

NECOEM Reporter

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The Medical Profession: Maintaining Ethics in an Unethical Environment

Kimberley Crocker Pearson, MD, MPH

Medicine has traditionally been held up as the quintessential profession. Physicians are held by society to professional standards of behavior including:

- High levels of expertise
- A means of maintaining standards
- A system of ethics

When physicians exhibit these behaviors, they are granted autonomy. When physicians fail to do so, they are held to an exter-

nal legal standard and disciplined by society through malpractice torts and licensure revocation.

An ever increasing number of physicians are employed by non-medical entities and may face the dilemma of being asked to behave in a manner inconsistent with the standards of the profession. A recent New York Supreme Court decision supports the employer's right to fire a physician for failing to accede to such requests.

In 1996, Dr. Sheila



Horn became the associate medical director of the *New York Times*. When she accepted the

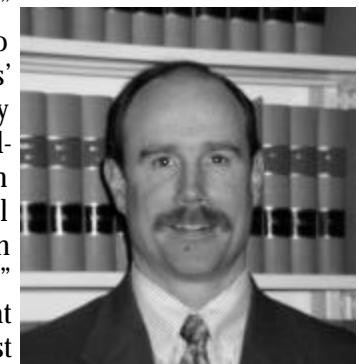
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The Massachusetts DIA's Impartial Physician Program: Helping the Workers' Compensation system on the Road to Recovery.

Judge Daniel J. O'Shea

As a result of the Massachusetts Workers' Compensation Reform Law of 1991, the Department of Industrial Accidents (DIA) has been charged with the responsibility of maintaining a roster of duly qualified "Impartial Physicians" to examine injured workers involved in certain medical disputes. The so-called

"Impartial Physician law" was created in an effort to streamline the workers' compensation adjudicatory process and to provide administrative judges with an "unbiased" expert medical opinion to rely upon when deciding "medical issue" cases. The legislative intent was to eliminate - or at least minimize - the number of



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MA Impartial

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situations where parties to a workers' compensation dispute would present voluminous, mostly conflicting medical evidence from what came to be known as "dueling doctors."

The role of expert medical opinions in workers' compensation cases is critical, since Massachusetts law requires judges to base their decisions dealing with medical matters on the strength of the medical evidence in the record. For instance, a judge cannot award an injured worker incapacity benefits, (i.e. temporary total, partial, or permanent and total incapacity benefits) unless there is competent medical evidence confirming the existence of a "personal injury," and medical impairments which are "causally related" to the person's employment. Similarly, a judge must rely upon medical evidence to establish whether disputed medical treatment is "adequate and reasonable" within the meaning of the Workers' Compensation Act. The stakes are often very high, and as such, litigants historically have had to spend a great deal of time and money developing the medical evidentiary foundation for their cases. Under the traditional "adversary system," parties have been permitted to submit medical evidence of their own choosing, subject to the "Rules of Evidence" and certain other DIA regulatory hurdles.

However, with the passage of the aforementioned "Impartial Physician law," which was enacted in 1991 as an adjunct to the overall workers' compensation reform legislation, the litigation model has been drastically altered. Now litigants are effectively precluded from relying on their own medical experts at the

time of an adjudicatory hearing, and instead must have a state-appointed medical doctor examine the injured worker and render a formal report to the presiding judge. Under the law, such a report would constitute "prima facie evidence of the matters contained therein" and "no additional reports or depositions of any physicians" would be allowed into evidence at the hearing. This essentially means that the impartial physician's medical opinion is the only medical evidence a judge may rely upon in deciding the medical issues in a case, although the judge could admit additional medical evidence if the report were found to be "inadequate" or the medical issues sufficiently "complex."

