

NECOEM Reporter

QUARANTINED IN FLIGHT: CAN THEY DO THAT?

Craig W. Curtis, M.D.

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NECOEM EVENTS

April 12
TOUR and DINNER
Liberty Mutual Research
Institute for Safety,
Hopkinton, MA

Featured speaker:
Dave Melton, CRSP, CDS,
Director of Transportation
Technical Services, LMRIS

**"Is That Commercial
Driver Really Fit to
Drive? An Update"**

May 17
DINNER MEETING
Cumberland Club,
Portland, Maine

Featured speaker:
Richard A. Aronson, MD, MPH
MCH Medical Director,
Maine CDC

**" Adverse Childhood Ex-
periences (ACEs): Their
Impact on the Health of
Workers,"**

November 29 and 30
NECOEM/MaOHN
ANNUAL CONFERENCE

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What does an "air-sick" passenger have to do with us, or an epidemic? A new DOT manual will shed some light on this intriguing concern.

Even though it killed at least 40 million people in less than a year, the 1918 influenza pandemic's most alarming features may have been that the response was initially unplanned, and it nearly extinguished the basic humanitarian impulses that bind civil society together. This calamitous

infectious disease pandemic killed more people in 24 weeks during 1918 and 1919 than AIDS has in 24 years. According to John M. Barry, "*those that were still healthy were too panicked by the disease's violent symptoms to even look in on their ill neighbors. Some of the sick, and their children with them, simply starved to death for lack of attention. Nothing seems to rouse them, children are starving and still they hold back, even in tight knit*

rural communities, neighbors didn't rally around."



(Continued on page 2)

Time to Use Tdap as a Booster

Cristine V. Amurao, MD, MPH

The Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) now recommends replacing the tetanus-diphtheria (Td) vaccine with the new tetanus-diphtheria-pertussis (Tdap) vaccine as booster shots for adolescents and adults. The Tdap would add protection against pertussis which is highly contagious with up to 90% of susceptible household

contacts developing the disease after exposure to the sick individual. Occupational health clinics should consider giving workers—especially healthcare workers with direct patient contact—Tdap instead of Td because, despite immunization efforts, incidence of pertussis in the United States has increased since the 1980s. After maintaining a level of about 5000-7000 cases per year



in the 1990s to 2000, incidence jumped to a record high of 25,827 cases in 2004. The mortality rate

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How would we respond today?

Occupational medical specialists play a wide variety of roles and functions protecting workers and intervening in public health hazards where indicated. Our roles are often intricately intertwined with the general preventive health and national health systems and many times we are asked to be involved in health events and problems that are national or global in scope. Most recently, pandemic infectious disease fears have permeated the public press, demanding much of the time and energy of our emergency preparedness, national health organizations and medical experts. Often, we operate in small microcosms in our daily roles as occupational specialists to local clientele and business communities. However, when dealing with pandemic infectious disease risks, we most certainly will be involved in many aspects of the planning, preparedness and readiness activities, and asked to respond, when this international crisis unfolds.

To that end, many of our national organizations have produced and distributed publications and communications regarding various aspects of these activities. One recent publication titled *"The National Aviation Research Manual for Quarantinable Diseases"*, as published by the US Department of Transportation, has received little publicity. I believe this treatise presents some interesting insights into aspects of epidemic response and control that we may be called to be involved with, and, have had little to do with. In this article I would like to bring some awareness to this publication, both because of its timeliness and its focus on these issues.

Pandemic flu, avian flu, S.A.R.S., among others, all present

potentially catastrophic infectious disease events yet to be realized in our lifetimes. Reading John M. Barry's *"The Great Influenza: The Epic Story of the Deadliest Plague in History (Viking 2004),"* I can only extrapolate the devastation that occurred worldwide in 1918 to today's culture of global travel and world economy. Unimaginable, and unthinkable timelines of illness and death to routinely untargeted populations were hallmarks of this deadly plague. It's daunting to think what would happen today (considering our global travel capacity allowing us to reach anywhere on earth in under 24 hours) if we were struck by a new world virus like the Spanish flu that struck earlier this century. I, for one, couldn't imagine the ramifications of such an event, but fortunately some of our medical colleagues, national emergency and political organizations have begun preparations for the return of such an event.

