

DANIEL FINE: ORAL HISTORY INTERVIEW
ON COAL MINERS' RESPIRATORY DISEASES

by Alan Derickson

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D: It's February 18th, 1992. I'm in the home of Daniel M. Fine, that's F-i-n-e in New Kensington. We're still in New Kensington?

F: Right.

D: We're in New Kensington, Pennsylvania. And it's our mutual understanding that he's giving me his informed consent that we're taping this interview. This is an oral history interview for historical research on black lung. And he understands that I will use this, I will, I may cite him, and I may even quote him, and that he has a right to stop the tape at any time. Is that our mutual understanding?

F: Yes, it is.

D: Okay. So let me just get a little background. You did your medical training where?

F: At Yale Medical School, Yale University School of Medicine.

D: Okay. So you got your MD at Yale in what year?

F: In 1950.

D: In 1950.

F: Right

D: And then where did you do your subsequent training?

F: Three years at the Peter Bent Brigham Hospital of Harvard Medical School and then one year at Downstate Medical Center, Maimonides Hospital in New York.

D: Okay.

F: City.

D: Okay, and that last year was a fellowship or

F: No, that was a senior residency. Yeah.

D: A senior residency at Maimonides

F: Right.

D: Okay, and you finished there in what year?

F: 1954.

D: '54. Now during the course of your, and that was in what, internal medicine?

F: Yes.

D: Okay. All of it was straight internal medicine?

F: Yes.

D: Okay. And during the course of all your training, both at Yale and subsequently, what programs or information or anything did you get about occupational disease in general and about respiratory diseases related to work in particular?

F: Virtually nothing.

D: Virtually nothing?

F: Virtually nothing. We had in medical school a course in public health, which was one of those standard curricular items.

D: This was at Yale. And who taught that?

F: It would have been whatever part-time instructors in the school of public health at Yale. It was a very limited course that would have been like one or two hours a week for maybe three months. I don't even recall. But a miniscule segment of that would have related to occupational disease issues. In the course of studying medicine per se, there would have been some brief period dealing with things like silicosis, berylliosis (which was a just being recognized at that time), asbestosis. That was really, and it would have been really miniscule as part of a not very special segment in learning about lung disease. In the residency training again it would have been, I think, zero explicit attention to that issue. We would perhaps have seen a case here and there of berylliosis or of silicosis, and it would have been part of the differential diagnosis of somebody's disease. And that basically would have been it. There might have

been minimal relationship to it because Harriet Hardy was there, was at Harvard at the time.

D: Okay. And when did you, you finished in '54?

F: Right.

D: When did you go to Russellton?

F: '57.

D: Oh, I see. And what did you do between '54 and '57?

F: I worked half-time in a research lab, doing a project that had to do with fluid electrolyte problems, which I was interested in. And I worked half-time in a medical group in the Health Insurance Plan of Greater New York, which is one of the early pre-payment programs.

D: Oh, I see, in New York

F: New York City, yep.

D: , And again, there at HIP were you in any way oriented toward occupational disease?

F: No.

D: No?

F: Not at all.

D: Oh, I see. So you go to Russellton in '57. When exactly in '57?

F: Ah, in, actually I began working for the clinic in July of '57.

D: July of '57, okay. When you get to Russellton, I just want to kind of get the sense of the scene. Like you show up at Russellton for the first time, and sort of what greets you, I mean? For example, well, before we get to that, how were you recruited to Russellton? How did you find your way to Russellton?

F: I was very interested in comprehensive health care, pre-payment. And at the time, among other things, the trade unions were playing a leading role in that, pioneering, I mean to whatever extent it existed all over the country. And the Mine Workers health program was certainly very well known at that time. The thing that was being done in this area, particularly in this region under the leadership,

really, of Les Falk was known among people who were interested in a pre-payment, labor-sponsored health plans, and so we were familiar with that. And actually, Anita and myself traveled around and visited the new, the sites where the new hospitals were being built in West Virginia and Kentucky under the auspices of the UMW. We visited Centerville, Bellaire, Russellton, as well as visiting Detroit and other places where, where these things were being initiated by trade union people. So that was basically the background, and it appeared that the UMW health program had had a particularly interesting concept, which was basing it in the community, basing it in comprehensive group practice, community-based clinics with the board being made up of local citizens, not part of the union per se, independent boards, but being very much catalyzed by the UMW. And in this plan in the Allegheny valley, they needed a medical director. And I came as medical director.

D: I see.

F: Basically. Actually, we arrived in the Pittsburgh area in January of '57.

D: Oh, good, because that explains something I had a little trouble with, you got here in July, and I had you, I already put you in a meeting in January and that was a little

F: Oh, for sure.

D: You stumped me.

F: Right, well, that had to do with, talking about archaic things, that had to do with a crazy Pennsylvania law, that if you were trained in internal medicine and didn't have a rotating internship, you couldn't be licensed unless you got a waiver after you were out of medical school seven years. And that came to be July of '57. So we came down here, and I worked at the University in Pittsburgh in what was the renal electrolyte segment there, but related very much to, during the six months, to everything that was going on in the program. Meantime, when I got down here, I was told that I wouldn't even be able to license then because I didn't have enough biology to go to medical school. So I had to go and get some points at Pitt.

D: Well, yes, from what you described, your training sounded pretty shoddy. So I could see where they would want to put you through some extra

F: Right.

D: Humiliation ritual.

F: Right, right.

D: To make sure you

F: It was pretty, yes, it was pretty funny.

D: That's disgraceful.

F: But anyway, that was the story. So I did relate to the program for those six months before but not, not as part of the program.

D: So you arrive in Russellton. And you, your work is what? What's your division of labor between administrative responsibilities and clinical practice?

F: Roughly 50-50.

D: So you saw patients roughly, what, 20-30 hours a week?

F: At least 20 hours a week. It was a clearcut principle, really, that our people that served as medical directors should be, should be working physicians. And that was partly philosophical, partly that, you know, we needed all the hands we could get for both things.

D: So you were seeing patients in, just to sort of speak broadly, late 50s, '57 or thereabouts?

F: Correct.

D: How many miners, say, per month or per year would you see who had some kind of occupational respiratory diseases, roughly, ballpark figure?

F: Per month?

D: Per month.

F: Twenty or thirty.

D: Twenty or thirty a month. So you'd see maybe somebody every day who had an occupational respiratory disease?

F: Very likely.

D: Okay. And how

F: Incidentally, I did this until 1968.

D: Okay.

F: And then I became, I stopped being medical director. So I then was a full-time staff internist in the

D: So you were seeing more, after '68. You actually saw more patients?

F: Yes, yes, yes.

D: Okay, okay.

F: Actually, I would have seen more as, as time went by, as my practice would have been built up and as the patient, the clinic load would have increased.

D: And when you dealt with those patients, in terms of diagnosing and treating them, was there some sort of protocol by that time? The clinic had been around for a few years. Was there some sort of understanding or formal set of guidelines about you worked-up those patients, or how you dealt with them? Or did you just proceed based on your training and experience and go ahead individually, individually?

F: Primarily that, the latter.

D: Okay.

F: However, and I, there's another person whose name I didn't mention before who was an allergist, who was at the clinic, who was interested in pulmonary disease, whose name was Macy Levine. And he was very much involved with seeing patients specifically for pneumoconiosis or occupational lung disease of coal miners, whatever, however you want to designate it. And he had, he had a protocol, and he's the one who really worked most directly with, with John Stoeckle. And he's still around. And he had, he did have a detailed questionnaire, and I don't remember what year he started using this.

D: So just to

F: But the practicing physician didn't have that. We had a general thing. We were oriented toward the possibility that miners had special lung problems.

D: Just to follow that through, how, how were you oriented? I mean, what was it that attuned you to those questions?

F: Well, I, there wasn't any formal orientation per se that said now you need to know about coal workers'

pneumoconiosis. There was certainly an atmosphere that that was a concern. It was part of the culture. The area administrative office under Les Falk had formal sessions where people were brought in from, mainly from England, but also from other areas. That would have whole, whole day sessions that would, that would be reviewing their research work and published stuff down in Pittsburgh. They would often come out for a field trip. And also some place during that time the group from the Mass General came down. And time would be spent on discussing how to set their selective process up and so forth. And then we would visit other clinics. There also is a preoccupation with the board, I mean in terms of the miners on the board being interested in this. And as medical director, I saw this as one of the things that we had a responsibility to orient ourselves as practicing physicians. So that we also would have had within the clinic, activities that would be helping to try bring this information. You also had a

D: Like what?

F: Well, we had, well, we

D: Case review kinds of things?

F: Yeah, well, we had an ongoing, we had an ongoing educational program devoted to ongoing education of staff. Actually, for a number of years a lot of this was carried out with total staff, not just physicians. But there also were specific physician month, weekly medical conferences.

D: And by total staff, you mean nurses?

F: Everybody

D: technicians, everybody in the place?

F: Everybody in the place. That was certainly the first five years that I was there. That was a strong orientation that we would have a monthly meeting of everybody. And there would be administrative issues, but also medical issues would be discussed. And this issue would have, would have been dealt with. In addition to that, the radiologist, whose name was Friedman, Lester Friedman was very interested in this. Lester Friedman was a radiologist who worked half-time for the clinic. He was very interested from the radiological point of view in identifying, classifying pneumoconiosis, so that he started from '57 or before to routinely classify chest X-rays, using the standard nomenclature. And we had a weekly radiology conference or at least very frequent radiology conference on a regular basis.

D: Involving all the clinicians?

F: Yes, and he would discuss all sorts of medical X-ray problems. But there would be from time to time very specific, in addition to looking at an X-ray generally of a coal miner that was specifically devoted to how you identify pneumoconiosis on chest X-ray.

D: So you were by virtue of all of this, all of these educational activities, attuned to this?

F: Yes.

D: But in terms of an individual clinical encounter, when a patient walked into you, just describe how in the late 50s you worked up a patient. I mean did, what kind of, did you have an occupational history form that you used? Or how you

F: Yeah, I can get it for you. We had, we had a form that was a general history form, and there was an occupational segment to it.

