

NECOEM Reporter

INSIDE THIS ISSUE:

MassCOSH	1,3
New RI Clinic	1,4,7
Highlights: Annual Conf.	2
Ethics Column	5
Downwind from Disaster	6
Editor Note	7
State Report, RI	8

Special points of interest:

- **NECOEM/MaAOHN Annual Conference 2001** at the Sheraton Boston, December 6 and 7. For more information, see highlights on page 2, call NECOEM at 978/373-5597 or email to NECOEM@aol.com
- Promoting Health and Safe Employment (PHASE) in Healthcare presents a conference: **Occupational Health and Safety in the Changing Healthcare Industry.** Friday, November 9. Holiday Inn, Tewksbury. For more information: www.uml.edu/phase or 978-934-2908.
- **MassCOSH's 25th Anniversary Celebration.** Thursday, November 8, Freeport Hall, IBEW Local 103. For more information call MassCOSH at 617-825-7233

MassCOSH, Occupational Health Doctors Partner to Protect Workers from Harm

Juan Aponte (not his real name), 21, came to Boston from Honduras eager for a better life in America. He took a job with a painting company scraping lead paint off local homes. The company provided no training or protective gear and soon Aponte was in the hospital suffering from acute lead poisoning. Yet, as an undocumented immigrant with a brother employed by the same company,

...Aponte feared his employer would fire his brother or call the INS if he spoke up.

Aponte's story is typical of

that of tens of thousands of immigrants in Massachusetts, who are often forced into jobs with the lowest wages and worst work conditions. Many work in the laundry, dry cleaning, and building cleaning industries and are subject to hazardous chemicals and long hours in back breaking positions. Others work in assembly and electronics, jobs that require long hours of rapid and repetitive motion with no breaks. They are often afraid to speak up because they are unaware of their rights, are afraid they may lose their job or are concerned about jeopardizing their



Marcy Goldstein-Gelb, Executive Director of MassCOSH speaking at rally of Kayam meatpackers, September, 2001

(Continued on page 3)

ACADEMIC OEM HEALTH CENTER OPENS IN RHODE ISLAND

In late 1996, David Kern, MD, Director of the Brown University Program in Occupational Medicine, and colleagues submitted an abstract for presentation at the scientific meeting of the American Thoracic Society. The study described

a new kind of interstitial lung disease ("Flock Workers' Lung") the authors had found in workers in the nylon flocking industry, an industry which manufactures an insulated fabric used in upholstery, clothing, and

automobiles. While the study itself stimulated wide interest in the scientific community, Brown's Program in Occupational Medicine was disbanded, and Kern's contract was not

(Continued on page 4)



**To Register: call 978-373-5597
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NECOEM/MAAOHN
Annual Conference 2001
Sheraton Boston, December 6 and 7

Session Highlights

Pediatric environmental health
triggers for asthma, lead and mercury exposures, and endocrine disrupters.

Government regulations, ethical dilemmas in occupational health practice.

Occupational safety and health aspects of using dimethylmercury.

Workplace stress and Violence,
breakdown of accountability in leadership, risk assessment

NEW Critical Incident Debriefing
post traumatic stress and recovery

Information technology for occupational medicine.
mobile/wireless, web and state of the art technologies assist with clinical, financial
and administrative knowledge.

Tools and experiences in complementary care

Implementing integrated disability management (IDM)

Mock trial that puts audience participants on the stand to testify.
common courtroom procedures and tactics

For further information regarding registration, conference educational sessions,
special events, accommodations, exhibits, or other topics, contact
Dianne Plantamura at NECOEM@aol.com or 978/373-5597.

(Continued from page 1)
immigration status.

The Massachusetts Coalition for Occupational Safety and Health's (MassCOSH) Immigrant Safe Work Initiative involves immigrants like Aponte, immigrant leaders, occupational clinicians, and labor groups in efforts to combat dangerous work conditions. MassCOSH offers training and technical assistance to workers in their own language, helping them identify hazards in their workplace and working with them to develop a strategy for addressing these hazards. Getting such improvements may involve pulling in other co-workers to speak to the employer about getting the necessary improvements made, taking steps to unionize the workplace, using governmental authorities like OSHA, or pushing for stronger public policies to protect workers. With support and assistance, immigrant workers become leaders for safe and healthy workplaces, preventing the victimization of other workers.

