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Low Participation in a Job Transfer Program Designed to Prevent Progression of Pneumoconiosis

To the Editor:

The Coal Mine Health and Safety Act of 1969 and, after it, the Federal Mine Safety and Health Act of 1977 provided periodic chest radiographs to underground coal miners at no cost to themselves (1). Since the National Institute for Occupational Safety and Health (NIOSH) was established in 1971, it has administered this health surveillance through the Coal Workers' Health Surveillance Program (CWHSP). If a miner has radiographic evidence of pneumoconiosis, an interstitial lung disease commonly known as black lung, they are afforded the legal right, authorized under 30 Code of Federal Regulations Part 90, to work under a reduced dust exposure standard through the use of engineering controls or job reassignment to a less dusty working environment. After a miner receives confidential notification from NIOSH that they have radiographic findings consistent with pneumoconiosis and are eligible for Part 90 accommodations, they can exercise this option by informing the Mine Safety and Health Administration (MSHA). Participation of eligible underground coal miners in exercising their Part 90 rights has historically been low: during the period from 1970 to 1989, participation was 23.2% (2,119 of 9,138) (2); during the period from 1986 to 2016, participation was 14.4% (509 of 3,547) (3, 4); and, in the most recent time period, 2016–2022, participation among underground coal miners was 22.5% (55 of 244).

The MSHA administers and enforces Part 90 provisions, and, in 2014, published a final rule extending participation in the CWHSP and eligibility for Part 90 rights to surface and contract coal miners (5). This rule also expanded miner health screenings to include spirometry testing and symptom assessments, even though results of spirometry and self-reported respiratory symptoms are not used as a basis for determining Part 90 eligibility. Between August 1, 2014, and June 30, 2022, NIOSH identified 171 surface miner participants with radiographs consistent with pneumoconiosis, along with

73 contractors. Of these, MSHA has received 13 (7.6%) valid requests from surface miners to exercise their Part 90 option and none from contract miners. Overall, 94.7% of eligible surface and contract miners have not exercised their Part 90 rights. Our intentions before analysis were to conduct a series of comparative analyses assessing geographic distribution of cases, demographic analyses, and occupational assessments. In the end, with 13 cases, we are unable to make any solid inference beyond the obvious: this system is not working as intended.

The Coal Act highlights the seriousness of black lung as a threat to the health and well-being of America's coal miners and sought to address that threat so they could work a career in the industry without being disabled by black lung. Measures to prevent black lung included: 1) review of dust control plans and inspections to evaluate exposures and 2) medical examinations for early detection of black lung with a guarantee that miners with evidence of pneumoconiosis have the option to work in less dusty conditions while retaining jobs and income (the Part 90 program). The Coal Act also provided financial benefits for miners totally disabled by black lung.

Although exposure control and workers' compensation have received substantial public, legislative, and regulatory scrutiny in the decades since the Coal Act was passed, the Part 90 program as a tool for prevention has received far less attention. Even though black lung continues to occur at high rates (6), the findings of this report underscore that participation in Part 90 remains low. Low participation, especially among surface and contract miners, raises questions about the barriers to participation in Part 90 and how participation could be improved.

There are a number of reasons why coal miners might be reluctant to participate in medical screening and job reassignment, including lack of awareness, privacy concerns, and fears about job security. These include fear of retaliation, job loss, loss of the potential for career advancement, and loss of the ability to find another job in the coal-mining industry if their current mine shuts down (7). This fear can be especially intense in parts of the country where there are few options for good-paying jobs other than coal mining. A study that interviewed 19 Appalachian coal miners with progressive

massive fibrosis about their work histories identified 7 who worked long after their first abnormal chest radiograph. One of these spoke poignantly about the need to support his family (8).

Whatever the historical and current reasons are for the lack of participation in Part 90, most eligible coal miners are not exercising their Part 90 rights. In 2018, NIOSH solicited a request for information from stakeholders, entitled “Barriers to Participation in the NIOSH Coal Workers Health Surveillance Program,” to inform efforts to improve participation in health surveillance (9). In a June 2022 address to the United Mine Workers of America, MSHA Assistant Secretary Chris Williamson commented on the lack of participation in the Part 90 program and committed to making efforts to reduce barriers to participation (10). To that end, MSHA and NIOSH have convened a working group to reduce barriers to participation and improve participation in the CWHSP and the Part 90 program. To date, NIOSH and MSHA have updated their websites, and MSHA has launched the Miner Health Matters campaign aimed at preventing and addressing health impacts in the mining community, including highlighting Part 90 and streamlining reporting.

Black lung remains a major problem in the United States more than 50 years after passage of the Coal Act. For working coal miners with early-stage disease, the protections afforded by Part 90 are an opportunity to prevent the most debilitating effects of the disease while keeping their jobs and income. However, these data raise questions about the effectiveness of a voluntary medical mitigation program with benefits limited to special work accommodations from a current employer in regions of the country where opportunities for good-paying alternative employment are limited (2). Unless participation in Part 90 improves, there will continue to be hundreds of coal miners each year with newly identified black lung who are not afforded the full protections from additional coal mine dust exposure first offered by the Coal Act. As long as there are coal miners working with black lung, the need for an effective Part 90 program will remain. ■

Author disclosures are available with the text of this letter at www.atsjournals.org.

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TeleCritical Care: Another Member of the Multidisciplinary Critical Care Team

To the Editor:

The recent Official American Thoracic Society Workshop Report (ATSWR), Symptom Assessment for Mechanically Ventilated Patients: Principles and Priorities, highlights the need for a more complete multidisciplinary assessment of the physical and

psychological status of mechanically ventilated patients to minimize distress, enhance patient experience, and improve short- and long-term patient outcomes (1). This report identifies and defines essential symptoms that should be assessed in mechanically ventilated patients, instruments for their evaluation, and potential strategies to enhance patient comfort, safety, and long-term recovery. While advocating a multidisciplinary approach, the report omits a key member of many critical care management teams, telecritical care (TeleCC).

Recent reviews suggest that nearly 20% of all U.S. hospitals with ICUs use TeleCC (2, 3). With the rapid expansion of inpatient telemedicine during the coronavirus disease (COVID-19) pandemic, the proportion of hospitals with TeleCC or inpatient telemedicine services may be even higher. Within the VA (Veterans Affairs) healthcare system, TeleCC is currently implemented in 74 facilities

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