D: So that was integrated into the history taking?

F: Yes, I did not have, although I mentioned to you, this Macy Levine when he would see a patient who was a coal miner, that would have his protocol. I didn't use that in day-to-day work. And he didn't, I mean, the other doctors didn't use that. There's one other thing I didn't mention - that we insisted that every physician that joined the group spent a day in the coal mines.

D: Oh, really?

F: And so we, and as medical director I would do it more frequently. But we would arrange a day when the physician would go and don the apparel of the miners and go down and spend a day in the mine. And that, that was an incredible experience.

D: What was that like?

F: Well, it was a matter of visualizing the feeling, the experience of being a coal miner generally but also going up to the face and seeing the, the continuous miners operating and the way the bratticemen rig the, the barriers to try to influence the flow of air, and so on and so on, and to see what it was like being at the face, and learning about rock dusting and learning about what cables were. And of course from day one, any miner you spoke to would relate an experience with burning cable. So it was something that we

learned very quickly from the coal miners, as well as it being discussed by people that were particularly interested in this kind of an issue. So we saw what cable was like and where it was and how this kind of problems arose. So that did, the fact that we insisted on, on, on physicians doing that per se, as well as the other things that I mentioned, meant that there was a certain awareness of these topics.

D: Sure. Well, that seems quite extraordinary.

F: Yeah, yeah.

D: I can't imagine that people, say, who were in solo private practice at that time were plunging into the mines.

F: No, certainly. And the other thing [inaudible] relate to in the history was -- and I don't know how general this was -- we asked the miner what they did. And they said they were a bratticeman, or an electrician, or they were a roof bolter (we saw roof bolting, of course, which had become fairly prevalent at the time), or timbermen, or, you know, whatever. We knew what they did. [inaudible] they operated a continuous miner, and so you could visualize it after having made the visit. And that, that was important in identifying dust exposure in that history.

D: You would go into these mines, under the auspices of the local? You'd go in with the local president or the committeeman, or how did that go?

F: The, somebody in the local, and particularly somebody in a local where there were maybe somewhat better relationship with management than might have existed in some other mine where the UMW would, not the UMW, the miner who was active in that local would go to the management and say we have some doctors or other people. Actually, Anita went down. We encouraged other staff people to go down, even if they weren't physicians who were heavily involved with the miners.

D: And once again, she was a social worker?

F: Yes, she was a medical social worker. To [inaudible] and administrative people and so forth. So they would arrange it. And the company had to give that permission and cooperation, and we'd get it. There was a person who was medical director of U.S. Steel who

D: Merle Bundy?

F: Yes. Who, who had some relationship with Les Falk. And so that I think probably his cooperation was probably

related, doing this in mines that related to U.S. Steel. He was, I think, probably atypical, but that did help.

D: So you would do a full occupational history to every job you'd ever had?

F: Yes.

D: How much, Did you ask them about what kind of dust exposure they'd incurred?

F: Yes.

D: You did?

F: Yes, yes.

D: And what kind of, I mean, I think, I'll try to talk to miners -- you've given me some leads here -- but what kind of characterizations do you recall? Did people say, I couldn't see my hand in front of my face? Or what, what kind of things did you hear about the dust conditions?

F: It wasn't really defined that specifically. They would say they had heavy dust all day long or whatever. And when, I don't know how much specifically about how much quantitation I did because it would have been related to having seen the job. And the one thing that we didn't see, for example, was hand loading, which was much bigger even before we came there. But we did see the continuous miner and then the loading machines that were operated. And we saw them loading that into the carts and then putting it into the coal cars and the other things that we didn't see directly in operation, the tipple operation. But we did see the preparation plant, which there was a big one up in Russellton, for example. So we had some idea of what happened in there and people who worked for the preparation plant or who worked at the tipple. Well, so that was mostly what it was like. It wasn't a matter of having some scale of dust severity by the visual or anything else like that. And we would get an idea of how much time they spent. Both in terms of hours per day and in terms of, of a you know number of years that they worked at x, y, x job. So we did, we did classify and categorize the number of years at each job.

D: You would do a history and a physical, and would you yourself take X-rays and read them? Or was that part of the clinic's operation was that there was a division of labor and the, and the radiologist took care of all of that? How did that work if you

F: Yeah, yeah, we had a radiology department. The X-ray was taken by a technician who had been trained to do it, to meet whatever the existing standards were for how you do it. I don't know all the technical details, but it was something that Lester Friedman, the radiologist, would have supervised. He would interpret the X-ray, and it's part of internal medicine training and whatever standards that an internist or physician should look at chest X-rays of their patients. So we would, and every patient had an official interpretation done by the radiologist.

D: Okay.

F: And we would also see the film.

D: Okay. And

F: Now in those early days if there were standard films -- I don't remember when they came in, they probably did exist then -- Les, Lester Friedman would have been using those. It wasn't until much later, I think after the period of your interest that somebody who like myself, who did provide expert testimony, used the standard films.

D: When did Russellton begin to do pulmonary function testing of coal miners?

F: Well, actually, before I came. It was a more modest apparatus, which would measure total forced vital capacity and one-second vital capacity. Later on, probably, and I'm not sure, but I'm guessing in the mid 60s, when the, after the new clinic opened up in, I think, late '62, which was the main center in New Kensington. I think at that point we got more sophisticated pulmonary function apparatus. And it was even later than that that we started measuring blood gases. I don't remember the exact dates.

D: All right, so you have a history. You have a physical. You've done some tests.

F: Yes, we did pulmonary function studies, such as they were.

D: Right, and you take this information and, say, late 50s, and make a diagnosis. To what extent -- maybe I'm putting this unfairly or rhetorically, you can take it that way -- to what extent was this still a radiologic diagnosis? This really hinges on what the X-ray says. If they had a certain pattern, it was CWP or silicosis or whatever it was. But that was really what this was still about was radiology.

F: Yes, but we never oriented ourselves to the X-ray alone. By that I mean, I mean, our orientation was a clinical one. And I don't mean to say that that was some kind of vague clinic impression. But it was a question of both evaluating from history and from examining the patient the degree to which there was a functional defect because the radiological diagnosis never meant anything to us as an isolated thing. It was something that was part of the formal diagnosis, to say that this person met the radiological criteria. But we always knew, for one thing, that particularly at the lower levels or even at the higher levels to some extent that the history was absolutely critical in making the diagnosis, an X-ray of pneumoconiosis one.

D: When you say always, so you took it as a given then that the X-ray findings and disability were poorly correlated.

F: Oh, absolutely.

D: Okay, that was a given.

F: And not only that, even the diagnosis, because we understood that a radiologist, not having any other information, could look at an X-ray, not know whether a coal miner worked, whether the person was a coal miner or not, could look at the X-ray and say that this was compatible to pneumoconiosis one, pneumoconiosis two and the person would never have been near a coal mine. Or it could be a coal miner and not have a radiological diagnosis. So we understood, for example, to say that a person had coal workers' pneumoconiosis required that there be in most cases, if not all the cases, that's a sort of fringe issue, but to know, to say that they had coal workers' pneumoconiosis that there would be a compatible X-ray and a competent history. And if the competent history wasn't there, we couldn't make the diagnosis.

D: And to what extent did you rely upon the pulmonary function tests back then?

F: It was one of the parameters as a clinician that was used to make a judgment about whether there was an element of disability. But it wasn't the only one. And, and that of course was long before we did blood gas studies. And we knew that those weren't perfectly corelated. But I, I would say that the pulmonary function study supported, was used to support or not support what was arrived at from history and physical examination.

D: What about when you took a history, how frequently did you get reports of melanoptysis, of people who really

brought up really large amounts of inky sputum? I know that's quite infrequent, but that's the classic

F: Well, it wasn't, yeah, it wasn't, it wasn't. Well, let's put it this way, in terms of the working coal miner, after a day's work, a lot of them would cough up.

D: But that would be some regular sputum with some coal [inaudible] it would

F: Exactly, exactly. What you're talking about would have been not that common because it would have been associated primarily with people who had PMF.

D: Yeah, did you see that? Or had you

F: Yes, we saw PMF.

D: Did you actually, literally see anybody spit up a few ounces of this stuff for you?

F: Yeah, yeah.

D: You did?

F: But it was not common. It was not common at all. And that wasn't, that wasn't a critical factor. I mean, that is, we saw people with PMF that had probably in most cases, maybe the most extreme degree of disability, but most of the patients didn't have PMF that we saw.

D: So you

F: So the question of what the sputum looked like wasn't, wasn't the critical factor in most of the cases in making a judgment about their disease.

D: You have all this information; you make a diagnosis. What terminology, again, we're still in the late 50s here, what terminology were you using when you wrote the diagnosis on their, in your notes? Were you calling it coal workers' pneumoconiosis? Or what did you, what did you write?

F: Yeah, I did. I think that was predominantly the case.

D: Okay.

F: Yes, yes, and it would depend. I mean, if a person was a, was a motorman, for example, then we would probably include silicosis in the diagnosis.

D: Did you ever use the term, did you ever use the term anthraco-silicosis?

F: Ah, yes.

D: You did, okay.

F: Yes, I'm, I'm just, I was trying to think and trying to, it's a little bit of a problem because of the periods [inaudible] and so on. But, but yes, that would have been used in situations where, well, on the one hand if the X-ray was strongly suggestive of silicotic characteristics or in somebody whose occupation, specific job description would have made high silica.

D: Like roof bolters, for example?

F: A roof bolter. Motormen would have been the most extreme example because, as you know, they had tremendous exposures to silica because of the, using the traction on the motors.

D: Well, I want to double back for one second to talk to you, about working up the patient. Did you do biopsies at all, lung biopsies?

F: No.

D: No?

F: No, we did not do lung biopsies. I can't say that lung biopsy was never done on one of our patients, but it wasn't done as part of the workup.

D: Okay.

