New England College of Occupational and Environmental Medicine

Volume 2 Issue 10

Spring 2004

NECOEM Reporter

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Utilization Review and Quality Assessment Enforcement

Catherine R. Farnam, RN, MS, CS, Director,
Office of Health Policy, Department of Industrial Accidents

Introduction:

When I was appointed the Director for the Office of Health Policy at the Department of Industrial Accidents (DIA) in March of 2002, one of my first mandates from the Commissioner's Office was to review the utilization review program to assess the level to which the DIA was meeting its regulatory oversight responsibilities for this program. Concerns raised in other states regarding the lack of enforcement of workers' compensation laws were the catalyst for the review.

In Texas, two lawsuits have been filed that are cause for concern by the DIA. The first lawsuit against the Texas Workers' Compensation Commission alleges non-enforcement of the law. The second lawsuit against several workers' compensation carriers and review companies relates to the problem of unwarranted "medical necessity" denials.

Points of Concern Regarding the Massa-

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Harriet Hardy Award Acceptance

December 4, 2003

I would like to thank the New England College of Occupational and Environmental Medicine for considering me worthy of this award.

I first met Harriet Hardy through her writings in the New England Journal of Medicine 28 years ago when I was in my last year of medical school. In 1975, Dr. Hardy cautioned us not to be seduced by the gifts and favors of corporate management and wrote harshly of medicine's track record to date.

Drs. Bill Patterson and David Kern

In 1975, Harriet Hardy wrote that "…it should be understood that basic change to prevent occupational illness in the United States is coming as a result of strong pressures such as workers' active protest, progressive union leadership and the strength of a few brave activists in federal and state agencies; medicine should provide another pressure

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Letter from the President
John W. Burress, MD, MPH, FACOEM

I'm honored and enthusiastic to be elected NECOEM's President. Allow me to touch on a few topics of importance to our organization and to share with you my thoughts on how NECOEM can grow as an organization.

We will improve our financial position, further improve our CME offerings and enhance the social fabric of our organization. Sounds simple. How to proceed? Thankfully, during the past few years we've made concerted efforts toward the first two items;. Seeds have been planted. Now it's time to cultivate.

NECOEM derives most of our income from CME offerings. Since I've been on the Board, a consistent focus has been regaining a solid financial base by cutting costs and boosting revenue. Hence, the Board decided to change Annual Conference (AC) venues and to allow sponsors. Our success depends on your tolerance to such innovation.

The May 20th Dinner Meeting represents a bold effort to acknowledge our component's geographical spread. The Maine contingency has arranged for what sounds like a wonderful location. Members to the North and South of Boston typically travel considerable distances to attend NECOEM Dinner Meetings held just outside of Boston. This will be an opportunity for those members in the Boston area to reciprocate. If the meeting to the north proves successful we will plan a meeting to the south of Boston in the future. Be brave. Pan to attend!

At the 2003 AC, we accomplished several key goals. We made money (approximately $15,000). We had two full days of offerings. Attendance was excellent. In the three years that I've served as AC Chair, I've never seen a course evaluation so rich with ideas on

topics and so spicy with constructive comments.

Dr. Stephanos Kales, a relatively new Board Member, assumed the role of AC Program Committee Chair for 2004. From the Committee's first phone conference emerged a promising start on a curriculum heavily based on the 2003 AC Course evaluation comments. The 2004 AC promises to be clinically relevant and academically strong. Let's get behind Stephanos Kales and the AC committee with our support. Let me give much deserved praise to Glenn Pransky for his input on the AC Committee over the past several years. We have benefited greatly from his keen mind and his ability to marshal intellectual resources within our professional community.

Of note, the 2003 AC was attended by a record percentage of the OEM Residents from the sole surviving residency in the area (Harvard). Good job Chief Resident Abe Timmons for spearheading that level of participation! Compared to when I was a resident in the early 90s, interest and involvement in NECOEM by academic OEM specialists is way up.