The CDC, NIH and other medical and emergency response organizations have put significant energy, effort and commitment to planning for the 'what if'. With many of these organizations publicizing and communicating strategies and plans, the recent manual released by the US Department of Transportation addresses an area that doesn't get a lot of focus. Specifically this manual titled *"The National Aviation Resource Manual for Quarantinable Diseases,"* published by the US Department of Transportation in association with the Center for Disease Control and Prevention, is the first comprehensive guide for the aviation community on preventing the introduction of threatening communicable diseases into the United States by international air travel. This document helps airlines, airports, and local governments recognize and control pandemic outbreaks before they have a widespread impact on public health. (<http://isddc.dot.gov/OLPFiles/OST/013334.pdf>)

This quote from the Mary E. Peters, Secretary of Transportation, introduces the publication.

"One hundred and three years ago, the Wright brothers unlocked more than the secret of flight. They unlocked the door of opportunity and growth. Since then, civil aviation has become a \$900 billion industry, employing more than 11 million people. It shrinks the world's vast distances and carries economic vitality and hope."

Unfortunately, the more than nine million flights a year that traverse our skies carry the risk of less welcome cargo: infectious diseases with the potential to disrupt our way of life and cause disastrous suffering and loss. Such quarantinable diseases include smallpox, cholera, viral hemorrhagic fevers, severe acute respiratory syndrome and—of particular concern today—those strains of the influenza virus that may cause a pandemic."

In order to prevent the spread of such diseases through the airline system, we have prepared this manual. Our objective is to bolster the capabilities of airport operators, air carriers, first responders and State and local governments. To prevent widespread transmission of quarantinable diseases, the manual provides a comprehensive guide for the organizations involved in planning for and responding to a quarantinable disease incident. We hope it will be an invaluable resource for those organizations as they develop more specific and detailed response plans to deal with emergencies."

With further definition of purpose from Health and Human Services Secretary Michael O. Leavitt we can imply much value and significance in the work that has been done:



Our nation's ports of entry are teeming with activity. Each day, more than 5 million travelers arrive to or pass through the United States by air, sea or land. These 317 ports represent the intersection of the transportation industry, public health, and homeland security. This document is a product of collaboration among those sectors. Where our public's health is most vulnerable, such collaboration is essential.

The Department of Health and Human Services (HHS), through its Centers for Disease Control and Prevention's (CDC) Division of Global Migration and Quarantine currently operates quarantine stations at 18 major ports of entry. Each of these 18 stations has responsibility for all other ports of entry within its assigned region of the United States. Our ports are thriving centers of commerce and trade, yet they are vulnerable to the entry of infectious disease—whether accidental or deliberate. The emergence of SARS illustrated the potential for a new disease to suddenly appear and spread, leading to widespread health, economic and social consequences. The SARS epidemic, the outbreak of monkey pox, and the ongoing reports of avian influenza demonstrate that emerging infectious diseases are a threat to the United States.

HHS is committed to preventing the importation and spread of infectious disease in the United States. We applaud the Department of Transportation for developing the Resource Manual, which provides information of critical importance to the airport operators and local health authorities who would be called upon to respond to a traveler with a suspected infectious disease. Continued collaboration between the relevant sectors will be essential to a consistent and integrated response at our ports of entry.

Michael O. Leavitt

The manual provides an overview on management and control of circumstances while a sick passenger is still mid air and when he or she arrives at a US airport from abroad. Nine communicable diseases are covered in the manual: *Cholera, diphtheria, communicable tuberculosis, plague, small pox, yellow fever, viral hemorrhagic fever, severe acute respiratory syndrome (SARS) and avian influenza with pandemic potential*, for which federal law requires dislocation or quarantine. It also sets out the roles and responsibilities of the pilot in command, airline operations center, the airport operator, state and local health and emergency management departments, law enforcement agencies, health care facilities, support organizations and federal government agencies in the event that a flight arrives bearing ill passengers. Treatment of passengers and the potentially exposed crew is discussed as well as recovery after an incident. The manual also provides guidance to communities on developing airport specific plans to respond to such incidents. I've included table of contents Section Headings for brief review.