F: And a miner who might have had a coincidental lung tumor or something like that would have had that. I'm trying to think. They may have done some lung biopsies in the people that went to the Mass General. I wouldn't be surprised if they did. There was a strong aversion to it. And I don't think that the people that were working at the clinic as clinicians felt that that was appropriate or necessary. There may have been some specific instances where that was discussed, where there seemed to be a strong reason, either clinically or because the person felt that they deserved some kind of compensation thing where that issue came up, where that might have been the only way that they could you know develop the issue. There also was the question of, I don't know if it's relevant, but what, what happened with autopsies.

- D: That, that was my next question, yeah. How frequently did you do autopsies?
- F: Well, we did them with fair frequency. But, but I think there was a very, a mixed kind of reaction to, on the part of patients as to whether they wanted to have it.
- D: On the part of their survivors?
- F: Yes, yes, yes. But we had a fair amount of patients that had it. And then there was somebody at Hershey, that may have been later on who was a, he might still be there. He was a pulmonary pathologist.
- D: Yeah, I forgot his name. It starts with a D
- F: It may have been later, though.
- D: Well
- F: It might have been after '69.
- D: Just to follow that through, was the impetus for these autopsies largely with respect to compensation? Is that what this was about in part?
- F: Yeah.
- D: Confirm the diagnosis for compensation.
- F: Right.
- D: Get the, get the death benefits for the comp.
- F: Yes.
- D: Okay.
- F: I mean, if there were a patient, again I don't remember the timing, this patient had had already a benefit, there might not have been any motivation for him or the family. On one hand if they thought there was a claim there and they had not succeeded in having it, then there would have been support for it.
- D: You would then on occasion fill out death certificates?
- F: Yes.
- D: Besides just writing clinical notes and
- F: Oh, yeah.

D: things in charts

F: As far as the death certificate was concerned
[inaudible] doc

D: And would put, you would enter in the 1950s, you would write coal workers' pneumoconiosis on the death certificate?

F: Yes, but I can't tell you what the date was.

D: That's all right.

F: Okay, no, no. If we thought, let's put it this way, if we thought that person had coal workers' pneumoconiosis, we made a special effort to put it on the death certificate.

D: Okay, now sometimes what you see in, 'cause the terminologic issues are very thorny because a lot of this goes directly to the next subject here, which is compensation, what you often saw, you see this throughout the, I think, almost throughout the century is a kind of double talk, in the sense that you'll see people writing one thing and putting something else next to it in parentheses. They would write anthraco-silicosis because that was what you could collect for. And then in parentheses, because they knew better and they knew more precisely what they were talking about, they would put in parens coal workers' pneumoconiosis. Or you'd see miners' asthma, if they thought they could collect for it.

F: Yeah, I was going to say

D: And in parens, you'd see something else. I mean, did you, was there any of that sort of linking of the terms, a sort of transitional form, where you'd

F: I think that occurred. I don't remember if it specifically occurred on death certificates or not. I wasn't aware that miners' asthma was a compensable

D: At one point in the code in Pennsylvania, it

F: Okay.

D: Miners' asthma had been written into the law.

F: Okay. I wasn't aware of that. And as matter of fact, the the notion that we had, perhaps erroneously, was that that was a catch-all, that was both accepted among the miners and among mine operators, that that was something

that a miner had. And it wasn't anything unusual or something that should be rewarded.

D: Ah hah, what did that mean, that it was not disabling?

F: Well, it was a part of life. I mean, so that we would have, in filling out death certificates, would not have deliberately not used that term. Maybe that was based on misinformation.

D: But the miners themselves used the term, what, in 1950s in Russellton, they were, they were still using that term?

F: Oh, yeah.

D: Yeah?

F: Yeah.

D: And the coal operators used it?

F: Yeah, I shouldn't say coal operators because I don't know that, but that we had relations in various ways with the company doctor, who would have used that term, yeah.

D: And so the, and what you're saying is that that term in a sense was used to trivialize the miners' problems?

F: Oh, yeah

D: It was just

F: Oh, absolutely

D: It was just around, and everybody had it.

F: And to some extent, to the extent that, that a particular miner might have accepted it as that part of fate and didn't, wasn't, didn't want to be contentious, that would have kind of shrugged.

D: But that's really quite curious because the assumption, because the assumption still was that this was work-induced. It was a miners' asthma.

F: Oh, yeah, right.

D: So here you have a disease that everybody accepted was work-induced probably and I assume they meant the same disease. They meant dust-induced.

F: Right.

D: Chronic respiratory disease.

F: Right.

D: Yet somehow, they've got a shell around it that says it doesn't count. It doesn't, you can't take that into the workers' comp.

F: Right, well, I, see, I don't, I really couldn't give you any kind of definitive thing. It might have been partly age-related, whether that person was an immigrant or not, whether they, I mean depending on the psychology of the individual miner as to the degree to which they would accept that as being part of life and not to be pursued, so to speak, in a compensatory way or vice versa

D: Was there also something in the connotation of asthma per se, that asthma was not that bad a thing, you know. Having asthma just meant you had some wheezing

F: Yeah, I don't know that it was not that bad or that it was a medical thing that in a sense was connected to mining because the word miners' was on it, but in a sense that it sort of overlapped with general medical conditions called asthma. But this was an asthma that miners got, that again didn't require or deserve special recognition. I think, just thinking back, my own mental reaction to it was it was, it was a term that I think people who felt that it should be done right and fairly and honestly would have been inclined not to use, would have seen it as a euphemism that was used to discourage

D: And of course the other thing that it wasn't was scientific, I mean.

F: Right.

D: I mean, this was really about bringing British medical science into this, and so this was

F: That's true

D: Sort of a vestige of popular culture in a way.

F: Oh, absolutely, absolutely.

D: Okay, okay.

F: I mean, the very idea of the word of asthma, which was still being used in non-occupational situations in certain

categories in medicine -- that if you wheezed, it was asthma. I mean, it didn't mean a

D: It was just

F: It wasn't an entity.

D: It was just a symptom.

F: Yeah, exactly.

D: Okay, because it's a very old term. I mean, that term has been around since the turn of the century. And the same sort of talking around it is going on. Some of the people who wanted to be seen as more scientific would say, "Well, we call it an asthma, by convention, but it's really pneumoconiosis." And so there was that kind of hedging around it that always went on. All right, we've sort of crept up on this issue already, but let me just walk through it more systematically. You would make a diagnosis and prescribe. Actually, before we get to that, what kind of treatment did you do?

F: Well, we, we, we, the only thing that we did was that we felt ourselves and informed patients that the degree to which there was an infectious element or the degree to which there was an obstructive element, that medication might help. And if they happened to have a silicotic element that there was a problem of tuberculosis, that we would, that this is [inaudible] that we would look at. But beyond that, there wasn't any treatment.

D: You didn't use positive pressure? You didn't use oxygen?

F: No, no, no.

D: You weren't into that? There was a whole industry of

F: Oh, yeah, I remember, it actually preceded me, inhaling aluminum dust and all that. No, no.

D: So the aluminum dust was thoroughly discredited in your view by the time

F: No, none of it. I mean, the positive pressure -- I'm not sure what you're referring to -- but the extent to which a person used an apparatus, it would have been, I guess, some unusual case where we treated it as another lung condition, it, which maybe it's going to be helped by that.

D: It was this intermittent positive pressure oxygen.

F: Yeah, right. But I, I don't think that that was seen as any kind of a real treatment, and we didn't know that oxygen would, well, we knew enough about general lung disease to know that oxygen had to be used in a very discreet and very special way. In anybody with lung disease, it was potentially more dangerous. And the business of chronic ambulatory oxygen therapy was not a concept or a technology that existed at the time for people with chronic low blood oxygen could be helped by that. So it was mainly using proper dilator agents, either administered just by a hand-held nebulizer or by a machine. And we had people who came in for those treatments. And there was that, or taking tablets like aminophylline or treating their infections as they came along or in some instances putting them on a regime that was hoped might be prophylactic, where they were periodically taking antibiotics to try to prevent recurrent problems.

D: And you did not a hospitalize people with

F: No, not per se. If they had very, very advanced pulmonary insufficiency, we would hospitalize them to the degree that we would anybody that had a non-occupational disease that had advanced lung disease and was in crisis.

D: Would you

F: I mean, actually we did because of the other concepts of health care. We emphasized ambulatory care.

D: That was my next point. Was it, would you say that was somewhat distinctive?

F: Oh, absolutely. Because

D: You were trying to keep people out of the hospital.

F: Not only that, we had deliberately as part of the concept that both the, the health program as a whole and what was being promoted in this region, particularly by Les Falk, of comprehensive ambulatory group practice services. We clustered every kind of service for diagnosis and treatment that made any sense that we could afford in the group practice centers. And so no, there were good statistics that showed that the hospitalization rate in our population was very, very low compared to both coal miners in areas where they didn't have our kind of a program or in the non-mining population in the Pittsburgh area. So no, absolutely.

D: With regard to how these diagnoses played into the workers' compensation system, you would write written reports to support workers' comp. claims?

F: Well, we would do two things. I think that, I don't think it was uniform in the clinic because I think that probably different doctors were more interested in this than other doctors. I mean, to the extent that you try to inform everybody and feel that not just for coal miners but generally that there is a recognized medical ethical responsibility for advocacy if a patient has a legitimate medical problem that deserves support. So we would encourage that. But there were certainly varying degrees of interest and participation by different doctors in the clinic. But to give you what we would think would be appropriate would be that to the extent that we identify something that we thought was occupationally related, we would feel there was a responsibility to inform the patient. We felt a responsibility to inform them that they might have a legitimate claim and to inform them that if they thought that that was something that they wanted to pursue, that they would need to get some advice from legal people.

D: . And just to make a clearcut distinction, for miners who were still seeing a company doctor or had been seeing a company doctor before the fund became in, how different, from what you heard anecdotally, how different was it? Were people, did, first of all, did company doctors ever make that diagnosis? And if they made it in the first place, would they have told the patient in the second place and in the third place would they have provided any support whatsoever for workers' compensation?