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Occupational clinicians play an important role in the effort to promote safe work conditions for immigrants. When Dr. Stefanos Kales of Cambridge Hospital began seeing a number of residential house painters, including Aponte, who were suffering from lead poisoning, he contacted MassCOSH and encouraged Aponte to do so as well. Unable to encourage the company to stop its unsafe practices, Aponte, with help from MassCOSH, filed a complaint with OSHA. OSHA ordered the company to desist from any painting activities involving lead paint and awarded Aponte wages he was

due during the time he was ill. His health and wages regained, MassCOSH worked with Aponte to reach out to his co-workers to warn them of the risks involved with lead paint. Though he no longer is a house painter, he continues to work with MassCOSH to encourage house painters to improve their work conditions

Like Dr. Kales, Dr. Rick Bird of Bowdoin Street Health Center sees the role of the health center as larger than health care provision. Dr. Bird and the occupational medicine staff had witnessed dozens of patients suffering from musculo - skeletal injuries, many of whom were immigrants and afraid to speak up. The staff decided to make it easy for their patients to get involved in advocating for an OSHA Ergonomics Standard so that other workers wouldn't have to suffer the pain that they had endured. They invited MassCOSH and other groups to provide a workshop for their patients. Twenty five injured workers learned about OSHA's standard - making process and dictated their testimony which was submitted to OSHA (many of them were unable to write due to their injury). One of the participants was selected to serve on a state-wide delegation that went to Washington D.C. to testify at the Ergonomics Hearings.

MassCOSH and its partners in the Immigrant Safe Work Initiative are trying to identify and address other public policy issues that are of particular concern to immigrants. Agencies like OSHA and the state's Division of Industrial Accidents employ frighteningly few bi-lingual staff to be able to effectively communicate with the state's large immigrant population. This can have serious consequences. For example, during

a workplace investigation, OSHA needs to be able to speak with workers in their own language in private to fully investigate health and safety violations. OSHA has, on occasion, relied on a bi-lingual supervisor to translate for non-English speaking workers which may present greater risks to the workers than not communicating with them at all.

As practitioners who see the impact of hazardous work conditions every day, occupational health clinicians have a particular responsibility and opportunity to become involved in efforts to prevent work-related injuries and illnesses. MassCOSH seeks to provide a vehicle for clinicians that makes it easy for them to do so: patients receive assistance in addressing the underlying causes of their injury or illness in their own language. Clinicians and their patients can become involved in advocacy efforts to support stronger work protections and enforcement. Only through collaboration and collective action can we begin to protect and preserve the health and well-being of all workers.

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Marcy Goldstein-Gelb,
Executive Director, MassCOSH

MassCOSH is celebrating their 25th anniversary on November 8. For information about joining in the festivities, call MassCOSH at 617-436-3710

(Continued from page 1)

renewed by the hospital which had been his employer, just after the abstract was submitted for publication (1,2).

These events, widely reported in *The Boston Globe*, *The Providence Journal*, *The New York Times*, *The Washington Post*, *The Nation*, the *Annals of Internal Medicine*, and the *New England Journal of Medicine*, led to much debate about academic freedom in academic medicine and the corporate influence on the research process (3). The end product of the debate, however, still left Rhode Island's labor and medical communities without a resource for the diagnosis, treatment, prevention, and study of occupational and environmental illness.

In response, and for the first time in recent history, the labor and medical communities came together, focused on recreating an Occupational and Environmental Health Center for Rhode Island. This Center would employ the highest academic standards in Occupational Medicine, but would also be completely independent, so that occupational and environmental illness could be studied, prevented and treated without prejudice. The Labor/Medical coalition was able to form a governing board that had wide representation from the labor, business and medical communities, and, with help from Dr. Kern, a medical advisory board comprised of nationally known occupational medicine physicians. The Coalition was able to reestablish a working relationship with Brown Uni-

versity School of Medicine, and, because of strong support from the Rhode Island AFL-CIO, was able to respond successfully to a request for proposal issued by the Rhode Island Department of Labor, resulting in startup financial support for four years.

The Occupational and Environmental Health Center of Rhode Island, opened its doors in November, 2000, and became a member clinic of the Association of Occupational and Environmental Clinics (AOEC) in May of 2001.

The Occupational and Environmental Health Center of Rhode Island is dedicated to promoting and protecting the health and safety of Rhode Island's workers and their families. In order to do this, the Occupational and Environmental Health Center of Rhode Island approaches occupational and environmental health from three perspectives: clinical; education; and research.



