

# NECOEM Reporter

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## Special points of interest:

- **NECOEM Dinner Meeting:** June 6, HealthPoint, Waltham., **Acute Hand and Wrist Injuries: More Than Meets the Eye.** **Steven N. Graff, MD.** Call or email NECOEM for more info.
- **Save the Date!** **NECOEM/MAAOHN Annual Conference, December 5-6, Marriott's Renaissance Hotel,** Bedford. Sessions to include: Spine and Post Surgical Care, State of the Art Research/Clinical Updates, Disaster Preparedness, Complementary Care.
- **NEAOHN 2002,** 87th Annual Conference. June 6 & 7th "Knowledge-Bridge to Success" at the Cape Codder Hotel and Resort Hyannis, MA 1-888-297-2200.
- NECOEM.org



## THE IME: PRESENT AND FUTURE TRENDS

At the dinner meeting held on March 7<sup>th</sup>, NECOEM members and guests were offered a superb meal, followed by time for networking with peers, old and new. The focus of the evening however was a presentation by Dr. Jennifer Christian. The audience was privileged to have this opportunity for a preview of her soon to be released article, *"Time to Release the Untapped Power of IMEs"* (April issue of the Journal of Workers' Compensation).

In regard to this multi-million dollar industry, a number of general trends around the IME (Independent Medical Exam) were noted. The "failure to focus on the use of the IME weakens many IMEs", Dr. Christian related. It was noted by a number of attendees that there was frequently a degree of frustration that their findings "went nowhere" and were not used to change the course of a case. In her research, the lack of adequate examiner training in performing IMEs was uncovered, as was the lack of a formalized tracking system to gauge the "aggregate quality, costs, utilization and outcomes" of the IME.

The use of "IME vendors" is becoming more prevalent. Dr. Christian related that this has resulted in the "transformation of IMEs into commodities". Vendors may promise an ease of administrative burden, shortened timelines, and reduction of costs, for example. There is however no evidence thus far that "shows that these vendors improve the average IME quality or effectiveness".

For the requesters, whether it be the claims examiner, the employer or perhaps the attending physician, suggestions were given with the goal of improving the ultimate quality of the IME or "medical opinion" report received. [Note: There was quite a bit of friendly banter in the audience around the issue of receiving an improved "packet" (IME request/instructions for the examiner/backgrounds/clinical). Heads were seen nodding in agreement!]

The quality of "the packet" could be improved by:

- ❖ Providing a good summary letter describing the claimant's situation and including the specific reason for the IME request.

- ❖ Asking specific questions.
- ❖ Including an organized and complete packet of records with actual studies, clinicals and test results.
- ❖ Ultimately providing feedback to the IME examiner.

The IME examiner was also tasked with recommendations for improving their report. Again, there were a number of anecdotal situations interjected during Dr. Christian's presentation that brought these issues to life for the audience. And now, some thoughts for the examiner...

- ❖ Insist on a "good packet"-give feedback to your requester.
- ❖ Use language that is appropriate for your reader/requester-It may be a lay reader who "needs the dots connected" for them.
- ❖ Answer each question clearly-Use a format such that each question is followed by its answer.
- ❖ Clearly outline the "key data, facts or observations" used to

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form your opinion. Think of this as a “persuasive or teaching” document...

- ❖ “Be cautious about answering un-asked questions”!
- ❖ Specifically state whether or not work is medically contraindicated.
- ❖ List all reference documents used.
- ❖ Sign your report.

An interesting notation of Dr. Christian’s to ponder.... “A high percentage of IMEs should appropriately be found in favor of the payer if claims examiners use good judgement in selecting claims for IMEs-there *should not* be a 50/50 split of outcomes”.

The presentation ended with suggestions as well as questions for consideration, for improving the IME at a systemic level. It was suggested that a “discussion and systematic study of appropriate use of medical opinions”

be initiated in the community. This was noted to be most beneficial if it was to span across multiple jurisdictions including health care providers, employers and insurers as well.

