

The 2004 ATS Statement on Asbestos Disease Diagnosis: Scientific and Ethical Problems

www.lakesidepress.com/Asbestos/ATS-2004Statement-rebuttal.pdf

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Summary

In September 2004 the American Thoracic Society published a long awaited update on diagnosis of nonmalignant asbestos diseases. Authored by a panel of 11 physicians, the ATS “Official Statement” (ATS-OS) covers developments over the past 2 decades and offers guidelines for diagnosis. By making statements unsupported (and in some cases contradicted) by the peer-review medical literature, and by omitting numerous key references, the authors evidence bias in favor of mass screening diagnoses made by plaintiff-attorney-hired physicians (PAHP). The PAHP diagnostic process has been largely discredited as non-objective, but this is not mentioned in the ATS statement. Instead, in making its recommendations the ATS-OS implicitly assumes the PAHP screening process and resulting diagnoses are valid. Publicly available letters and articles document a long-standing, pro-plaintiff bias of key ATS officials and ATS-OS authors, and help explain the article’s skewed presentation. Finally, ATS violated its own ironclad policy by not publishing the authors’ conflict of interest statements.

Introduction

There has been an ongoing ‘epidemic’ of asbestos disease over-diagnosis in the United States, fueled by plaintiff-attorney-manufactured mass asbestos claims. The majority of these claims, when objectively analyzed, are medically unfounded. The process by which plaintiff-attorney-hired-physicians (PAHP) have helped create these asbestos claims has been criticized and analyzed in medical (Egilman 2002; Egilman 2004; Gitlin 2004; Janower 2004; Jensen 2005; Martin L [www...AsbestosEditorial]; Martin L 2004 [e-letter]; Martin L 2004 [www...ATS-openletter]; Martin L 2005; Reger 1990; Rosenberg 1997), legal (Bernstein 2004; Brickman 2004; Houser 2002; Mealey 2005; Setter 2003), and lay publications (Berenson 2002; Brickman 2003; Crenshaw 2001; Curran 2005, Hudak 2002; Parloff 2002; Schmitt 2001; Sherrid 2001; Taylor 2002; Thomas 2002), and has also been the subject of comprehensive reports by the Rand Corporation (Carroll 2003) and the American Bar Association (ABA 2003).

In 1986 the American Thoracic Society (ATS) -- the world’s preeminent medical organization for lung diseases -- published a committee-authored “Official Statement” on criteria for diagnosing non-malignant asbestos diseases (ATS 1986). Non-malignant asbestos disease covers the two principal diagnoses in mass asbestos claims: asbestosis and asbestos pleural scarring. Asbestosis is scarring within the lungs, and is generally far more serious than pleural scarring, which affects only the lining of the lungs. As the only “official” medical document on asbestos diagnosis, the 1986 ATS article was often quoted in legal proceedings resulting from asbestos claims.

In 2004 ATS published its long-awaited update. The new ATS “Official Statement” (ATS-OS),

authored by 11 physicians, appeared September 15, 2004 in ATS's principal scientific publication, American Journal of Respiratory and Critical Care Medicine (ATS 2004). AJRCCM has an audience of both practicing physicians and researchers in the field of lung diseases.

Throughout the 2004 ATS-OS there is evidence of author bias. The article contains several un-referenced and unfounded assertions that seem to support plaintiff-attorney-manufactured asbestos claims, and omits numerous key references that disprove several of its conclusions. Also, AJRCCM violated its own ethical standard by failing to publish any author conflict of interest statements. This review will detail both the scientific and ethical problems I have found with the article.

Scientific Problems with the 2004 ATS Asbestos Statement

“Scientific problems” refers to statements characterized by one or more of the following: 1) they are not referenced or based on evidence; 2) they omit crucial information or key references directly germane to the subject; 3) they represent a logical fallacy. To illustrate, I will give 3 hypothetical examples for each category. 1) If I write in a medical article that lung cancer can be presumptively diagnosed by examining just the fingernails, and offer no references and no evidence, it is fair to say that statement is not scientific. 2) If I write a review on the causes of coronary artery disease, and fail to mention diet (perhaps because I've worked for the fast food industry in the past), that is not scientific. 3) If I state that anyone with 99 degree temperature can have pneumonia, and then opine that everyone with 99 degree temperature can be presumed to have pneumonia, that conclusion is a logical fallacy and not scientific.

The ATS article contains numerous such non-scientific statements. They are listed in Table 1, along with comments on their medical/scientific flaws. (This list is not meant to be comprehensive, and only reflects my analysis of the article; others may uncover different statements they deem biased or non-scientific.)

Ethical Problems with the 2004 ATS Asbestos Statement

An Official Statement from an international scientific organization (over 13000 members) is obligated to present a balance review. In this aspect ATS was probably doomed to failure from the outset, simply because there was no attempt to achieve balance on the ATS-OS committee. Table 2 documents biases by two recent past ATS presidents (during whose tenure the Statement committee was formed and met), several ATS-OS authors (including the committee chairman), and two committee advisors (credited in the article).

Their biases regarding asbestos diseases include: subjectivity in diagnosis; tacit acceptance of PAHP-generated diagnoses; liberalization of criteria for workers' compensation; total ban on asbestos use; defeat of asbestos litigation reform. On the other hand, no ATS official or member of the Statement committee or its advisors has, as far as can be discerned, ever advocated or lobbied for asbestos litigation reform, authored an article or essay critical of the attorney-

sponsored asbestos screening process, or argued for objective diagnosis of asbestos diseases. Thus everyone associated with the 2004 ATS-OS has either been vocal in a way that supports the status quo (plaintiff-attorney-sponsored diagnoses without objective review), or silent.

Discussion

It is noteworthy that AJRCCM initially published no author disclosures for the ATS-OS, a clear violation of its own editorial policy. The journal's disclosure form, which every author must sign (AJRCCM Disclosure), clearly states the importance of protecting against bias in fact *and* spirit:

“A conflict exists not only when judgment has been clearly influenced. It also exists when judgment might be influenced or might be perceived to be influenced. That is, a conflict exists before any actual breach of trust, and irrespective of whether a breach of trust actually occurs.” (AJRCCM Instructions)

It is apparent that key physicians associated with the ATS-OS are very opinionated regarding patient advocacy issues and asbestos legislation (Table 2), and that these biases are every bit as important as potential financial conflicts. In 2004, the former editor of AJRCCM, Dr. Martin Tobin, wrote of 10 measures of journal performance, and used AJRCCM to illustrate them. His no. 8 is particularly germane here:

“An *eighth* measure of performance is steps taken by the editor to ensure the integrity of the literature. Because clinicians and researchers rely heavily on biomedical publications, they have a vested interest in their integrity. There is broad agreement that integrity of a journal rests jointly on the ethical behavior of authors and editors -- an aspect of science that should not be confused with the honest errors inevitable in vigorous research. An editor's greatest responsibility is to ensure that every item published in his or her journal satisfies the highest standards of scientific integrity. How an editor is perceived to handle this responsibility has far-reaching effects on the trust of readers in a journal. And without trust, there is no worthwhile journalism.” (Tobin 2004)

Physicians are certainly entitled to have socioeconomic biases, but they should be balanced so as not to skew scientific articles, including “official statements” about diagnosis. The point here is not specific disagreements I or others may have with these physicians' biases, but that they have clearly infused what should have been an objective, scientific article. Simply stated, their unidirectional biases were not counterbalanced, resulting in the scientific problems noted in Table 1. Anyone knowledgeable of plaintiff-attorney-manufactured asbestos diagnoses can appreciate how many of the quoted passages can be used to support medically invalid claims.