OEHC-RI at 410 South Main St, Providence, RI

The primary focus of the Center is clinical. The Center sees patients

(referred from a variety of sources) to be clinically evaluated for condition(s) that are possibly related to an occupational and/or environmental exposure(s). Since opening in November 2000, patients have been referred to the Center by their primary care providers, self-referred, referred by attorneys and by the state of Rhode Island Department of Health. In order to avoid fragmented medical care, the Center evaluates patients and then refers those patients back to their primary care providers for definitive treatment in consultation with the Center.

In addition to fulfilling our clinical mission, the Center also acts as an educational resource. The Center maintains a library with occupational and environmental medicine resources that may be utilized by medical professionals and all Rhode Island residents. The Center also participates in medical education by precepting residents with an interest in occupational medicine. We are

also available to precept medical students. The Center's educational efforts are not only geared to physicians and medical students, the Center also provides training for other health professionals. The Occupational and Environmental Health Center of Rhode Island provides a wide variety of training programs to meet the needs of the workforce throughout the state. The Center provides Basic Life Support training through the American Heart

(Continued on page 7)

Ethics Column:

In the last issue, I had described a case in which a patient was experiencing a slow recovery from a work-related injury apparently due to the employer's inability or unwillingness to comply with the physician's recommended work restrictions. I would like to thank Dr. Blum of Maine for his thoughtful response:

"Regarding Dr. Pearson's "Ethics Column": I would not hesitate to place the employee off duty if that is the only way true clinical improvement can result. However, I would attempt to speak with a company official above the HR contact (HR supervisor, Vice President, or CEO) before writing the off duty slip. This can be an excellent "teaching moment" to educate management on the value of an effective restricted duty program. If they respond with an appropriate accommodation, employee, employer, and doc all benefit. If the employee goes off duty, management understands that you have tried to salvage the situation, and the employee recognizes you have acted in his best interest."

In his approach, Dr. Blum addresses the issue of the dual agency inherent in the practice of occupational medicine. The occupational physician can be seen as having a duty to both the employee and employer that frequently conflict. The actions that the physician might take may be very different depending upon how the conflicting duties are weighed. Dr. Blum responds to this situation by taking the time to communicate clearly and effectively with all parties. While "telephone tag" can be difficult to win in the midst of a busy office practice and it is certainly easier to just write the note, avoid face-to-face conflict with the patient and use voice

mail to buffer the response of the employer to a lost time incident. I would argue that Dr. Blum's approach is far more reflective of an ethical response to the dual agency problem.

On to this issue's problem that I have informally titled "If it quacks like a Duck..."

You are performing an independent medical examination on behalf of an employer's insurer. The employee is a 46-year-old clerical worker who has been out of work for nearly a year. Her diagnosis is poorly articulated in accompanying medical records. She describes an episode that occurred just over a year ago in association with new construction in her workplace. On the day that her symptoms began, she recalls a particularly noxious and astringent "chemical" odor originating from the construction area and permeating her workstation. She experienced difficulty taking a full breath and burning of her eyes that resolved when she left the building. Since then, she has episodically experienced the sensation of not being able to get a full breath generally associated with strong odors. She has been fully worked up by an occupational pulmonologist and found to have no signs of airway hyperactivity. In addition, she has been experiencing joint pain, episodic numbness and tingling of the extremities, and headaches. She has not been back to work since the day of the incident. No other employees at the workplace are ill.

Here is the dilemma: having failed to get any relief from her discomfort from a variety of subspecialists, she has self-referred to an alternative medicine physician. He is treat-

Kim Pearson, MD,MPH

ing her with dietary modification, supplements, and "detoxification" treatments and is now proposing intravenous treatments with vitamin C as an "antioxidant". She does feel a little better since beginning alternative treatment, other than some gastrointestinal distress. A plethora of laboratory reports accompany the patient, who is not experienced in healthcare. The laboratory data have been interpreted for her as representing nutritional deficiencies and weakening of the immune system. To your surprise, she has consulted her primary care physician about the treatment to date who told her "it probably won't hurt". The insurer has paid for the treatments thus far but is questioning the vitamin C treatments.

You would not be faulted at this point to fall behind the IME standard bearer, determine that you have no "doctor-patient relationship" with this woman, and write a banal letter to the insurer in which you reiterate the vagaries of the diagnosis, the unproven nature of the treatments, and the questionable causality. In all likelihood, her treatment will then be denied. But this woman states to you that if she is denied, she will use her meager financial resources to continue the treatments.

What should you do? To which of these parties do you have a duty in this situation: The insurer? The patient? The profession? Society?