Questions included *How can we:*

- ❖ Quantify R.O.I. (return on investment) in using the IME? This has not been documented thus far.
- ❖ Encourage stronger “connections and communications between the medical and casualty insurance sectors of the economy” when this has been “historically weak”?
- ❖ Best develop strategies to reduce the unnecessary use of IMEs?
- ❖ Assure state-of-the-art training for providers performing IMEs?
- ❖ Provide training in decision-support criteria for IME requester’s?
- ❖ Assure that providers do a “good IME” and are rewarded for their good efforts (or experience con-

sequences for the not so good ones!)? Audience participants were quick to note the lack of financial incentives in performing the IME as it stands now!

- ❖ Enable IME “best practice” studies to be executed and published?

Our thanks to Dr. Christian for this thought-provoking presentation which might also have been entitled “The Independent Medical Exam 101”! It certainly answered all of my questions from “What is an IME?” to “Why request an IME?” and beyond...

Submitted by:  
Susan B. Gris , BS, RN  
Ergonomic Consultant, Aetna

## EDITORIAL

The editorial does not represent the views, nor should be seen as an endorsement by the NECOEM Board of Directors.

The IME (Insurance Medical Exam) is a cog in the wheel of Managed Care enabling the consolidation of wealth and power in the insurance industry. It is an often unspoken truth that the medical insurer is not a friend to the patient. The insurer is, by its nature, adversarial and succeeds by placing the burden of proof on the patient. It therefore, implicitly absolves itself and an employer of culpability for workplace hazards.

When doctors perform an IME they separate themselves from the most sublime component of their “professional” identity. That is, the “professed” standard of compassion, confidentiality and advocacy. This standard helps to constitute our professionalism as embodied in the Doctor-Patient relationship.

When an IME doctor abdicates from this relationship s/he avoids responsi-

bility for his/her actions. This violates one of the most fundamental ethical postulates of human thought. When the IME doctor leaves the professional role of patient advocate (in an adversarial system) s/he becomes a mere tool of the payer. These clinicians cease to be “professional” at that point and assume the role of adversary.

The IME doctor may claim that the truth of the case is what is being sought. However, no truth about a patient can ever be gained outside of the Doctor-Patient relationship. The truth is what a real relationship with a patient yearns to achieve. Only in service to that patient, can a doctor help them seek their own vulnerable truth and validation.

Doctors must remain cognizant that the relationship with a patient is a trusting one despite a huge imbal-

ance of power. Patients are vulnerable, weak and dependent on doctors’ skills and knowledge that bewilder them. Helping them regain some control of their own lives and medical experience is part of patient advocacy. The IME performs the opposite of this and leads to further feelings of helplessness, distrust and anger in the patient.

We need our patients as much as they need us! Together, within the sacred Doctor-Patient relationship, the doctor and patient become more conscious and caring people. Otherwise, without the relationship, the doctor becomes an interchangeable part of a for-profit machine. S/he risks the ominous prospect of being alienated from the meaning that can be derived from his or her own work.

Ed.

The following is a discussion of the ethics case presented by Dr. Kim Pearson in the October NECOEM Reporter. **If it quacks like a duck...**

I will don the white coat of the Independent Medical Examiner and not prejudice this case in my discussion of the ethics involved. While there may be different technical details in the governing workers' compensation laws and regulations in various states I will address three general professional and ethical considerations faced in performing an IME.

The first consideration is the role of the Independent Medical Examiner. The IME is being conducted "on behalf of the employer's insurer." While the insurer may have requested the IME, you have presumably been chosen from a list of impartial specialists approved by the state Industrial Accident Board to perform IMEs, and have agreed to the principle of providing a neutral scientific opinion. You therefore have no greater obligation to the employer than the employee, regardless of who may be paying your fee.