[U.S. Department of Transportation
National Aviation Resource Manual
for Quarantinable Diseases](#)

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Recent headlines highlighting avian influenza outbreaks in Europe and Asia, have necessarily heightened our awareness of our own vulnerabilities to similar events. The general public has noticed too. With the seeming inevitability of facing a 'pandemic flu', will we be ready? Will we recognize it and respond or will it paralyze our response and that of the world? As we know today, nature is hardly predictable and many times not prevented from its ultimate expression. That doesn't mean we can't work toward a plan and strategy to intervene. Just as a football team prepares and practices a 'game plan' before the big game, so too can we implement planning and strategy for this potential threat to the world health.

Our 'game day' planning efforts, such as this DOT manual for quarantinable diseases, allow

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REMARKS UPON RECEIVING THE HARRIET HARDY AWARD Howard Hu, M.D., M.P.H., Sc.D., December 1, 2006



First, allow me to express my profound thanks to NECOEM and especially Tom Gassert and Dianne Plantamura for their kind atten-

tion and assistance in helping me to accept this wonderful award. I am deeply, deeply honored. And about those funny stories Tom just told about me—I have a bunch of my own that I won't bore you with but many of you will recognize the man when I tell you that what he will be remembered most for, when he practiced in our academic OEM unit at Kindred Northeast Specialty Hospital, is the respect he had for the dignity of his patients AND for having the longest problem lists ever seen for each patient evaluated, including those coming in for the briefest of visits. They were exhausting to read. He treated the ENTIRE patient.

I also bring you greetings from the Midwest Occupational Environmental Medicine Association. But I can tell you, as a migrant from Massachusetts and a new member of MOEMA, that when one steps away from this cozy part of the world, one can newly appreciate just how great NECOEM really is.

It is a terrific professional organization that strengthens our professional identity in so many ways. You all deserve a round of applause.

[CLAPPING]. In preparing for these remarks I have also had the opportunity to review previous Harriet Hardy addresses and marvel at the eloquence of so many of the speakers. Here is Bob McClellan quoting the poet Rilke, "Above all, in the most silent hour of your night, ask yourself this: Must I write? (Must I do what I do)?". Rilke was the favorite poet of my third serious girlfriend and I think his poetry is great, but I'd have to admit that in the most silent part of the night, if I happen to be awake, I am more typically thinking about the dry cleaning my wife asked me to pick-up that I forgot to do, or the remark made by my assistant earlier in the day--did she really mean to make fun of my tie?

I guess I will have to tap my own source of wisdom--Yogi Berra—to provide a quote relevant to the occasion. He is reported to have said "Making predictions is tough--especially if it's about the future.". And that is so true of the biggest issues in environmental health and medicine today..., some of which I reviewed in the morning lecture—we deal with so much uncertainty, not only in terms of the contributions of the environment to present day infirmity and disease, but in terms of what our global environment has in store for us tomorrow. But that can-

not stop us from making decisions and acting upon the best available information.

I also want to return to the main themes of this award that were so well embodied by Harriet Hardy herself, the themes of courage and devotion---and raise a topic that I care about. It is NOT going to be a popular topic for some of you, and I may not be invited back. But it is an important topic. I want to talk to you about Multiple Chemical Sensitivities (MCS)---also known as Idiopathic Environmental Intolerances. Many of you know that over the 10 years prior to my leaving Massachusetts, my clinical practice had become a magnet for MCS sufferers. Did I have a magic cure? No. Was I doing it for money? Definitely not. It is true that I did research on MCS, including a 1996 study with colleagues at the Brigham & Women's Hospital of rigorously screened MCS patients and age- and gender-matched normal controls in which we used Single Photon Emission Computed Tomography and demonstrated results suggesting differences in cerebral blood flow in key parts of the brain. But most of all, it was because I came to realize that many of these patients had no where else to go as they spiraled downwards. It is true that there remains no biological "proof" that these patients are suffering from a physiological, molecular, or systemic disorder. It is true that there remains no physical "proof" that can

