortality rate for lung transplantation is 50%. Placing a silicosis victim like Mr. Mahar in an asbestos settlement trust simply because he may have some asbestos exposure in his work history (when he does not have asbestosis), would destroy his right to seek a

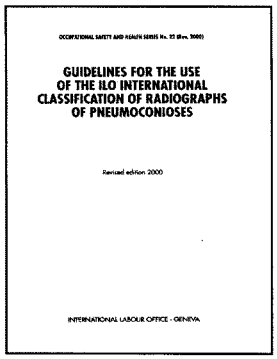
timely remedy. For many silicosis victims, time is of the essence where their families are concerned.

If someone is exposed to asbestos, it does not mean that they will contract asbestosis. Many workers who have worked around asbestos for their entire lives never develop a disease. But if they have another lung disease, they should not be forced into the Trust just because they experienced asbestos exposure some time in their work career. Such a requirement would place the trust into a logistical quagmire of claims which the Trust could neither decipher nor understand. The financial burden and administrative cost on the trust could be overwhelming. Most important, victims who face a tragic non-asbestos occupational illness that often progress to disability and early death would have no recourse for their families. Their rights to protect themselves and their families will be destroyed by placement into a Trust that will neither serve their needs nor pay them compensation.

Another requirement under Section 403 (b) (2) is that the Plaintiff provide a "B read report." B read reports are often the product of mass screening asbestos efforts, but are rarely used in silicosis or silicate related disease. Likewise, "B read reports" do not constitute a representative diagnosis. "B-Read" reports are a classification system that was created by the International Labor Organization in 1972. The ILO has specifically explained the purpose of a "B read" report and declared the following:

> ***"The object of the Classification is to codify the radiographic abnormalities of the pneumoconiosis in a simple, reproducible manner. The Classification neither defines pathological entities nor takes into account working capacity. . . No radiographic features are pathognomonic of dust exposures. Some radiographic***

features that are unrelated to inhaled dust may mimic those caused by dust.



GUIDELINES FOR THE USE
OF THE ILO INTERNATIONAL
CLASSIFICATION OF RADIOGRAPHS
OF PNEUMOCONIOSES

Revised edition 2000

INTERNATIONAL LABOUR OFFICE - GENEVA

See, Guidelines for the Use of the International Classification of Radiographs of Pneumoconiosis, International Labor Office p. 1 & 2 (2000). **There are less than 150 "B readers" nation-wide, and often pulmonary experts do not rely upon a "B read" before making a diagnosis, in or out, of the medical legal context. B readers are not common or available in every medical community. To use "B Reads" as a legislative standard is inconsistent for the purpose which they were created and impractical from the standpoint of availability certified B readers.**

From a pleading standpoint, it would make more sense to exclude from preemption all claims that do not plead asbestos as a causal factor. Such a simple provision would allow those men who suffer from other debilitating occupational lung diseases to seek redress in a more equitable and efficient manner.

MEDICAL ANAYLSIS: ASBESTOS VS. SILICA

	Asbestos	**Silica**
Related Cancer Disease	Mesothelioma	N/A
	Lung Cancer	Lung Cancer
	Cancer of the Colon/Stomach/Esophagus	N/A
Related Non-Cancer Disease or Illness	Asbestosis	Silicosis
	Cor Pulmonale	Cor Pulmonale (end stage)
	Pleural Effusions	Plueral Effusions (end stage)
	Digital Clubbing	N/A
	N/A	TB/opportunistic bacterial and fungal infections
	N/A	Rheumatoid Arthritis
	N/A	Scleroderma
	N/A	Lupus
	N/A	Connective Tissue Disorder
	N/A	Glomerulonephritis of Kidney
	N/A	Progressive Massive Fibrosis
	No Acute Process	Acute Silicosis Disease - silicoproteinoisis
X-Ray Perspective	Lower Lobe Finding	Upper Lobe Finding
	Appears Irregular Scarring	Appears Rounded Nodules
	N/A	Eggshell Calcified Nodules with hilar and mediastinal adenopathy
	Calcified Pleural Plaques	N/A
	N/A	Emphysematous Appearing Change
B-Read	Identified as S,T,& U	Identified as P,Q, & R
	N/A	Large Opacity Formation & Conglomeration
Pathologically	Ferriginous Bodies	N/A
	N/A	Silicotic Hylanized Nodules
	N/A	Crystals under Polarized Lights

Pulmonary Function Test	Airway Restriction Most Common Finding	Airway Restriction is Sometimes Found in advanced disease
	Small Airway Disease Causing Obstruction May be Evidenced	Airway Obstruction is the Most Common Finding

Statement of Dr. Theodore Rodman given before the United States Senate Committee on the Judiciary on February 2, 2005.

I am a 77 year old pulmonary physician who retired about four years ago.

After about fifty years of practice, teaching, and research, I ended my career as a professor of medicine at Temple University Medical School.

I began my medical career at the University of Pennsylvania Medical School and was on its faculty for a number of years.

Early in my career, I developed an interest in occupationally related lung diseases.

In the following half century, I examined and participated in the care of hundreds of such patients.

I reviewed x-ray studies on thousands of such patients.

By virtue of its industrial base, the Delaware Valley, with its shipyards, power plants, oil refineries, and manufacturing facilities, has had no shortage of patients with occupationally related lung diseases.

The commonest exposure by far was to asbestos in shipyard and construction industry workers.

We also saw many who had been exposed to silica, primarily those who worked in mines, quarries, tunnels, and foundries.

Of the hundreds whom I examined, I can remember only one or two who gave a clear-cut history of significant occupational exposure to both asbestos and silica – not surprising considering the disparity in occupations in which asbestos and silica exposure commonly occur.