F: No, absolutely not. I mean, in general, no. And I think the way that was dealt with was

D: No to all of those things?

F: Oh, absolutely.

D: Didn't make the diagnosis. Didn't tell the patient. Didn't help them work up a comp. claim.

F: No, absolutely.

D: Okay.

F: And to the extent that that was recognized, and I think the UMW as a whole, their information to miners as a whole and particularly the kind of thing that Les Falk tried to do was to really alter and enlarge the information base. So there were many miners that really had a dual system of

health care, that would be taken care of by either a company doctor or a doctor who was a company doctor but also was practicing in the area but also came to the clinic when they felt that they had a problem that they needed a different perspective on. So that happened very freely.

D: So people would stay with their, I suppose someone who in many cases was also their family doctor.

F: In many instances. I mean, there was a shift over time with people getting confidence as a purveyor of general medical care you used the clinic. But, and we tried to place them so they were accessible in their own communities, and they didn't have to travel. But there were people, a lot of people who would do both -- who would come to the clinic for something they felt where they needed support that they didn't think would be coming from their family doctor, either out of ignorance or because of their relationship to the company.

D: I also assume that over time you developed a track record. You were winning.

F: . Oh, absolutely.

D: It was a kind of magnet, I assume.

F: Oh, absolutely. And then, then the local union organization was familiar with this. I mentioned Fred Uzelac to you. And I

D: Let's spell his name. His name is spelled

F: U-z-e-l-a, U-z-e-l-a-c, okay. I think from the point of view of at least my notion of what a union might do to service its miners, it was the most enterprising in every way, in trying to serve the coal miners. And part of that was to strongly inform them that that there was a problem of lung disease and that there was some legitimate rights there for a person [inaudible] problem. So they would refer people.

D: Does that mean that it was then the local unions, some of them, that drove this process in a sense, not the lawyers looking for business, or not

F: Oh, absolutely.

D: Okay. So this was a very much a grassroots

F: Oh, absolutely.

D: Bottom up kind of

F: And when they were union leaders like Fred Uzelac, that would be a strong concern and issue on their part.

D: And how would they convey that, in local union meetings or just talking around the mines?

F: I can't think of a specific instance. But just to recall the scene in my mind, but he was the kind of person, and there were one or two other people, who would actually ask doctors to come out and to come to the union meetings and to talk briefly about the problem, how it could be pursued, if the people felt they had a problem.

D: This problem being occupational respiratory disease?

F: Yeah.

D: Yeah.

F: Yeah, I don't remember what year. It may have been later on or not. What year Jan Lieben was doing his thing?

D: That will come up.

F: That was later.

D: Yeah.

F: Okay, that, that played a big role in, these mobile things that went around, played a big role in raising the level of consciousness about it.

D: Just, as long as we're on that point, just the execution of that study raised consciousness?

F: Oh, absolutely, yeah.

D: To return to workers' comp., you would write a written report, saying that I believe this man has work-induced

F: Again, I don't remember the chronology, but we would tell them that at a point where we thought they had an occupational disease. We would tell them. We would tell them that they might want to pursue it. And I think there was another element, and I don't remember if that was later or earlier, that they had a, had a finite period in which they had to act on it. And if they didn't, they lost.

D: There's always a statute of limitation for

F: No, no, this is a one-hundred-and-twenty-day notice thing, and I don't remember when that became operational. But it was important to inform them that they had one hundred and twenty days to act on it once they were informed.

D: Did

F: It might have been later, I don't know.

D: Did most of the miners who were diagnosed immediately pursue comp. claims? Or did they say, "I'm not disabled; I'll keep working. I'll file in five years when I really can't work any more"? How did that play out across a continuum?

F: Oh, oh, well, it was clear that disability was an element, not the presence of the disease.

D: Okay.

F: So we would try to get them into non-dusty things, situations. We would tell them what the problem is, and we would support them in that, if a person had an extensive problem, whether or not they had a lot of early symptoms or not. If radiologically it was an extensive thing, we would tell them and advise them to move. And I, it may have been again under a later law, but they had a right, the companies had an obligation.

D: That's after '69.

F: Okay.

D: Do, when miners were told you have some disease, you'd be best to move into a less dusty part of the mine, do you know how they did that? Did they just go through the normal channels of bidding on a job? Or did the union expedite the process in any way through job actions or pressure of any sort? Or how did, do you have any sense of how that played out? Again, this is not your area, but how that played out within industrial relations that they would move these people. I mean, you know, in the olden days there were these customs of light duty. And, you know, in anthracite they'd take the old broken-down guys whose lungs were shot and put them back in the breakers, picking slate with the little boys. And there was always like, a set of customs about how you moved people around based upon their disability. Do you have any sense that there were those customs, or how did you deal with these folks who were partially disabled in 19-, in the late fifties?

F: There were, but I really can't give you an accurate picture. I just, having raised them, I would have thought [inaudible] I recall that people were given jobs in the lamp house, fixing up the lamps and handing them out or whatever. But I don't know really, formally how it worked out. My impression would be it would vary from local to local, depending upon what the relationships were. And in response to something you asked before, there would be miners who would leave mining. They'd say, "I've had enough," and you know, "I understand from what you're saying [inaudible] that I have a problem, and it's not worth it to continue." And that would vary depending on the opportunities and what the economic impact was. And there were other miners who took it in a fateful kind of way and would say, you know, I'm not going to quit.

D: Did you take part in workers' comp hearings as an expert witness? Did you go in and testify?

F: Oh, yeah.

D: How frequently did that happen?

F: . Frequently.

D: Really, and what was that like? Was it highly contentious?

F: Yeah, again I, I guess it varies from person to person. It wasn't something that, once I understood it and had some experience with it, it wasn't something that was, you know, overwhelmingly trying.

D: So it was quite mechanical? You basically reported your findings and reported your workup, and that was that?

F: Yeah, it took three forms. One was giving a deposition in the office, where there would be an attorney for the company and an attorney for the miner, and it was simply a matter of sitting in the office and with the record being questioned and then responding. The other thing a, that was the most common. The other was hearings in front of referees. So it was a quasi-judicial situation. But it wasn't a court situation. And the rarest was in court, and I really can't, that was not common. Most of these things were dealt with by the referee. And I really can't even remember specifically how many times that there was a court situation that dealt with coal workers' lung disease per se.

D: And did in the course of those proceedings, besides repeating your own assessment of the patient, would you be

called upon to criticize the alternative interpretation of the company? Obviously, there would be a company doctor.

F: Oh, sure.

D: Company doctor who would state, oh, the man could run the marathon or

F: Well, that would happen very commonly in deposition settings, and it did occur.

D: And how did that go? Would you

F: My experience in general, and this is, is probably -- well, I don't know if it's unique or not -- but the attorneys would have that information. So sometimes before and sometimes during the deposition process, I would have a chance to look at the medical information on which the company attorneys were basing their case. And it was very often that the information in there, I found helpful in supporting the position that I had. And I have to say one other thing, and I'm sure that the viewpoint would be the mirror image on the other side: that there were a group of competent physicians in Pittsburgh that routinely would be company experts. They would have given, done examinations, given reports in which one or two things would happen routinely, that is that they would not see pneumoconiosis there. There'd be a major disagreement on the X-ray from in some cases radiologists and in other cases general internists or even pulmonary doctors, that would have a much lower interpretation than we did or than our radiologists did. And the other was that even when their studies acknowledged the presence of pneumoconiosis, that there was one of two things -- either a strong downgrading of the level of disability, indicating that there was no disability present, or an attribution of the whole thing to cigarettes.

D: That was my [inaudible] my next question, was when they started blaming things on smoking.

F: I don't remember exactly the time, but it was as

D: As long as you were in the game, this was going on?

F: I would, yes, I think it was, it was, it was very widespread.

D: Okay.

F: And I don't know if it's relevant again. But my position on it was that there were two, in my view, there were two elements that, that, that were competent pathogens

for the lung, and I really couldn't sort them out. And I, I, it was my theory, if you will, that I couldn't prove as a clinician that they, just by logic or other medical analogies, knowing they're both present there and knowing whatever I knew about the pathology of dust and of pneumoconiosis, etc., etc., that they had some synergistic, complimentary effect. And I couldn't sort out the role. The other factor, of course, is that coal miners couldn't smoke while they were working. So that while they did smoke off the job, they, they didn't have as much cigarette exposure in many instances to non-coal miners would work, who would smoke on the job.

D: How prevalent was smoking behavior among miners at this time?

F: It was not uncommon.

D: More than 50%?

F: I don't know, I couldn't tell you. It was, it was, I think it was probably as common as it was in the population. I don't know what the numbers on that are.

D: , When

F: And we would get a quantitative cigarette history also, of course.

D: When, so you normally work, when you took the initial history you worked that up?

F: Oh, absolutely. That was part of our testimony.

D: And you would use pack years as an indicator?

F: Right, and if the person inhaled.

D: When the employer, employer's physician controverted your assessment of the patient, to what extent were they still using as a bench or as a yardstick classic silicosis. They would say, this man does not display the

F: I don't recall that as being a major

D: They didn't use silicosis as a rigid standard that, that these people couldn't meet?

F: I don't recall that. No, I don't think so. I think it was more an issue -- and these were people in Pittsburgh, either as a practicing internist who did a lot of this for the company, you know [inaudible] or even in some cases pulmonary doctors -- it was along the lines that I

indicated. Either they felt it was a different level of pneumoconiosis radiologically, or they felt that the person wasn't disabled, or they felt that in this disability, that the criminal was cigarette smoking.

D: Okay. And what's your recollection of the share of the cases that, that were valid cases that the miner won? I mean, were people winning the benefits, or were they largely being defeated?

F: I think it depended on the chronology, and I really can't remember that. But the success rate was lower earlier. It became much greater, and I don't know at what point in terms of the legal background that was the case.

