Testimony of

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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.

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 not 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.

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