How do we enhance our social interactions? Excellent CME offerings should pave the way to a more solid financial position. Does the social time preceding Dinner Meetings and the breaks during the AC suffice to meet our needs socially or should we look for more as a group? My take on this is that we are at a distinct disadvantage compared to our grandparents' generation. I was struck by the fond memories alluded to by surviving physician colleagues of my grandfather. The memories were not about specific lectures but of fun they and their spouses had traveling to and participating in medical meetings together. Who planned and facilitated their events? Our current situation, including my own, involves a seemingly more hurried existence with dual career families. Hence, if we are to enjoy similar collegiality with our peers during our own professional lifetimes, then we must be the initiators. Please come forward with any ideas (e.g., starting a Journal Club, having a potluck at a member's house, hosting a movie night or a nature walk with a guide).

I'm pleased to announce the appointment of two new NECOEM Board members, Tom Gassart and Geoff Shreck. Every organization lives or dies based on its ability to attract and foster active members who take their turn at the wheel of leadership. If you've been a member for some period of time and have not stepped forward, consider doing so.

In closing, I believe NECOEM, with our now seasoned Executive Director, Dianne Plantamura, active Board, and serious commitment to excellent CME holds a strong position from which to grow to the next level. The challenge will be to sustain momentum by fostering new leadership, continuing to innovate on costs, and by more actively pursuing congenial social interaction.

(Continued from page 1)UR, QU

chusett's Workers' Compensation Utilization Review and Quality Assessment Program

After review of the Massachusetts' system, we have identified two areas similar to those in Texas: a) adjusters denying claims based on their own opinions without proper utilization review, and b) review agents recommending denials in the absence of an ordering provider's medical documentation and in disregard for use of medical standards as required by Massachusetts' workers' compensation laws. Both are serious violations that may result in irreparable harm to injured workers. After numerous discussions, the Department determined that more needed to be done in terms of oversight and enforcement to ensure that injured workers' medical claims were not being arbitrarily denied for the purpose of cost savings.

In Massachusetts, utilization review is not, and should not be, viewed as a cost containment program. Workers' compensation health care should be determined in the same manner as the general public to the same extent possible. The Massachusetts workers' compensation statute mandates that all health care services are made in accordance with approved standards of medical practice. Further, utilization review agents, approved by the DIA, are required to determine all care using and documenting these standards. Failure to review health care service requests in accordance with approved standards of care such as the Massachusetts' Health Care Services Board Guidelines and Review Criteria or other secondary medical sources such as The Medical Disability Advisor and/or another scientifically based, medical research source renders the agent's decisions arbitrary. If an injured employee requires care and is harmed because care is denied, and that denial is: 1) determined by an adjuster who is not a licensed health care professional and/or 2) the determination is rendered by an agent without using and documenting approved research based standards of medical practice, the utilization review organization and/or the insurer that withheld the care may be held legally accountable for any harm that occurs as a result.

The Problem of Insurance Adjusters Determining Health Care for Injured Workers

In Massachusetts, all utilization reviewers must be licensed in accordance with state law. When a non-licensed insurance adjuster recommends denials of health care, they do so in violation of the workers' compensation law that requires that a licensed practitioner conduct such review, the insurance adjuster is, for all practical purposes, practicing medicine without a license in the Commonwealth (a very serious offense).

Utilization Review Vs. Case Management in Massachusett's

Utilization review is mandated in Massachusetts and the law requires that after October 1, 1993 all health care services, irrespective of date of injury, be reviewed for medical necessity and appropriateness of care by a Department approved utilization review agent in accordance with relevant state regulations and state developed treatment guidelines. Utilization review is defined as a retrospective, prospective, and concurrent review of all health care services for medical necessity and appropriateness of care.

Utilization Review

Although conducted on a regular basis by insurers, case management is neither mandated nor regulated in Massachusetts. Therefore, case management is a voluntary service that requires informed consent by the injured employee. However, the Department is concerned that many utilization review agents may be conducting case management under the utilization review regulations 452 CMR 6.0. Whether case management is good or bad is not for the DIA to determine. When a utilization review organization is found to be conducting case management in place of utilization review, the DIA issues a cease and desist order. Failure to comply with this order jeopardizes the organization's continued approval in the Massachusetts' utilization review and quality enforcement program. In Massachusetts, utilization review is one of the systems that make workers' compensation effective. When conducted appropriately, utilization review regulates insurer activity and protects worker interests by ensuring medical treatment decisions are made by licensed health care professionals. The Department is now conducting audits of all agents to ensure that utilization review is conducted as mandated.