I will be arguing that you have a duty to all of the above. Argue back at necom@aol.com.

Downwind From Disaster

I'm an industrial hygienist based in New York City. I run a small non-profit corporation that provides safety services to the arts. I am also the Safety Director for Local 829 of the International Alliance of Theatrical Stage Employees. My office/residence is about 15 blocks from the World Trade Center. I saw the attack and smelled the smoke.

The next day, the smoke became a personal issue when I had my first asthma attack in 10 years. My doctor telephoned in a prescription for an inhaler. My pharmacist was out of inhalers because of the increased demand. She called other pharmacies in the area. They also had none. Despite vehicular traffic being prohibited in our area we were lucky to locate a single refill.

Over the next few days, as my symptoms and those of my neighbors increased, the EPA issued regular bulletins saying that the air quality was acceptable. This also caused many of the ground zero workers to stop wearing respirators. Then on September 20, when people began reclaiming their dusty homes and businesses nearer ground zero, an allergist named Dr. Feingold, in an interview published in the *New York Times* advised people to clean up the dust with a \$3.00 mask and a broom. I was appalled.

In response, my nonprofit organization formed a coalition with the Environmental Law and Justice Project. I told their Executive Director, attorney Joel Kupferman, how to take dust samples and maintain a chain of custody from the site to the laboratory. The Policemen's Benevolent Association took Joel into ground zero to take the samples. From our samples and from those analyzed by other groups, we found that the dust was not uniform. Asbes-

tos levels ranged from a trace to 5 percent. Most importantly, fiberglass was present in almost all samples usually in the range of 10 to 80 percent. Fiberglass is highly irritating, sensitizing (due to urea formaldehyde resin coating) and is listed as "reasonably anticipated to be a human carcinogen" by the National Toxicology Program.

We issued a joint press release on September 22 with our findings. Our aim was to convince workers to keep wearing their respiratory protection and to advise home and business owners to test their dust before cleaning. We suggested a 24-hour laboratory in the City that analyzes samples for about \$25.00 each by PLM (polarized light microscopy).

Next, we began providing clean up advice on our free telephone and email hotlines. Our advice is determined in part by the PLM analysis of the caller's dust. If the dust contains one percent asbestos or more, professional asbestos abatement is the only ethical strategy. Under both the OSHA and EPA rules, one percent is the level at which a material must be treated as asbestos.

If the dust contains nearly one percent asbestos, we recommend they pay for more expensive TEM (transmission electron microscopy) tests. TEM can detect small fibers that are missed by PLM.

If the dust doesn't contain asbestos, we talk to the person who will do the cleaning. People with respiratory problems or other impairments are advised to check with their doctors before considering this job. We also ask about children and other family members that might be exposed. We

are also concerned about what needs cleaning. Of particular interest are fiberglass-lined ventilation ducts, wall-to-wall carpets and other design elements that cannot be successfully cleaned by any method. These must be removed.

Then we discuss cleaning methods, HEPA vacuums and personal protective equipment. Most importantly, we do not recommend that untrained people wear a mask or respirator in a situation where high exposures are expected. The OSHA regulations require medical certification, professional fit testing, and training before workers wear respirators. Some callers were trained in respirator use on their regular jobs and we felt these people could safely clean up non-asbestos dusts.

As I talked to hundreds of people over the next two weeks, it became clear that two things are essential for public and worker safety during a disaster.

Professionals must only provide advice they are qualified to give. Allergists should not provide advice on asbestos abatement. Industrial hygienists must refer callers with symptoms to doctors.

Health agencies must not calm people by withholding data or downplaying hazards. I found that New Yorkers were just as courageous in dealing with dust and air quality issues as they were in dealing with the disaster. Withholding information from us means that a decade from now, those people who develop dust-related diseases must be added to the list of World Trade Center casualties.

Monona Rossol, M.S., M.F.A.,
Industrial Hygienist
President: Arts, Crafts and Theater Safety
Safety Director: United Scenic Artists, Local 829,
IATSE

The atrocity of September 11th, 2001 is traumatic, profoundly sad and enraging for all of us to some degree. However the editor would like to take this opportunity to remind the readers of the important work they do, day in and day out. We serve a diverse and pluralistic population of workers in the cause of the broad Public Health goals that we espouse. The immigrants that we care for remind us of our own roots. The workers who put their bodies on the line daily remind us of our own toil. The children who may occasionally accompany their parents to receive Occupational healthcare remind us of the reasons for working beyond the integrity and pride derived from work itself. In this time of our shared grief and horror, I speak for many in re-dedicating ourselves to the meaning we derive through loving and caring for one another, acts of kindness and the Greatness of God. Please try and change the images we have witnessed in these times to those that are affirming of life, everlastingly renewed. ed. note