Among the thousands of chest x-rays which I reviewed in asbestos and silica exposed individuals, I cannot remember a single chest x-ray which showed clear-cut findings of both asbestos exposure and silica exposure.

During the decades of the seventies, eighties, and nineties, in connection with the asbestos litigation, I evaluated a large number of litigants.

Not one of them had medical records suggesting a history of significant silica exposure.

I found evidence of asbestos related changes in many.

I found no evidence of silica related changes in any.

I found no evidence in the reports of any physician – whether retained by the plaintiff or the defendants – that concluded that the patient had silica related changes.

On the basis of this personal experience, I have concluded that both asbestos and silica related changes and disease are common but rarely occur in the same patient.

The medical literature and textbooks with which I am familiar are consistent with my conclusion.

In contrast, when we took care of the anthracite coal miners, combined occupational lung disease was seen commonly in the same patient.

These miners were exposed to both coal dust, producing coal workers pneumoconiosis (black lung) and silica (from drilling into stone) producing silicosis.

The changes of both occupational lung diseases were readily apparent.

This combination was and still is known as mixed dust pneumoconiosis.

It is seen rarely in patients with asbestos related disease because they are rarely exposed to silica.

Comments on illustrations

In conclusion, my experience in the asbestos litigation in the Philadelphia area has created in me the impression that the plaintiffs' attorneys had assembled a small collection of medical experts who were willing to perceive on chest x-rays and testify that asbestos changes were present when in fact none were.

This impression was recently supported by a carefully controlled research study done at Johns Hopkins Medical School in which review of these x-rays by a panel of impartial expert pulmonary radiologists confirmed the absence of asbestos related changes in the vast majority of these x-rays.

I have been told that there has been a dramatic increase in the United States in the number of silica injury lawsuits. Many initiated on behalf of plaintiffs who had previously received monetary awards for asbestos related injuries.

Based upon my experience that asbestos related disease and silicosis very uncommonly occur in the same individual and based upon my observations in the asbestos litigation in the Philadelphia area, I strongly recommend that medical evaluation for litigation purposes of such litigants should be done by an impartial group of physicians free of any vested monetary interest in finding silicosis present or absent.

This medical evaluation should include a careful review of all available prior medical records and x-rays.

Statement of David Weill, M.D.,
Associate Professor, Division of Pulmonary and Critical Care Medicine,
University of Colorado Health Sciences Center, Denver, Colorado

Before The Senate Committee On The Judiciary Concerning
Asbestos: Mixed Dust and FELA Issues

February 2, 2005

Senator Specter, Senator Leahy, and Members of the Judiciary Committee: Thank you for the opportunity to testify before the Committee about medical issues concerning silicosis and asbestosis. My name is Dr. David Weill, and I will focus my remarks today on two subjects. First, I will compare silicosis and asbestosis from a medical point of view. As I think you will see, silicosis and asbestosis are different diseases; they are not easily confused in practice; and it is very rare for one person to have both diseases. Second, I will comment on the medical claims that have been made in the recent wave of silica lawsuits, many of which involve diagnoses of both silicosis and asbestosis. In many cases, these two distinct diagnoses are based on the same clinical information – that is, the same worker is diagnosed with asbestosis at one point in time and silicosis in another, and the two diagnoses are then used in separate lawsuits.

Before turning to the substance of my testimony, I should say a few words about my background. I am board certified in Internal Medicine and Pulmonary Medicine. I received my bachelor's degree from Tulane University and my medical degree from the Tulane University School of Medicine. My training includes a residency at the University of Texas Southwestern Medical Center and two Fellowships at the University of Colorado Health Sciences Center (first in the Division of Pulmonary and Critical Care Medicine and subsequently in the Lung Transplant Program).

From 1996 to 1999, I served as the Director of Pulmonary Rehabilitation and as Medical Director of the Lung Transplant Program at Medical City Hospital in Dallas, Texas. From 1999 to 2002, I was Associate Professor of Medicine, Division of Pulmonary and Critical Care Medicine, and Medical Director of the Lung Transplant Program at the University of Alabama at Birmingham.

Currently, I hold several positions at the University of Colorado Health Sciences Center in Denver, Colorado. I am Associate Professor of Medicine, Division of Pulmonary and Critical Care Medicine, Associate Director, Lung Transplant Program and Attending Physician, Surgical Intensive Care Unit. Since 1999, I have also been Associate Editor for the Journal of Heart and Lung Transplantation.

At the University of Colorado respiratory center, we are referred and treat patients with both common and rare respiratory conditions that are amenable to either novel medical or surgical therapy. Such referrals include people with cases of asbestosis or silicosis, and in my pulmonary practice I have diagnosed and treated patients with both diseases. I am also a "B Reader," which means I have been certified by the National Institute of Occupational Safety and

Health ("NIOSH") as competent to classify x-rays for lung conditions (pneumoconiosis) such as those caused by exposure to silica and asbestos dust.

In addition to seeing silicosis and asbestosis patients in my clinical practice, I have in the last five years been involved in reviewing asbestosis and silicosis claims made in lawsuits. I have reviewed hundreds of patient histories and chest radiographs during this time. A few years ago the number of silica claims that I saw was comparatively small. That number has increased dramatically since 2002, however, and the trend line is still going up.

In the Spring of 2004, I had the privilege of serving as visiting professor at the National Institute of Occupational Medicine and Poison Control in Beijing, China. One purpose of my tenure in China was to determine the feasibility of a collaborative study involving silica and asbestos exposed workers in the Chinese workforce. During my time in China I saw hundreds of cases of asbestosis and silicosis, many involving very serious and advanced stages of disease. The Chinese experience is sobering, and far different from what I have seen in the U.S., where genuine cases of these diseases are quite rare.