D: But in the late 50s, early 60s, what share, just ballpark, what's your sense of how many people who really had disabling work-induced

F: I'm sorry I can't give you the time thing. That's important because at some point I would say they were highly successful. At some point they became highly successful.

D: Well, in '65 there's a major change in the law

F: Well, it may be that that's when the change

D: That's where things tip

F: And again I can't, I can't date it. But my guess is that that we became much more active probably at that point than we were earlier.

D: Okay.

F: That, that it was also people coming to us knowing, not even having learned it from the clinic, learning it through other -- union or public information or friends -- that it was a legal situation that gave them a strong position. But at that point, at some point, if we gave a strong medical basis, and they had a lawyer that was knowledgeable about how to do it, I would say there was a fairly high success rate. And the other thing was that, again, there were changes at the time, and I can't recall them. At one point the referees tended to be less knowledgeable about it and less sympathetic, and then later on they seemed to be more positive about it.

D: To what extent was Yablonski and the District 5 leadership supportive of filing these claims and actually helping to stimulate workers' comp action?

F: Again, I'm going to have a big problem in, in giving you the chronology. I would say that for extended periods of time they were very supportive and really promoted it very heavily in terms of getting the information out and in terms of encouraging people to act, in terms of telling people we now have a medical source of evaluation that we never had before. So that existed. It was some place along the line, and I think it was much later, and this is totally non, this is totally anecdotal and I can't even pin it down, that there was some impression I had or that miners had that you shouldn't push too hard or too much across the board because somehow it might adversely affect the industry.

D: But that, is this your sense that, that was after 1970?

F: I think it's much [inaudible], much later, yes.

D: With regard to comp in the 50s, early 60s, what's your recollection of the role of John Wusels?

F: Okay, that brings me to something that, that [inaudible]. Wusels, I think, was quite supportive, and now what he did in the background I don't know. But he, you know, he was quite supportive. And he was, he had trained himself to be a kind of non-professional attorney, and I heard him on a number of occasions talking about the issue and giving testimony of various kinds in these hearings. And he was very effective. And then there was the person who succeeded him, who, who may have been after '69.

D: After '69?

F: Who was his assistant before that, who was helpful. And what was very important was that in, starting in 1963 when they moved to New Kensington, it was a position established at the clinic, which was John, Jesse Wilkinson, who was a retired miner who incidentally died of what I would consider to be an occupational lung disease.

D: This is Wilkinson, W-i-l-k-i-n-s-o-n?

F: Yeah, and he was the president of one of the locals here. It was called benefits counselor. And I think it was established at all the clinics. And that person was expected to be knowledgeable about the whole range of, of potential things that could help miners, might have nothing to do with coal mining. But one of the focuses was educating, supporting, interviewing coal miners.

D: Was that done case by case? Was that a case study kind of approach?

F: It wasn't a study, it was a

D: I mean case

F: It was both general, and it was person to person.

D: So they went out to locals and gave educational presentations about your rights to get Social Security disability

F: Yeah.

D: Or whatever it might be

F: Yeah, I don't, I can't tell you to what extent it was done that way. But it was done that way, and then it was done on a person-to-person counseling basis where people actually

D: And they actively then facilitated workers' comp claims?

F: Yes, well, however, informing people, arranging for them to see the doctor, to get the studies, etc., etc., etc.

D: So it was a triage sort of function?

F: Yes, yes, yes. Among other things, a lot of people, miners came in through that network rather than directly to the doctor.

D: Well, this gives me, I think, a really good portrait of what the practice was like in the late 50s early 60s and how it then played into compensation issues. What I wanted to do now, if it's all right with you is to walk through a chronology of events just to tick off some meetings and names and places and see if you have any recollections. Well, we'll try. We'll see what you recall and what you don't. This must have been right when you were coming on board: in January of 1957 there's a meeting in Pittsburgh involving the medical staffs of all the clinics to talk about clinical research. This one seems to be at least in part an outcome of the little, I shouldn't say little, the clinical research project that Levine and Hunter had done at Bellaire and to kind of go on in that vein. You have any recollections of that meeting or of that initiative?

F: I don't remember that meeting. I remember the initiative very well because there were many meetings. There were meetings at Les Falk's house that you may have no record of, that, that, that looked at that and tried to pursue that. It wasn't only in relationship to

pneumoconiosis. It was in relationship to medical care generally.

D: But just sticking with CWP and the things immediately around it, do you have any a recollection of any of these early meetings in early '57? Very quickly the group gives itself a name. It's called the Pneumoconiosis Study Unit. And there's a meeting, for example, in February of '57 at Bob Schwartz's house, where they are working on protocols and

F: What was the date of that?

D: February 14, 1957.

F: Okay, I don't remember that. No, I don't remember that.

D: Basically, what they're trying to do is figure out a way to study pulmonary disability. They already recognize that.

F: I didn't mention to you. Have you heard the name Tom Ferrier?

D: .Sure.

F: Okay, well, Tom Ferrier is somebody who I haven't spoken to in five years or more, but he lives in Canada, and he was in Sault Ste. Marie Steelworkers program. And he was very much involved in that.

D: Will you spell Sault Ste. Marie?

F: I haven't spelled it for five years. He was a. He's very important to talk to for two reasons particularly around these questions. One, he was the medical director that preceeded me. He was a general practitioner who was very interested in this. And he was involved in developing some of the original protocols of Macy Levine. And then when I became medical director, he worked part-time in the fund office and part-time got an MPH at the School of Public Health. And then he was here until I think around '62 or '63, when he went to Sault Ste. Marie. And he would know a lot of that. Macy Levine is another person you should speak to, definitely, since that's the direction you're taking. I was working at the medical school and so for that and the fact that I hadn't assumed the job yet. Some of those things I may have missed [inaudible]. I was, I was not at Schwartz's house, I know that.

D: Okay.

F: But I was at a number of meetings that was interested in this issue.

D: Well, actually in fact that initiative doesn't really go anywhere. They're going to design a project, and it doesn't really

F: Well, I think maybe it did in the sense that the Stoeckle, Harriet Hardy thing was the outcome of that. And the protocol that was used for the questionnaire, I think, was probably designed at least in part by Tom Ferrier and Macy Levine.

D: I see.

F: Maybe with Stoeckle.

D: How about some of these British visitors? In 1958 Jethro Gough comes to Pittsburgh. Do you have recollections of that?

F: Yeah.

D: What was that like? Tell me about that.

F: Well, again I can't remember the whole day specifically, and again I may be, I may be merging these other things. But my recollection is that it was an all-day, at least one all-day thing, might be more than that, at the fund office in which he presented his stuff. I believe he had lung sections, and he would show them, etc., etc., etc.

D: And was that, obviously this is '58, and the clinic staff are already on board. You're already conceptualizing this as CWP. This isn't news to you. But were there practitioners from the community who were brought in who were

F: You mean non-clinic?

D: Yeah, were there people for whom this was an eye-opening?

F: Well, there was some pulmonary people in Pittsburgh who were friendly with the fund. No, I can't tell you what their reaction was. He would invite people in Pittsburgh who participated in the fund program as well as clinic people. The people from the clinic who would come wouldn't have been the whole clinic staff in Pittsburgh. I would have come, and probably Macy Levine would have come, and Tom Ferrier would have come. Probably Les Friedman would have come. I don't recall Gough coming out to the clinic. He

may have spoken at some other clinics, but I don't remember him coming to the Russellton Clinic.

D: But you have no other, any other recollections of that day?

F: No, except that these sessions were very dramatic. I mean

D: Very dramatic?

F: Yeah.

D: Okay. In December of '58 there's an episode that maybe you can shed some light on. The Harwick local, H-a-r-w-i-c-k local, mounts some sort of criticism of the Russellton physicians.

F: I remember that very well.

D: Of their handling of an occupational disease case.

F: Yes, yes, I don't remember enough about it, but I remember very well there were, there were three miners who somehow ended up having their disease recognized, who had been in some way, had come to the clinic and had felt that it hadn't been. That was the story.

D: So, that, they, they didn't get their disease diagnosed as work-related at the clinic? Or they got it diagnosed, but the reports weren't put together in such a way that they could win compensation? Or

F: I don't remember the, I don't remember the details of it.

D: Okay.

F: I remember that Mike Troyan, who was on the board

D: How do you spell that?

F: T-r-o-y-a-n, and who became a very big supporter, I think largely after that episode but was very critical of the clinic. I think he carried a lot of the If you had minutes of the meetings, it would be in the

D: The minutes are very sketchy.

F: You don't have board

D: I do have board minutes, but they're very, very sketchy.

F: Huh.

D: Here's what I have from the board minutes.

F: There were three, three miners. I think there were three. And I think that Tom Ferrier was involved with the program very much at the clinic, even though he had left, and Macy Levine. And I don't remember what happened except that they didn't feel that there was the recognition of the problem that it should have been. And then somehow I think that there was a doctor who was practicing, he wasn't a company doctor but he was practicing in Springdale which was right near Harwick, who was like a family doctor to many of the people. And I think he is the one who kind of supported them in some way or told them they had a problem. And that's what happened. Well, how come Doctor -- gee, I forget his name, it begins with an A -- how come, you know, what do you call it where our clinic didn't

D: Because he was making the diagnosis on cases that the clinic was unable

F: Well, it was these three particular cases. It was three particular individuals.

D: And once again, I'm still fuzzy on this. These, they just didn't get diagnosed?

F: I think you might, they either didn't get diagnosed, or they didn't have, they didn't feel they had the support that they should have had.

D: You mean in waging a comp claim?

F: Yeah, or initiating it or whatever.

D: Here's what I have. This is quite sketchy. December 21, of 1958, you tell the clinic board that there are going to be some changes made in light of this episode. And there're three things. Maybe this will help clarify some of this. First, from here on, all, you're suggesting that all miners have chest X-rays when they retire.

F: Okay.

D: This sets some kind of baseline, I guess.

F: Right, right.

D: Second, you're going to go out and recruit an occupational respiratory disease specialist, a pulmonologist. Whom, whom did you bring in then? Was this Lebovitz?

