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Asbestos Screening and Education Programs for Building and Construction Trades Unions

Sandra Tillett and Patricia Sullivan, BA

Worker notification involves informing current and past employees of their risk of disease. It also involves suggesting ways to reduce their risks. The asbestos screening and education programs designed for the building and construction trades unions were a national multisite effort that focused on improving the health of eligible union members and retirees at high risk of developing asbestos-related disease. The asbestos screening and education programs were made available to "high-risk," asbestos-exposed local union members through the efforts of a number of international unions, including the International Union of Elevator Constructors and the Laborers' International Union of North America—both affiliates of the Building and Construction Trades Department, AFL-CIO. Consultation and program assistance in developing and implementing these programs were provided by the Occupational Health Foundation, a labor-sponsored, nonprofit organization with a multidisciplinary safety and health staff. Program components included identification of "high-risk" individuals, notification of risk, education, medical screening, legal referral, and various support services. Community-based physicians and/or physician-staffed mobile testing units provided services on a contractual basis according to a standardized medical protocol. Between 1988 and 1991, 2,136 union members and retirees from 89 local unions affiliated with the Elevator Constructors or the Laborers were screened in 59 regional programs. A general description and historical perspective are offered concerning program implementation, integration into existing union infrastructures. Emphasis is placed on the role of the unions in advancing members' interests when dealing with the health and socioeconomic implications of asbestos-related disease.

Key words: high-risk management, medicolegal screening, elevator constructors, union health programs, worker notification, laborers, risk communication

INTRODUCTION

During the past decade, a number of international unions have become involved in research or service activities that include the delivery of asbestos screening and education programs to workers who have been or who may be exposed to asbestos during the course of their work. Among these unions are several affiliates of the Building and Construction Trades Department, AFL-CIO, including the International Union of Elevator Constructors (Elevator Constructors) and the Laborers' Interna-

Occupational Health Foundation (S.T.) and Center to Protect Workers' Rights (P.S.), Washington, DC.
Address reprint requests to Sandra Tillett, Occupational Health Foundation, 815 16th Street, NW, Washington, DC 20006.
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tional Union of North America (Laborers). Between 1988 and 1991, the Elevator Constructors and the Laborers sponsored national asbestos screening and education programs directed at local union members at high risk of developing asbestos-related disease because of past exposure. Efforts were facilitated by the Occupational Health Foundation (OHF), a labor-sponsored, nonprofit, safety and health service organization with experience in the design and delivery of large-scale, multisite health screening and "high-risk" management programs [Tillett et al., 1986]. The OHF collaborated with each participating union in providing coordination at the national, regional, and local levels.

All programs followed the same model, which comprised a standardized protocol and questionnaire along with uniform reporting forms. Slight variations in program design were made, when necessary, to accommodate differences in union structure and/or to address unique circumstances. Generally, the programs were limited to those with more than 20 years since first exposure to asbestos. To date, 2,136 union members and retirees from 89 local unions affiliated with the Elevator Constructors or the Laborers have participated in 59 regional programs.

This paper provides a general description and historical overview. Emphasis is placed on the program design and on the role of the unions in making this service possible. With a desire to advance members' interests and to promote an enhanced quality of life, the program incorporates elements of public health and reflects union ideology in addressing the socioeconomic implications of occupational disease. Still, this program should be viewed as a demonstration effort, providing a union-based example of one possible approach in responding to the needs of designated high-risk populations. Many methodological, organizational, and economic difficulties still need to be adequately addressed in developing effective approaches to notification and intervention for high-risk occupational groups [Schulte and Ringen, 1984; Samuels, 1982].

The "union model" described here initially focused on the development of a standardized medical protocol and forms. Attention was also directed toward identifying program financing, identifying community-based physicians and attorneys, identifying and communicating with "high-risk" individuals, providing logistic and support services to unions and health care providers (e.g., determining eligibility, scheduling, etc.), providing educational programs and materials, and assisting locals and members with follow-up issues. The program was designed to accommodate research initiatives, but was not conducted as a scientific study.

BACKGROUND

By the mid-1980s, attorney-sponsored asbestos screening programs were being widely offered to local and international unions with members who had been potentially exposed to asbestos over the years in a variety of trades and crafts. These programs were directed at identifying individuals with asbestos-related disease for the purpose of initiating third-party, toxic tort law suits against the manufacturer(s) of asbestos products or materials. At that time, settlements or court awards to workers ranged from thousands of dollars to a million or more dollars, depending on the diagnosis and severity of disease. Attorneys typically agreed to provide legal representation on a contingency basis–agreeing to be paid a percentage of the amount received. It was not uncommon for attorneys to ask for 40% contingency rates.