directly relate a chemical exposure to the causation of the state. It is true that a higher proportion of these patients suffer from pre-morbid psychiatric disease. But it is also true that there is growing evidence that there are neurobehavioral pathways and mechanisms that underlie our body's response to environmental stimuli and their expression for CFS, fibromyalgia, etc. There are likely genetic predisposition factors that could very well explain both psychiatric morbidity as well as predisposition to MCS (one does not cause the other). The prevalence of this condition is higher than we thought (as demonstrated by, for example, the Kreutzer study, which found >11% of Californians reported some degree of environmental sensitivities). This is an area that desperately needs better research---but somehow, in no small part due to lobbying from special interest groups, our federal agencies have completely failed to create even a single mecha-

nism for funding research on MCS. And it is also true that these patients deserve respect and caring, to the extent that is feasible, and **THERE ARE NO OTHER PHYSICIANS WHO ARE IN A BETTER POSITION TO PROVIDE THIS THAN OURSELVES.** In the Spring 2006 issue of the NECOEM reporter, your president said "Leadership with compassion is really what we are all about, and it is that aspect of our daily work of which we should be most proud" and he quote an ancient Chinese tract on the three essentials of leadership: Humanity, Clarity, and Courage. I am telling you today that Humanity means we need to treat these patients with respect and compassion, even if it turns out that their disorder is purely psychological. Courage means that we need to be able to stand up for them when they are being discriminated against. Clarity means we will understand more about the science of the mind-

body interface---we have to acknowledge that dichotomization of the mind from the body is as false as the dichotomization of genes from the environment, and we can do a better job of being an advocate and a home base for our patients with this illness. We can help them get psychiatric and behavioral counseling and therapy as an adjunct to their treatment without invalidating their illness and ascribing it simply to psychological disease. We can do a better job of explaining the unsettled state of the science while still advocating for reasonable accommodations. And we can do better at listening and understanding what they're up against.

I thank you all again for this great honor and hope you will visit me out in Ann Arbor. Best wishes to you all and please enjoy the rest of this wonderful conference.

(Continued from page 3) **Quarantined in Flight**

us to formulate, review, and practice these strategies before they are needed in a crisis. I encourage all medical and allied health professionals to review this provocative treatise and then become involved in ongoing planning efforts. We will have a role to play, but it is up to us to choose that role. I am ever optimistic that we will be able to **"count on our neighbors to rally around..."**

Craig Curtis is the Medical Director of HealthWORKS in Bangor, Maine and is a member of the NECOEM Board of Directors

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Impairment Rating Tips

By Christopher R. Brigham, MD

The assessment of impairment using the AMA Guides to the Evaluation of Permanent Impairment can be challenging and often ratings are erroneous. Each week www.impairment.com offers impairment rating tips; you can view these at www.impairment.com/tips or subscribe to receive these free tips at www.impairment.com/subscribe. The following are three recent tips of interest to occupational medicine physicians who perform impairment assessments.

Combining Impairments

Most values in the Guides are combined, not added. A few points:

- The "Philosophy and Use of the Combined Values Chart" is presented in Section 1.4 on pages 9 and 10, and the Combined Values Chart appears on pages 604 through 606 (follow the directions). This philosophy is such that a region or part of body should never exceed the maximum value for the region or part of body. (ie. There can never be a person with greater than 100% WPI).
- The March/April 2002 issue of the Guides Newsletter featured an article on "Combining Values" explaining the rationale and practical aspects.
- Most impairments are combined, with the notable exception of: 1) range of motion deficits at the same joint, 2) range of motion deficits of the thumb, 3) total hand impairment (eg, hand impairment contributed to by each digit), and 4) rating hip or knee replacement results.

□ Chapter 16, The Upper Extremities, on page 438 advises "If three or more values are to be combined, the two lowest values are first selected and their combined value is found. The combined value and the third value are then combined to give the total value." (However, in California, per the Permanent Disability Rating Schedule, the two largest numbers are first combined.)

□ A common error with bilateral upper extremity impairment is combining at the upper extremity level. First, combine upper extremity impairments on one side and then convert to whole person. The whole person impairments from both sides are then combined.

□ In California, per the directives of the Permanent Disability Rating Schedule, specific impairments are converted to whole person for "adjustments" prior to combining the resultant disability rating.