UR Agents Must Comply With Medical Standards: Monitoring Treatment Guideline Compliance

It is very important that ordering practitioners understand that all determinations by utilization review agents must be based on standards of medical practice, i.e., treatment guidelines. This prevents physicians from issuing determinations based soley on their sole opinion and experience, rather than medical standards and criteria. I recently reviewed a medical record with a report from a physician stating " patient has family who should be helping patient at home." This is only one example of the type of subjective, arbitrary determinations we find documented in case records during

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(Continued from page 3) UR, QA

medical record audits. We are doing a great deal of training with utilization review agents and informing them that these types of arbitrary determinations will no longer be accepted in Massachusetts. If agents cannot have their physician advisors conduct appropriate and objective reviews that include recommendations based on scientific standards of practice, they risk suspension and/or revocation of their approval to conduct business in Massachusetts.

Utilization Review Monitoring and Enforcement

The DIA is required to monitor the quality of care rendered to injured employees, the utilization review techniques used, determinations made by utilization review agents and to ensure compliance with all regulations. While the purpose of the Office of Health Policy to ensure compliance is clear, this is not an easy task to accomplish. The Department regulates agents across the country, which makes compliance monitoring very difficult.

Recently, as part of a quality improvement initiative, the DIA established new initiatives that support a well-designed UR/QA system including, but not limited to, implementation of regular quality assessment audits for all agents. The goal being to improve monitoring and oversight of all agents both in state and out-of-state. The initiative is greatly improving regulatory compliance with requirements such as timely notification of approvals and denials, documentation of clinical rationales for denials, and information about the right to appeal a decision in a timely manner. Without an onsite review of medical records, it is impossible to ensure that agents are in compliance with these reporting requirements.

For example, prior to the audit initiative, UR agents were choosing whether they would conduct an expedited or standard appeal of a denial of care. Injured workers were often left without care for long periods while an agent reviewed their request. The DIA now requires all prospective and concurrent appeals to be completed on an expedited basis (within two (2) business days).

When unwarranted and/or arbitrary decision making is found, the Department provides education to the agent regarding the standards and regulations required in Massachusetts. If the agent refuses to comply after the on-site audit and education, The agency will conduct a hearing, which could result in suspension and/or revocation of their approval.

Utilization Review Standards and Practice

The Department's goal is to ensure quality health care to all injured workers and to ensure that cost is not the determining factor in approving or denying medical care to any worker. Utilization review companies are for profit businesses. The purpose of the requirement for UR agents to base all medical determinations on scientifically based statutory standards is to ensure that these businesses are not profiting from improper, unwarranted denial of medical care to injured workers. The audit of medical records is the only way to ensure that the decisions are not arbitrary and subjective in nature.

In light of recent audit findings that indicate a lack of regulatory compliance by some utilization review agents, the DIA is continuing to increase surveillance of this program. The DIA recently notified all agents that they would be subject to annual Quality Assessment Audits, which will include both medical record reviews and onsite visits. Through the audit process, the DIA will attempt to ensure that injured employees are receiving due process concerning their right to appeal denials made by agents and their right to file a complaint against any agent that they feel is in violation of the law. The DIA investigates every complaint received. If an agent continues to violate the law, they are subject to a hearing to determine whether their approval to conduct UR in Massachusetts should continue.

The DIA encourages providers and workers to report any and all concerns regarding utilization review to the Department. We follow up on each and every complaint. We learn a great deal about the actual practice and compliance and/or lack of compliance with the law from injured workers, physicians and attorneys.

As word gets out that the Department is responding very aggressively to allegations of improper utilization review procedures by agents, complaints are increasing. This is the best way for the Department to conduct a thorough review of the entire organization. Recently, due to a challenge of the Department's authority to conduct onsite reviews, the DIA established a formal hearing process for agents that are alleged to have violated the law. The Department is beefing up its regulatory processes and the message is being communicated that we take this responsibility very seriously.