Anecdotal information and physician review of selected protocols indicated varying levels of content and quality in a number of attorney-sponsored programs. The unions expressed support for their members in pursuing their legal right to compensation but did not feel confidence in many of the programs that were being provided. Reports of minimal services and high contingency fees raised questions about whether the best interests of their members were being represented.

By 1987, the OHF had prepared a document to provide "guidelines to local unions in selecting physicians or attorneys." Its availability was announced to a number of unions with populations believed to be in a high-risk category. This resulted in a number of articles in union newsletters and distribution to local unions seeking advice from their internationals. Efforts were also directed at identifying and/or developing a "model" asbestos screening and education program that could be tailored to meet individual union needs and structural organization.

Meetings between union officials, physicians, and attorneys raised many medical, ethical, and economic issues. Several attorneys advocated a low-cost screening program that utilized a "no-frills" assembly-line approach and relied on a single posterior-anterior chest X-ray. With some exceptions, a lack of attention to education and physician follow-up was apparent. Some of the programs utilized vans that traveled the country, stopping at union halls to screen members who were standing in line for their "free" examination. Notification of screening results were sometimes sent by physicians or van companies and sometimes by the attorneys sponsoring the examinations. The content of the letters was varied but often they were not understandable to the people who received them. In some instances, only those who were found to have a possible asbestos-related disease were notified of their results. The focus was on representing the legal and financial interests of those identified with disease.

Unable to influence effectively the majority of attorneys contacted, the unions and the OHF identified consulting physicians to begin the development of an appropriate medical screening protocol. Among the issues the unions stressed in designing their programs were the following: 1) identification of community-based physicians for screening and/or follow-up services, 2) the need for a defined and appropriate medical screening protocol, 3) "timely" transmittal of medical results to all participants (not just those found with an asbestos-related disease), 4) transmittal of information more readily "understandable" to working populations, 5) the need for education, 6) the need for logistic and support services to unions and health care providers (e.g., determining eligibility, scheduling, billing, etc.), and 7) consultation and assistance to local unions in the conduct of the program and in providing follow-up services. Under the direction of an occupational health physician, a medical protocol, questionnaire, and reporting forms were developed. Field testing of survey instruments was conducted. Various physicians, public health officials, attorneys, and union safety and health specialists conducted reviews at various stages of the project. A number of funding options were identified, and, in January, 1988, the first pilot programs were conducted for local Laborers' unions based in Washington, DC, and Detroit, Michigan.

BUILDING AND CONSTRUCTION TRADES UNIONS

Unions affiliated with the Building and Construction Trades Department, AFL-CIO, represent members whose work includes building construction, rehabilitation,

renovation, demolition, and maintenance activities. Workers in the trades are often hired on a temporary contract basis. They report to a variety of employers at different worksite for varying amounts of time during the course of the year. Many have been exposed to a wide array of asbestos products over extended periods of time. In addition to first-hand exposure, construction and demolition jobs traditionally involve multiemployer work environments where the potential for bystander or neighbor exposure is high. This paper focuses on the experiences of two Building and Construction Trades affiliates in providing asbestos screening programs for their membership, the Elevator Constructors and the Laborers.

Among the potential exposures identified for Elevator Constructors employed in construction, renovation, and maintenance operations is asbestos. This substance is present as sprayed-on insulation in elevator shafts, as elevator clutch or brake linings, and as insulation in the doors of elevators and in various places in elevators' powerhouses.

Laborers have been exposed as "helpers" or "tenders" for the other trades or in "cleaning up" the work sites. They have carried insulation for asbestos workers, mixed dry asbestos into plaster compounds for plasterers, and cut asbestos shingles for roofers. In addition to construction and demolition, they have been potentially exposed in shipyards, in powerhouses, in mining and tunneling, and during pipeline construction.

FINANCING

The programs described here were financed through jointly administered union-management Health and Welfare Funds. These funds provide health insurance coverage to eligible members at the national, regional, or local level. Within the scope of the plan, the program was viewed by the Trustees of participating Funds as a health benefit similar to wellness activities already underway. The Trustees adopted appropriate resolutions in support of the program, allowing eligible members to claim a benefit payment. Those identified during the screening with a possible asbestos-related disease were referred for further tests and a diagnostic evaluation. Repayment to the Fund for costs incurred could be arranged for those members with a definitive diagnosis of a work-related disease who were successful in obtaining workers' compensation or a legal award or settlement.