I. Silica and Asbestos from a Medical Perspective

Let me turn now to my first subject – a comparison of the diseases caused by exposure to asbestos and silica, respectively. I will focus on two non-malignant respiratory diseases – asbestosis and silicosis -- because that is where the confusion normally occurs. For most other diseases caused by either asbestos or silica inhalation, there is no conceivable overlap. Asbestos exposure can cause mesothelioma, for example, but silica exposure does not. Conversely, some observers have associated silica exposure with autoimmune disorders and tuberculosis, but those diseases are not associated with asbestos exposure. The only category where overlap is possible is lung cancer, which some believe can be caused both by asbestos and silica exposure in certain situations.

A. Silicosis and Asbestosis

1. Silicosis

Silica (silicon dioxide) is the most common mineral in the earth's crust and comprises 20% of the crustal weight of the earth. It is found in sand, gravel and all soils and is the principal constituent of 95 percent of the earth's rocks. Silicosis can result when sufficient amounts of respirable silica are inhaled and become deposited in the lungs, overwhelming the body's natural defense mechanisms. Whether disease develops depends on the intensity and duration of exposure, and, likely, on individual susceptibility.

The principal disease associated with silica exposure is silicosis. Silicosis can occur in three different forms: chronic silicosis (subdivided into simple or complicated forms of the disease), accelerated silicosis, and acute silicosis.

Chronic simple silicosis is the most common form of the disease in the United States today. Chronic silicosis, in its simple form, typically requires more than twenty years of moderate exposure. It is characterized by rounded nodules, like tiny marbles, principally in the

upper lobes of the lungs. In its lower grade forms, simple silicosis does not generally result in respiratory impairment. It may progress, or become more serious over time, especially in workers who continue to be exposed to silica. However, progression tends to be slow and depends on several factors.

In the complicated form of chronic silicosis, the small rounded nodules found in simple silicosis form conglomerate lesions, whose largest diameter exceeds 1 centimeter. Most patients with complicated silicosis have respiratory impairment with abnormal pulmonary function test findings typically indicating lung "restriction" or a reduction in the lungs' capacity for inhaled air. Accompanying airway obstruction is not uncommon. Rare today, accelerated silicosis results from higher exposure to silica, usually over a period of five to ten years. This form of the disease may progress whether or not continued workplace exposure occurs. Chest x-rays can show either a pattern of small rounded nodules alone or in conjunction with larger conglomerate opacities.

Acute silicosis is a rapidly progressive, fatal disease. It occurs after massive exposures which can be as short as several months to a few years. In acute silicosis, the spaces in the lung where oxygen exchange takes place (the "alveoli") become filled with fluid and cells. In contrast to chronic and accelerated silicosis, acute silicosis is not characterized by small rounded nodules.

Accelerated and acute silicosis are rarely found in developed countries today, although there have been case reports many years ago of acute silicosis among sandblasters and drill workers drilling through silica-containing rock. In developing countries the picture is very different, and during my visit to China a year ago I saw a number of cases of accelerated and acute silicosis

2. Asbestosis

Unlike silicosis, which is characterized by the presence of small nodules in the lungs, asbestosis involves fibrosis in the parenchymal tissue of the lungs in the area where oxygen exchange takes place. Asbestosis can result in both a "restrictive" pattern of disease – effectively a reduction in the volume of the lungs – and interference with the gas exchange process. From a pathologic, radiographic, and clinical perspective, asbestosis and silicosis are very distinct diseases.

B. Diagnosis

In general, the diagnosis of both silicosis and asbestosis focus on three clinical criteria: (1) an occupational exposure history, including sufficient latency, to cause disease; (2) the presence of characteristic chest x-ray abnormalities; and (3) the exclusion of other pulmonary diseases that can mimic either disease radiographically. While, of course, it is impossible to diagnose either disease on the basis of chest x-rays alone, there are characteristic differences in the way these diseases appear on x-ray films. Outside the litigation setting, confusion between silicosis and asbestosis does not occur.

In evaluating pneumoconioses, chest x-rays are normally interpreted using the International Labor Office ("ILO") radiograph classification system. The purpose of the ILO

system was to standardize the interpretation of chest x-rays using descriptions of the size, shape, and degree of involvement (i.e., the profusion) of radiographic abnormalities. The system is used to describe shape (regular or irregular) and size (regular: p, q, r and irregular: s, t, u) characteristics of radiographic abnormalities. The extent of radiographic abnormalities (profusion) is numbered from normal (or 0) to increasingly abnormal (1,2, and 3). The ILO classification scheme also addresses which of the six lung zones are involved (upper, middle, and lower in either the right or left lung). Also, particularly important when distinguishing between asbestosis and silicosis, the presence and type of pleural abnormalities are noted.[1] In completing the ILO form, the reader is directed to include all the abnormalities that exist.

Chronic silicosis (simple) is characterized by tiny round nodules, primarily in the upper lobes of both lungs. On an x-ray, these round nodules show up as small, rounded opacities, which would be rated on the ILO form as p, q, or r. In contrast, asbestosis is characterized by linear parenchymal fibrosis, which shows up on an x-ray as small irregular opacities (s, t, or u), primarily in the lower lobes of both lungs.

Chronic silicosis (complicated) is even harder to confuse with asbestosis on chest x-rays than is the simple form of the disease. In complicated silicosis, the tiny round nodules found in simple silicosis join together, and the opacities that show up on the x-ray film are large, measuring greater than 1 centimeter (as opposed to 1 to 3 millimeter nodules in simple silicosis). No form of asbestosis shows large opacities on chest x-rays.