□ At www.impairment.com/tools there is a tool that will combine up to 3 values (easier than referencing the Combined Values Chart)

Rating Spinal Degenerative Disease

Question:

In rating spinal impairment, should I use the range of motion method if there are findings of multilevel degenerative disc disease?

Answer:

Not necessarily. As explained in Section 15.2, Determining the Appropriate Method for Assessment (5th ed, 379-381), the Range of Motion (ROM) method is used in certain situations. On page 380, at the top left, indication 2

states when there is multilevel involvement in the same spinal region (eg, fractures at multiple levels, disk herniations, or stenosis with radiculopathy at multiple levels or bilaterally). On the same page at the bottom right, item 4 provides further clarity stating to use the ROM method if there is radiculopathy bilaterally or at multiple levels in the same spinal region. However, the ROM method is not used merely for degenerative disk disease and effects thereof, including disk bulges and herniations that show on imaging, but without radiculopathy by history, physical exam, or EMG. In the May-June 2001 Guides Newsletter, Robert Haralson, III, MD, the Spine Chapter Chair, and Dr. Brigham clarified this point stating, This refers to disk herniations with radiculopathy at multiple levels or bilaterally or spinal stenosis with radiculopathy at multiple levels or bilaterally. . . disk herniations are commonly seen among asymptomatic individuals, and these findings alone may not be significant. (Guides Newsletter, May – June 2001, 10) Thus the key feature is the presence or absence of radiculopathy. Radiculopathy means symptoms, physical findings, and electrodiagnostic abnormalities (if such testing is performed) consistent with nerve root impingement or dysfunction. The symptoms may be pain, numbness, and/or tingling in distribution of the nerve root, with weakness of the limb. Physical findings are weakness of the involved myotome, diminution in or loss of the corresponding deep tendon reflex, numbness of the appropriate dermatome and, in the case of the lumbar spine, positive root tension signs. Unequivocal electrodiagnostic evidence of acute nerve root pathology (radiculopathy) includes. . . multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root. (5th ed, 382) Without radiculopathy, imaging changes other

than fracture are insufficient to produce an impairment. The common increasing prevalence of degenerative changes with age, including disk herniations, is discussed on page 378 in Section 15.1b, Description of Clinical Studies.

Rating Sleep Disturbance

Question:

My patient has had sleep disturbance since his back injury. Would it be appropriate to rate him per section 13.3c, Arousal and Sleep Disorders?

Answer:

No. Chapter 13 provides criteria for evaluating permanent impairments due to documented dysfunction of the brain, cranial nerves, spinal cord, nerve roots and/or peripheral nerves and muscles, as explained on page 305. All the criteria for Table 13-4, Criteria for Rating Impairment Due to Sleep and Arousal Disorders, require that there be reduced daytime alertness. The Guides notes it is expected that the diagnosis of excessive

daytime sleepiness has been supported by formal studies in a sleep laboratory. Pain induced sleep disturbances are common, but, absent a separate brain disorder, the sleep disruption from back pain would not be ratable by Chapter 13. Sleep is an Activity of Daily Living listed in Table 1-2. As such, it is already included in the rating for back pain in the various DRE categories or ROM Method calculations. When choosing an impairment percentage from the available range for a DRE category, the rating physician would include the effect of spinal pain on sleep when considering how symptoms impact activities of daily living. We were subsequently asked three questions relating to sleep disturbance. The answers provided were jointly authored by James Talmage, MD, Associate Editor of the Guides Newsletter, Robert Haralson, MD III, MD the Chair of Chapter 15, The Spine, and Tom Mayer, MD the Contributor to the Chapter 15, the Spine and Chair of the Spine Chapter in the Sixth Edition,

and myself (Editor of the Guides Newsletter); therefore they should be considered as a definitive response by the leading experts on spine impairment evaluation.

Question 1:

Will a disc injury or diagnostically confirmed radiculopathy support a chapter 13 sleep disorder?

Answer:

No, this is not an appropriate application. Interference for sleep is reflected in the value assigned within a DRE Category range. Furthermore, typically a "sleep disturbance" associated with back pain is usually not permanent in nature. Sleep is an ADL listed on page 4 in Table 1-2, and as such it is already factored into the DRE rating. Examples of central nervous system diseases that are appropriately rated for sleep impairment are found on page 317, column 2, paragraph 2.