ELIGIBILITY

Participants in the medical screening programs were generally limited to those with 20 years or more since their first exposure to asbestos in their work or to those with respiratory or other physical problems that warranted inclusion in the screening program. In addition, it was necessary to be eligible for insurance benefits through the Health and Welfare Fund at the time the screening occurred or to self-pay for the cost of the examination.

Eligibility for insurance coverage during a specific period of time required that the member work a predetermined number of hours prior to the insurance coverage period. Generally, the year was divided into quarters (3-month periods). Coverage was provided to members who worked the predetermined number of hours during the preceding 1 or 2 quarters. Members without the prerequisite number of hours could

elect to pay the cost of the insurance premium themselves. Retirees were permitted the option of continuing insurance coverage after retirement by self-paying the entire cost or a reduced cost, depending on the Health and Welfare Fund structure. Most retirees, however, discontinued this insurance coverage when they became eligible for Medicare.

IDENTIFICATION OF PHYSICIANS

Screening programs were provided in community-based clinics or doctors' offices, at union halls, or through the use of mobile testing units. Each local program required identifying one physician to direct local efforts, including organizing and staffing for each program. Physicians residing within close proximity to the members and their families were given preference in the selection process. Criteria for selection of physicians included the following: 1) specialized training, experience, and an interest in the conduct of large-scale health screening and health promotion programs in occupational high-risk groups, with appreciation for stated objectives and a willingness to report collected data; 2) possession of or access to necessary equipment or facilities; 3) experience working with unions on behalf of workers; 4) willingness to conduct education sessions for groups of workers; 5) competitive costs; and 6) willingness to provide quality assurance.

In setting up these programs, there were several acknowledged problems, including the limited number of physicians competent in the area of occupational disease and willing to conduct screening programs for a reasonable cost. Also of concern was the wide geographic dispersal of local unions in large and small cities along with the possibility that, in some instances, few eligible workers would be available for screening. This was compounded by the unions' stated desire to have the programs conducted on Saturdays.

Within these constraints, primary consideration was given to finding appropriate community-based physicians. In some instances, arrangements were made for local health care providers to collaborate with identified physicians in order to gain experience in the conduct of large-scale asbestos screening programs. In other cases, van testing was provided with an on-site physician who had established a link with the local medical community. Communication between participating physicians was encouraged, and a consulting occupational health physician was available to answer questions or provide direction.

Participating physicians generally provided the programs at a discounted rate, often according to a "sliding scale," with greater reductions offered for higher participation. Cost savings were achieved, in two instances, by scheduling two different local unions with small numbers on the same day–one group in the morning and the other in the afternoon. Physician charges covered the cost of medical examinations as well as administrative fees and attendance at educational sessions. They ranged from $105 to $205 per participant.

MEDICAL PROTOCOL

The minimal medical components of the screening program included: 1) administration of a standardized occupational and personal health history questionnaire; 2) limited physical examination, including blood pressure measurement, examination

of the chest, and examination for clubbing of digits; 3) two chest X-rays, PA and lateral (with "A" or "B" reading); 4) spirometry (to include FVC, FEV_1, and midflows), which met the following criteria: three acceptable FVC maneuvers at a minimum. ("acceptable" includes adequate understanding by the patient, an unhesitating start, and apparent maximal efforts, with a smooth continuous exhalation; two of the three acceptable efforts must be within 5% or 0.1 liter of each other, whichever is greater); and 5) stool specimen for guaiac test. Agreements required that follow-up medical procedures be performed in accordance with standard medical practice. This included referrals to community physicians or a return visit for those individuals, identified in the screening program, with abnormalities including pleural disease, increased interstitial markings, decreased lung function, or other medical diseases not currently under treatment.

Participants in the program received available preliminary results on the day of screening, a meeting with the physician, and final written results within 4–6 weeks of the examination. Sample letters, designed to be more readily understandable to workers, were provided to offer guidance in the transmittal of final results.

OUTREACH AND PROGRAM LOGISTICS

Notification, outreach, and recruitment for the program were accomplished through the local union. Consultation and direction were available through the respective international and the OHF. The international and/or district offices assisted in a variety of ways. Each situation was assessed on its own merit, and a contribution was made as the need was identified. Among the services provided were administration and reporting at the international or district level, assistance in negotiating the program with the Health and Welfare Funds, publishing newsletter articles, generating computer listings of eligible members, and general "trouble shooting" as the need arose.