In her capacity as Director of the Office of Health Policy, Department of Industrial Accidents, these are Ms. Farnam's personal opinions and observations and not necessarily the opinions of the Department of Industrial Accidents.

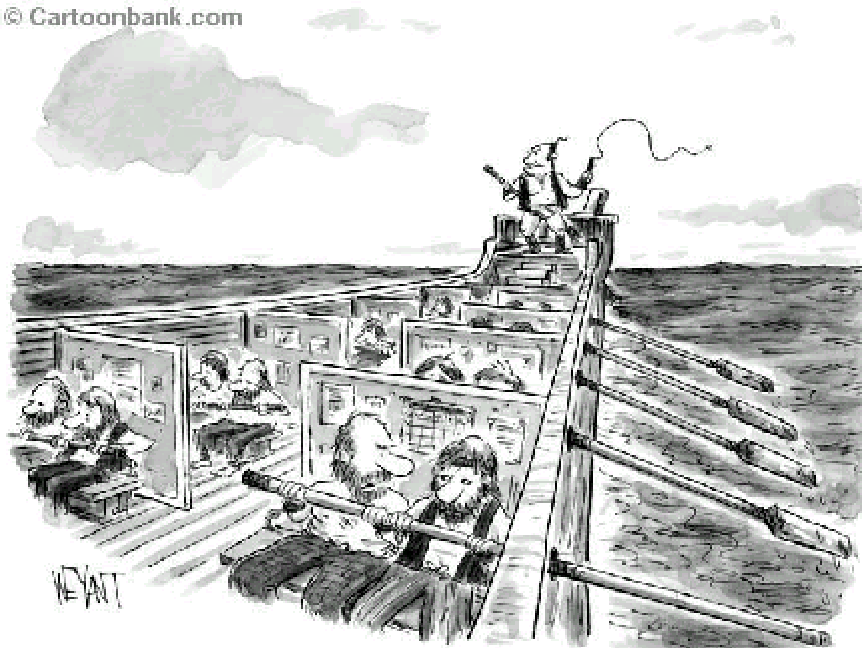
(Continued from page 1) Award

from an objective stance." With respect to the latter, Benoit Nemery, a Belgian pulmonologist and toxicologist, more explicitly defined the physician's reality in the conflict-prone context of occupational health when he wrote: "...most of the time conflicts around occupational health issues remain within the anonymity of the 'class struggle.' The latter phrase, as well as the analysis underlying it, will appear somewhat outmoded to some, but there is no doubt that occupational health practitioners are always part of the relations and the balance of power that exist between work and capital, and they have to make choices, both in principle and in daily practice."

Thirty years ago, Philip Hallie, an American philosopher and student of ethics and human cruelty, came upon a brief account of how the Protestant clergy and villagers of Le Chambon, a small town in southern France, had saved more than a thousand Jewish children in full view of both the Vichy government and a nearby division of the Nazi SS. While reading the account, Hallie, a self-described hardened scholar, became annoyed by a strange sensation on his cheeks. Reaching up to brush away what he presumed to be dust, he felt tears upon his fingers. Within the year, Hallie would go to France to discover how the people of Le Chambon had found the courage, resources, and moral strength to actively but non-violently resist the evil in their midst. His book *Lest Innocent Blood be Shed* details his findings.

Hallie learned that the Huguenot villagers of Le Chambon adhered to the simple belief that all human life is precious. Merely holding such a belief and doing no harm, however, were considered insufficient. The village's minister, André Trocmé, believed that: "In times of crisis, theories and predictions are a refuge for cowards.....[and that] ...'decent people' who stay inactive out of cowardice or indifference when around them human beings are being humiliated and destroyed are the most dangerous people in the world." Hallie left Le Chambon in the hope "...that if another crisis should come, we would with whole hearts do the kind of things they did...[and]...that even in these less dangerous times we can do the kinds of things they did."

