

*Albert Miller, MD, FACP, FCCP
179 West Shore Road
Great Neck, New York 11024*

*Professor of Clinical Medicine
New York Medical College
Valhalla, NY*

*Telephone: (718) 558-7227
(516) 829-5665*

*Clinical Professor of Community Medicine
7203
Mount Sinai School of Medicine
5668
New York, NY*

*Fax: (718) 558-
(516) 829-*

*Pulmonary Program Director
St. Vincent Catholic Medical Centers of New York
88-25 153rd Street, Suite 3J
Jamaica, NY 11432*

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Dennis W. Archer
President American Bar Association
750 North Lake Shore Drive
Chicago, IL 60611

Dear Mr. Archer:

I had the honor to be one of “a group of ten of the nation’s most prominent physicians in the area of pulmonary function”* who was “interviewed at length at the Chicago offices”* of the ABA by the Commission, to establish a Standard for Non-Malignant Asbestos-Related Disease Claims. I was most courteously received and at first considered this interaction between our noble professions to be a rewarding one.

It has not proven to be. The ABA Standard for Non-Malignant Asbestos-Related Disease Claims does not reflect my statements or my many years of clinical experience and research in these diseases, although my name and academic affiliation are listed therein.* Others of these “most prominent physicians” have communicated similar dismay to me. We received no advance draft of the Standard for our input.

Rather than being inclusive in insuring that valid claims of pulmonary impairment are admitted into the system, as the Standard attests,** the proposal is exclusionary and bars claims for many characteristic manifestations of such impairment.

1. Significant asbestosis can be present with an x-ray profusion less than 1/0 or even with a normal x-ray. Impairment from this asbestosis can be manifest by demonstrated decrease in diffusing capacity (DL) (with or without a decrease in forced vital capacity, FVC) or abnormality in ventilatory and gas exchange parameters on respiratory exercise testing. Diffusing capacity is available at any lung center, is standardized⁽¹⁾ and is known to be abnormal in interstitial lung disease (ILD) even when FVC and x-ray are normal. Perversely, if DL is significantly decreased without a decrease in FVC, the X-RAY REQUIREMENT OF THE ABA STANDARD IS EVEN HIGHER (2/1).

Impairment from asbestos can be manifest by the FVC when the x-ray is normal; such impairment is not admissible under the ABA proposal.

Asbestosis can be detected radiographically by CT scan when the x-ray is normal. CT scan is universally available in the U.S. and used by all pulmonologists in the assessment of ILD.

2. The section on impairment from asbestos-related pleural scarring is vastly insufficient. Diffuse pleural scarring can be associated with greatly diminished FVC regardless of the extent or thickness of the scarring on x-ray or its bilaterality⁽²⁾. It is therefore exclusionary to insist on “bilateral” diffuse pleural thickening of at least B/2.

Analysis of large numbers of patients with asbestos-related pleural scarring has shown that extensive circumscribed pleural scarring (plaques) can be associated with a significant decrement in FVC sufficient to bring about impairment in individual patients.

3. Impairing asbestosis and asbestos-related pleural scarring can co-exist with obstructive airways disease. Asbestos inhalation can cause some degree of airways obstruction by itself^(3,4). Evidence also points to an interaction between asbestos and the most common cause of airways obstruction, cigarette smoking, in bringing about a combined (restrictive-obstructive) ventilatory impairment.⁽⁵⁾ The mere finding of airways obstruction should not bar a claim for non-malignant asbestos disease.

I have belabored you with these medical considerations in the hope that the ABA Standard can be amended so that it truly achieves the Association’s goal not “to unfairly exclude any significant number of deserving claims.”

Most sincerely,

Albert Miller, MD

AM/eb

*from Section II, The commission’s Process, ABA Standard for Non-Malignant Asbestos-Related Disease Claims

**”The Standard adopts less restrictive alternatives than some physicians recommended. The Commission recognizes that the effect of this may be to allow claims that do not really belong in the tort system, but PREFERS TO TAKE THAT APPROACH RATHER THAN TO UNFAIRLY EXCLUDE ANY SIGNIFICANT NUMBER OF DESERVING CLAIMS.”

References:

1. American Thoracic Society. Single breath carbon monoxide diffusing capacity (transfer factor). Recommendations for a Standard Technique. Am Rev Resp Dis 1987; 136:1299.
2. Lilis R., Miller A, Godbold J, et al. Pulmonary function and pleural fibrosis: quantitative relationships with an integrative index of pleural abnormalities. Am J Industr Med 1991; 20:145.
3. Rodriquez-Roisin R, Merchant JE, et al. Maximal expiratory flow-volume curves in workers exposed to asbestos. Respiration 1980; 39:58.
4. Begin R, Cantin A, et al. Airway function in life-time nonsmoking older asbestos workers. Am J Med 1983; 75:631.
5. Miller A, Lilis R, et al. Spirometric impairments in long-term insulators. Chest 1994; 105:175.