F: It was the Lebovitz-Silverman group.

D: Okay.

F: Yes, yes, they were in Pittsburgh. And I think they went to Centerville, but they didn't come to, to Russellton. No, wait a second. There was another person that came from Johnstown named, his name might have been Goldman.

D: I think that's the name I've seen in the records.

F: Okay, in any case, I think the criticism was leveled -- you refreshed my memory a little bit -- against Macy Levine, who was seeing, with or without Tom Ferrier, most of these cases. And Macy wasn't identified as an occupational disease specialist. He was a allergist who was interested in lung disease, who then became interested in this. He may have been recruited, so to speak, to do this by Tom Ferrier. Tom Ferrier was very interested, but we didn't have anybody that was recognized as that. And Silverman and Lebovitz and Goldman in, in Johnstown were. And again I don't remember the sequence, whether we had Goldman for a number of years, then he became ill, and we got Lebovitz's group or what.

D: Was Levine coming under attack by the employer's physicians, saying the man there really isn't qualified. He isn't, he's not a pulmonologist.

F: No.

D: Or he just

F: No, I think the attack came because of this incidence, this occasion.

D: And the third thing that you told the board you were going to do was to establish a register of

F: Right.

D: People with respiratory disease for

F: Right.

D: Follow-up.

F: Right.

D: What did follow-up mean -- an annual physical, or annual X-ray, or how? What did it mean that you were going to follow them up more systematically?

F: Well, I don't remember. You have to get the thing. But basically, I think it was getting their name down in the system and then have periodic follow, periodic visits for that reason.

D: In June of 1960.

F: I was very upset about it at the time.

D: Well, why was that?

F: Because it seemed on the one hand that we had failed in something that we had a central responsibility to do. I had just come on board very shortly before that. I don't know, what was the date on that?

D: This is the end of '58 here.

F: . Okay. So I was there for a year and a half and hadn't been, you know, that heavily involved so to speak in terms of, I think Tom Ferrier and Macy were doing it. And Tom Ferrier was certainly very powerfully motivated to do the job. And so it was partly that objectively we hadn't done a good job in, and this was an instance at least that I had become aware of. I don't think I was that aware that we had any defects in what we were doing. And secondly, because I mean objectively we weren't, and secondly because here's a situation where I think we were very conscientiously, well, both established for that purpose and trying to do it. But we're seen as, as, so to speak, at the best unsympathetic and as at the worst an enemy.

D: An enemy?

F: Well

D: Were, that sort of claims were made?

F: Well, you have to know Mike Troyan. You have to know the atmosphere of, of a board meetings were always big battles of all sorts. I mean it was a very, it was like a union meeting. There were mostly coal miners on the board and a

D: But this was also at a time when the -- and not to get into these larger issues that would take us too far afield -

- but this was also at a time when the clinic was very embattled, I mean.

F: Oh, absolutely.

D: I mean.

F: Absolutely, and there were all sorts of divisions and schisms. And a lot of it had to do with the fact that, that the, I mean, it became a very complicated mesh work of issues, that from 19, before I came to 1962 our doctors were excluded from the medical staff of the local hospitals by deliberate action of organized medicine and the medical staff.

D: To what extent would, did that larger conflict keep the advances that the fund and the clinic was making in the area of occupational disease from being more broadly disseminated, the fact that you folks were seen in a sense as lepers and as outsiders and unworthy of inclusion in the fraternity and all the rest of it. Would, did that mean that ideas like the conception of a coal workers' pneumoconiosis was somehow suspect? And was there, I mean, am I making too much of this or was there, but there was something there, right? You were marginalized.

F: Well, that's true. But I don't know that it played into the compensation issue.

D: It didn't discredit. I mean, not within the individual claims, but within the medical community, ideas didn't flow as readily if you folks weren't in the mainstream. Is that correct?

F: Oh, well. In the medical, are you talking about the larger medical community?

D: Yeah.

\ F: Well, it, of course everything was very muddied by this vision of these radical doctors and union people. I mean it was a kind of McCarthy, whole thing that went on on the local staffs. And on the medical side we were excluded from the medical society. I'm not sure whether Les, Les Friedman was kicked out of the radiology society. But our urologists were kicked out of the urology group. And, I mean, the whole thing was really wild. So what doctors as a whole may have thought, you know, I don't know. I mean, there was the problem that we were highly credentialed. We were, we were the best, most qualified specialists in the area, with one or two exceptions. There were very few certified trained people in medicine in the valley here then. There were

about two when we started. And then, so it became very complicated. I mean, I mean there was sometimes very grudging respect for us. On the other hand, you know, we were we were going to destroy medicine and health care. And to some extent there were allies recruited among the miners where they had a particularly strong relationship with a particular family doctor. I don't think that played a role in this particular instance because the particular doctor's name I can't think of certainly overtly was never an enemy of the clinics. He was a private practitioner in Springdale. He didn't set himself out as being, gee, I'm helping you, would you look at those no-good people up there. So I don't know that it played a role in that.

D: But in general in the terms of the way that the clinics were ostracized, isn't it, wouldn't you say that that to some extent this inhibited the flow of information and knowledge about

F: Oh, absolutely.

D: Coal workers' pneumoconiosis. If you had been

F: Well, about everything. We were totally cut off from the regular medical professional establishment.

D: Okay.

F: Absolutely, there's no doubt that.

D: So you where you might have been going to the county medical society and presenting a little paper on coal workers' pneu, case report of coal workers' pneumoconiosis, it just wasn't happening?

F: Oh, absolutely not.

D: Okay.

F: Absolutely not. I mean, I mean, we were in fact I [inaudible] the word lepers or whatever. We were totally persona non grata in, in organized medicine in the local hospitals and everything else like that.

D: Oh, now I don't want to push this too far, but do you think there's an extent to which it even made your general disputes and disagreements even made the notion of a coal workers' pneumoconiosis somewhat suspicious? It was another one of their crazy ideas.

F: Yeah, I, I mean, that definitely was, was a view that existed. And I, it would be hard for me to say how that

related to the other part of the conflict. There's no question that that existed.

D: But it was

F: The diagnosis was not made. In, in, the radiologist didn't know there was such a thing.

D: And so mainstream radiologists in the metropolitan area, Pittsburgh in the late 50s or early 60s, there was, am I being unfair to say, for most of them there was silicosis or nothing?

F: Yes.

D: Okay.

F: That's true, and they never would have included that in their diagnosis, even though there were instances where there were autopsies that, you know, showed this, that, and the other thing. So no, there's no doubt about that.

D: Okay.

F: No doubt about that.

D: And is it also fair to say that with, this was, the controversy over occupational respiratory disease, was inextricably bound up with these larger issues?

F: Yeah.

D: Okay.

F: Well, the whole idea that there would be a medical organization or physicians that were in any way related to coal miners in any kind of a quasi-organized way or the unions was quite a big, big factor in there.

D: And just, I have to ask you about this. What in particular did mainstream medical community think of the idea that miners sat on the board that governed the clinic?

F: Oh, the whole thing was just totally out of bounds, foreign, I mean. It's probably peripheral to what your main interest is. But you may find some stuff in the file. But I mean there were all kinds of crazy ads put in the newspaper on how we were going to destroy the pharmacists and the dentists and destroy medical care, and it wouldn't be available on Sunday. I mean here we were, open on Saturdays and Sundays and the evenings. And here's ads in the paper saying about how, you know, medical care would be

a nine-to-five thing if, if they let us into the hospital. And I don't know if you know, we eventually brought suit against the hospital and the medical staff. But it was extremely acrimonious. And there was very powerful [inaudible] not only to marginalize the clinic but to pose it as an absolute threat to everything that people should be defending -- the family, and hearth, and everything else.

D: But what you just said is of course just, just, [inaudible] that the role of miners in the leadership of this clinic in general and in this episode in 1958 particularly forced certain issues about occupational disease recognition to the forefront.

F: Oh, absolutely, forced to the forefront, forced whole ideas about medical care in places like coal fields, absolutely, in terms of the role of the company doctor, which was, you know, very substantial, both as the person that dealt with all sorts of day-to-day occupational things for coal miners and then also had started out functioning as the family physician for these people. The history of the Russellton Clinic in terms of why they were willing to organize, these five miners and so forth, was that they were having a terrible time with the local company doctor in Russellton. And it (the local union from Russellton) came to the, Les Falk and the fund people and said, we don't want to have this doctor as our check-off doctor any more. You know about check-off. And we don't want to relate to him at all, and we all heard such horror stories. We don't, maybe you don't

D: Did any of that specifically have to do with occupational disease?

F: Oh, there's no question that it had to do with work-related issues. Whether it had anything to do with pneumoconiosis, I don't have any idea. But there's not, yeah, no, no doubt about it. And they came to Les Falk and said, would you get us a check-off doctor of our own. We don't want to relate to this man any more. And it's a complicated story, but Tom Ferrier was in the area. And Les Falk had decided he wouldn't go with any comprehensive group-practice clinics. So they came back and offered to the local miners this kind of package, that we'll get you check-off doctors if you people will organize your own clinic. And so Tom Ferrier, and that was Tom's thing, Tom didn't want to come just as a solo practitioner. He was doing that in Imperial, which is south of Pittsburgh. But he wanted to have that kind of, you know, real program and a comprehensive service.

D: And was some of that just for camaraderie, that you had a group of people, like-minded people you worked with. I would think it would be pretty isolating to be in solo practice out in a coal camp.

F: No, it was very much a conception of health care. I mean, it was, there was a personal element to it. But more importantly, there was a strong conception that this is the way health care generally and specifically health care for people like miners working in a coal camp should be organized. And so basically the clinic, Tom Ferrier initially, took care over the check-off because the miners, the fund as you recall never did provide primary care. So it was the old check-off thing, I guess, imported from Wales [inaudible] that.