The experts who crafted this article must know that the entire legal morass over asbestos is predicated on questionable diagnoses rendered for money by a few willing physicians, the PAHP. Given its scope and importance, the 2004 ATS-OS should not have ignored the system

that generates the vast majority of asbestos diagnoses in this country. Letters from past ATS presidents have stated the organization ‘has no position’ on legislation aimed to correct the problem (see Table 2). For ATS – the only national organization that presumes to publish an “Official Statement” on asbestos diagnoses – not to have a position on the PAHP diagnostic process is tantamount to endorsing it.

In October 2004 I sent a brief letter to AJRCCM regarding my concerns over the article, and it was initially rejected for publication. I then posted some of the information in this article on the internet, and notified the ATS president, president-elect, and AJRCCM editor, plus other ATS members (Martin 2004 [www...ATS-openletter.htm]). On January 13, 2005 I received a group e-mail sent by ATS president Dr. Sharon Rounds. In this e-mail she admitted the need for author disclosures, stating that ‘no disclosure’ had been a policy for ATS Official Statements because they include too many authors to list all the disclosures. (That excuse appears lame when one considers that other multi-authored articles contain disclosures, that AJRCCM has an ironclad disclosure policy for everyone else, and that the internet is routinely used to present additional data for many medical articles.) She also wrote: “...the ATS fully supports and stands by the 2004 ATS Asbestos Statement...While I certainly respect Dr. Martin’s right to his personal opinions, I strongly disagree with his criticisms and claims.” (Rounds 2005)

On March 1, 2005 AJRCCM published two letters critical of the ATS-OS (Weill 2005; Ghio 2005). After responding to these two letters, AJRCCM also belatedly published highly selected (mostly financial) conflict of interest statements for each author (Guidotti 2005, p. 528). However, none of the biases and conflicts cited in Table 2 were published. Also, a disclosure for one of the authors, Dr. Harbut (M.R.H.), that recently appeared in another medical journal was omitted from the AJRCCM listing. His AJRCCM disclosure states:

“M.R.H. presented at the White House and the U.S. Congress on aspects of the Hyde-Ashcroft Asbestosis reform bill; his airfare and hotel were paid for by Public Citizen and he received no other compensation. He wrote a position statement for the Association of Occupational and Environmental Clinics which set ethical guidelines for physician participation in asbestosis screening. In the early 1990s, he participated in an asbestosis screening program which was associated with investigations from multiple government agencies. No impropriety or wrongdoing was found.”

The disclosure for Dr. Harbut and two co-authors, for a letter published in *Academic Radiology* last year (Oliver 2004), states (italics added):

“The authors of this letter have done medical-legal work in the area of asbestos-related disease in the form of medical reports and testimony for patients seen in their clinical practice, and in some cases for individuals not examined. *The major portion of this work has been for plaintiffs’ attorneys.* For this work we have received consultation fees.”

There is nothing inherently wrong with this activity, but it should have also been explicitly stated in the AJRCCM disclosure.

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Without any notification of acceptance, on February 17, 2005 I received the pre-publication galley of my original letter! It was published March 15, 2005 (Martin L, 2005), along with one other letter (Smith DD, 2005). Table 3 quotes a few of the criticisms from all four letters, the ATS Statement Committee's responses (Guidotti 2005, p. 528; Guidotti 2005, p. 666), and my comments on each.

In general, the Statement Committee's responses to the letters show the same pattern of unsupported statements, disconnected logic, and confusion as found in the main article. Moreover, they do not address the central criticisms: unbalanced makeup of the Statement committee; unsupported statements that don't reflect the medical literature or clinical experience; omission of numerous key references; promulgation of 1/0 profusion for presumptive diagnosis of asbestosis when that is provably not valid; failure to address the non-scientific attorney-sponsored screening process; and implicit acceptance of PAHP-generated diagnoses as valid.

These lapses discredit the article, its authors, and the ATS, a sentiment also expressed in the published letters. Regarding omission of key references about smoking and chest x-ray opacities, Weill and Weill wrote:

“Decades of investigation have provided insight that cigarette smoking can confound the diagnosis of asbestosis. To disregard this evidence discredits the American Thoracic Society as a scientific body and contradicts the Society's recognition of interstitial lung disease associated with smoking.” (Weill 2005)

Ghio and Roggli wrote:

“In our opinion [the ATS-OS] did not fully consider alternative points of view and all of the available literature in several important areas...We take no satisfaction in concluding that the process leading to this Statement has failed to result in a useful and credible summary of current knowledge on causal aspects of asbestos related health effects. The ATS imprimatur demands great rigor in the development of official statements, particularly those that have substantial potential influence on assessment of public and occupational health risks and related public policy decision making, and are likely to be controversial if they are not balanced.” (Ghio 2005)

In its response to these general criticisms the Statement Committee wrote:

“The alert reader may detect a disproportion between the particular objections raised by the correspondents and the blanket denunciations of the Statement, and by extension the Society itself, in the closing paragraphs of both letters. We invite Weill and Weill, as well as Ghio and Roggli and any others who may be interested, to provide the Committee with the “point-by-point rebuttal” they propose in their letter. The Committee is prepared to discuss these issues in a suitable ATS forum and is planning such an opportunity for the 2005 Annual Meeting.” (Guidotti 2005, p. 528)

This article is my “point by point rebuttal.” Irrespective of how (or whether) the Statement Committee responds to each specific point, there is now little doubt that the 2004 ATS-OS has failed to meet Dr. Tobin’s “highest standards of scientific integrity.”