The second consideration is the burden of proof. The employee claiming a work-related injury or illness carries the burden of demonstrating the presence and nature of the medical condition alleged and the causal relationship of the condition to the employee's work.

The third consideration involves the criteria you apply in assessing what weight to give to the information provided by the parties. While an IME is not itself a judicial proceeding, the results should meet a standard that assumes your report will be entered into subsequent adjudicatory proceedings. The standards you use in assessing both medical opinions and diagnostic test reports should comply with contemporary rules of evidence as promulgated by the U.S. Supreme court in the Daubert case: These standards include whether the evidence can and has been tested, whether the test or theory has received peer review and publication, the demonstrated error

rate in a test, and the degree of acceptance of the test or theory within the relevant scientific community.

These three considerations must be applied. This is your obligation when you submit your CV for consideration for your state's IME list. It is not a question of whether or not you have a "doctor-patient relationship," but the nature of "doctor-patient relationship" you have while conducting an IME. Your "doctor-patient relationship" would clearly extend to the levels of professional confidentiality and to the application of a scientific medical approach. Admittedly, it is somewhat different than that of the primary care physician. It need not, and should not, consider the "social" concerns about the welfare of the "whole patient".

I do not believe it is likely that this patient has met the burden of proof to demonstrate to a reasonable level of medical certainty the existence of any physical condition beyond a constellation of poorly defined subjective complaints. Absent the demonstration of a recognized "medical condition", further consideration is not needed. While it is clearly possible that the employee's reported symptoms reflect mental rather than physical illness, neither the employee or her health care providers are alleging mental illness. In the absence of such allegations, you (a non-psychiatrist) need not consider this possibility.

The "plethora of laboratory reports" are unlikely to meet the criteria enunciated under Daubert, and therefore unlikely to be admitted in any subsequent adjudicatory process. If upon evaluation of the specific test reports submitted to you by the employee, you conclude that they do not meet the Daubert criteria, you should not consider them in the formulation of your IME determination.

You would also apply the Daubert criteria in considering the "expert opinion" of the "alternative medicine physician" that certain detoxi-

fication treatments, intravenous antioxidants, etc., are medically indicated and necessary for the employee's care. Unless this physician has provided such a basis (and again, the burden is on the employee and her physician to do so), you must recommend against including these treatments in any regimen paid for by the employer's insurance company. Absent objective scientific evidence to support the efficacy of the recommended "alternative" treatment in the presence of such diagnoses, you must recommend against approval of insurance payment for continued treatment.

By following the approaches I have described above, I believe you will have met your duty to the insurer, the patient, the profession and to society (by resolving this dispute between the two parties according to the principles established by the elected legislature). Were you to consider the broader social questions posed by Dr. Pearson, you would not have met your ethical obligation to any of these "parties" to the case.

Dr. Pearson asks you to consider whether the employee will be denied the treatment of her choice and whether she will be forced to deplete her "meager financial resources" on the treatments she feels are best for her. These are not issues that you can or should consider when performing an IME. When you agree to conduct an IME, you have implicitly accepted the social compact between employer and employee that has been enshrined in law. Any emotional concern for the employee that you may have, and any consideration of what choices she may elect to make as a result of your report, should play no role in the formulation of your opinion. This may be a hard choice for you to make. But if you can't, you probably should not be performing IMEs.

*James Ryan, MD, MPH, FACOEM  
Medical Director, OEM  
Boston Medical Center*

## CHRONOLOGY OF HARRIET L. HARDY, M.D.

AS COMPILED BY LLOYD  
TEPPER, M.D.