Although acute silicosis is now almost never seen in the United States, it would also be hard to confuse with asbestosis on chest x-rays. Acute silicosis, which involves fluid and cells in the air sacs of the lung, has a completely different appearance on x-rays, causing consolidation in the lung which would appear radiographically as uniformly "white".

In summary: When confronted with the presence of diffuse abnormalities on chest x-rays, pulmonary doctors attempt to categorize the abnormalities into broad radiographic patterns. Asbestosis involves reticular, or "linear" abnormalities; silicosis is characterized classically by nodular (rounded) abnormalities. Not only are these appearances different in individual cases, these two broad radiographic patterns point one toward entirely different diagnostic categories. Diseases other than asbestosis fall into the reticular group. Examples included idiopathic pulmonary fibrosis, radiation pneumonitis, chronic hypersensitivity pneumonitis, and chemotherapy-induced lung disease. Diseases other than silicosis fall into the nodular group, including sarcoidosis, berylliosis, coal workers' pneumoconiosis, and metastic cancer. Distinguishing among diseases that fall into the same radiographic categories requires the clinician to consider other factors, most notably a careful history and pulmonary function test. There should not, however, be confusion between diseases that fall into different categories, such as asbestosis and silicosis.

Although asbestosis and silicosis are different diseases that look different on x-ray films, it is theoretically possible for one person to have both diseases. A person could be exposed to

[1] *See* INTERNATIONAL LABOUR ORGANIZATION, GUIDELINES FOR THE USE OF ILO INTERNATIONAL CLASSIFICATION OF RADIOGRAPHS OF PNEUMOCONIOSIS (2000).

both silica and asbestos in sufficient quantities to cause either disease, but it would be extremely unusual for one person in a working lifetime to have sufficient exposure to both types of dust to cause both diseases. In my clinical experience in the United States, I have never seen a case like this and colleagues who saw patients in periods where exposure levels were much higher have difficulty recalling an individual worker who had both asbestosis and silicosis. Even in China, where I saw workers with jobs involving high exposure to asbestos and silica (such as sandblasting off asbestos insulation), I did not see anyone or review chest radiographs of anyone who had both silicosis and asbestosis.

II. Recent Silica Litigation

I was first asked to review the medical evidence in support of silica claims about five years ago. In the beginning, there were relatively few claims, but they have accelerated since then. All in all, I have reviewed 300-400 case files, more than half over the last two years. I have reviewed numerous diagnoses in the ongoing multidistrict litigation ("MDL") concerning silicosis liability in the United States District Court for the Southern District of Texas. Almost invariably these cases have involved alleged, low profusion category simple chronic silicosis in which one would not expect significant respiratory impairment caused by the presence of silicosis.

From a medical standpoint, it is puzzling to see so many ostensible silicosis cases in such a short period of time. In my clinical practice and those of colleagues in the occupational medicine field, it is unusual to see new silicosis cases, at least in the United States, largely because of the workplace regulations that have been put in place by OSHA. The situation in China, and the rest of the developing world, is very different.

Although statistical evidence is incomplete and imperfect from a methodological point of view, few would question the proposition that industrial dust control mechanisms have made silicosis much less common today than it was a generation ago. This conclusion is supported by reviews of death certificates undertaken by NIOSH. Death certificate data has limitations because (among other things) there is no rigorous control over the filling out of death certificates and because the frequency with which a given cause of death is reported can vary over time due to factors such as the prominence of certain diseases in doctors' minds and patient family's ability to recall accurately the involved diagnoses. Further, invalid diagnoses may have been assigned to patients who did not in fact have a reported disease and only carry a certain diagnosis because rigorous diagnostic criteria had not been previously applied.

Nevertheless, even with methodological reservations, the overall picture with silica is very clear. As NIOSH reports, "Over the past several decades, silicosis mortality has declined, from well over 1,000 deaths annually in the late 1960s to fewer than 200 per year in the late

1990s."[2] In fact, from 1968 to 1992 "mortality associated with silicosis . . . declined more than that associated with other types of pneumoconiosis."[3]

Silicosis and, for that matter, all pneumoconioses are dose-dependent, meaning that increased level and total amount of exposure results in increased risk and/or severity of the diseases. Conversely, as workplace exposures have been substantially reduced in the last several decades, silica - related health effects have become less prevalent. The declining incidence of silicosis should be associated with fewer and fewer silica lawsuits, but in my experience exactly the opposite is taking place. Silica lawsuits are sharply increasing even though from a medical perspective silicosis is declining.

I have several observations about the silica litigation that may help explain this discrepancy.

First, nearly all of the litigation diagnoses do not come from treating physicians but from screening companies that sell their diagnostic services to plaintiffs' law firms. The screening companies employ a small group of physicians who have been certified by NIOSH as B Readers and who make diagnoses of silicosis or asbestosis or both. As I shall explain, whether a screening company diagnoses silicosis or asbestosis appears to depend on litigation rather than medical factors.

Second, among the three or four hundred silicosis claims I have reviewed, only two involved actual silicosis. One of those cases involved significant breathing impairment, and the other did not. The remaining cases were in my view clearly not silicosis at all.

Third, many of the silicosis plaintiffs have also been diagnosed by plaintiff experts, at one time or another, with asbestosis. In my experience, in the vast majority of these cases of dual diagnoses, the plaintiff has been x-rayed twice. The first x-ray was typically taken as part of an asbestos screening conducted several years ago, before the recent increase in silicosis claims, and resulted in the conclusion that the plaintiff had abnormalities consistent with asbestosis. Subsequently, the screening companies and lawyers have asked these plaintiffs to return for a second x-ray, and a new, silicosis diagnosis is based on the second film (which in all instances was very similar to the first x-ray). Almost never does the second "diagnostic report" mention the first "diagnostic report".