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Table 1: Scientific Problems with the ATS Official Statement

Quotes from article (ATS 2004)	Comments
<p><u>Page 696</u> “A critical distinction is made between films that are suggestive but not presumptively diagnostic (0/1) and those that are presumptively diagnostic but not unequivocal (1/0). This dividing point is generally taken to separate films that are considered to be “positive” for asbestosis from those that are considered to be “negative”.”</p>	<p>There is no reference for this statement, and no medical basis; this dividing point (0/1 to 1/0) exists only in the play book of plaintiff attorneys and their hired experts. Furthermore, advocating a profusion reading of 1/0 as “presumptively diagnostic” for asbestosis is highly problematic for three reasons:</p> <ul style="list-style-type: none">• Profusion of 1/0 is the most common reading by plaintiff-attorney-hired physicians making the diagnosis of asbestosis for claim purposes. Yet it is non-specific and non-diagnostic, as small opacities are commonly found in middle-aged smokers and in ex-factory workers never exposed to asbestos. References that show the non-specificity of a 1/0 reading (Dick 1992; Meyer 1997; Weiss 1984; Weiss 19991) were omitted from the ATS-OS.• References were omitted that have shown large variation in B-reader interpretations when chest x-rays are read objectively, by physicians not paid for their positive diagnoses (Ducatman 1988; Ducatman 1991).• References were also omitted that show plaintiff-attorney-hired physicians significantly over read surveillance films for asbestos disease (Reger 1990; Houser 1999; Gitlin 2004).

<p><u>Page 692</u> “TABLE 1. CRITERIA FOR DIAGNOSIS OF NONMALIGNANT LUNG DISEASE RELATED TO ASBESTOS</p> <p><u>1986 Guidelines:</u> Chest film (irregular opacities)</p> <p><u>2004 Guidelines:</u> Imaging methods</p> <p><u>Comparison and notes:</u> Chest film, HRCT, and possibly future methods based on imaging. The 1986 guidelines specified ILO classification”</p>	<p>Table 1 in the ATS-OS supposedly compares the 1986 and 2004 guidelines. However, unlike other categories in Table 1, for radiologic imaging there is no explanation for the change, i.e., why 1/0 is the threshold for asbestosis in 2004 (as stated on page 696; see above), whereas the stricter 1/1 was the profusion threshold for diagnosis in 1986. The wording used simply does not support the table’s premise, i.e., to explain the difference between the two sets of guidelines.</p>
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Page 697

“As with other interstitial lung diseases, the classic finding in asbestosis is a restrictive impairment. Mixed restrictive and obstructive impairment is frequently seen; isolated obstructive impairment is unusual.”

Page 700

“Large airway function, as reflected by the FEV1/FVC ratio, is generally well preserved.”

Page 700

“...airway obstruction can also be observed and can be seen alone in nonsmokers who have asbestosis. These patients usually have a restrictive pattern of lung function, but clinically they also feature an obstructive component characterized physiologically by increased isoflow volume, and increased upstream resistance at low lung volumes. These obstructive findings may be due to asbestos-induced small airway disease.”

Page 708

“Asbestos-related chronic airway obstruction may result in reduction in the FEV1/FVC ratio associated with reduced FEV1.”

Page 708

“In general, the magnitude of the asbestos effect on airway function is relatively small. This effect, by itself, is unlikely to result in functional impairment or the usual symptoms and signs of chronic obstructive pulmonary disease.”

Page 709

“Whereas the FEV1/FVC ratio may be reduced in asbestos-exposed persons with no or low profusion of small, irregular opacities...In individuals who develop asbestosis, physiologic findings associated with airflow obstruction (e.g., reduction in the FEV1/FVC ratio) become less prominent as the asbestosis progresses...”

This sequence of quotes pertains to air flow obstruction, and gives a muddled message on whether asbestos can cause it. Regarding the first quote, mixed impairment is “frequently seen” *only in cigarette smokers*. It is NOT frequently seen in non-smokers. Leaving out smoking as the cause of air flow obstruction in asbestos claimants allows the sentence to be quoted as an isolated “ATS statement” in a legal proceeding.

The authors obfuscate on whether asbestos inhalation can cause a reduced ratio of FEV-1/FVC, the principal parameter clinicians use to determine that someone has “air flow obstruction.” There is no evidence that asbestos inhalation alone, without smoking or other industrial pollutants, causes either reduced FEV-1/FVC or symptomatic air flow obstruction. (This point is also discussed in two of the letters to the editor [Weill 2005, Smith DD 2005]; see Table 3.) Yet a clinician reading these quotes can only come away confused by the conflicting messages (summarized for each statement below by ‘yes’ or ‘no’).

Page 697: ‘ Yes’ (asbestos causes reduced FEV-1/FVC and/or symptomatic large airway obstruction)

Page 700 (first quote): ‘No’ (asbestos does not cause reduced FEV-1/FVC and/or symptomatic large airway obstruction)

Page 700 (second quote): ‘No’ (Note: “isoflow volume” and “upstream resistance” are research tests not related to reduced FEV-1/FVC, and are not helpful in determining clinically significant air flow obstruction)

Page 708 (first quote): ‘Yes’

Page 708 (second quote): ‘No’

Page 709: ‘Yes’

<p><u>Page 700</u> “The abnormal PA chest film and its interpretation remain the most important factors in establishing the presence of pulmonary fibrosis. Compensation systems may require that the chest radiographs be classified by the ILO system once it is established that the patient has been exposed to asbestos. A profusion of irregular opacities at the level of 1/0 is used as the boundary between normal and abnormal in the evaluation of the film, although the measure of profusion is continuous and there is no clear demarcation between 0/1 and 1./0....The specificity of the diagnosis of asbestosis increases with the number of consistent findings on chest film, the number of clinical features present (e.g., symptoms, sings, and pulmonary function changes), and the significance and strength of the history of exposure.”</p>	<p>The authors make no attempt to reconcile this statement and the statement on page 710: “The sensitivity of the plain chest film for identifying asbestosis at a profusion level of 1/0 has been estimated at or slightly below 90%. The corresponding specificity has been estimated at 93%.”</p>
<p><u>Page 710</u> “Workers referred for evaluation of asbestos-related disease today differ from those referred in past years. Exposure to asbestos among these workers is likely to be more remote in time and to have been less intense. Exposed workers may live longer and progress later to more advanced stages of disease. They are more likely to survive to develop additional outcomes associated with asbestos, such as malignancy, and to present more complicated management challenges (Ohar 2004).”</p>	<p>This paragraph has a single reference (Ohar 2004), which has been challenged by four letters to the editor (De Vuyst 2004; Lange 2004; Martin L, 2004 (e-letter); Smith DD, 2004); none was answered by the authors. Though peer reviewed, the Ohar, et al article is an example of “junk science” because the asbestos diagnoses in their cohort were made exclusively by plaintiff-attorney-hired physicians. Thus the article was based on asbestos diagnoses by physicians paid to make them for purposes of filing claims -- hardly an objective diagnostic process. Unfortunately, the article by Ohar, et al is quoted as if its conclusions were valid when, because of the biased study design, they have no scientific validity whatsoever.</p>