It is this last phrase which has given me pause: "...that even in these less dangerous times we can do the kinds of things they did." Or, more precisely, it is the antithesis that has given me pause. That is, if we cannot do these kinds of things now, what can we hope for in more dangerous times. And so, in the two-year period from November 1997 through August 1999 I became increasingly despondent, not because of the actions of corporate, hospital, or university administrators but because of the inaction of numerous individuals, organizations, and bureaucracies. This is not to say that I ever lost sight of the counterbalancing support provided by numerous organizations and individuals. Rather, it was the extent of indifference, tantamount to complicity, that was so undermining as I recalled Ian Kershaw's commentary that "...The road to Auschwitz was built by hatred but paved with indifference."



"I don't mind the whip. It's the cubicles I find demoralizing."

Now, five years later, with the world becoming progressively more dangerous, I believe it is all the more important to publicly identify and celebrate those who refused to remain silent and indifferent in my time of personal crisis. Their words and actions, which I did not solicit, remain inspirational both in their own right and in representing an alternative to the silent acquiescence of others. As Cynthia Ozick wrote in the forward to a book entitled *The Rescuers: Portraits of Moral Courage in the Holocaust* - "These few are more substantial than the multitudes from whom they distinguished themselves; and it is from these undeniably heroic and principled few that we can learn the full resonance of civilization." And so I pay tribute to the following.

Robert Crausman, MD,

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Charles Kuhn, III, MD, and Kate Durand, MHS, CIH, my research collaborators, stood by me despite being institutionally-based with me at Memorial Hospital, the epicenter. With grace and courage, they accepted my recommendation that we not withdraw our initial scientific submission despite numerous demands and legal threats to do otherwise, tried to educate hospital and university administrators about the principles involved, and, all the while, maintained their focus on rigorous, objective scientific research. Dr. Crausman, moreover, would later find himself appropriately asking Memorial Hospital's Internal Medicine Residents to reconsider their decision to name me Teacher of the Year, given both our Residents' need to obtain fellowship recommendations from an adversarial Chief of Medicine and, their tenuous immigration status. Noting the absence of any other formal mechanism by which they could support me, the Residents quite poignantly refused to change their decision.

Dr. Robert Vanderslice, Chief, Office of Environmental Health Risk Assessment, RI Department of Health, stood head and shoulders above an otherwise gray, silent Rhode Island State pubic health bureaucracy. Dr. Vanderslice was aware that the company's threat to sue, should we to disclose our findings to the medical, scientific and public health communities, was providing hospital and university administrators with an excuse for inaction and worse. Consequently, relying on the state's Rules and Regulations Pertaining to the Reporting of Communicable, Environmental and Occupational Diseases, Dr. Vanderslice ordered me to report my findings to him. Eight days later, I was notified that both he and the editor of the CDC's *Mortality and Morbidity Weekly Report* (*MMWR*) had concluded that our findings should be published in *MMWR* given their broad public health significance.

Six Brown University faculty members submitted to the Faculty Executive Committee a list of charges against Memorial Hospital's President and Chief of Medicine, the latter a Professor of Medicine and Community Health and Associate Dean for Primary Care. The two were charged with ordering me to withdraw a submitted scientific abstract, terminating the program in occupational and environmental medicine, prohibiting me from providing medical care to my patients from the company in question, and in turn, with undermining principles of academic freedom and the legal obligation to report environmental health hazards. At the urging of its vice-chair, Professor James Baird, the FEC in turn notified both the Dean of Medicine and Brown University's President of its conclusion that my academic freedom was being violated.

These six faculty members - Kim Boekelheide, MD, PhD, Lundy Braun, PhD, Dan Brock, PhD, Charles B. Sherman, MD, Harold Ward, PhD, JD, and Sally Zierler, DrPH - all were engaged in work either directly or indirectly touching on occupational and environmental health issues and ethics. In submitting their charges, the six, especially Drs. Braun and Zierler, placed themselves at substantial risk, and all deserve our gratitude for their efforts on behalf of the field of occupational and environmental medicine and for attempting to hold our university to its professed principles.

More than one hundred of our occupational and environmental medicine colleagues from this country and abroad, numerous academics from other fields, Brown University alumni, and lay people, wrote to administrators at Memorial Hospital and Brown University. Many of these engaged in additional creative activities. Although these individuals risked little, they too I consider heroes in my lexicon. That is, they refused to be indifferent bystanders. Their involvement reflects a belief in the power of the individual to make a difference, in the need to stand up for principles, and in the societal importance of supporting colleagues and kindred spirits.