The OHF provided assistance to local unions in identifying eligible members and in facilitating membership notification, educational activities, appointment scheduling, and billing. Representatives participated in planning meetings, as needed, and acted as liaison between the local, the Health and Welfare Fund, medical facilities, physicians, and counsel involved in specific screening programs.

Union officials and staff provided local coordination and assisted the members and retirees as needed. While extensive outreach was generally not conducted, local unions did send out letters of invitation, announced the program at membership meetings, and advertised its existence in a variety of ways (e.g., articles in union publications, notices on bulletin boards, etc.). Local union officers and staff assisted the members and retirees with explanations, scheduling, and a variety of follow-up services. Some of these services included assistance in explaining the medical results they received, filling out insurance papers and other forms, helping to reconstruct work histories, and assisting in obtaining follow-up medical treatment.

EDUCATION

Stated educational objectives called for providing information on: 1) asbestos-related disease, 2) safe work practices, 3) future medical needs, 4) smoking cessation, and 5) legal rights. This was accomplished in a variety of ways.

Written educational materials were developed or identified including brochures, "fact sheets," and other documents. These were tailored to each membership to accommodate differences in literacy rates and type of work performed. Written materials were provided to inform family members of their potential risk. Each contracting physician was asked to provide written information about the availability of local smoking cessation programs.

Laborers' locals sponsored "education sessions" approximately 2–4 weeks before the screening date at a general membership meeting, with the local health care provider and attorney in attendance to make presentations and answer questions. All members were encouraged to attend, not just those deemed eligible for the screening examination. At these meetings, two 10–15 min video tapes produced by the Laborers' Health and Safety Fund of North America (a union-management organization) were available to 1) describe the screening process and health risks to exposed members and 2) offer medical and legal information to those who might be found with an asbestos-related disease.

Elevator Constructors, whose members may live great distances from the cities where their local unions are based, asked that physicians supplement written materials with presentations and/or meetings on the day of screening. Educational efforts were directed at the total membership through letters and publications mailed to their home.

Both unions requested a postscreening meeting with the physician and attorney in attendance. This generally occurred 6–8 weeks after the screening and included a presentation by the physician providing the aggregate results and the attorney providing an overview of legal issues. The physician and attorney were present to answer questions or administer to individual needs.

PARTICIPATION

Local unions were invited by their internationals to participate in these programs. When feasible, unions in close proximity to a centrally located city were asked to participate as a part of a regional initiative. While the unions determined what constituted a "reasonable" driving distance, efforts were made to ensure that the majority of the members were within a 1 hr drive and/or that buses were provided or car pooling arrangements made. Fifty-nine regional programs were conducted in 54 cities. In two cities (Shreveport, Louisianna, and Little Rock, Arkansas) Elevator Constructors and Laborers participated on the same day, one group in the morning and the other in the afternoon. In three cities (Detroit, Michigan, Cincinnati, Ohio, and Louisville, Kentucky), programs were provided for both groups but not on the same day. In each instance, the programs were separated by at least 6 months. Members were invited to participate by their locals (sometimes in combination with the international or district office).

The Elevator Constructors' program began with a pilot screening in Philadelphia, during November, 1988. Over the course of the next 2 years, beginning in Boston on January 28, 1989, and ending in Wichita, Kansas, on April 5, 1991, a total of 1,088 union members and retirees from 60 local unions were seen in 42 cities.

The Laborers' pilot efforts began in Washington, DC, and Detroit in January, 1988. To date, 29 local union asbestos screening programs have been conducted by

various physicians involving 1,048 members in 17 cities throughout the United States. This program is ongoing.

Individual participation rates appear to be low. They should be viewed, however, only as approximations, since they rely on local and/or international union counts of their eligible membership, i.e., those with greater than 20 years since first exposure to asbestos. Prior to scheduling appointments, eligibility was confirmed by assessing responses on a short self-administered questionnaire that provided information on past exposures and birth date. This was, however, done only for those wishing to participate in the program.

Given the aforementioned limitations, the overall rate for Elevator Constructors was calculated at 16%; for the Laborers it was 17%. It is acknowledged that the invitational nature of the program and the need to have health insurance through the Fund to cover examination costs raises additional questions about the reliability of these figures. It should also be noted that the program was offered in a time of recession; in many parts of the country, the lack of jobs had a corresponding effect on the number of members eligible for health insurance coverage. Of additional concern is the fact that very few retirees maintained insurance coverage after retirement, and their participation was severely limited by the need to self-pay for the examination. Of the 2,136 participants, 151 (8%) elected to self-pay. The majority of the self-payers were retirees.