D: Now just to return to the check-off doctor, did prior to these [inaudible] the clinic, did the check-off doctor actively promote -- as you, as you picked it up second-hand, or maybe you talked to some of these fellows and they actually said it to you -- did they actively promote and perpetuate this idea that there was a miners' asthma that was essentially benign and inevitable and not very disabling? Did they keep that conception alive?

F: I really can't honestly tell you explicitly that I know that. There's no question that it was part of the thinking. I mean, I got to know Dr. Reynolds, who was a company doctor, after we got on the hospital staff. We used to sit down and have coffee together sometimes. It was a pervasive part of the thing that, that on the one hand they, you know, worked as a personal physician. But as the company doctor, there weren't really problems coal miners had related to their occupation. And that part of their role was to keep people working.

D: Second-hand, I assume you must have had patients who came into your office, who you knew had seen company doctors for years and years, who at one point said to you, "Doc, I have miners' asthma." And that they probably, or even said, "The company doctor, who saw me for twenty years, told me I had a little bit of miners' asthma." And it was no major concern. There must have been encounters like that.

F: Well, yeah, I mean, there's no doubt about it, that, that they had a problem, and in many instances there was no effort even to treat it. There was a lung problem that the miner often would relate to the occupation but was discounted as a problem by the, by the local doctor, and partly company doctors or other doctors who didn't even have

a company role but did, that certainly had no orientation to this kind of issue.

D: And just in terms of how this played out in the community, did people -- you often hear about these customs that people had, a shot and a, a shot and a beer after work was supposed to clean the dust out -- I mean, did you ever hear those kinds [inaudible] or

F: Oh, cigarette smoking was good.

D: Oh, really?

F: Yeah, where that notion came

D: Helped you cough stuff up or

F: Yeah, yeah.

D: Oh, I see. What about patent medicines or cough syrups or any of those others, was there much of a market in that sort of thing?

F: . I wouldn't know, really.

D: Okay, I [inaudible] sort of the way this was dealt with informally within the community, but

F: Yeah, I just don't know the answer to that.

D: In a June of 1960, the Pennsylvania Health Department brings its prevalence study to Russellton. Do you have any strong recollections of that experience?

F: This is Jan Lieben's?

D: Lieben's study.

F: Yeah, oh, yeah.

D: What was that like? Did the clinic help bring people in?

F: Oh, yeah, yeah. There was, I, I, I can't tell you details, but I know there was a very strong consciousness of that study, the opportunity, the desire to, to make it as inclusive as possible. And there would have been, I'm almost certain, although I can't think of the instance, there would have been discussion at the board level. There would have been discussion in the medical group clinic level of this. And then they came, and I can't tell you all over,

but a number of places they set up adjacent to the clinic. The

D: So they'd be in your parking lot or somewhere?

F: Exactly, and we tried to get the word out. And the unions, the local unions did have people come. And I happened to be interested in some other general miners' issues, for example, a thing called [inaudible] contraction and so on. We would have somebody that would also meet some of the doctors, miners there. I made it my business as medical director to be there in a number of instances. And to, you know, have a clinic presence, so to speak.

D: And what were your impressions of Lieben individually? Was he a

F: Well, it was very positive. He seemed like a very knowledgeable, very competent, and very devoted to getting to learn to making his study a success.

D: And there's a second study. There's a second state study in '63. Do you have any recollections of that?

F: As separate from the other, no.

D: One, one thing that is striking in retrospect, you know, it's easy to impose your own sensibility on the past and find, find people lacking. But it's striking in light of the right-to-know movement in occupational health in the last fifteen years of so, that it was part of the protocol of that state study that patients were not going to be notified of the results of their X-ray, unless they had active T.B. or they found cancer. They weren't going to be told what the results were. Did that stick in anybody's craw at the time, or is that just a later concern that we now have about that kind of the patient's right to information?

F: I don't remember that as an issue.

D: Okay.

F: I would not have remembered it if you hadn't reminded me now. If I try to think retrospectively, I guess the thinking would have been that was part of the deal. And, and that if they found a serious disease that needed some treatment, that they would but otherwise that was going to be

D: So it was in no way controversial, either with Russelton Clinic or

F: I think it was sold to miners to the extent that it was a compromise there. And I don't remember the issue coming up. But it was sold to miners as that this would advance knowledge of the disease and the problem that they had.

D: With regard to the Harwick case, how that might have been instigated was what exactly?

F: Was that I think that the miners might have seen their doctor in Springdale and either through him or perhaps not through him have seen Dr. Lebovitz and Silverman in Pittsburgh, and they were the ones who pursued the thing. And part of the background was that, again trying to recall, that the clinic did not have somebody explicitly like Silverman and Lebovitz, who had been seeing some -- memories are coming back. I think that they may have been the earliest people in the Pittsburgh area that supported miners. And that relates now, coming back to the terminology anthraco-silicosis, that I think they were the ones who used that terminology and had started winning cases.

D: Okay, so they were the ones who were. I seems to me that what the suggests then is that the Harwick, these three people got a glimpse of something different. They got a glimpse of perhaps a higher level of expertise. These were pulmonary specialists.

F: Yes.

D: And second, that they were using the magic words that were installed in the compensation code that won the cases.

F: I think that that's the case.

D: Okay.

F: And so the, the idea was that here was this clinic that had been set up by the miners and related to all sorts of things [inaudible], that some miners strongly supported and felt loyal to and other ones hadn't gotten into the thing. And here it was, a miners' clinic. But the clinic had somehow had overlooked this problem. They go into Pittsburgh and saw these people who were unassociated with the clinic, succeeded in the thing. How come? And I think that that was the background and one of the ways that we thought we should deal with it, which was the recommendations that you're talking about. There was to say, "Well, let's bring these people up to the clinic, and

we'll have the service there." And I think, that was the history of that.

D: Okay. Because, right, there's a plan to recruit an occupational medical, or an occupational respiratory expert, but in fact you don't hire someone and put them on staff. You set up what? It's a consultant relationship with Lebovitz.

F: Well, yeah, except that that was the way we dealt with all sorts of subspecialties that we couldn't afford. I mean, we weren't that big at the time to have on a full-time basis. Now at some point I, and maybe I don't have the sequence right, because it could be even that that's when we got Goldman from Johnstown. It may have been there or afterwards, but in any case there were those two people who came in specifically to, not only our own people, screening them and having them and being triaged into that kind of evaluation, but that, but we had these people who were recognized as, as historically and otherwise as having done that.

D: In the middle of '64, there's the long-awaited federal prevalence study. The Public Health Service does a study. They do it over the course of '63 and '64, but it's in Pennsylvania in the summer of '64. Have you any recollections of that experience?

F: Yeah, I'm afraid that maybe I've merged some of these things. There was several waves of these things. And I, I really can't separate out in my mind what part was Jan Lieben's study and what part was the federal study.

D: This was people like Henry Doyle and Clark Cooper.

F: Yeah, but I, they didn't have the kind of presence that Jan Lieben did. I mean, I mean in terms of our consciousness. So I really can't separate.

D: Okay. Later in '64, on November 30th and January, or December 1st, there's a conference in Harrisburg, the Governor's Conference on Pneumoconiosis. Did you go to that conference?

F: No.

D: No. But that leads directly in the following legislative session to workers' comp reform in Pennsylvania. Did you have any involvement in testifying or helping shape a bill or rallying support for those reforms? You weren't involved?

F: No

D: Okay. Well, that really takes me through a lot directly or events directly in Pennsylvania. I guess I, the only thing I'd like to ask you in terms of the chronology of events here is, how you perceived the explosive developments in West Virginia in '69 -- the whole black lung insurgency in, in the, you know, the legislative hearings and the massive demonstrations and the big strike? Did that have shock waves that ran or rippled through this part of the world? Or how did you see that?

F: I don't remember it as a, I don't remember it as a separate and distinct thing that, that, you know, was different than what we saw developing here.

D: Okay.

F: I mean, it seemed to be like it was becoming a much more mass within the union situation, I suppose a more explicitly politicized thing. But I, again, I can't separate the chronology. But I thought, I think my notion would be that the existence of our network of clinics and everything else was, kind of meeting the need. And that they were reflecting something there that hadn't occurred.

D: You were in, because Pennsylvania did have workers' comp reform and

F: Yeah, yeah, and then of course there was also the whole thing that I again, I can't in retrospect separate out but with the MFD and with, with what was going on here between Yablonski and Budzanoski, and I don't know if you know those things. And we did have a certain amount of familiarity with Yablonski and everything else because he was the person who kind of started the Centerville Clinic.

D: And what was your general perception of Yablonski's interest in occupational disease in particular?

F: I can't separate out from other things. He was seen as a very militant, very outspoken [inaudible] advocate of, of miners. Whether he was that or not I don't know. But

D: This is a

F: He was a very, he was a very personally powerful kind of person. I don't mean in the sense that, I don't mean in the sense that simply of what his supporters meant in a political situation. But if you were in the room with him, you felt the power of his personality.

D: Did your clinic see people from West Newton? Is that in your area, or is that with Centerville?

F: I don't remember that place.

D: Okay.

F: We saw people from wide areas, but I don't recall that.

D: Well, there was an episode in the, actually, a strike in West Newton with a local. Unfortunately, I'm blocking out. I can't remember whether I actually may have written it down.

F: We did, by the way, see people that were sent by the benefits counselor from Centerville because their medical staff was not that supportive.

D: Really, how could they not be? I don't understand.

F: Well, it was a matter of having [inaudible], and I don't remember whether it was during a little window time because I know that Silverman went down there from time to time. I mean, I know that he came there on a regular basis. I remember meeting him down there. Whether that relationship ended or whether there were specific instances, I'm trying to think. And it may have been, I'm trying to think of the dates. After Bob Schwartz left, there was a person who became medical director there who was -- this is beside the point -- he was an ex-army officer. And as I recall, he wasn't that sympathetic to a lot of these notions, and it was. I mean they were [inaudible] doctors, and [inaudible] there was some question as to whether they were being helpful in the occupational and lung disease area. The person who had Jesse Wilkinson's job down there -- I don't know if he's still alive -- his name was Mike Encrapera.