- 1906 Born in Arlington, Massachusetts.
- 1928 Graduated from Wellesley College. Elected senior class president.
- 1932 Graduated from Cornell Medical School. Enters internship at Philadelphia General Hospital.
- 1935 Becomes school physician at Northfield Seminary or Girls and "country doctor" with general practice.
- 1939 Becomes Radcliffe College Physician. Has part-time assignment in medical out-patient department at Massachusetts General Hospital (MGH) and participates in clinical research.
- 1945 At suggestion of Dr. Joseph Aub at MGH takes job as physician with the Division of Occupational Hygiene of the Massachusetts Department of Labor. Continues Dr. Irving Tabershaw's investigations of "Salem sarcoid" in the fluorescent lamp industry.
- 1946 Publishes (with Tabershaw) "Delayed Chemical Pneumonitis Occurring in Workers Exposed to Beryllium Compounds". Achieves wide professional recognition.
- 1948 Spends year in occupational medicine at the Los Alamos Scientific Laboratory.
- 1949 Establishes occupational medical clinic at MGH and the Occupational Medical Service at MIT. The text *Industrial Toxicology* by Drs. Alice Hamilton and Hardy is published.
- 1952 Organizes the Beryllium Case Registry to facilitate study of the epidemiological and clinical characteristics of beryllium-related diseases.
- 1952-1968 Career peaks. Engages in almost two decades of extensive travel abroad and develops collegial relationships with authorities around the globe. Develops active clinical practice at MGH and MIT and joins faculty at Harvard Medical School and School of Public Health. Serves on multiple advisory committees advisory to government, labor unions, and academic institutions. Receives numerous awards
- 1971 Joins part-time faculty at Dartmouth Medical School.
- 1973-1993 Retires to Lincoln, Concord, and Holyoke, Massachusetts
- 1983 Publishes autobiography, *Challenging Man-Made Disease*



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problem. These studies also found that ways exist to prevent these disorders by making changes in the workplace that are often easy and inexpensive, yet save many times their cost in workers' compensation and medical savings. In fact, the National Academy of Sciences estimates that doing nothing about ergonomic injuries is costing our economy more than \$50 billion each year. Meanwhile, in poultry processing companies like Pilgrim's Pride in Lufkin, "Workers with repetitive stress injuries are given aspirin and ice and sent back to the production line," according to United Food and Commercial Workers International Vice President John Rodriguez. The UFCW has just filed a

complaint with the Labor Department over conditions at Pilgrim's Pride where the majority of workers at the Lufkin plant, like most poultry plants, are new immigrants and minority workers who are afraid to report injuries even though they are undergoing surgery at "epidemic" rates. But instead of working constructively with the Department of Labor to fashion a response to this workplace epidemic, anti-regulatory ideologues in the Chamber of Commerce, the National Association of Manufacturers and other industry associations continue to argue that there is no science behind ergonomics, and continue to oppose not only an OSHA ergonomics regulation, but even voluntary guidelines and standards. On this

sad anniversary let us pause to remember the millions of working people whose lives are ruined every year just by going to work every day. And in this time when Enron's corporate crimes have robbed thousands of their jobs and retirement savings, let's also take this opportunity to demand that our government not allow unscrupulous companies to take away workers' health as well.

***Sweeney, based in Washington, D.C., is president of the AFL-CIO.***

*Note: As we went to print, the Bush Administration did issue voluntary ergonomic guidelines.*

## COMMENTS ON ACCEPTING THE HARRIET HARDY AWARD

Rose H. Goldman, MD, MPH  
December 6, 2001

I want to thank the members of NE-COEM for presenting to me this award—which has particular meaning for me. Dr. Harriet Hardy was not just a luminary from the past that I admired, but for me, a living role model. From my limited contact with her, as well as my knowledge of her work, I admired her as a superb clinician and also as an academician who did practical clinical research that led her to implement changes in the workplace. I thought of her as someone who was bold, outspoken, and stood up for what she believed. It is no wonder that her autobiography is called *Challenging Man Made Disease*.



Receiving this award has prompted me to recall the ways my path crossed hers, and in some ways paralleled it. I would like to start by reflecting on how I have been inspired by Dr. Hardy, and others from the past, and then discuss how we can use her example to inspire and guide us in the future.