Howard Frumkin, MD, DrPH, a Brown alumnus and Chair of the Department of Environmental and Occupational Health at the Emory University School of Public Health, and known to many of you, worked with the Association of Occupational and Environmental Clinics and the Occupational Health Section of the American Public Health Association (APHA) to initiate a letter-writing campaign. Howie would latter co-author a letter published in the New England Journal of Medicine (NEJM) as well as an International Journal of Occupational and Environmental Health (IJOEH) commentary that is likely to serve as my eulogy. Additional letters and IJOEH commentaries would be written by Ben Nemery, MD,PhD, of Belgium, Katherine Venables, MD, of England, and Rokho Kim, MD, DrPH, PhD, of South Korea.

William Beckett, MD, Department of Environmental Medicine, University of Rochester School of Medicine, chaired the scientific session at which my colleagues and I first presented our work at the American Thoracic Society's International Meeting. He would later write to Brown University's President: "By insisting on the need to present this scientific information now, Dr. Kern was able to alert physicians and scientists from five continents of a serious occupational lung disease concern. Others may be at risk. Lives may be saved by his action."

David Christiani, MD,

known to all of you, wrote letters to Brown University administrators, co-authored an additional letter with Mark Cullen, MD, of Yale's Occupational Health Program, and then, with David Wegman, MD, wrote to the Boston Globe. To the latter, they argued that had I originally refused to sign the contested confidentiality agreement and, as a consequence, not entered the plant, my professional "integrity" would have been maintained but at the expense of the workers' health. Dr. Christiani later would present our case to the membership of the Environmental and Occupational Health (EOH) section of the American Thoracic Society (ATS), prompting the ATS to warn Brown University's President that "Barriers to the open communication of scientific information must be resisted. In particular, the threat of litigation and/or elimination of financial support to prevent the open communication of scientific information is abhorrent."

David Wegman, MD, wrote to Brown University's administrators, and was interviewed on public television about the issues raised by our case.

Barry Levy, MD, as President of the APHA, wrote early to Brown University's administrators and has provided ongoing assistance over the years.

James Keogh, MD, a much missed colleague, from the University of Maryland Occupational Health Project, wrote to Brown's Dean of Medicine: "I'm puzzled that you would respond to this attack on Dr. Kern, this assault on academic freedom and most of all this challenge to the integrity of the medical profession by appointing a committee. Don't you think this is something you ought to be dealing with directly, personally and promptly? How can we teach our medical students to make the ethical and moral decisions their patients will expect of them if we don't do the same?" Shortly thereafter, Jim and Janie Gordon, ScM, then chair of APHA's OHS section, would invite me to address their first year medical school class.

Joe LaDou, MD, long a respected force in the field of occupational and environmental medicine, and editor of the International Journal of Occupational and Environmental Health, would write to Brown's administrators, publish my solicited manuscript in IJOEH, and provide ongoing support to me in numerous ways.

John Balmes, MD, of the University of California at San Francisco, would write to the University, shepherd a supporting proposal through the ATS's EOH section, and along with numerous other academic colleagues, generously offer continued academic employment.

J. Frederic Green, MD, immediate past President of the American College of Occupational and Environmental Medicine (ACOEM), contacted me to offer assistance. ACOEM rapidly generated a letter to Brown University's administrators, warning that: "History is replete with examples where delay or suppression in the reporting and dissemination of health risks led to serious human and financial consequences. The essence of scientific investigation lies in the free exchange of ideas amongst members of the scientific community. This is the cornerstone of scientific progress. Academic freedom to further this dissemination is critical. Preservation of the principle of open discussion of public health and preventive medicine matter is vital. Investigation of these health issues cannot and should not be restricted."