D: Uh huh, I've seen his name on a number of work-ups

F: And you want to pursue some of these things that you can get better insight in, from speaking to Yablonski.

D: I actually don't have anything more, chronologically. I guess I just want to catch your recollections of a few people. Les Falk, was he a supportive guy? Or what was your relationship with him?

F: Just incredibly devoted, I mean, he was, I would say, incredibly devoted to three kinds of things at least. One was the general medical care, phenomenal in that he participated and led the spawning the idea that the regionalized community based group practice thing with

consumer pro-union governance [inaudible]. And secondly, he was very supportive of the union having a presence in these things. And thirdly, he was interested to this occupational disease issue. There were a lot of other people who came through besides Gough that came through. I don't remember them.

D: Well, let's touch on some of those if they made any

F: Well, they did. I can't remember their names. If they

D: Well, I think Fletcher came through at some point. And a

F: I can't sort them out.

D: Yeah, well

F: The point is that there was a whole series every year or every two years of there being this thing that was organized by the fund office, that we'd invite people in the clinics who were interested, like the medical directors if it was people like Tom Ferrier, or Lebovitz. And we would invite other people in the community.

D: Did that

F: And we also would invite people like Merle Bundy and other people. It was a real attempt to reach out to the whole area, to have them have an opportunity to hear these people who were being brought in.

D: Did that give people a clear sense that they were really in touch with the sort of cutting edge of this?

F: Well, much more so than if it hadn't been, absolutely, no doubt about it.

D: What about, the person who orchestrated a lot of those visits was Lorin Kerr. Did you have much of a relationship with Lorin Kerr, or any? Do you have any anecdotes of any experiences with Lorin that might be worth preserving?

F: Yeah, he was, he was a very devoted to this issue and, and to the question of health care for the coal miners, yes, absolutely. [inaudible] that, gee, starting before '57, starting in the early 50s that he was involved in them. And I heard about his involvement before I ever came here.

D: Really? How about when -- I left this out somehow -- John Stoeckle did come to Russellton?

F: Oh, yeah, he came repeatedly.

D: Stoeckle is S-t-o-e-c-k-l-e?

F: I think I've got that right.

D: Okay. Well we

F: Its close enough that you can find him

D: We'll look it up.

F: If you check with Mass General

D: What, what was your interaction with him? I mean what, what

F: It wasn't that much. It was mostly knowing that he was coming down, meeting him. I don't remember if I made it to any of the presentations or not. But he would spend most of his time with either Tom Ferrier or Macy Levine, going through their protocols and selected [inaudible], I mean, looking at specific cases and deciding whether they were ones that they wanted to bring for the deep study up in, in Mass General. I think he probably saw patients when he came down, too.

D: Do you think that they, among the other clinicians with the clinic, did the Harvard study contribute to their rethinking the disease, thinking of it in broader terms because obviously the Harvard people were concerned

F: Who's their?

D: The Harvard people, this broader conception of, of the wide range of hazards that all conspired to bring about a [inaudible], you know.

F: Well, I don't think, I'd say that we gave that to them. I think that's [inaudible]

D: No, no, I'm talking, did they give, did they influence your thinking about the

F: Oh, yeah.

D: The range of factors that went into the

F: Oh, I think so, sure.

D: Okay.

F: Yeah.

D: Because it seems that there's always been this tension between broad conceptions of the problems and narrow conceptions. And CWP was in a sense, was in a way a narrow conception. Black lung is a broader umbrella-type term. Miners' asthma, for all its limitations and connotations, was an umbrella-type term. And there's always this tension between conceptions, you know, a narrow construction and a broad construction.

F: Well, I, I really can't tell you how it impacted in a broad way. It impacted very strongly on me. Because as I looked at the problem as a clinical problem or as I looked at it in supporting people's claims, it seemed appropriate. That was always something that I was very impressed by, the broad conception. And so in giving testimony or whatever, that was my starting point. I did see the necessity of connecting that with the magic words. And that was really what I did and that, I mean that, [inaudible] there are some little studies here and there that had nothing to do with pneumoconiosis, but for example studies that showed that dust nonspecifically does things to the airways -- you know, whether it's coal dust or anything else -- that that is potentially deleterious. And, and the fact that chronic bronchitis, which is always used as the disease that these people have from smoking, I always try to see and understand as being something that occurs to people that have been exposed to dust. And that, again, you couldn't distinguish it, I mean, in terms of how the airways react and how mucus cells reacted and that sort of thing. So it was always seen in a very global way by me. And I think that they had a big impact on the way I thought about it and, and in terms of dealing with it as an occupational disease or as a legal issue. That was always the way I approached it.

D: But clearly bronchitis was not a winner in the workers' comp setting. You couldn't get anybody workers' comp in Pennsylvania in the 50s and 60s for bronchitis.

F: No, but, but, but as somebody who as a physician was trying to give information, I, I would tell people that dust does a bunch of different things. And it causes pneumoconiosis, and it causes deposition, and it causes micronodulation and, and, and the terminal emphysema kind of things and so forth and so on. And you know the fact that they smoked, that wasn't something that I could sort out. And if in that context I felt the person was disabled, that there was X-ray evidence that there was a history of a lot dust exposure, that there was X-ray evidence of pneumoconiosis, that that's the approach that I took. And at least at some point, and I can't tell you in the history

of the law or giving testimony before '69 or after '69. I mean, it may be that my giving testimony in these cases really was more later than earlier. Because as long as Lebovitz, Silverman and Goldman were doing that, most of that was done by them.

D: Ah hah. And they were very much wedded to seeing this radiologically. Seeing this as, they were, they were willing to, they saw that there was something called CWP. But they weren't as, were they not as comfortable with broader notions of industrial bronchitis?

F: I don't know that. I don't know that. But they, they handled the expert witness part of it, mostly because that's what they were doing at the clinic. They were seen as the experts. They had had much more experience than, you know, than we had had or that a primary physician or an internist would have had. So I can't tell you, I know, and I suspect that it had to do with as the legal things became more clearly established, in terms of the law in Pennsylvania and otherwise, that people like myself became much more, much more involved in, in not only taking care of people clinically as personal physicians but also as a people who gave expert testimony

D: Okay. I think that about exhausts the topics that I at least came here with. Was there, is there anything else you want to observe about the history of coal miners' diseases in the period of the 50s through the 60s?

F: Well, in terms of our microcosm, I think that, that looking at it and trying to understand it in a broad way really depended upon the kind of health care system that the fund and specifically Les Falk promoted. I mean, I mean, by having this kind of a relationship and this kind of a history and being out in the community, I think that was very important. Incidentally, again this is probably tangential to your interest, but you know within the fund there was a certain amount of tension and controversy about as to whether this kind of program was even worthwhile.

D: Which program?

F: Having community based.

D: Oh, okay, the clinics.

F: Clinics, yeah. They started out, you know, totally as being a cash indemnity type of thing that under the guy, what was his name now, who was the first director of the fund [inaudible]?

D: Draper

F: Draper, yeah. I mean, he was brought there as, as being an establishment person. And, and, and he learned along the way that you couldn't provide health care that way because the fund was raped. And so he, he became more sympathetic over time. And then Josephine Roche became more sympathetic over time. But there were always people in the fund who didn't think they should be encouraging the development of these kinds of programs.

D: So that created a (phone rings). So to characterize the way in which the clinic structure helped bring about disease recognition, it was a number of the dimensions of that, that it was partly that you were just that much closer to the miners. Instead of being some big citadel in the middle of a city that the people had to go to from some distance, you were down in the community. That was part of it. That you were multi-speciality, that you could exchange information among yourselves and the staff that much more readily.

F: Yes.

D: . Were these all parts of it?

F: Yes, absolutely, plus the fact that the history and the resources came from the miners for the general medical care. We had a responsibility to take care of what miners and their families needed.

D: And besides the money, the governance structure, they were the board.

F: Oh, oh, oh, yes, absolutely. And that was an important point that I was going to make, that this Harwick thing, which I had completely forgotten and was just, I think, a great example of something that happened in terms of providing a service, that would've kind of slid by, probably without happening in that form had it in a sense of of bringing us more expert or experienced service to the community, not in Pittsburgh, and having it as part of the general health care. I mean it was seen as part of the total universe of health care, which was, was not going to be separated out of that. That's why it's broader. That was very important.

D: Well, well, that, that, that seems to be a real deep problem in general is the failure to integrate occupational health or occupational medicine into primary, or any part of medical care, primary care, or secondary care, whatever. Is that, that just wasn't happening, that occupational health was something that the company doctors did and screened

people, and there was the compensation disability aspect of it. But it was really not something that was at all in the mainstream.

F: Oh, absolutely, plus the fact that physicians don't generally, unless they do it instinctively as individuals, understand their responsibility as advocates. I mean, the profession, like most professions, is a conservative profession. But it is recognized within the domain of medical care in a, in a, in a explicit kind of way of standards that that is a role of a doctor. But in terms of translating that into real life and the subjective thing that, parts of it, and I don't know what the social, sociological analyses would be in terms of how doctors see themselves and who they relate to. But the idea that, that physicians do have an obligation to try to relate to these issues and to the extent that people need help -- whether it's an occupational disease or whether it's Social Security benefits that they're entitled to, whatever -- they have a role. And the whole clinic structure and culture was such as to give greater support to that kind of a notion and responsibility and because of the board, because of the history, because of the financing, etc., etc., because of the presence of, I mean, Les Falk played an important role, I mean, trying to project out a kind of philosophy of health care.

D: Well, I think we've hit some of the main points that I wanted to hit. And if there's nothing else that you wanted to add

F: I may think of things because, I said, I always prided myself on my memory, but you demonstrated how poor it is, you know, for some of these details. On the other hand, you did trigger, you know, remembering some names that I had forgotten. And if you decide to pursue the miner interviews, call me because I'll try to think more about it, to get names. And I would encourage you, if that's going to be a part, as I said, don't wait too long.