The grounds for admitting additional medical evidence have been the subject of much litigation over the last 11 years, and the cases have articulated a number of meaningful guidelines and parameters dealing with those issues. There have also been a number of "due process" and other legal challenges to the system, but the Supreme Judicial Court of Massachusetts has on every occasion upheld the "facial" constitutionality of the impartial physician law. As a result, the Massachusetts impartial physician system will remain an integral part of the DIA's dispute resolution process for some time to come. The DIA therefore has to fulfill its statutory mandate to keep the impartial physician program healthy and alive, and in so doing, will need a substantial roster of qualified doctors willing to take on the role of "medical expert" in workplace injury and illness cases.

Since the inception of the impartial physician program, the DIA's roster has included hundreds of prominent doctors in many medi-

cal specialties. The roster has waxed and waned over the years, and in an effort to attract and retain qualified physicians from across the state, the DIA has increased the fee for appeals filed after November 1, 2002 from \$350 to \$450 per examination. The fees are paid by the party or parties involved in the litigation, and the appointed impartial physician receives the entire amount. The DIA does not retain any portion of any impartial physician fees.

In order to become an impartial physician on the DIA roster, an eligible doctor will need to complete a state-approved contract. Although the contract contains a number of other important terms, impartial physicians agree to the following:

1. *To serve on the Roster of Impartial Physicians pursuant to Chapter 152, Sections 11A and 8(4) of the Massachusetts General Laws, to examine and evaluate workers' compensation claimants when selected by the parties, or when appointed by an Administrative Judge or by the Senior Judge,*
2. *to conduct an impartial examination within forty-five (45) calendar days after date of notice of appointments; to render a report within twenty-one (21) calendar days of each Section 11A examination, and within fourteen (14) calendar days of each Section 8(4) examination; and, to render a supplemental report if required by the Administrative Judge (see: par. 5 - "Fee Schedule"),*
3. *to render to the DIA, in a format acceptable to the DIA, a report containing your findings and the basis of your opinion as to: whether an impairment of function exists; whether such impairment is total or partial, temporary or perma-*

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Review: NECOEM Healthpoint March Dinner Meeting Presentation

By Alan Rodgers, MD



On March 11, 2003, George Anstadt, MD, FACOEM (OH+R Rochester, Medical Director) gave a fascinating and provocative talk on "OEM: Ramazzini's Unprofitable Hobby or The Economics of Work and Health and OEM Practice" as the NECOEM dinner speaker at HealthPoint. He more than fulfilled his moderate goal of giving everyone in the enthusiastic audience at least one useful thought. The preview and promotion of the talk was that "When attempting to understand a complex social issue, follow the money". The premise of the talk was that physicians only provide services for which they can also get paid for – a necessary but difficult assumption in the current financial model of healthcare that is based primarily on disease treatment. The best hook OEM physicians have to tie into this system is by establishing the link between health and productivity – a rather obvious observation that was known already to the ancient writer, Agricola, who noticed the poor health of miners. Yet, early occupational medicine physicians, who pioneered such essential concepts as safety, industrial hygiene, ergonomics, audiometry, spirometry, and EAP, rarely made any money. Even such a towering figure

as Ramazzini had to hide his interest in workers' diseases from his wealthy paying patients. Unfortunately the current situation is just as difficult today, with much of the workplace healthcare taken over by lower-cost providers such as Occupational Health RNs, NPs, Chiropractors, or Physical Therapists. The administrative aspects of Occupational Health Care has become the territory of business professionals.

Dr. Anstadt reminded the dinner meeting audience that the value of the medical license required to treat diseases and provide clinical preventive services is a protected space that Occupational Medicine physicians should guard. While ours is a small specialty with only 0.9% of all US MDs being active members in ACOEM, and only a third of this number actively practicing with OM board certification, OEM outcome results are better than those of a generalist (up to 52% less expensive than generalist or emergency room care). As matter of fact, when a physician has little or no concern for the productivity and economic costs of prolonged disability, the interests of employees and the physician potentially collide with a result of increased costs and prolonged disability.