My first inspiration in medicine was my father, a family practitioner who was always praised by his patients as being a great clinician and doctor. I thought if I'm going to do medicine, I'm going to be like him.

I had been interested in environmental issues for many years while growing up in Florida. I did my internal medicine residency at Waterbury Hospital, located in a very industrial town, and found myself wondering about the impact of the various work exposures on my patients. Dr. Irving

Selikoff was in the news a lot then, proclaiming the adverse effects of asbestos. As a junior resident I contacted him about doing a rotation with him at Mount Sinai Hospital, and to my delight, he took me on. Watching Dr. Selikoff in action, I saw a highly skilled

and inspiring clinician, and a researcher who was not too proud to work with unions. That month at Mt Sinai was my awakening to Occupational Medicine! I had found my field—an ideal fit for me: medicine, chemicals and substances, politics and social issues—it was the absolutely perfect brew for me. When I returned to Waterbury, I proclaimed myself an occupational/environmental medicine physician! I was ready to do “teaching” consults and talks. One of the reasons I felt so prepared, was that I had returned with a very experienced companion: Hamilton and Hardy's *Industrial Toxicology*. I loved that book—I loved reading all of the clinical vignettes about the various chemicals and metals—it accompanied me on my consults, electives, and wherever I could find an excuse to read it. I learned the breadth of clinical occupational medicine from that book—and

so felt that Dr. Hardy became one of my teachers and mentors before I had ever met her.

After Waterbury, I had to choose a place to train in Occupational and Environmental Medicine. I spoke with Dr. Nancy Sprince, a pulmonary physician at Mass General Hospital who had assumed some of Dr. Hardy's work on beryllium and the Beryllium Case Registry. Nancy had decided to pursue more training in Occupational Medicine herself and was planning to go to Harvard School of Public Health. I thought, if

Harvard School of Public Health was good enough for her, someone who had actually worked with Dr. Hardy, I guess it was good enough for me. Nancy also told me that if I were coming to Boston to study Occupational Medicine, I had better go the Schlesinger Library and learn more about Alice Hamilton and Harriet Hardy by reading through their collection of letters. It was very inspiring to read their letters, and hear the voices of these female physician leaders, grappling with the various Occupational Medicine and social issues of their times. I thought, if I'm going to do Occupational and Environmental Medicine, I'd like to be like them, blending academics with social action.

Like Dr. Hardy, I decided to combine clinical medicine with work at

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the Massachusetts Division of Occupational Hygiene. Nancy Sprince and I went to visit Dr. Hardy before I started the job at the state. I remember how she encouraged me and shared some of her stories. Like her, I tried to follow up on some leads. She was very happy when I published my work on lead poisoning in radiator repair workers and I received a lovely note from her congratulating me on its appearance in the *New England Journal of Medicine*. The 1986-1987 winter issue of *Harvard Medical School's Perspectives* magazine published an article about Harvard Women in Occupational Health (Drs. Alice Hamilton and Harriet Hardy) passing the torch to Nancy Sprince, Chris Oliver, and myself. When I went to the hanging of the portrait of Dr. Harriet Hardy, in the hallowed halls of Harvard Medical School (1986)—the first visage of any female faculty to go up— I felt encouraged in my own struggles to further the cause of Occupational and Environmental Medicine there..

In my career I have tried to promote values and directions in Occupational and Environmental Medicine held dear to both Dr. Hardy and myself— values that I think are still important to us in this new millennium. From the clinical perspective, it is worth emphasizing the importance of the history in evaluating the individual patient, and in serving as the potential launching point for other actions. Dr. Hardy wrote in her autobiography, “As I grow older, the details of a sophisticated physical examination elude both my skill and my interest, but the treasures from taking a subtle and complete history cannot be exaggerated. The challenge of making a large part of the diagnosis by acute obser-