<p><u>Page 710</u></p> <p>"The sensitivity of the plain chest film for identifying asbestosis at a profusion level of 1/0 has been estimated at or slightly below 90%. The corresponding specificity has been estimated at 93%. Applied to populations with varying prevalence of disease, the positive predictive value of the minimally abnormal chest film alone in making the diagnosis of asbestosis may fall below 30% when exposure to asbestos has been infrequent and exceed 50% when it has been prevalent. This suggests that screening programs based on the chest film alone may vary considerably in their yield of true cases depending on the characteristics of the population being screened. In the general population and for occupational groups with low levels of exposure they may be unreliable in identifying asbestosis. The application of multiple criteria, as outlined in this statement, is a preferable approach (Ross 2003)."</p>	<p>This paraphrase of an article by Ross exemplifies much of what is wrong with the ATS-OS. Being committee-authored, it twists and turns in its deliberations, never sure if it wants diagnostic criteria to be simple and subjective (favored by plaintiff attorneys) or comprehensive and objective (the real world, apart from litigation). Thus there are unreferenced statements about the plain chest x-ray that can be used by plaintiff attorneys to make or support a claim, and then there are more reasoned statements that the authors can perhaps use to say 'this is what we really mean'. I doubt that all the authors are naive in the ways of litigation, and surely they must at some level appreciate the quagmire they have written.</p>
<p><u>Page 711</u></p> <p>"In the spring of 2001, the Association of Occupational and Environmental Clinics adopted a resolution recommending necessary standards for screening programs. This action was taken in response to the proliferation of screening programs undertaking to identify cases for possible legal actions in which counseling and education may be lacking, but the recommendations also apply to those conducted for patient care and protection."</p>	<p>This is the only mention of problems with attorney-manufactured asbestos claims, and it is an oblique one at that. In this paragraph the authors assume that the main problem arising from the attorney-sponsored screening programs is inadequate "counseling and education" for people diagnosed with asbestos disease. Nowhere do they acknowledge the fact that most ILO readings by plaintiff-attorney-hired physicians (PAHP) are over-interpreted (Reger 1990; Houser 1999; Gitlin 2004), that PAHP are paid more for a positive diagnosis than a negative one (Egilman 2002), or that the attorney-sponsored mass asbestos claims process has been thoroughly discredited in numerous medical, legal and lay articles. In the aggregate, this information should invalidate all medical conclusions based on "diagnoses" generated by PAHP (such as those published by Ohar, et al). "Counseling and education" are lacking because the real world of treating doctors does not find the diagnoses made by PAHP. (For more on this paragraph from page 711, see comments under Martin L, Table 3).</p>

<p><u>Page 711</u> “These criteria and the guidelines that support them are compatible with the Helsinki criteria, developed by an expert group in 1997, which represents substantial consensus worldwide (Anonymous 1997).”</p>	<p>The Helsinki criteria (Anonymous 1997) was a completely unreferenced editorial in a European medical journal. It also did not acknowledge any of the mass-asbestos claim abuse evident at the time, nor did it provide any Conflict of Interest Statements for the authors.</p>
<p><u>Page 711</u> “CONCLUSIONS: The diagnosis of nonmalignant asbestos-related disease rests, as it did in 1986, on the essential criteria described: a compatible structural lesion, evidence of exposure, and exclusion of other plausible conditions, with an additional requirement for impairment assessment if the other three criteria suggest asbestos-related disease. Each criterion may be satisfied by one of a number of findings or tests. The 2004 criteria are open to future testing modalities if and when they are validated. For example, HRCT has greatly increased the sensitivity of detection and has become a standard method of imaging. Evidence for exposure still rests on the occupational history, the demonstration of asbestos fibers or bodies, or pleural plaques. Impairment evaluation is largely unchanged from 1986 and remains an essential part of the clinical assessment. Potentially confounding conditions, such as idiopathic pulmonary fibrosis, are better understood and many, such as tuberculosis, are less common than in the past so that the clinical picture is less often confusing.”</p>	<p>This conclusion, while seemingly objective, is at singular variance with many of article’s statements. This is another example of how the Official Statement twists and turns, at one point allowing for simplistic and subjective diagnosis, then reversing course and requiring comprehensive and objective assessment. This would all be academic were it not for the fact (again, never acknowledged) that the vast majority of asbestos diagnoses in this country are attorney-driven (e.g., all the cases in the Ohar, et al cohort), and do not “exclude other possible conditions.” Nor do they satisfy the “additional requirement for impairment assessment.”</p> <p>Never once, in evaluating hundreds of claims on behalf of defendants, have I come across PAHP-authored reports that considered a non-asbestos diagnosis for an abnormal profusion reading. In the real world of pulmonary medicine, such an obviously biased evaluative process would be instantly discredited.</p>

<p>Page 691: “On the other hand, the risk of cancer may be elevated in a person exposed to asbestos without obvious signs of nonmalignant asbestos related disease. However, a diagnosis of nonmalignant asbestos-related disease does imply a lifelong elevated risk for asbestos-related cancer.”</p> <p>Page 705: “The presence of [pleural] plaques is associated with a greater risk of mesothelioma and of lung cancer compared with subjects with comparable histories of asbestos exposure who do not have plaques (Hillerdal 1994; Hillerdal 1997).”</p> <p>Page 711: “Persons with a history of exposure to asbestos are also at risk for asbestos-related malignancies.”</p>	<p>The authors have ignored a mountain of data that either contradicts these statements or at least puts them in perspective. Of the three statements, only one (p. 705) is referenced, and it cites just one article and one abstract by Dr. Hillerdal, a Statement committee author (Also see Comments under Dr. Hillerdal, Table 2). Omitted from the ATS-OS are several studies that present a different viewpoint (Hughes 1991; Weiss 1993; Smith DD 1994; Jones 1996; Browne 1996; Weiss 1999).</p> <p>The phrase “history of exposure” is so vague and broad that it could encompass every patient with lung cancer (170,000 new diagnoses each year in U.S.) who ever worked in a factory, warehouse, gas station or garage. Considering the fact that very few of the hundreds of thousands of attorney-solicited asbestos claimants have a documented history of working with friable asbestos, this wording is, in the context of rampant asbestos litigation, irresponsible. (Also see Comments under Dr. Wagner, Table 2.)</p>
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Page 700

“Some studies suggest that smokers without dust exposure may show occasional irregular opacities on chest film, but if so the profusion is rarely as high as 1/0; smoking alone therefore does not result in a chest film with the characteristics of asbestosis (Zitting 1996).”