For example, one screening firm is responsible for many of the silicosis claims in the ongoing Texas MDL. To generate these claims, this firm simply screened for silicosis many of the same people it had previously screened for asbestosis years earlier. But the lapse between the first and second x-rays is not always a matter of years. I encountered one case where a different screening firm diagnosed a plaintiff in February and then again in March. The former screening generated an asbestosis "diagnosis" while the latter generated a silicosis "diagnosis."

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[2] U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL INST. FOR OCCUPATIONAL SAFETY & HEALTH, WORK-RELATED LUNG DISEASE SURVEILLANCE REPORT 2002, DHHS (NIOSH) Pub. No. 2003-111, at xxiv, 53, 54 (2003).

[3] U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL INST. FOR OCCUPATIONAL SAFETY & HEALTH, WORK-RELATED LUNG DISEASE SURVEILLANCE REPORT 1996, DHHS (NIOSH) Pub. No. 96-134, at 2 (1996).

Silicosis was not mentioned in the first report, and asbestosis wasn't mentioned in the second one. A treating physician, of course, would have noted all potential abnormalities on the first report. This is one important way in which medical reports in clinical practice are different from the litigation-oriented reports that I have reviewed.

In the remaining cases involving dual diagnoses of silicosis and asbestosis, the claimant was x-rayed only once and has received two different and divergent diagnoses (asbestosis and silicosis) based on the same x-ray film. I understand that this practice enables plaintiffs to pursue separate asbestosis and silicosis claims, seeking compensation for each. There is no satisfactory medical explanation for it. Even in the rare case in which a person might have both asbestosis and silicosis, a doctor performing an examination for medical reasons would indicate both diseases on the same form.

By contrast, in the two cases of actual silicosis I have encountered in litigation, each patient had been x-rayed once and diagnosed once. As these cases demonstrate, there do exist real cases of silicosis. But the majority of silicosis claims I have seen are not valid; they are simply recycled or duplicated asbestos claims.

III. Conclusion

The current rise in silicosis claims cannot be explained by medical factors. In a disease like silicosis that is dose-dependent, a reduction in exposure levels would be expected to result in a decrease in disease incidence, and this is exactly what we have seen in the clinical setting. In the litigation arena, the vast majority of the alleged silicotics that I have reviewed do not involve real silicosis at all, which is not surprising because silicosis is a relatively rare disease today. Unfortunately, many of the silicosis claims are derived from the same workers who originally filed asbestos claims. However, based on characteristic chest x-ray findings and other clinical factors, it should not be difficult for a doctor to distinguish between these two conditions – genuine confusion in a purely medical setting would be rare.

Testimony of Laura Welch, MD

Medical Director, Center to Protect Workers Rights

On Asbestos Related Diseases and Other Dust Diseases

Before the Senate Judiciary Committee

February 2, 2005

Chairman Specter, Senator Leahy and members of the committee, I want to thank you for the opportunity to appear before the committee to testify on asbestos-related diseases and other dust diseases. I had the honor of testifying before this committee in June 2003 on the medical and diagnostic criteria for asbestos related diseases, and appreciate the chance to again assist in the development of legislation to establish a trust fund to compensate workers with asbestos-related diseases.

I am a physician with board certification in both Occupational and Environmental Medicine and Internal Medicine. I received my medical degree from the State University of New York at Stony Brook, and have held faculty positions at the Schools of Medicine at Albert Einstein, Yale and George Washington Universities. I have extensive experience in diagnosis and treatment of asbestos-related diseases. I have been in occupational medicine practice for over 20 years, and a substantial part of my practice has always been devoted to examination of workers exposed to asbestos.

In addition, I have many years of experience in medical surveillance programs for asbestos. Since 1987 I have been the medical advisor to the Sheet Metal Occupational Health Institute Trust, a joint labor-management organization within the sheet metal industry established to provide medical examinations for sheet metal workers exposed to asbestos and other respiratory hazards. To date, SMOHIT has provided medical examinations to over 30,000 sheet metal workers, and is now the largest epidemiological database of asbestos-exposed workers in the country. I also developed similar medical screening programs for the Laborers National Health and Safety Fund and other construction trades, in conjunction with the Occupational Health Foundation. I currently serve as medical director for a Department of Energy-funded medical screening program to provide medical examinations for former construction workers at a number of former atomic weapons production facilities. In each of these programs I have designed programs to detect asbestos-related disease, and designed algorithms for the examining physicians to use in interpretation of the results. I have been active in efforts to improve validity and reliability of x-ray reading to detect asbestos related disease in the United States; this work included publication of a paper on variability between readers' classification of x-rays using the

International Labor Organization Guide to Classification of Pneumoconiosis, based on an analysis of results from these screening programs.

I currently am medical director at The Center to Protect Workers Rights, a research institute devoted to improving health and safety in the construction industry. Attached as Exhibit 1 is a copy of my current curriculum vitae, which sets forth my education, training, professional affiliations, research activities and publications.

We are here today to discuss a trust fund for compensation of asbestos-related disease, and the best way to ensure that those who have asbestos-related disease are compensated fairly by that fund. The bill to establish the trust fund sets for specific criteria to confirm that the disease present is related to asbestos, and to measure the impairment due to asbestosis in Levels I-V. The bill does not set forth diagnostic criteria for other occupational lung diseases, nor does it need to, for the criteria in the bill ensure that diseases compensated are caused by asbestos.