(Continued from page 4)

Association. The Center is also a training agency for the National Safety Councils' Cardiopulmonary Resuscitation, First Aid, Automated External Defibrillator, and Bloodborne Pathogens programs. The Center also provides Emergency Medical Technician – Basic/ Cardiac refresher programs and the Emergency Medical Technician – Cardiac (EMTC) course. The EMT-C course is a five-month program that prepares individual to take the licensure examination administered by the Rhode Island Department of Health. The Center develops training programs to assist the workforce in the interpretation and implementation of safety and health regulations. This includes both state and federal regulations. The Center is currently developing computer-based training programs to assist in the training of employees at the workplace. These programs can be used by training personnel at a facility to teach the employees about OSHA regulations, and other safety and health issues.

The third mission of the Center is research. Although the Center is not directly involved in any research projects at this time, we intend to participate in these activities over time. The Center has recently received a grant from the Agency for Toxic Substances and Disease Registry (ATSDR) (through AOEC) for a community environmental health intervention project to provide health evaluations for residents who live near the Central Landfill in Johnston, Rhode Island. It is hoped that this project will result in at least one published paper in a peer-reviewed journal.

In summary, the OEHC-RI is the only academically oriented occupational and environmental health center in the state of Rhode Island. The Center fills the void that was left when Dr. Kern's program was closed. It is our hope that the Center will carry on David's vision and commitment to improving the health of the people of Rhode Island.

1. Kern DG, Durand KT, Crausman RS, Wasko RM, Burkhardt J, Nayer A, et al. Nonspecific interstitial pneumonia in the synthetic textile industry (Abstract) *Am J Respir Crit Care Med* 1997; 155, A-810.
2. Chronic interstitial lung disease in nylon flocking industry workers – Rhode Island, 1992-1996. *MMWR Morb Mortal Wkly rep.* 1997; 38: 897-901.
3. Davidoff, F. New Disease, Old Story. [Editorial] *Ann Intern Med.* 1998, 129:327-328.

Submitted by:

Michael Fine, MD, President of the Board of Directors of the Occupational and Environmental Health Center of Rhode Island; Robert Parker, Administrator for the Occupational and Environmental Health Center of Rhode Island; and Thomas Hicks, MD, MPH, Medical Director of the Occupational and Environmental Health Center of Rhode Island.

THIS ARTICLE IS IN TRIBUTE TO DR. DAVID KERN.

EDITOR NOTE

New England College of Occupational
and Environmental Medicine

22 Mill Street,
Groveland, MA 01834

Voice/Fax: 978-373-5597
Email: NECOEM@aol.com

NECOEM Reporter,
Editor: Robert Naparstek, MD
NECOEM President: Fred Kohanna, MD, MBA
Executive Director: Dianne Plantamura, MSW

NECOEM

"NECOEM is a not-for-profit, regional component society of the American College of Occupational and Environmental Medicine, the pre-eminent 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 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."

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Below the Beltway: Report from the State of Rhode Island

Is Rhode Island's (or any) Worker's Compensation system good? That is the challenge for the Technical Resources Center of the RI State Department of Labor. On September 25, 2001, the TRC made its first report of the results of a pilot study of injured workers, employers and providers in RI.

Judging from the pilot study, care for injured workers is good. There are also several areas that can be improved.

RI is a patient-choice state for treatment of work injury/illness. While 89% of employers knew this, 73% of providers and 67% of injured workers did not. Only 5% of injured workers reported a

problem with initial access to care for an injury and that initial visit occurred within 24 hours of the injury for 48% of the injured.

Was it good care? 79% of injured workers reported that they were very satisfied with the quality of care and 72% reported overall satisfaction with their experience of health care.

Obtaining prescription medications under comp insurance was reported as a problem by 32% of clinicians and 9% of injured workers.

The survey was done eight months after the reported date of injury.

At that time, 80% of respondents reported that they were back to work. Employers ranked the performance of injured workers as same or better in 88% of the cases.

As the RI Legislature seeks input in its re-evaluation of the 1992 reform of worker's compensation, the efforts of the TRC will guide areas of policy and administrative change needed to inform and provide care for all injured workers. While 80% is good, no one would be happy with a car that started only 80% of the time!

Steven G. McCloy, MD