This statement distorts the extant literature on the subject. It quotes only one article, a study from Finland, and omits several disproving articles (Mastora 2001; Meyer 1997; Weiss 1984; Weiss 1991; Dick 1992). This omitted literature shows that small opacities in smokers and ex-smokers are *not* rare, and may be confused with asbestosis. As Weiss wrote in his 1991 paper:

“The prevalence [of small opacities] increased with increasing age to 31.6% among smokers aged 50-64. Prevalence was 10% among ex-smokers of cigarettes. Among current cigarette smokers, prevalence was 5.3% in those who smoked less than one pack per day, 31.3% in heavier cigarette smokers, and 52.9% in 17 heavy cigarette smokers aged 50-64...The data in this study indicate that such abnormalities are directly related to age and smoking habits among workers not exposed to hazardous dust.”

TABLE 2: Examples of bias by ATS officials and Statement authors regarding asbestos diagnosis and litigation

Physician/Documents	Comments
<p><u>Dr. Thomas R. Martin</u> (no relation to author), ATS President, 2002-2003</p> <p>1. Letter to Dennis Archer, President, American Bar Association (Martin TR; undated, during 2003)</p> <p>2. Letter to the editor from Dr. Joseph Renn to AJRCCM concerning Dr. Martin's letter to Mr. Archer (Renn 2003); reply from Dr. T. R. Martin (Martin TR 2003).</p>	<p>1. In this letter Dr. T. R. Martin argued against the ABA proposal for strict criteria on asbestos diagnosis for purposes of compensation (ABA 2003): He wrote: "The medical criteria used in the [ABA] document do not reflect the current state of screening and diagnosis for asbestos-related diseases," without acknowledging that the "current state" is defined by plaintiff attorneys and their hired physicians, not the body of practicing pulmonary specialists in the U.S. In this respect his letter is supportive of the screening status quo, i.e., the plaintiff-attorney-run program discredited in numerous documents (none cited by Dr. T. R. Martin).</p> <p>2. Dr. Renn criticized Dr. T.R. Martin for espousing a personal opinion and conveying it as the official ATS position, and for making statements about asbestos diseases unsupported by the medical literature. Dr. T. R. Martin's reply in AJRCCM gives a window on the biased workings of the ATS-OS author committee: "An ATS working group consisting of internationally recognized experts and chaired by Tee Guidotti, M.D., is finalizing a new ATS Statement on asbestos-related diseases, which we expect to be published in 2004.... Early in 2003, members of this group learned that the ABA was drafting a position on new asbestos legislation under consideration in Congress. Because they believed that the ABA position was based on outdated information, and because of the upcoming ATS Statement on asbestos-related disease, they encouraged me as ATS President to communicate with the President of the ABA by letter. Members of the ATS asbestos committee helped to draft the ATS letter to the ABA and approved the wording of the final draft... In this letter, we informed the ABA that the medical information that they were using was not current and that the ATS was finalizing a new statement on the medical aspects of asbestos-related lung disease. This letter was sent to the President of the ABA in April 2003."</p>

<p>Dr. Homer Boushey ATS President, 2003-04</p> <p>Authored letter to Senators Orrin Hatch and Patrick Leahy (Boushey 2003)</p>	<p>Dr. Boushey’s letter argued against the proposed asbestos litigation reform then before the Senate committee chaired by Senators Hatch and Leahy. By way of introduction he wrote: “The ATS does not have a position on the need for, merits of, or construction of asbestos reform litigation.” Considering that the vast majority of asbestosis diagnoses were/are being made by a completely unscientific screening process, this statement from ATS (which had already convened its committee to rewrite the Official Statement on asbestos diagnosis) is troubling. For ATS not to have a position on the diagnostic screening process is tantamount to endorsing it.</p> <p>In his letter Dr. Boushey also erroneously presented statement about asbestos exposure and colon cancer as established fact. He wrote: “Evidence supporting the link between asbestos exposure and colon cancer is at least as strong or stronger than evidence linking asbestos exposure and stomach cancer.” The evidence in both conditions is in fact weak, debatable, and not widely accepted among the scientific community. Even the ATS-OS ended up noting: “Studies suggest that there may be an elevation in the risk of colon cancer, although this remains controversial.” (ATS 2004; page 711) In his letter to Senators Hatch and Leahy, Dr. Boushey did not indicate the link was “controversial.”</p>
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<p>Dr. Michael Harbut An ATS Official Statement author</p> <ol style="list-style-type: none">1. Quit American College of Chest Physicians over its endorsement of the HR 1283 - The Fairness in Asbestos Compensation Act (Committee, Judiciary 1999).2. Authored strong statement supporting world wide asbestos ban (Harbut [undated]). He wrote: "Over the past 12 years I have treated thousands of persons with diseases associated with asbestos."3. Letter to American Medical Association (Harbut 2000). In this letter he argued against asbestos litigation reform pending before Congress: "Although most informed persons feel the existing legal approach is in desperate need of reform, this letter does not speak to the legal matters raised."4. Co-authored 2004 letter to Academic Radiology (Oliver 2004).	<ol style="list-style-type: none">1. In 2000 ACCP endorsed HR 1283 - The Fairness in Asbestos Compensation Act , an industry-backed bill designed to "streamline the compensation process for asbestos victims." (Smith C 2003) The bill was approved by the House Judiciary Committee and headed to the full house for consideration. Dr. Harbut, chairman of ACCP's environmental committee, wasn't consulted prior to the endorsement and quit in protest. In resigning he wrote: "There is no interest in medical science. There is no interest in helping patients with asbestos-related disease beyond the proposed law written by an asbestos company attorney."2. This experience can only be considered a gross exaggeration, far outside the norm of any practicing physician in the U.S.3. The cause of the entire problem regarding diagnosis is "the existing legal approach," but he wouldn't address it in 2000, and did not in the 2004 ATS-OS. In this letter Dr. Harbut also wrote (if proposed legislation were to pass): "That leaves payment up to everyone except those who caused the illness." This statement shows lack of cognizance (or concern) that perhaps an asbestos diagnosis may be bogus, or that companies sued for claims may have had nothing to do with the manufacture or dissemination of asbestos. His bias here is 'guilty as charged' without concern for either medical or legal legitimacy.4. Dr. Harbut, along with Drs. Laura Welch and Christine Oliver, criticized an Academic Radiology study that showed PAHP over diagnosed chest x-rays for asbestos disease 90+% of the time (Gitlin 2004). Yet Dr. Harbut, et al have never critically analyzed the PAHP-sponsored screening process. That Dr. Harbut, et al sought to discredit the Gitlin, et al study, but at the same time accept (by their silence) the methodology used by PAHP, is hypocrisy borne out of extreme bias. It exemplifies the pseudo-objective attitude toward asbestos diagnosis that pervades the 2004 ATS Official Statement.
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<p><u>Dr. Albert Miller</u> One of ATS Official Statement authors</p> <p>Expressed belief that in some cases, radiologic asbestosis can be defined with scores starting at 1/0 (Miller 1998)</p>	<p>Dr. Miller was long associated with Dr. Irving Selikoff, who in the 1960s helped document asbestosis among insulation workers. Dr. Miller commits a logical fallacy by extrapolating from <i>some</i> asbestos cases he has diagnosed that have a “1/0” profusion reading, to the population of <i>all</i> cases diagnosed by plaintiff-attorney-hired physicians (PAHP). His logical fallacy is outlined below (assuming a is true, b does not follow; c does not follow from a and/or b):</p> <p><u>Dr. Miller’s Error of Logic</u></p> <p>a) In some cases, radiologic asbestosis can be defined with profusion scores starting at 1/0 (Miller 1998)</p> <p>b) All 1/0 profusion readings by PAHP are accurate (implied throughout ATS-OS, and specifically accepted as true by relying on conclusions from Ohar, et al [Ohar 2004], a study based entirely on PAHP diagnoses).</p> <p>c) Therefore, any 1/0 profusion reading is presumptively diagnostic of asbestosis (2004 ATS-OS, page 696).</p>
<p><u>Dr. Gunner Hillerdal</u> One of ATS Official Statement authors</p> <p>Dr. Hillerdal wrote an article on asbestos disease in Sweden (Hillerdal 2004), stating: “We can already see how asbestos-related diseases in people exposed to environmental “background levels” of asbestos are increasing, but the risk is much less for these people than for those with heavier exposures.”</p> <p>As a recognized expert on asbestos pleural disease (5 of his articles are quoted in ATS-OS), Dr. Hillerdal likely authored section on risk of cancer from pleural plaques (See Table 1).</p>	<p>Dr. Hillerdal provides no reference for this assertion. His statement appears to indicate a belief that all the PAHP-generated diagnoses are true and accurate.</p> <p>He provided no countervailing articles, citing only his own work on this issue (see Table 1, and also letter by Weill and Weill 2005).</p>