This NECOEM newsletter review of the March meeting presentation attempts to summarize, highlight, and comment on Dr. Anstadt's talk. For those who missed the live talk, the full presentation is available and has been posted on the NECOEM web site as an Acrobat file.

Dr. Anstadt left no doubt about his bias on the subject as he is well-known as a leader in OEM and

a past-president of ACOEM. He has a wealth of experience and credentials that include Corporate Clinical OEM practice (Kodak), Clinical Toxicology (Kodak Director Clinical Toxicology), Pharmaceutical Medicine (Eastman Pharmaceutical), Medical Device Medicine (Lucid Medical Director), Corporate Administration of OEM (Kodak), Benefits (Director, Health Plans, Kodak), a Kellogg mini-MBA, and his current free-standing Clinical OEM practice.

The advanced stated goals of the talk were to understand the economic value of healthy employees, how employers buy healthcare, the current economic environment of medicine and workforce productivity-the key to the 21st century. One view of this places high value on the practice of occupational and environmental medicine (OEM).

The general view is that the current role of health insurance focuses on paying for disease, which sets the patterns for future insurance premiums (chicken or egg). The poorly integrated US healthcare system is not population based, leaving 40 million uninsured, although Dr. Anstadt's thoughts were that a pluralistic Federal, State, Business and individual coverage is basically a good approach.

Dr. Anstadt related his personal experience at Kodak, where he saved \$20 million on the ever escalating medical insurance premiums in the early 1990s to both employer and employee satisfaction. However, the one problem was that it failed to improve

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The Medical Profession...

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job Dr. Horn assumed that having been hired to serve as a physician, she would conduct her practice in accordance with the standards of the medical profession. Like any occupational medicine physician, she knew that she would face ethical dilemmas in the course of her work.

Dr. Horn provided medical care, treatment and advice to the newspaper's employees. She examined employees who were seeking workers' compensation benefits to verify that their injuries were work-related. On frequent occasions various departments of the *Times* directed her to provide them with employees' confidential medical records without the employees' consent or knowledge. Additionally, the vice president for human resources instructed her to misinform employees regarding whether injuries or illnesses they were suffering were work-related so as to curtail the number of Workers' Compensation claims. Understandably concerned about the propriety of such requests, Dr. Horn sought direction from the New York State Department of Health, which advised her that such conduct would violate legal and ethical duties to patients. She therefore refused to turn over patients' medical records to other department heads without the patients' consent.

The *Times* fired Horn, asserting it was due to economically induced restructuring of the department. In response, she sued the newspaper, alleging that the actual reason for her termination was her refusal to divulge confidential information without patient consent. The *Times* moved to dismiss Horn's suit for failure to state a viable claim, asserting that it had the absolute legal right under New York law to termi-

nate her for any or no reason because she was an at-will employee.

The lower courts agreed that Dr. Horn had sufficient cause to go forward with her suit, however, the Supreme Court of New York overturned the ruling and dismissed the complaint, declaring that even if a doctor is fired for refusing to divulge confidential employee medical information, she has no cause of action against the employer. It should be noted that on a motion to dismiss, the Court must accept as true the facts as alleged in the complaint and determine only whether the facts as alleged fit within any clear legal theory.

Compared with laws in other states, New York has some of the strictest rules regarding when an employee has grounds to proceed with a lawsuit against an employer.

In one rare exception, *Weider v. Skala*, the courts allowed a lawyer to proceed with a case in which he claimed that his law firm had fired him for complying with the lawyer's Code of Professional Responsibility and insisting that the misconduct of another associate be reported to a disciplinary committee. The court in that case recognized the lawyers' obligation to his profession and said his employer should have also.

The difference between the physician's case and the lawyer's case, the majority of the court said, was that the lawyer was suing a law firm that was bound by the same ethics. Dr. Horn, the court said, was suing a non-medical employer that wasn't bound to the same ethics she was. Ironically, the *Times* has published editorials championing the confidentiality of medical records, warning about the potential for "erosion of privacy between doctors and patients". The Supreme Court did not concur with the appellate di-

vision who felt that "any employer who hires a physician to provide medical care knows, or should know as a matter of common knowledge, that the physician is bound by the patient confidentiality provision of the ethical code of the medical profession. Although Dr. Horn and the *Times* were not engaged in a common enterprise, it is universally known that a physician owes her patients a duty of confidentiality."