Among the numerous other American OEM physicians who generated letters of support, names familiar to you would include: Elisha Atkins, Ronald Balkisoon, Drew Brodkin, Robert Castellan, James Cone, David Egilman, Kathleen Fagan, Kevin Fennelly, Alfred Franzblau, George Friedman-Jimenez, Laurence Fuortes, Rose Goldman, Bernard Goldstein, Ian Greaves, Gary Greenberg, Tee Guidotti, Jay Himmelstein, Michael Hodgson, Thomas Horiagon, Rafael de la Hoz, Howard Hu, Stefanos Kales, Karl Kelsey, Howard Kipen, Stephen McCurdy, Don Milton, Sandra Mohr, Richard Monson, Lee Newman, Peter Orris, Lewis Pepper, Glenn Pransky, Thomas Robbins, William Rom, Cecile Rose, Kenneth Rosenman, Maryjean Schenk, Brian Schwartz, David Schwartz, Dennis Shusterman, Nancy Sprince, Eileen Storey, Michael Wolfson, Craig Zwerling, and Stephen McCloy. The latter, presumably because he was based in Rhode Island, chose his words carefully in writing to Brown's Dean of Medicine: "I can understand (but cannot respect) Memorial's whoredom before a prominent donor and employer. I neither understand nor respect Brown's response of first submitting this issue to the lawyers..." There were additional OEM voices from Europe, Australia, New Zealand, Asia, Canada, and Africa.

Additional guiding lights outside our field included Drummond Rennie, MD, deputy editor of the Journal of the American Medical Association, and author of an incredible editorial (JAMA 1997;277:1238-43) entitled "Thyroid Storm," who would later arrange for me to interface with the Committee on Scientific Freedom and Responsibility of the American Association for the Advancement of Science; Frank Davidoff, MD, then editor of the Annals of Internal Medicine; Nancy Olivieri, MD, and her Canadian colleagues; a number of academic bioethicists; the Harriet Hardy Institute; the Ethical Society of Bos-

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NECOEM

NECOEM is a not-for-profit, regional component society of the American College of Occupational and Environmental Medicine, the preeminent organization of occupational and environmental physicians in the United States.

NECOEM has over 200 physician members and is dedicated to preventing and treating occupational injuries and illnesses. NECOEM provides continuing medical education for its physician members and other clinicians in order to enhance the care that they provide to men and women in the workplace. NECOEM is an advocate for workplace safety, occupational health research, raising public awareness of occupational and environmental health issues, guiding public policy, and recognizing outstanding achievement by individuals in occupational and environmental health."

The editorial board welcomes letters to the editor. Write or email to NECOEM at the above address. The editor reserves the right to edit letters for publication purposes.

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ton; and many other wonderful souls and organizations too numerous to name.

And so, as I contemplate all this goodness, I return to the notion of choice. In the early1960s, political philosopher, Hannah Arendt, wrote her still controversial *Eichmann in Jerusalem: A Report on the Banality of Evil* after attending Eichmann's trial for crimes against humanity. Her phrase "the banality of evil" has since become part of our language. I long for a "banality of goodness." As Mordecai Paldiel, director of the Department for the Righteous at Yad Vashem, wrote: "In searching for an explanation of the motivations of the Righteous Among the Nations, are we not really saying: what was wrong with them? Are we not, in a deeper sense implying that their behavior was something other than normal? Is acting benevolently and altruistically such an outlandish and unusual type of behavior, supposedly at odds with man's inherent character, as to justify a meticulous search for explanations? Or is it conceivable that such behavior is as natural to our psychological constitution as the egoistic one we accept so matter-of-factly."

I find his logic compelling. Yet, if this tiny spark of optimism is not to be extinguished, we must confront the fact that as long as there are both perpetrators of evil and victims, there will be a far larger mass of initially unaffected human beings. The hope of civilization is that the seemingly unaffected can be turned from indifference and complicity to resistance by the example of Ozick's "undeniably heroic and principled few." It is in this spirit that I celebrate those who have acted.....and, indeed, I consider it a responsibility to do so, mindful of the ever lurking risk so hauntingly depicted by Holocaust survivor Primo Levi who, in *The Drowned and the Saved*, wrote that we "....are so dazzled by power and prestige as to forget our essential fragility. Willingly or not we come to terms with power, forgetting that we are all in the ghetto, that the ghetto is walled, that outside the ghetto reign the lords of death, and that close by the train is waiting."

David G. Kern, M.D., M.O.H.