I understand that some have the concern that cases of asbestosis will be filed as injury attributed to other dusts such as silica either in addition to this fund, or instead of this fund. I don't think this is a problem. Asbestosis and silicosis cause a different pattern of lung injury, and can be distinguished with occupational history, pulmonary function testing, and x-ray, so a case of asbestosis can't be turned into a case of silicosis or another dust disease. Let me explain in more detail.

Differentiation of Asbestosis from Other Dust Diseases of the Lung

The hearing today addresses the differentiation of asbestosis from silicosis or other occupational lung diseases, the "mixed dust" issue, and the need for additional language in the legislation for these questions.

The term "mixed dust" has been used broadly, and in my view inappropriately. To understand the issues being raised, it is important to be clear what we are talking about.

First, there are a whole range of diseases caused by exposure to dusts. A subset of the lung diseases from dusts is called pneumoconioses; one of these pneumoconioses is asbestosis. The pneumoconioses are distinct diseases caused by exposure to different substances. Asbestosis, the focus of the legislation, is a scarring of the supporting structures of the lung, called interstitial fibrosis. Silicosis is due to the formation of nodules in the lung, on pathology quite distinct from the scarring seen in asbestosis. Coal workers' pneumoconiosis is caused by the lung's reaction to coal dust often in combination with silica, and appears as bronchitis, emphysema, and nodular lung scarring.

The textbook definition of mixed dust pneumoconiosis is lung disease caused by simultaneous exposure to crystalline silica and other dusts such as iron oxides, coal, and graphite. Asbestos exposure is not a contributor to this mixed dust pneumoconiosis.

In addition, there are many other minerals, fibers and dust agents such as beryllium, cobalt, cotton dust, and wood dust, that cause occupational lung diseases but are not included in the pneumoconioses. Each disease has its own characteristic appearance and diagnostic criteria. These agents cause different kinds of lung disease, and result is different patterns of lung injury, such as obstruction, restriction, asthma, and bronchitis. They are clearly distinct from asbestosis.

It is important to point out that as a result of exposure to multiple hazards, which is not uncommon for workers; it is possible to have two diseases, such as asbestosis plus COPD from dust exposure. The question has been raised is it possible to differentiate these diseases. The answer is yes. Asbestosis, silicosis and coal workers' pneumoconiosis (CWP) are different diseases, separable from each other based on occupational history, chest x-ray, and pulmonary function testing.

- Asbestosis primarily causes loss of lung volume, and had a characteristic pattern on chest x-ray.
- Classic silicosis and CWP, in contrast, cause primarily obstructive lung disease with decreased air flow and an increase in lung volumes, and a different characteristic pattern on chest x-ray.
- The occupational histories of workers with these diseases are clearly different.

To understand how these diseases can be distinguished, one must understand how the chest x-rays are viewed and how pulmonary function testing measures lung disease.

Brief Overview of Pulmonary Function Testing

Spirometry measures lung volume and air flow with equipment that is readily available in many physicians' offices. Spirometry is reliable and reproducible when performed according to the specifications set by the American Thoracic Society (ATS). The primary measures produced by spirometry are the forced vital capacity (FVC), the forced expiratory volume in one second (FEV1) and the ratio of the two (FEV1/FVC). FVC is a measure of lung volume. The FEV1/FVC ratio measures how quickly that lung volume is expelled from the lung, and so measures airflow. A reduction in FVC with a normal FEV1/FVC ratio is due to loss of lung volume (restriction), while a reduction in FEV1 with a reduced FEV1/FVC is likely due to air flow obstruction.

Total lung capacity (TLC) is a more extensive test than spirometry; it also measures lung function. Determination of lung volumes can be done by the gas dilution method or by body plethysmography; both are standard measures and also are reliable and reproducible. When the disease in the lung causes restriction, the TLC is decreased. If the lung disease is one of obstruction, TLC may increase.

Overview of the International Labor Organization Classification of the Radiographic Appearance of Pneumoconioses

The International Labor Organization provides a system of grading chest x-rays for dust diseases of the lung (pneumoconiosis) that is accepted around the world. The most recent version is the 2003 Classification of the Radiographic Appearance of Pneumoconioses. It provides a standard notation, so that if one reader calls a film a "1/1" another reader will know to what the first reader is referring.

The classification uses a 12-point scale to define the degree, or severity, of increased lung markings. This scale runs from 0/- to 3/+; a "0" film is normal and a "3" film has the most severe scarring. Each reading on the scale is characterized by a number between 0 and 3, and a second number, separated from the first by "/". The first number, preceding the "/", is the final score assigned to that film by the reader. The second number, following the "/", is a qualifier. The numbers 0, 1, 2, and 3 are the main categories. An x-ray read as a category 1 film might be described as 1/0, 1/1, or 1/ 2. When the reader uses the descriptor "1/1", he is rating the film as a 1, and only considered it as a 1 film. If he uses "1/0", he is saying he rated the film as a "1", but considered calling it a "0" film before deciding it was category 1. Finally, when the reader uses "1/2", he is saying he is rating the film as a "1", but did consider calling it a "2" film. Any category "1" film is abnormal; therefore a 1/0 film in an asbestos-exposed worker is consistent with asbestosis.

The classification also uses a series of letters to denote the type and size of the scarring seen on a chest x-ray. P,Q and R means that *rounded* opacities are present, with P representing diameters up to 1.5 mm, Q from 1.5 to 3 mm, and R diameters between 3 and about 10 mm. (Opacities over 10 mm are describes as large opacities in a different part of the reading form). Small *irregular* opacities in the same size ranges are classified as S, T and U.