Dr. William Beckett

Advisor to the ATS Statement committee

In 1997 Chest published two editorials with opposing views on whether asbestosis was being diagnosed with enough specificity to justify the large number of litigation-related claims. One editorialist felt the diagnosis should be more specific (Rosenberg 1997), while the other felt it was sufficiently specific for this purpose (Beckett 1997). Both editorials quoted a 1991 study that used 1/1 profusion for initial diagnosis and then performed open lung biopsies (Gaensler 1991). Regarding this 1991 study, Dr. Beckett noted that: "95% of the clinically diagnosed cases [i.e., diagnosis before biopsy] did indeed have asbestosis, and 5% had other diseases...The problem of over diagnosis, if it exists, is not any failure of these criteria, but only failure to apply them."

Dr. Beckett made the same error of logic as Dr. Miller, i.e., he extrapolated from a small population with real asbestos disease to a vastly larger population of claims created by PAHP. The problem of over diagnosis by PAHP was already apparent in 1997, yet Dr. Beckett was seemingly unaware of it ("...if it exists"). He could not have been unaware in 2004; in the intervening years numerous studies, articles and congressional hearings extensively documented the problem.

Germane to all this is the unexplained change, by ATS, of the minimal small opacity profusion criterion for diagnosing asbestosis. "1/1" was promulgated in the original ATS statement (ATS 1986), and clearly accepted by Dr. Beckett in his 1997 Chest editorial. Inexplicably, ATS-OS, advised by Dr. Beckett, changed the criterion to the less strict 1/0 in the 2004 ATS-OS.