MEDICAL RESULTS

Medical results have not been analyzed. They would not provide reliable figures, due in part to the low participation rates achieved and potential for self-selection bias. These programs were designed to provide a service, and the aggregate reports submitted by physicians for each local union have, to date, been the primary basis for arriving at gross estimates. The Laborers did request the return of standardized reporting forms, which are currently being reviewed.

Preliminary information abstracted from available summary aggregate data, physicians' reports, copies of notification letters, and/or medical provider reporting forms suggests that approximately 18% of Elevator Constructors and approximately 37% of Laborers, participating in local screening activities, were found to have evidence of an abnormality consistent with asbestos-related disease.

LEGAL ASPECTS

Local attorneys were identified for each of the 59 regional programs. They were asked to conduct education sessions during various phases of the program and, if approached, to assist members with occupational disease in pursuing their legal right to compensation for lost income, medical treatment, and other related damage. Stated objectives in selecting local attorneys required that they: 1) be knowledgeable about cases that involve exposure to toxic substances, 2) be experienced and able to pursue workers' compensation claims in full, and 3) have the ability to communicate with union members and to respond to the union members' needs.

Attorneys were asked to provide basic educational information concerning workers' rights, the types of compensation that may be available to union members with occupational injury or disease, information about the state's statute of limitations

(which requires injured workers to act affirmatively by initiating legal action within a prescribed period of time), and other pertinent information. The identification of local attorneys who met the selection criteria and who were willing to participate in the program was not as difficult as the physician selection process. This was due, in part, to existing relationships between unions and the attorneys who represent their members in this area of law. It was also facilitated by existing nationwide attorney networks.

Reduced contingency rates were offered in bringing third-party suits-generally in the range of 25% to 33.3%, depending on the complexity of the case. Some fees were reduced to 20% for claims handled through an administrative proceeding. Fees for workers' compensation cases were those fees customary to that particular jurisdiction, usually set by the workers' compensation agency.

CONCLUSIONS

The programs described here were developed and implemented in the face of a litigation-driven trend to identify individuals with asbestos-related disease. In many instances, the attorney-sponsored programs constituted "notification" of risk to segments of the work force not previously studied or identified as a high-risk cohort in the scientific literature. With varying levels of guidance, attorney-sponsored programs with different medical components, services, and benefits were put together and made available to local unions. Their existence reinforces the need for greater attention in developing appropriate models and programs to address the health and socioeconomic needs of workers previously exposed to a variety of toxic substances and processes in the workplace.

One positive outcome of these endeavors was the development of a national model of notification, screening, and education for high-risk asbestos-exposed union members. This model is easily modified to accommodate other substances and health issues. Union staff and volunteer members have gained knowledge and experience in the administration and delivery of such public health-oriented programs.

There are a number of obvious limitations in assessing the overall effectiveness of these union-sponsored programs, including the absence of a formal evaluation plan. This was due primarily to a lack of available funding. Efforts should be directed at fostering associations between unions, who wish to deliver service programs, and researchers, who can assist in identifying and obtaining research funding to support such activities.

Even in the absence of supporting data, union personnel at the international and local level felt that the programs were successful. The programs were initiated by the internationals in response to pleas from local union officials representing the interests of members seeking asbestos screening examinations. It is typical for unions to deliver various services in response to requests that follow these channels of communication. Their interest was in offering a well-designed and implemented program in the absence of other alternatives. The fact that 18% of Elevator Constructors and 37% of Laborers screened may have had asbestos-related abnormalities was somewhat alarming but reinforced the unions' decision to provide these programs. The Laborers are currently reviewing data collected from participating physicians involved with their program. Limited analysis efforts are underway for at least one

Elevator Constructors' local union. Such endeavors may yet result in additional benefit.

The unions expressed satisfaction in those instances when competent community-based physicians were identified who were previously unknown to the local union members. This offered an opportunity for the local to create an ongoing association with a knowledgeable physician to assist members in the future with other occupational disease problems. It was also gratifying to know that these efforts generated a sizeable body of expertise in screening and notification among many of the health care providers and attorneys that participated in the program.

Education of the membership was another area where union officials felt there was some success. Construction workers tend not to work at permanent work sites and rarely receive even basic safety and health training from their temporary employers. This program provided an opportunity to invite the membership to meetings with physicians and attorneys, who provided information and answered questions about occupational disease, health promotion, and safe work practices. While unions do not typically have the resources or the personnel to devote to programs of this nature, these endeavors do demonstrate the ability of the unions to use their existing infrastructures effectively in delivering programs designed to meet the needs of designated high-risk workers.

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