ACOEM along with several other physician organizations filed an *amicus curiae* brief in the case. The brief notes two key concerns. First, the *Times* argued that Dr. Horn was not required to conduct her practice of medicine in conformance with the governing standards of conduct of the medical profession because she was employed by the *Times* and not other physicians, and because a portion of her practice involved performing employment-related medical examinations. However, the *amici* note, nothing in the law exempts an industry-employed physician from conducting her practice within the strictures of the legal and ethical obligations of the medical profession. Indeed, the AMA's Council on Ethical and Judicial Affairs has determined that an industry-employed physician's practice of medicine must comply with all governing laws and standards of ethical conduct.

Second, in the face of clear statements to the contrary included in both the AMA and ACOEM codes of ethical conduct, the *Times* contends that a physician's obligations to maintain patient confidences and impart truthful information to patients are not "primary" or core ethical rules of

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Economics of Work...

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health. This is also the typical problem with HMOs whose financial goals do not encourage investment in prevention and disease management.

THE CORPORATE HEALTH BIG PICTURE is an economy dominated by knowledge workers (a corporation's primary source of competitive advantage) with employers that know they must invest in the human capital of their workforce. The capital investments in equipment can replace manual workers but not knowledge workers in the information age. Companies are seeking value in optimal health per dollar.

The corporate goal is aimed at employee satisfaction, to attract and retain top people. After-tax profits and health benefit costs do not include related productivity costs. The differences in health economics do matter to business competitiveness. There are few sources of competitive advantage in most industries as they all buy health insurance and workers' comp insurance from the same suppliers, bid the same contracts, etc. Therefore, a good health strategy can be a major source of competitive advantage. The link between health and productivity become more evident to the CFO and CEO when considering for every \$1 an employer spends on healthcare cost, on average they spend \$3 on related lost productivity costs (absenteeism, presenteeism, disability) as refer-

enced in Brady, Loeppke, Anstadt, et.al. JOEM 1997.

The concept of "presenteeism" was reviewed and identified as a key factor in evaluating productivity of human capital. Dr. Anstadt defined presenteeism as employees present at work but limited in some aspect of job performance by health problem(s). This can range from slight deconditioning in a competitive athlete to mania in a stock trader. Presenteeism can have effects on the quantity of work, quality of work, creativity, executive functions and work culture.

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"Nonsense, Braddock, you do have a life."

eeism can have effects on the quantity of work, quality of work, creativity, executive functions and work culture.

Absenteeism is evidenced by employees not present at work, including the categories of turnover, STD, LTD, early retirement due to poor health, death (Premature Mortality Costs), FMLA and other unpaid leave. The impact of absenteeism is obviously large, but better valuation methods are needed.

As for measures of health and productivity, Lane Ryland, PhD, was quoted, "Eastman Kodak has no idea who is productive, who is not" leading to a discussion of the importance of quantifying productivity effects on human capital.

Frederic Taylor is the father of productivity improvement. The work that he did in organizing manual labor will now be repeated for the knowledge worker in our century. The resulting metrics will cause huge problems as well as huge improvements now as it did in Taylor's era. Self-report experience and intuition, not hard data as yet, foretell that the self-report instruments will prove to be increasingly valuable to management science. We may want to seek partners to develop tools that work well together.

The annual AOHC in Atlanta dedicated several sessions to Health & Productivity Measurement and Demonstrating the Business Value of Good Health, including reviews of the specific tools, self-report questionnaires, and examples of these types of analyses.