vation and patient conversation remains as my gift.” I share that interest and skill in history taking, and have tried to enhance the medical history by emphasizing the occupational and environmental history component in my talks and publications. Even in the midst of high tech medicine we need to cultivate and cherish the gift of history-taking, and pass it on to our students. And speaking of students— we need to strive to teach the principles of Occupational and Environmental Medicine to all who will listen, and to inspire the next generation. In Dr. Harriet Hardy's autobiography she has a chapter entitled, “Trials and Tribulations,” where she describes “failures in my professional program”. One of the areas of disappointment for her was HMS's reduction of her teaching time in Occupational Medicine from 12 hours to one hour. She felt frustrated by her inability to increase the hours and attention to Occupational Medicine at HMS. This is certainly an arena in which I, too, have tried to carry the OEM flag— developing and inserting more OEM material into the curriculum, and striving to have OEM appreciated for the important field that it is. It is still amazing to me that when I introduce myself as an OEM specialist, I am frequently asked to explain what that means! Like Dr. Harriet Hardy, I have tried to be an activist academic— involved with practical research, implementing changes and preventive occupational health practices, supporting efforts that improve health and safety at the workplace, and in the environment. I hope we can all find the words and time to be as outspoken as Dr. Hardy in promoting a safer workplace and environment.

### Letter to the Editor:

November 19, 2001  
Dear Dr. Naparstek:

I read with interest the article in the October issue regarding the academic OEM health center in Rhode Island. As an occupational health professional for almost twenty years, I support the establishment of independent occupational and environmental health centers with broad representation. However, I take issue with the statements that the closing of the Brown University program in Occupational Medicine had “left Rhode Island's Labor and Medical Communities without a resource for the diagnosis, treatment, prevention and study of occupational and environmental illness.”

Occupational Health + Rehabilitation Inc. (OH+R) operates two occupational health centers in Rhode Island. We employ two experienced occupational health physicians, one of whom is board certified and several highly qualified occupational health physicians assistants and nurse practitioners with over 25 years of combined experience. We provide services to a broad range of clients, including private employers, public agencies, individuals, and both plaintiff and defense attorneys. For almost ten years, OH+R has provided Rhode Island's employer and labor communities with access to high quality occupational health care, and we anticipate continuing to do so into the future.

We acknowledge the availability of occupational health services provided by OEHC-RI, and we are happy that there will be a stronger academic OEM presence in Rhode Island. We wish them well.

Sincerely,



William B. Patterson, MD, MPH, FACOEM  
Medical Director, Massachusetts  
Chair, Medical Policy Board  
Board of Directors, NECOEM

## VERMONT

A new bill (H.412) would put this state more in line with the rest of the country for drug screens. Vermont has been the only state that has a restricted drug screen law allowing only for probable cause testing, a category much more restrictive than reasonable suspicion. One has to document signs of active use such as acting impaired. Only preplacement testing with a ten day advance signed consent exists. The new bill is in its first revision. The first writing allowed reasonable suspicion, random testing, preplacement without the 10 day wait, but had large methodology errors such as not using an MRO and having the testee give information/explanations directly to the lab. The lab was to report directly to the employer and perform mandatory split samples. The newer version has corrected much of this but does not allow random testing and subsequently the business community has withdrawn its support. It is doubtful it will pass this year. All interested members should provide input to their legislators.

## MAINE

Governor King has proposed LD 2202, a bill designed to reverse the so-called "Kotch" decision. The decision, issued in February by the Maine Supreme Court ruled that non-occupational injuries, i.e., pre-existing conditions such as diabetes, sports injuries, hernias, high blood pressure and their resulting partial incapacity may be "stacked" with an

occupational injury that results in a partial incapacity.

Under current law, 25% of workers' comp cases involving permanent injury must be eligible for lifetime benefits rather than benefits of limited duration. In *Kotch v. American Protective Services*, the Court ruled that work-related and non-work-related injuries could be combined to determine a worker's level of impairment.

With this ruling, many more people will be eligible for lifetime benefits, regardless of whether or not their injuries result from their employment.