<p><u>Dr. Tee Guidotti</u> Chairman of the Statement Committee</p> <p>1. In 2000, resigned from American College of Chest Physicians when ACCP endorsed The Fairness in Asbestos Compensation Act (Smith C, 2000)</p> <p>2. Letter to the editor favoring a total asbestos ban in Canada (Guidotti 2001)</p> <p>(Continued)</p>	<p>1. Dr. Guidotti “sent a letter to executives of the organization to say he was not renewing his membership because of the way the group handled the endorsement.” (Smith C, 2000)</p> <p>2. In this letter he wrote: “A smoker exposed to asbestos is more than twice as likely as a smoker who was not exposed to asbestos to die of lung cancer (whether there is a synergistic effect at that level of exposure or not), a conclusion supported by the totality of the literature and individual studies of chrysotile-exposed workers in which the data have been so analyzed.” Dr. Guidotti’s “totality of the literature” was a <i>single</i> reference to a single study done in <i>asbestos factories in China!</i> If that was the only extant study, his statement might not seem so unreasonable. In fact, though, he omitted other studies that argue strongly to the contrary (Browne 1996; Jones 1996; Weiss 1999). (This type of non-supported, key-references-omitted statement is used throughout the 2004 ATS-OS.)</p> <p>Dr. Guidotti also argued that if the association between mere asbestos exposure and lung cancer was recognized, “many claims now denied would be accepted [from] smokers who were exposed to asbestos and developed lung cancer.” He never explained how “exposed to asbestos” would/should be interpreted, leaving the door open to whatever the plaintiff attorney or hired expert want it to be. He must know that many claims are made simply because the worker and some asbestos product were located in the same plant, not because there was any evidence of actual exposure to friable asbestos.</p>
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<p><u>Dr. Tee Guidotti (continued)</u></p> <p>3. Review article, "Apportionment in Asbestos-Related Disease for Purposes of Compensation" (Guidotti 2002)</p>	<p>3. This article -- really an extended editorial -- shows clear bias toward liberalizing criteria for asbestos-exposed workers' compensation claims. His aim is to show how to 'prove' asbestos causation when exposed workers who smoked develop lung cancer or airway obstruction. In my opinion there are several scientific mistakes in this article, the most serious of which is that he assumes a loss of FEV-1 greater than predicted over time confirms airway obstruction from asbestos inhalation. FEV-1 decrement by itself is not a marker for airway obstruction, a fact known to all pulmonologists. Dr. Guidotti's bias appears to underlay the unsupported statement in the ATS paper (page 697; see Table 1) on air flow obstruction in asbestos disease.</p> <p>In this review article Dr. Guidotti also proposed a "crude rule of thumb" to apportion loss of respiratory function between smoking and asbestos, noting: "it is probably an overestimate (thereby "giving the benefit of doubt to the worker", appropriate to workers' compensation)..."</p> <p>Dr. Guidotti provided no reference for "giving benefit of doubt to the worker," as the phrase is his own. Thus his bias is apparent, and it infuses the supposedly-objective 2004 ATS Official Statement.</p>
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<p><u>Dr. Jerrold Abraham</u> Advisor to the ATS Statement committee</p> <p>Published medical article titled: “Asbestos inhalation, not asbestosis, causes lung cancer” (Abraham 1994).</p> <p>Vocal on environmental issues (Schneider 2000, Schneider 2002, Sacramento 2003)</p>	<p>There is a scientific disagreement in the medical literature over whether asbestos causes lung cancer when there is no asbestosis (i.e., no definite lung scarring from asbestos). In 1994 Dr. Abraham entered the debate with this article, and has presumably held the view expressed in the title ever since.</p> <p>Relevant to this issue is a 1999 review of the literature by Dr. William Weiss, who wrote: “Much debate has resulted over the hypothesis that excess lung cancer risk occurs only among those workers who develop asbestosis, some favoring the hypothesis [citing Churg 1993, Brown 1996, Jones 1996] and some opposing it [3 articles cited, including Dr. Abraham’s 1994 paper].” From his review Dr. Weiss concluded: “The evidence indicates that asbestosis is a much better predictor of excess lung cancer risk than measures of exposure and serves as a marker for attributable cases.” In essence, Dr. Weiss’s review disagreed with the conclusions of Dr. Abraham and others. Neither Dr. Weiss’s paper nor his 3 supportive references were cited in the ATS-OS when it discussed asbestos exposure and lung cancer.</p> <p>Several news accounts document Dr. Abraham’s strong environmental views and criticism of government inaction on asbestos issues. I am not critical of his positions, but only point out that they are in concert with the other architects of the 2004 ATS-OS, and confirm lack of balance on the author committee.</p>
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<p>Dr. Gregory Wagner One of ATS Official Statement authors</p> <p>Dr. Wagner, Director, Division of Respiratory Disease Studies, National Institute for Occupational Safety and Health (NIOSH), testified before the Subcommittee on Superfund, Toxics, June 20, 2002, regarding health hazards of asbestos. Part of his testimony is quoted below (Wagner 2002).</p> <p>“Exposure to asbestos significantly increases the risk of contracting several diseases. These include:</p> <ol style="list-style-type: none">1) Asbestosis...2) Lung cancer - for which asbestos is one of the leading causes among non-smokers, and which occurs at dramatically high rates among asbestos-exposed smokers:3) Malignant mesothelioma...4) Nonmalignant pleural disease... <p>In addition, asbestos exposure is associated with excess mortality due to cancer of the larynx and cancer of the GI tract.”</p>	<p>Dr. Wagner’s purpose in Congressional testimony was to draw attention to the horrible consequences in Libby Montana, where vermiculite caused a high rate of true asbestos-related disease (from tremolite asbestos, which makes up about 10 to 20% of vermiculite). Nonetheless, his use of exaggeration and generalization shows bias. For example, lung cancer <i>does not</i> occur at dramatically higher rates among asbestos-exposed smokers, if one defines “asbestos exposed” as anyone who ever worked in a location where asbestos was simply in the vicinity (e.g., in the pipes and walls, stacked in the shipping department). It is actually controversial whether lung cancer risk is increased in the absence of true asbestosis. There are peer-reviewed articles on both sides of the issue (see Comments under Dr. Abraham).</p> <p>The phrase “asbestos-exposed” has been degraded by the attorney-driven claims process, to the point of losing all meaning, and should not be used without qualification – especially by scientists writing for the ATS. Dr. Wagner knows the importance of qualifying “asbestos-exposed.” In 1999 he was quoted in a Montana newspaper regarding asbestos hazards: “The most obvious and serious contributing factor is smoking...combination of smoking and asbestos exposure creates a multiplicative chance for lung cancer. That number [of lung cancer cases] is going to depend on the intensity of exposure.” (Dinny 1999)</p> <p>Without qualification (and, in a legal claim, documentation) ‘asbestos exposure’ conveys no useful information. Yet the unqualified term appears in the ATS-OS in the context of cancer risk. The reason is familiar – the authors erroneously extrapolate from real and deadly disease (e.g., Dr. Selikoff’s original cohort of insulation workers; the people exposed in Libby, Montana) to hundreds of thousands of diagnoses manufactured solely for the purpose of filing claims. Intuitively, even without firsthand experience in evaluating manufactured claims, the ATS authors must know that not all of them can be legitimate, that not all the 1/0 readings can be substantiated, that not all the hundreds of thousands of workers had significant exposure to friable asbestos. If that is the case, then the only reasonable explanation for allowing unwarranted generalizations into the ATS-OS is bias.</p>
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Table 3. Selected quotes from letters to the editor of AJRCCM, ATS Statement Committee responses, and comments on each

Quotes from letters to the editor

ATS response and my comments

<p><u>Ghio and Roggli 2005</u> “The Ad Hoc Statement Committee submits that the American Thoracic Society currently recognizes no confounding by cigarette smoking in the radiographic presentation of asbestosis. This challenges the current state of science in this field. Small, irregular opacities are recognized to be present on the posteroanterior chest X-ray in a significant number of individuals (@ 5%) without any prior history of exposure to either particles or fibers. There is voluminous investigation defining the capacity of cigarette smoking to result in such a profusion of irregular opacities (Meyer 1997)...Decades of investigation have provided the insight that cigarette smoking can confound the diagnosis of asbestosis. To disregard this evidence discredits the American Thoracic Society as a scientific body and contradicts the Society’s recognition of interstitial lung disease associated with cigarette smoking (ATS 2002).”</p>	<p><u>ATS Statement Committee Response</u> “Ghio and Roggli suggest that the Statement does not recognize confounding by cigarette smoking in the radiographic presentation of small opacities and may lead to misdiagnosis. We direct their attention to page 700, column 1, paragraph 3, where we address this issue. Given that the criteria require evidence for nontrivial exposure to asbestos, the limited effect of even relatively heavy cigarette smoking on the profusion of small opacities (at most one minor category [Barnhart 1990]), and the criterion requiring exclusion of alternative diagnoses, misdiagnosis is unlikely in practice.”</p> <p><u>Comment</u> In fact misdiagnosis is extremely common “in practice”, since the main “practice” of asbestos diagnosis is by plaintiff-attorney-hired physicians. Anyone with experience examining mass asbestos claims should appreciate this fact. Unfortunately, unbalanced makeup of the Statement Committee precluded physicians with this experience. As a result, the ATS-OS statements seem to emanate from a disconnected ‘ivory tower,’ and not from real world experience.</p> <p>Furthermore, a careful reading of the passage on page 700 shows another logical error. It states: “Some studies suggest that smokers without dust exposure may show occasional irregular radiographic opacities on chest film, but if so the profusion is rarely as high as 1/0; smoking alone therefore does not result in a chest film with the characteristics of asbestosis.” Since 1/0 is, by the authors’ own standards, “presumptively diagnostic”, and smoking can cause 1/0 (much higher than “rarely”; see Dick 1992; Meyer 1997; Weiss 1984), then smoking alone <i>does</i> result in a chest film with the characteristics of asbestosis. The authors’ bias does not allow them to admit this simple fact.</p>
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Weill and Weill 2005

“With regard to pleural plaques being associated with increased malignancy risk...other data were not included in the Statement. For instance, in a longitudinal study of asbestos cement workers, the presence of pleural plaques (in the absence of asbestosis) was not associated with an increased lung cancer risk (Hughes 1991)...Additionally, a meta-analysis by Weiss (Weiss 1993) concluded that the weight of the evidence favors the position that persons with asbestos-related pleural plaques do not have an increased risk of lung cancer in the absence of asbestosis. This viewpoint is not considered in the statement.”