Briefly, Dr. Anstadt's benefits are based upon the observation that patients usually know that they are becoming nonproductive well before management. Constructing a set of incentives and protections that will allow employees to communicate this information in a win / win setting for the individual and the business is the central challenge to implementation.

Disease specific health and productivity data were presented by Dr. Anstadt, with examples of the associated costs of diabetes, obesity, heart disease, stroke, migraine, depression, neck & back conditions, and arthritis. The example for diabetes showed the annual cost climbed from \$98 billion in 1997 to

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MA Impartial..*(Continued from page 2)*

ment in nature; whether within a reasonable degree of medical certainty such impairment of function has as its major or predominant contributing cause a personal injury or illness arising out of and in the course of the employee's employment; and, any other matters relevant to your report. Residents and fellows in training may observe and participate in a limited capacity for purposes of education only, but may not be solely or primarily responsible for conducting the examination or interpreting findings, and may not write the report to the DIA.

4. At the direction of the DIA, in some instances, to render a report based on your review of an employee's medical records without an examination.

5. To accept this "Fee Schedule" as compensation for your services:

- . \$450 for each report you submit;
- . \$500 for the first two hours of your deposition (paid by deposing party);
- . \$100 for third hour of your deposition (paid by deposing party);
- . \$225 for your review of medical records without examination of worker;
- . \$125 for each supplemental report;
- . \$100 for cancellation on less than 24 hour notice to your office.

6. To submit to DIA's periodic quality assurance reviews throughout the term of your appointment and reappointment, to include, but not be limited to, documentation as to basic qualifications for appointment to the Roster, such as:

- . copy of your license to practice as a physician;
- . copy of your board specialty certification;

. copy of declarations page of your medical malpractice insurance policy;

. copy of declaration page of your workers' compensation insurance policy.

7. Criteria for eligibility during the period of your appointment and reappointment:

- . current full state license rendered by appropriate board of registration;
- . board certification as a specialist within your discipline;
- . active clinical practice e.g. minimum of 8 hours/week of clinical, or combination of 4 hours/week clinical teaching plus 4 hours of clinical teaching or research;
- . no unresolved/non-frivolous complaints with the disciplinary board of your practice to include the National Physicians' Data Base and/or the Health Care Services Board;
- . staff appointment and/or admitting privileges at a JCAHO-approved hospital or health care organization (desirable, but not essential, if other criteria are met);
- . Workers' compensation insurance coverage, where needed.

8. To report to the DIA any change(s) in the your eligibility (see par. 7) which might adversely affect your ability to meet the basic qualifications for inclusion on the Roster such as cancellation or non-renewal of: a. medical license; b. board certification; c. workers' compensation coverage.

9. To refer any requests for information or subpoenas for reports written by you for the DIA to the Deputy Director of the Division of Dispute Resolution.

10. To disclose to the DIA in writing when you are affiliated with any independent medical examination organization or corporation of physicians with a primary purpose to provide litigation-related examinations

exclusive of treatment and follow-up evaluations; to enable the DIA to assign you work which does not put you in conflict with work done on behalf of the claimant (or the adverse party) by a medical examination service with which you have the declared affiliation; to provide the DIA with reports authenticated by your personal signature.

11. To be available in a timely manner for a deposition with the understanding that:

- . requesting attorney schedules deposition directly for a time/location convenient to you;
- . depositions often take under two hours and are generally limited to cross-examination;
- . requesting attorney pays you for up to three hours before deposition begins;
- . no deposition exceeds three hours' duration without an agreement between you and all parties, or unless as authorized in writing by an Administrative Judge on motion by a party, with a copy filed with the Senior Judge;
- . if more than three hours' time is required, neither statute nor regulation prohibits the parties and the impartial physician from agreeing upon a dollar amount sufficient to compensate the physician for that portion of the deposition extending beyond the three-hour ceiling.

The impartial physician system in Massachusetts has greatly contributed to the success of the 1991 Workers' Compensation reforms, and continues to be a vital part of the dispute resolution process. Impartial physicians provide an invaluable public service by using their medical expertise to examine injured workers and render unbi-

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State Happenings...