Since only 25% of injured workers receive lifetime benefits, this means workers in need from serious work-related injuries will be competing for limited funds with workers who have non-work related conditions. This also puts an unfair burden on businesses to bear the costs for impairments that are completely unrelated to the work performed by their employees.

For years, Maine businesses struggled with skyrocketing workers' comp costs. The 1992 Blue Ribbon Reforms enacted by the Legislature succeeded in lowering costs for businesses while maintaining an appropriate level of benefits for injured employees. These Reforms were intended to bring Maine's comp costs in line with the national average. The Kotch decision will result in Maine again costing dramatically more than the rest of the country.

Like the rest of the country, Maine is struggling with an economy in recession and a state budget hobbled by reduced revenues. The last thing Maine needs is a business community further burdened by health care and workers' compensation costs as it struggles to expand the economy and provide good jobs for Maine citizens.

Clearly the court decision has caused great concern within the business community. The Maine Chamber

along with other concerned business groups approached the Governor and requested legislative action be taken to correct this decision. The Governor has agreed that this decision is detrimental to Maine employers and our economy. Furthermore, a request was made to the National Council of Compensation Insurers (NCCI) to provide an estimate of a cost impact of the "Kotch" decision. Based on prospective costs only, it is estimated that the effect of the "Kotch" decision will result in a 15 percent workers' compensation premium increase for every employer in the state of Maine. This translates into roughly a \$43 million per year increase in Maine workers' compensation costs. What makes this more disconcerting is that the retroactive application of this decision could be even larger. Currently neither self-insured employers nor insurance carriers have reserve for the results of this decision. The Kotch decision puts our workers' compensation system at a crisis point and should it remain in effect, would give us one of the three most costly workers' compensation systems in the United States.

Governor King's bill entitled, *An Act to Ensure that 25% of Workers' Compensation Cases with Permanent Impairments Remain Eligible for Duration of Disability Benefits in Accordance with the Workers' Compensation Act* was heard on March 26th before the Joint Standing Committee on Labor.

The Governor's bill will restore that balance between the need to provide benefits for seriously injured workers and the need to maintain manageable costs for the business community.

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## 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 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 to NECOEM at the above address. The editor reserves the right to edit letters for publication purposes

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### **Waited long enough to make workplace safer** By JOHN J. SWEENEY

ONE year ago this week, after token debate, Congress voted to repeal a rule protecting American workers from the biggest workplace health and safety hazard today. On March 20, 2001, in his first significant legislative action, President Bush repealed the Occupational Safety and Health Administration's ergonomics standard. Since the rule was overturned, 1.8 million workers have suffered ergonomic-related injuries such as back injuries and carpal tunnel syndrome -- many that could have been prevented. They include dedicated nurses who have had to give up their chosen profession of caring for our sick families and friends. They include the low-wage workers who process the food we put on our tables every day, including many poultry workers throughout Texas. In order to ease the consciences of congressional representatives who voted to repeal the ergonomics standard that had been 10 years in the making, Secretary of Labor Elaine Chao promised on the eve of the vote to lay out "a comprehensive

approach" to ergonomics "that may include rulemaking." She promised the administration would announce their plan by the end of September. When that deadline was understandably delayed due to the tragic events of Sept. 11, she then committed to take action by the end of the fall, and then by the end of the year. Today, a year later, no action has been taken. Millions of American workers continue to wait, continue to work in pain and continue to lose their livelihoods from these injuries. The only response we've seen from the Bush administration is the recess appointment of Eugene Scalia, one of the main architects of industry's decade-long campaign against protecting workers from these disorders, to the powerful job of solicitor of labor. The most disturbing aspect of the Bush administration's failure to act is the fact that these injuries are well recognized and easily preventable. Two congressionally mandated National Academy of Sciences studies sought by opponents of the ergonomics standard found that work-related musculoskeletal disorders are a serious, widespread

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