Differentiating Asbestosis and Other Dust Diseases Using the ILO Classification

The diagnosis of silicosis is based on an appropriate history of exposure to silica, characteristic chest x-ray findings, and the absence of other diseases that mimic silicosis. On chest x-ray, simple silicosis is characterized by *rounded* opacities less than 1 cm in diameter in the upper lobes of the lung (P,Q or R on ILO scale), often accompanied by characteristic calcium deposits in lymph nodes. Silicosis can progress to massive fibrosis, in which the nodules of simple silicosis appear to aggregate into masses in the lung; this is a very distinct finding of silicosis.

In contrast, on chest x-ray classic asbestosis is characterized by small *irregular* opacities less than 3 mm in diameter in the lower lobes of the lung (S, T on the ILO system), often accompanied by pleural scarring. Asbestosis does not cause calcification in lymph nodes nor massive fibrosis.

Determining That Impairment on PFTs Is Caused By Asbestos

Asbestosis primarily causes a reduction in lung volume, leading to a reduction in FVC and total lung capacity on pulmonary testing *(restrictive disease).* Asbestosis also causes reduction in

diffusion capacity, and this test is included for classification for Level V in the current legislation.

Silicosis and CWP cause a reduction in air flow out of the lung *(obstructive disease),* and cause an increase in lung volume.

Since the general pattern of injury is different, we can establish medical criteria that largely differentiate asbestos-related diseases from other lung diseases. The ratio referred to as the FEV1/FVC ratio serves as a measure of the amount of obstructive lung disease present, and is an objective test that has been incorporated into the medical criteria for the trust fund in Levels II-V.

The differentiation of these diseases of course also depends on the occupational history, and the fund as proposed incorporates exposure to asbestos as one of the criteria for compensation. This is important, for there can be components of obstruction in asbestosis as well as components of restriction in silicosis. It is the sum total of the occupational history, PFT and chest x-ray that allow differentiation of silicosis and asbestosis, or identification of workers who have a component of injury from both.

The Medical Criteria in the Bill (Section 121) Have Been Developed to Identify and Compensate Asbestos-Related Diseases

As I stated earlier, I had the honor of working with this committee in 2003 on the development of the medical criteria in the bill. It is important to understand that the medical criteria were designed to identify and compensate individuals for asbestos-related diseases, not other dust diseases. Indeed there was great debate about what the specific criteria should be, with industry greatly concerned that the criteria not be set to result in compensation for diseases that were not related to asbestos. The x-ray requirements were designed to identify asbestosis and pleural disease caused by asbestos. And, similarly the pulmonary function test criteria were set to evaluate loss of lung function as a result of restrictive diseases. Level II of the bill does recognize that some workers with asbestosis may also have an obstructive disease caused by smoking or some other exposure. But the compensation provided to these workers - $35,000 – is only for their asbestos-related disease and is much lower than the awards for Levels III – V.

Comments on Proposed Language in the January 19, 2005 draft on Treatment of Non-Asbestos Claims

The January 19 Discussion Draft includes provisions for the treatment of Non-Asbestos claims. The provisions set conditions that must be met for any personal injury claim attributable to airborne dust, fibre, or minerals may proceed in the tort system. I am not here today to testify on the legal aspects of current tort litigation related to such exposures. However, as a medical matter, I do believe that the proposed language is seriously flawed; and that if adopted would bar workers with serious dust related diseases from seeking redress for their injuries.

Section 403(b)(1)(A)(i) and (ii) of the draft requires that to proceed with a civil suit for a disease attributable to a airborne dust, fibre or mineral that a claimant must prove that their functional impairment was not caused by exposure to asbestos. This is an impossible requirement to meet.

As a physician, I cannot swear that exposure to asbestos made no contribution to a patient's lung disease. I can make an affirmative statement, that a particular exposure was a substantial cause, even a predominate cause of a disease. But it is not possible to make the opposite statement, that an exposure had no effect. It may be the case that all exposures to asbestos elicit an inflammatory response in the lung, and lead to some scarring. It would be impossible to prove asbestos had absolutely no role, even when a physician does not diagnose asbestosis.

The medical criteria for the fund do require a physician statement that asbestos exposure is a contributing factor in causing the pulmonary condition in question and excluding other more likely causes of that pulmonary condition. This is in keeping with medical practice. Medicine focuses on diagnosis, using diagnostic criteria to reach the most probable diagnosis. The focus of medicine is to pinpoint a disease so that the right treatment can be used. It is irrelevant to medicine if there is a small contribution from a secondary exposure, for that will not change the diagnosis or the treatment.

The scope of diseases and exposures covered in the definition used in 403(b)(1)(A), "personal injury claim attributable to exposure to airborne dust, fibre, or minerals"—is very broad, and would apply to hundreds of exposures and diseases.

The term mineral encompasses over 500 substances, and includes all metals and metal compounds. Attached as exhibit 4 is a list of minerals and a list of occupational diseases recognized to be caused by minerals As you can see, this is a very extensive list, and includes silicosis, coal workers' pneumoconiosis, byssinosis from cotton dust, asthma from wood dust, nickel, flour and other organic dusts, chronic beryllium disease, hard metals disease and many others.

Under section 403, any individual suffering from one of these diseases would be barred from filing a personal injury claim unless they could prove that their impairment was not caused by exposure to asbestos, which as stated above is an impossible requirement.

Moreover, as the legislation is currently written, any person with a personal injury claim for any of these diseases, or due to any of these exposures, would have to submit the evidence required in 403(b)(2)(A), even though these diseases have nothing to do with asbestos exposure. The language could cover personal injury claims for medical malpractice, for some minerals are therapeutic drugs with significant toxicity.

The number of workers with silicosis or other occupational lung diseases other than asbestosis that also had asbestos exposure, and so might be impacted by 403(b)(2)(A), is very large.

