Evaluating Work Relatedness of Byssinosis for Worker Compensation Purposes

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There is a provision in each state Workers' Compensation law that should be designated as the "catch-22" section. It is the provision which imposes on the claimant the burden of proving that his disability arose out of his employment. Offhand, this seems a reasonable requirement. Surely a worker whose disability was not caused by conditions on the job should not receive worker compensation benefits.

Yet, when this apparently reasonable requirement is put into practice, it leads to a nightmare of frustration. This requirement is the major reason why some 19 out of every 20 severely disabled victims of occupational disease in the U.S. are not receiving worker compensation benefits. It is also the reason why 99 out of every 100 disabled byssinotic subjects have not received worker compensation benefits.

Why is this provision so frustrating? Because it demands that medical science do something which it lacks the capability of doing, i.e., to discriminate between lung diseases that are occupational and those that are non-occupational in origin.

The fact is that the symptoms of occupational diseases are generally the same as those of diseases caused by nonoccupational factors. A chronically disabled victim of byssinosis will have the same breathing difficulties as a person who has not been exposed to cotton dust, but who has asthma, chronic bronchitis or emphysema. The respiratory system of both will look the same on x-ray film and they will perform the same way on pulmonary function tests.

Medical science has no reliable means of distinguishing these two persons. It is no wonder that contradictory medical testimony is so often offered by the claimant and the defendant in a contested worker compensation case. Doctors can generally be found to testify that the condition of the claimant could have arisen from working conditions or from other conditions.

This is the heart of the "catch-22" situation confronting textile workers disabled by byssinosis. It is the principal reason they have to wait two years or more and go through multiple medical examinations before their claims can be determined, and it is the reason so many byssinosis victims have felt compelled to accept insurance company offers averaging less than one-quarter of the wage-loss they suffered.

This inequitable system must be changed. The failure of state workers' compensation agencies to provide prompt and adequate benefits to disabled workers causes severe hardship to the victims and shifts the cost of necessary income maintenance from the employers to the federal taxpayers (primarily through the Social Security disability program).

The work-relatedness issue can be dealt with rationally by establishing presumptive criteria for determining whether a worker's claim for total, permanent disability is likely to be work-related. In the cotton textile industry, where epidemiologic and laboratory evidence clearly links dust exposure with the development of disabling lung disease, it is appropriate for presumptive criteria to be applied. Bouhuys recommended the following criteria:

1. The worker has worked in a job in which exposure to cotton dust occurred.
2. The results of the worker's lung function test indicate a pulmonary function less than 50 percent of normal (based on forced expiratory volume after 1 second).
3. The worker's low pulmonary function cannot be improved materially by bronchodilator drugs.
4. There is no positive evidence of other more important causes of lung function loss.

Application of these criteria to establish a rebuttable presumption that the claimant is entitled to Workers' Compensation for total disability would put an end to the abuses prevalent under present law. It would no longer be necessary for the claimant to prove something that medical science does not have the capability to prove. The only role for medical evidence under this proposal would be to seek to establish whether a worker's disability was caused by conditions other than the worker's on-the-job exposures.

Doctors employed by companies and the insurance industry frequently claim that smoking contributes more to textile workers' disabilities than does exposure to cotton dust. This view is contradicted by the studies conducted by independent scientists such as Bouhuys et al., Merchant and Beck. Bouhuys et al. found that "recent epidemiologic studies . . . support the view that one should not assign any overriding role to the effects of smoking in judging the causative factors in the chronic lung diseases of cotton textile workers . . . . Both among non-smokers and among ex-smokers and current smokers, the prevalence of disabling function loss is close to three times higher than among community residents of the same age."

The data of Bouhuys et al. on the dose-response relationship between smoking and lung function loss indicate that for a typical worker who fulfills the above criteria for disability compensation, only 25 percent of the lung function loss might be attributed to the effect of smoking.

Merchant has concluded, on the basis of a review of extensive epidemiologic and laboratory studies conducted among cotton textile workers, that "the current data available indicate that the amount of respiratory disease is caused at least as much and in most cases more by the cotton dust exposure than by cigarette smoking."

In view of the clear evidence that "the effect of smoking is likely to be a minor component of the irreversible

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function loss even in relatively heavy smokers,” I support Dr. Bouhuys’ conclusion that “it would seem reasonable to ignore the possible effects of smoking for purposes of the proposed (presumptive) standard.”

These criteria would substitute relatively objective measurements of loss of lung function for the subjective opinions of doctors. They would make it possible to fulfill the purpose of the Workers’ Compensation law and put an end to the present system of frustrating the claims of byssinosis victims through “catch-22” provisions.

REFERENCES

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Administrative Law Problems with Byssinosis

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When Sir Henry Morgan, in 1665, instituted the first provision for workers’ compensation as a recruitment inducement to buccaneers, I feel confident that he did not perceive that the benefits would apply to disease in any form. His only promise to his men was that if any of them lost a limb in combat, he would see that they were taken care of. When the first Workers’ Compensation Acts were passed in America, diseases were excluded. In 1920 New York became the first state to make provision for compensation for certain named diseases.

The Federal Occupational Safety and Health Act in the early 1970s had as a peripheral feature the appointment of a task force to study state Workers’ Compensation Acts. One of the 19 essential recommendations of that task force was that all occupational diseases in every state be given the same benefits as accidental injuries. Each of the 50 states now has some type of occupational disease coverage, but in some states the benefits paid for occupational disease are limited, and the statute of limitations is so restrictive as to, in effect, preclude any recovery.

Byssinosis has been compensable in North Carolina since the enactment of Chapter 553, Session Laws of 1963. That act changed G.S. 97-53(13) so as to make compensable any “infection or inflammation of any internal or external organ of the body due to exposure to materials or substances in employment.” If these criteria are met, the same benefits are payable as would be payable for an accident. This covers payment for partial disability or total disability or death, in the same fashion that on-the-job accidents have been covered since 1929.

The cited statute was rewritten in 1971 to read that “any disease which is proven to be due to causes and conditions which are characteristic of and peculiar to a particular trade” is compensable. All ordinary diseases of life to which the general public is equally exposed outside of the employment are not compensable. The change was made at the insistence of employees who felt the 1963 statute might be too restrictive, but in my opinion the change in language altered no substantive rights.

The 1971 version of our occupational disease law has been interpreted by our Supreme Court in only one case—Booker vs Duke Medical Center, 297 N.C. 458. Our Supreme Court held in that case that the incidence of a particular disease was higher in a given occupation, the disease was occupational in origin and therefore compensable. In the Booker case, the Court was dealing with serum hepatitis in a laboratory worker who daily handled hepatic blood. The result reached in Booker was an excellent one, but I do not believe the dicta contained therein will be followed literally unless it can be shown that the employment environment contained a causative agent that, based on a reasonable medical certainty, could have caused the disease. Only future appellate decisions in this field will bring us the answer to this.

Our first case was handled in North Carolina about 1972. As of Nov 1, 1980, we have had 1,535 claims filed, most of these in the past three years. Of these, 717 have been finalized, 468 have been paid by agreement or award, 22 have been denied, and 227 have been dismissed or withdrawn. Seven million dollars in compensation benefits have been paid to these workers in the cases that have been closed.

Very early in the processing of these claims, we found few physicians in North Carolina sufficiently cognizant of the disease to make a competent diagnosis. For this reason, we named those chest physicians in North Carolina whom we knew were familiar with this problem to an ad hoc Textile Occupational Disease Panel. They are private practitioners who are board certified in pulmonary medicine. The only pay they receive is their usual and customary fee for examining the...