Question 2:

Is a sleep study required for any Class of sleep disorder on Table 13-4. Or,

(Continued on page 8)

(Continued from page 1) **Tdap**

has also increased from about 10 per year in the 1990s to about 20 per year

The Food and Drug Administration (FDA) has licensed two Tdap products. Boostrix, by GlaxoSmithKline (GSK) Biologicals, can be used for people aged 10-18 years and ADACEL, by Sanofi Pasteur, is for adolescents and adults from 11-64.

The ACIP lists the following indications and recommendations for use of Tdap among adults aged 19-64 years:

For routine use to replace a single dose of Td for active booster vaccination against tetanus, diphtheria, and pertussis if they received their last dose of Td 10 or more years ago.

For wound management as tetanus prophylaxis

For Health-Care Personnel (HCP) in hospitals or ambulatory care settings who have direct patient contact, a Tdap booster should be given as soon as feasible. *(If it has been less than 10 years but 2 or more years since the last Td, Tdap still may be used to protect against pertussis, particularly in settings where there is increased risk for pertussis or its complications. According to ACIP the potential benefits outweigh the risks for local and systemic reactions after vaccination.)*

Other HCP (i.e., not in hospitals or ambulatory care settings or without direct patient contact) should receive a single dose of Tdap to replace the next scheduled Td according to the routine recommendation at an interval no greater than 10 years since the last Td, although they are also encouraged to receive the Tdap dose at

an interval as short as 2 years following the last Td.

To prevent spread of pertussis among infants: Adults who have or who anticipate having close contact with an infant <1 year such parents, especially pregnant and post-partum mothers, grandparents aged <65 years, child-care providers, and HCP

Note: After getting one dose of Tdap, individuals should receive Td or TT for booster immunizations against diphtheria and tetanus according to previously published guidelines, as Tdap is not licensed for multiple administrations.

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will the Epworth Sleepiness Scale suffice (see page 317 of the Guides) and is excessive daytime sleepiness the same as reduced daytime alertness (table 13-4)

Answer:

In rating for sleep disturbance, there should be objective documentation of a sleep disorder, not merely a self-report. This is stated on page 317, column 2, paragraph 2, the last sentence states it is expected that the diagnosis of excessive daytime sleepiness has been supported by formal studies in a sleep laboratory.

Question 3:

If the sleep disturbance results from the actual radicular pain or numbness, will this be enough to support a Chapter 13 impairment rating.

Answer:

No, this is not appropriate. The use of Chapter 13, The Central and Peripheral Nervous System, is to rate injury or illness involving this system. This chapter should not be misapplied to situations that are not appropriate. Impairment ratings must be accurate and unbiased.

In the next issue we will share further tips.

*Christopher R. Brigham, MD, the President, Brigham and Associates, Inc. (www.impairment.com) is Board-Certified in Occupational Medicine (ABPM), Founding Director of the American Board of Independent Medical Examiners (ABIME), a Certified Independent Medical Examiner (CIME), a Certified Impairment Rater (CIR), a Fellow of the American Academy of Disability Evaluating Physicians (FAADEP), a Fellow of the American College of Occupational Environmental Medicine (FACOEM), and a Master Fellow of the Academy of Independent Medical Examiners of Hawaii (AIMEHI). He serves as the Editor of The Guides Newsletter (the American Medical Association publication on the use of the AMA Guides to the Evaluation of Permanent Impairment), Primary Editor of The Guides Casebook (the companion AMA textbook to the Guides for both the Fourth and Fifth Editions), co-author of the text *Understanding the AMA Guides in Workers Compensation*, has authored over one hundred articles on impairment and disability evaluation and other texts, has trained thousands of physicians throughout the US, Canada and internationally on how to use the AMA Guides, served on the Senior Advisory Committee to the Fifth Edition and now the Sixth Edition, and has consulted for numerous organizations (including governmental jurisdictions) on the AMA Guides. His firm is the developer of Internet based resources including www.guidesig.com (online training on the AMA Guides) and www.exemplaryreports.com*