Analysis of fiber burden in the lung in the 1980s found that asbestos could be found in the lungs of almost everyone in the American population, showing that essentially everyone had had exposure to asbestos. [1], [2]. Since workers filing a personal injury claim attributable to exposure to airborne dust, fibre or minerals would have been alive in the 1980s they can be presumed to have been exposed to asbestos; the language in 403(b)(2)(A) would require submission of an x-ray and B reader report in thousands of cases, even for cases where the type of disease at issue would not need an x-ray or be medically subject to a B reader review.

The Effect of Section 403 is to Bar Thousands of Workers with Serious Diseases from Seeking Redress for their Injuries

As set forth above, Section 403 is extremely broad in its scope covering hundreds of toxic agents and dozens of different diseases. As crafted, it imposes impossible burdens on claimants, and would bar personal injury claims for many occupational diseases.

It is important to point out that most of these claimants would not have a right to compensation under the Asbestos Trust Fund, since most do not have an asbestos-related disease. Those claimants who have some asbestos disease, but predominantly another disease (e.g. silicosis) would also be greatly disadvantaged, since under the bill's medical criteria, the maximum compensation for a claimant with two such diseases would be $35,000 for disease Level II, since the bill's medical criteria for the higher levels and awards are set to identify and compensate only asbestos-related diseases.

Asbestos-Related Disease and Silicosis – Are These Diseases Still Occurring?

Although my testimony addresses issues specific to compensation of asbestos-related diseases, it is important to understand the context in which those diseases occur. Decades of uncontrolled use of asbestos, even after its hazards were known, have resulted in an occupational disease crisis both in the United States and throughout the world of monumental scope. In this country, from 1940 to 1979, 27.5 million workers were occupationally exposed to asbestos in shipyards, manufacturing operations, construction work and a wide range of other industries and occupations; 18.8 million of these had high levels of exposure. As a result hundreds of thousands of workers and their family members suffered from or died of asbestos-related cancers and lung

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[1] Roggli, V. Pathology of Asbestos Related Diseases, Little-Brown, Boston 1992

[2] Churg, A. Chest. 1983 Sep;84(3):275-80, Current issues in the pathologic and mineralogical diagnosis of asbestos-induced disease)

disease, and more than a million more cases of malignant and non-malignant disease are expected. In the year 2003 alone, almost 10,000 people in the United States were expected to die from asbestos-related diseases. Because of the long lag between exposure to asbestos and the development of an asbestos related cancer or another asbestos disease, the asbestos disease epidemic is only now reaching a peak.

Groups known to be at highest risk at the time of the Nicholson report were insulators, shipyard workers (many who worked during World War II) and workers engaged in the manufacture of asbestos products. Other high- risk industries and occupations included other construction trades, railroad engine repair, utility services, stationary engineers, chemical plant and refinery maintenance, automobile maintenance and marine engine room personnel. Exposures for some of these workers regularly exceeded 20 – 40 f/cc, levels that are 200 – 400 times the current OSHA standard of 0.1 f/cc, with exposures of several months resulting in an increased risk of mesothelioma and lung cancer. The 1982 Nicholson analysis projected that the occupational exposures that occurred between 1940 and 1979 would result in 8,200 – 9,700 asbestos related cancer deaths annually, peaking in 2000, and then declining but remaining substantial for another 3 decades. Overall, the Nicholson study projected that nearly 500,000 workers would die from asbestos related cancers between 1967 and 2030. It is important to point out that these projections did not include mortality or morbidity from non-malignant asbestos diseases, which have or will affect an even greater number of workers.

Due to the long delay between exposure to asbestos and the onset of most asbestos related diseases (this latency can be over 40 years), many of the cases of disease today are occurring among workers who were first exposed in the 1940's, 1950's and 1960's, before asbestos was regulated and controlled. Information on the **current** impact of asbestos-related disease is presented in the recently issued National Center for Health Statistics report, Health, United States, 2004 (Table 48 – Exhibit 2). It shows that reported deaths from asbestosis have **increased** from 1,259 in 1999 to 1,467 in 2002, and reported deaths from mesothelioma have **increased** from 2,485 to 2,573 during the same time period. In addition a report from NIOSH in 2002, the Work Related Lung Disease Surveillance Report (WoRLD 2002). Exhibit 3) shows the dramatic increase in hospitalizations with a diagnosis of asbestosis. Hospitalizations of persons with a diagnosis of asbestosis have increased from 300 in 1970 to 20,000 in 2000 (see table 1-11). These data show that Americans are still sick from and dying of asbestos-related diseases.

The same data sources tell us that Americans are also hospitalized and dying from silicosis, coal workers pneumoconiosis, and other occupational dust diseases of the lung, and also show that hazardous exposures to silica and other dusts are still occurring. In 2000, there were 146 deaths and an estimated 1000 people were treated in a hospital with a diagnosis of silicosis, and for coal workers pneumoconiosis there were 850 deaths and 10,000 hospitalizations.

Exposures to silica are not yet well controlled. Exhibit 3 includes data from the WoRLD report showing that exposures to silica in construction exceeded the OSHA permissible exposure limit in 47% of the samples taken by OSHA in 1999, and exceeded a more protective NIOSH

recommended exposure limit in 58% of samples. A similar pattern is seen in other industries with known silica exposures (see exhibit 2 table 6-15b, 6-16). It should be pointed out that both NIOSH and OSHA have recognized that silica exposure still poses a serious threat to workers and both agencies have had special programs directed towards reducing exposures and disease. OSHA has recognized that the current permissible exposure limit for silica is inadequate to protect workers and is in the process of setting a new standard that will reduce the legal exposure limit for silica. But unfortunately even with these current actions, we will see cases of silicosis for decades to come.