“In the section on chronic airway obstruction, the Statement implies that clinically significant chronic airway disease can be caused by asbestos exposure alone. However, the studies cited are unable to support that conclusion given their lack of dose-response information and failure to control for other factors (e.g., smoking, radiographic abnormalities, and age) that impact lung function. Despite this, the Committee reached conclusions that are contradictory and that were not based on a comprehensive review of the available literature.”

ATS Statement Committee Response

The 1997 review by Hillerdal and Henderson cited in the Statement examines 10 studies and comes to a different conclusion than that of Weiss (Weiss 1993; Weiss 1999), a conclusion that has since been confirmed by the findings of Karjalainen and colleagues (Karjalainen 1999) in a 1999 study not then available to Weiss. A new study that also confirms this finding has been published (Cullen 2005). The Committee believed that clinicians should be aware of this association, which is now supported by a substantial body of evidence.”

Comment

The Committee believes that clinicians should be aware “of this association,” but not be made aware that it is controversial, that there is countervailing science against it, or that physicians might want to make up their own minds. This is a paternalistic, non-scientific presentation, borne out of the bias of several Statement Committee authors and their advisors (see Table 2).

Committee Response

“Weill and Weill actually appear to agree with the Committee on the association of chronic airway disease and asbestos exposure on almost every point. They do raise the question of whether these changes are of clinical importance and allege that the Statement makes “strong assertions” about the clinical implications of these changes. In fact, the Committee was careful to describe the magnitude of the asbestos effect on airway function as “relatively small” and provided supporting documentation demonstrating that the asbestos effect, in isolation, is quite limited. The possibility of clinically significant impairment is suggested only when the asbestos effect is “superimposed on another disease process... in persons with low levels of lung function,” and as a possible factor in accelerated loss of lung function observed among asbestos-exposed workers.”

Comment

This response simply ignores the confusing message that the ATS-OS presented on this issue (See Table 1).

<p><u>Martin L 2005</u> Letter title: "2004 Asbestos disease guidelines ignore mass screening abuse"</p> <p>"The authors provide no reference for their assertion that the difference between 1/0 and 0/1 profusion readings is "generally taken to separate films that are considered to be positive for asbestosis from those that are considered to be negative". "</p> <p>"The authors provide no explanation of why ATS lowered the profusion score for diagnosing asbestosis from 1/1 (in 1986) to 1/0 ("presumptively diagnostic")."</p>	<p><u>Committee Response</u> "Dr. Martin's letter is entitled "2004 Asbestos disease guidelines ignore mass screening abuse," as if the Statement condoned abusive practices. In fact, the Statement favorably cites both a 2002 white paper from the National Institute of Occupational Safety and Health [National 2002] and a 2000 resolution by the Association of Occupational and Environmental Clinics [Reference 158] regarding characteristics of responsible and ethical screening programs."</p> <p><u>Comment</u> Reference 158 is to a link (www.aoec.org/asbestos-screen.htm) that no longer works. In any case, the paper is quoted only to highlight lack of proper counseling for claimants diagnosed with asbestos disease (Egilman 2004). The 2002 "white paper" is an equally obscure document quoted to emphasize that screening programs should be under the direction of a "qualified physician or other health care provider." Neither paper is quoted to address the mass screening diagnostic abuse; indeed, references on this topic, all readily available, are conspicuously omitted by the ATS-OS. Referencing just these two obscure papers as the only 'critical' comment on attorney-sponsored mass screening programs exemplifies the ATS authors' pro-plaintiff bias.</p> <p><u>Committee Response</u> "Dr. Martin makes two substantive allegations of error...one involves the interpretation of 1/0 readings, which the Statement describes, correctly, as "presumptively diagnostic but not unequivocal": this interpretation is inherent in the International Labour Organization (ILO) Classification system."</p> <p><u>Comment</u> It is inherent in the ILO system only to those who are biased and seek to distort the ILO classification. In fact 1/0 means the chest x-ray on first review appears abnormal (the 1) but on further review may also be normal (the 0). Nowhere does the ILO state this reading presumptively diagnoses a specific disease.</p> <p><u>Committee Response</u> None</p> <p><u>Comment</u> ATS's refusal to explain this change suggests it was done to conform with what works best for attorney-manufactured asbestosis claims (see also comments in Table 1, for ATS-OS page 696).</p>
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<p><u>Martin L 2005 (continued)</u></p> <p>“Considering the partisanship of asbestos litigation, each author’s experience consulting for plaintiff versus the defense should have been spelled out <i>in detail</i>.”</p> <p style="text-align: center;">- - -</p> <p><u>DD Smith (March 15, 2005)</u></p> <p>“Pleural plaques are evidence of exposure and do not indicate a greatly increased risk for asbestos-related disease in those workers with equal exposure and no radiologically visible plaques.” (Smith 2003)</p> <p>“The implication that asbestos contributes to clinically significant COPD is not supportable.” (Smith 2004)</p> <p>“The role of the International Labour Organization (ILO) B-reader chest x-ray interpretation has recently come into question (Janower 2004; Gitlin 2004).”</p>	<p><u>Committee Response</u> Selected disclosures were belatedly published March 1, 2005 issue of AJRCCM (and repeated in the March 15 issue).</p> <p><u>Comment</u> The biases noted in Table 2 were not revealed in AJRCCM’s belated disclosures.</p> <p style="text-align: center;">- - -</p> <p><u>Committee Response</u> “With respect to his comment on pleural plaques, the Committee stands by what was written and the evidence cited.”</p> <p><u>Comment</u> See my comments under Weill and Weill, above.</p> <p><u>Committee Response</u> “With respect to the contribution of asbestos exposure to airway obstruction, the Statement says that asbestos exposure might be clinically significant in the presence of low lung function.”</p> <p><u>Comment</u> See my comments under Weill and Weill, above.</p> <p><u>Committee Response</u> “ In point of fact, the B-Reader Program belongs to NIOSH. It is not an activity of the ILO.”</p> <p><u>Comment</u> This response is completely tangential to Dr. Smith’s comment and the two references he cited.</p>
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