In Massachusetts...

VISIT THE
MASSACHUSETTS DEPARTMENT OF PUBLIC
HEALTH
BUREAU OF ENVIRONMENTAL HEALTH ASSES-
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ments Important Links to Environmental Health Information

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250 Washington Street, 7th Floor, Boston, MA 02108

In Vermont...

Another attempt is being made this year to pass an effective drug screening bill and bring Vermont into line with support for a drug free workplace. Last year's attempt was watered down. The final result only removed the 10 day advance warning provision for pre-placement examination, but did not include random or for cause testing. Many technical issues remain to be addressed as well.

Labor and Industry released a warning for CO poisoning in Vermont: "Assistant Fire Marshals from the Fire Prevention Division have been involved in dozens of investigations this winter where people have been made sick or hospitalized from carbon monoxide, and last year carbon monoxide investigations included three fatalities," said Robert Howe, Chief Fire Prevention Officer. "Carbon monoxide poisoning can be prevented."

Verne Backus, M.D., M.P.H.

Medical Director

Northwestern Occupational Health

St. Albans, VT

MA Impartial...

(Continued from page 6)

ased, reliable medical conclusions which form the basis of decisions issued by the presiding judge. The success of this program largely depends upon both the quality and quantity of the doctors willing to serve on the DIA roster. To that end, the DIA would like to hear from qualified physicians, especially those with an interest or specialty in occupational injuries or illnesses. For more information or to request contract materials, please contact:

Senior Judge Daniel J. O'Shea,
Department of Industrial Accidents
600 Washington Street, Boston, MA
02111
617-727-4900 x354
e-mail: danielo@dia.state.ma.us

The Medical Profession...

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the medical profession. They argue that "confidentiality... does not relate directly to the quality of medical treatment. However, the amici state that "Nothing could be further from the truth. These long-recognized obligations further important public policy goals, foster the necessary trust in the physician-patient relationship, and are crucial to the medical profession. Indeed, physicians face potential professional discipline – including the loss of license – in the event they violate these key obligations."

The concept that the courts can decide what the "core ethical rules" of the medical profession are is almost as offensive

as the concept that a physician can be fired without recourse for following them. In some settings, "ethics clauses" are being included in employment contracts, stating the employer will not impede the physician practicing according to the ethical guidelines of the profession. While ethical dilemmas may continue to arise over which a physician might have to sacrifice her job for her principles, one can only hope that it will not be over such basic values of our profession as confidentiality and truth-telling.

~

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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 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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Economics of Work...

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\$132 billion in 2002. Direct medical costs of diabetes more than doubled, from \$44 billion in 1997 to \$91.8 billion in 2002. Indirect costs, included lost-work-days, restricted activity days, death and permanent disabilities, totaled \$39.8 billion (not including presenteeism costs).

A recent study by the Institute for Health & Productivity Management found that 53 percent of companies (with 1,500+employees) are measuring and using productivity information. Another 29% are planning to do so. {Noted fact: Pharmaceutical companies see the value in selling their products, the non-sedating anti-histamine as a plus for improving productivity, an ACOEM supported effort.}

OEM Medical Practitioner advantages identified in this move-

ment towards health & productivity management is that we have the availability, affordability, and ability to provide these services. Dr. Anstadt closed by identifying some OEM Physician directions. Practice high quality medicine and remember the patient comes first. Seek to improve the health and productivity of your patients. Subspecialize to identify & address the OEM needs of employers and employees, leading to in-depth understanding of the problems of your special groups, e.g. MRO, DOT, FFA, Firefighter. Seek to leverage your specialized knowledge to other similar populations. Learn the insurance rules, contracts, etc. and adapt to them. Learn digital tools of medical and business practice. Strive to improve processes by feeding aggregated data back to the process. As a last resort, consider a radiology residency.