

Notification of Workers at High Risk

Design and Implementation of a Program to Address Their Needs

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Although the passage of the High-Risk Notification Bill is not finalized, this report assumes that the major provisions of the bill as passed in the House will be unaltered by the Senate. Although some provisions of the bill, such as the identification of clinical facilities to evaluate workers, need clarification, I believe that if implemented with sensitivity, it can be a major force in the prevention of occupational disease.

I intend to concentrate on practical issues that must be addressed if workers are to be given the facts on which they can make informed decisions. If this bill is enacted, the following issues have to be addressed:

1. Who will get the letter?
2. What will the letter say?
3. What role will unions have in determining the content of the letter sent to their members. Will union health and safety officers have access to the names of union members receiving the letter?
4. What should workers do when they get the letter?
5. What medical resources are available to provide workers with high quality medical examinations?
6. Who is responsible for paying medical fees?
7. How can a prevention component be integrated, because occupational medicine must be concerned with both primary and secondary intervention?
8. How can we evaluate whether the program has been "successful" or effective?

1. WHO GETS THE LETTER?

A. However high risk is defined, clearly a list of workers who fit the definition will have to be assembled. It is unclear from what sources these data will come, and how far back in time searches will be made for names to add to the roles of exposed workers.

B. Validation of available addresses from companies with exposed workers will have to be a part of this exercise. The list will presumably involve current, past, and retired workers. In my experience, attempting to obtain addresses of *current* workers revealed a large error rate. Identification of the addresses of past workers and retired workers will have an even larger error rate.

C. Will these lists be matched with death registries? It would be unfortunate if

the same letter were sent to survivors and the spouses of those already dead. However, it is almost impossible for the ascertainment of death status to be 100% correct. This implies that the letter must be written with appropriate sensitivity.

D. How will the lists be ordered, that is, who will receive the letter during the first year of the program, who during the second, and so on? What are the consequences if NIOSH starts with their own records as the first pass in sending letters?

2. WHAT WILL THE LETTER SAY?

A. Will this letter provide technical information on the nature of the exposure and potential health consequences? Preparing such a letter using language that is understandable and not frightening to the recipient is an extremely difficult task.

B. How individualized will these letters be? It would seem medically unethical not to send out individualized letters. How specific will the letter be about the individual worker's length of exposure and risk associated with that length of exposure, or will, for example, the same letter be sent to a worker exposed to asbestos for 1 year as someone exposed for 30 years?

C. Similarly, will the letter explain that not all workers with the same exposure have the same risk of disease? For example, with asbestos exposure, smokers have a higher risk than do nonsmokers. Will the letter reassure nonsmokers about this issue or, conversely, stress the urgency of seeing a physician in the letter to a worker exposed to both asbestos and heavy smoking for 30 years?

D. Will the letter contain any information on preventive measures that might be taken? For example, a letter to a worker with high-lead exposure could suggest that removal from exposure or transfer to a low-head area is the option.

It is in the foregoing areas that I see a role for the health and safety departments of those unions, such as the United Steel Workers of America, who for many years have made a major commitment to their members in the area of health and safety. For many years the USWA has been involved in legislation designed to give their members access to information about their workplace environment. In addition, education programs have been developed for members in particularly hazardous operations such as coke ovens, lead smelters, and arsenic smelters. Although concerns in regard to confidentiality might prevent the union from having access to individual names, presumably there would be no problem with the union's knowing which plants were to be involved in the notification process.

E. What recommendations will be made in seeking medical care? My understanding of the bill is that the workers will be recommended to go to one of the designated centers of expertise. As most of you know, many of the Education Resource Centers do not have a clinical component to date. However, there are several excellent occupational medicine programs throughout the United States that could provide the highest quality care and consultation. If more flexibility is not built into the designation of evaluation centers, many competent occupational physicians who have already developed experience in handling occupational health issues would be excluded from an opportunity to help in these particularly emotive evaluations.

However, it is inevitable that the majority of workers will first seek advice from their primary care or family physician. Thus, the letter should include educational material for the person's physician, and serious consideration should be given to communicating with and arranging meetings of local medical societies in all areas to which the letters are sent. Thus, education programs should be pre-

sented for general practitioners who will probably be the first physicians consulted by a large proportion of notified workers.

There is another issue in this regard. Although the workers who receive letters are at high risk of contracting the specific disease, many of them will be older and possibly retired and will present with disease that requires attention, but that is not related to the exposure of concern. The evaluation must be comprehensive and would best be carried out in a center in which there is a close liaison between occupational medicine and general medicine clinics, so that efficient and high quality care is readily available for nonoccupationally related disease. Good liaison with the worker's family practitioner is essential; otherwise, it is almost inevitable that miscommunication and misunderstanding will occur.

Finally, I am concerned with the legal aspects of this notification program. Those of us who are involved in handling workers' compensation and toxic torts recognize that this bill potentially provides a bonanza for the legal profession. Unfortunately, too many incompetent lawyers are already involved in such suits, with a lack of preparation being common. Many lawyers take on too many cases and do not bother to evaluate the merits of individual suits. In the last year I have been involved in cases in which the lawyer, instead of dropping weak or nonexistent cases, has attempted to sell them to other unsuspecting colleagues. The opportunities from such practices with this bill are legion. I believe that it would be possible to establish a committee with representation from the legal profession, the medical profession, and the affected worker population that would develop a code of practice and criteria that should be used for legal cases developing from the notification process. The outcome of such a committee should be a model for an agreement between a lawyer and his client that can only be of benefit to the worker in these days of high contingency fees. I am sure my colleague, Professor Rothstein, will have more to say on this issue.

SUMMARY

I believe the high-risk bill is an opportunity to protect the health and well-being of the millions of workers who have been exposed to a myriad of chemicals that we know have the potential for disease. The practical details of implementing such a bill call for a high degree of sensitivity during the implementation of the program to the issues I have outlined; otherwise, its potential for good will possibly be swamped by frustration, miscommunication, and misunderstanding, and this will result in the provision of less than high-quality care for a group of people who deserve the best care and consultation available.