Greetings fellow NECOEM Members! For those of you whom I have not had the privilege of meeting in-person, my name is Matthew Lundquist and I became your NECOEM President as of the 2018 Annual Conference. I am honored and humbled to have been chosen by the Board to lead our organization for the next two years, along with my fellow Executive Committee members and our wonderful Executive Director, Dianne Plantamura. I am also most grateful for the excellent leadership that our outgoing president, Dr. Ron Blum, provided for the past two years. While our specialty as a whole continues to have membership challenges, NECOEM benefits from strong regional participation and holds an outstanding Annual Conference that consistently draws over 300 attendees for two education-packed
days. Our 2018 conference presented terrific topics and speakers, highlighted by the Harriet Hardy awardee Dr. John Howard from NIOSH. We also heard from experts on hip and shoulder examinations, disaster preparedness and response, and had two panel discussions: the first on fitness for duty with a focus on opioid use during the US opioid epidemic; the second on spine disorders and return to work. The breadth of topics at our conference never ceases to amaze me and I am thrilled to report that our Annual Conference Planning Committee, expertly chaired by Dr. Tom Luna, already has much of the 2019 program in place. As always, we are looking forward to another well-attended and intellectually stimulating AC...so save the dates of December 5-6, 2019.

Over the next two years, our work will be focused on multiple initiatives. I will be working with our Board to continue the “Meet-Up Dinners” throughout New England – please consider attending a local site for an evening of networking, education and hopefully meeting some new colleagues. We are also working on enhancing collaboration between ACOEM Components, engaging in state-level advocacy for lead law changes in Vermont, and considering hosting a course in conjunction with NIOSH for training new B-readers in New England. We will actively try to engage medical students, residents, and fellows, as well as local practitioners who already provide some occupational medicine services to their patients but are not formally involved with NECOEM. Please get in touch with us if you have academic affiliations and would like assistance in perhaps presenting to a local university or medical school about our specialty.

During this time, I also challenge each of you to become more active in NECOEM – please join one of our committees, such as the “Outreach” or “Annual Conference planning committee,” consider submitting an article or case report for publication in the NECOEM Reporter, and make plans to attend the Annual Conference in December. Lastly, do not hesitate to reach out to me or any Board Member directly, if you have any ideas, questions, or if you need us to offer some other assistance.

From left to right: Kenji Saito, MD, JD, Ron Blum, MD, FACOEM, FAAFP, John Howard, MD, MPH, JD, LLM, MBA, Harriet Hardy Awardee 2018, Matt Lundquist, MD, MPH, FACOEM, Bill Buchta, MD, MS, MPH, FACOEM
Dr. William Buchta, ACOEM’s current president, does not need an introduction to many. He is currently the Vice President and Chief Medical Officer of Logistics, Inc., in La Crosse, Wisconsin and has been an active contributor as a member and expert on the Medical Center Occupational Health List Serv.

I caught up with Bill at the recent NECOEM conference and he graciously agreed to sit down for an interview with me. Here are the excerpts:

AK: Welcome to Boston!

Bill: Thank you. Glad to be here.

AK: How does it feel to be among your northeast/New England OEM colleagues?

Bill: Of all the ACOEM components, the New England, Western and my own component, the Central States, are not only the largest, but they also conduct the best conferences compared to AOHC. And, it demonstrates the point that when we have critical mass and a large group of colleagues that get together, we can create conferences that are meaningful and offer an opportunity to network as well as meet with different exhibitors. I think all these factors make for a robust conference. Some of the things that happen here are more valuable than at the national level, at AOHC. This is because some of the issues that are discussed here are more relevant as regional issues, for example, medical marijuana and how it affects New England states. So, to answer the question, this is the best part of being the ACOEM president: visiting the different components such as NECOEM and getting to hear what our component members would like to get from a national organization such as ACOEM and to inform them how they can contribute.

AK: So, I take it that you love being here…. It is special for us in New England to have you here!

Bill: Yes, I have been frequently coming to NECOEM conferences. This is probably my 8th time in the last 20 years and I love being here.

AK: Bill, can you comment on three important initiatives that you have undertaken and/or are involved in, as president of ACOEM?

Bill: One of my major initiatives is “inclusivity”. If we consider occupational medicine the domain of physicians only, we will soon become a dinosaur society. Medicine is changing rapidly and so is technology. We have to acknowledge the contribution of other professionals in this field, such as PAs and NPs and realize that we do not own the specialty. In other words, if we take the stance that this is a “physicians only” club, we will become an extinct species. This is not necessarily an adversarial thing; this is a team approach. We don’t have enough occ docs to fill all positions. Just ask the recruiters! What does that tell you…. physicians are retiring at an alarming rate and we are not training enough to fill those spots....

AK: With residency programs closing and being scarce as they are.

Bill: A third of residency slots that exist are not funded currently. We have 25 programs now; twenty years ago, we had 45. Our pipeline is small and gradually decreasing…. We have to figure out how to make this work. We have to start thinking in terms of what we physicians bring to the table. We have more years of training, we spend more years in school, and that needs to be acknowledged - I am not diminishing that fact. But the point is that we cannot see all the DOT physicals, we cannot do all of the Fitness for Duty exams. About 5-10% cases really need our expertise. I did not always believe this way. We also need to keep work-life balance in mind. We are currently ranked first as a specialty that provides a good work-life balance, which is great. What I am saying is that we need to acknowledge the value of other providers and give them due recognition. Probably one of the best examples is right here. You have physicians, PAs, NPs and nurses all collaborating here in this conference and attending the same lectures. At other organizations such as ICOH, credentials are virtually meaningless. You can have a president that is a nurse, a respiratory therapist, an industrial hygienist or someone with a Master’s degree in Safety, and can be a MD, too, and it works very
well. How do we do this in our organization? Do we make PAs and NPs voting members of ACOEM? At this point, they are not. We do have observers on the Board of Directors, one PA and one NP. ACOEM now has a new section of nurse practitioners. I have a task force that Dr. Tacci is heading, to look at the feasibility of developing subsidiary organizations of ACOEM – occupational PAs, occupational NPs, occupational respiratory therapists, occupational physical therapists, etc. They would have their own governance.

AK: When you speak of subsidiary organizations, are you referring to these being separate organizations entirely or sections or components under the general ACOEM umbrella?

Bill: Somewhere in between. Sections belong to ACOEM. The ACOEM Board of Directors does have a shared responsibility with Sections. Components, on the other hand, have a relationship with ACOEM. ACOEM collects dues; however, components have their own separate bylaws and governance. We are thinking of these organizations as somewhere close to the components in their structure; we have to figure all that out. But we do want to give them an environment where they can share and discuss issues affecting them and then bring them to ACOEM.

AK: Apart from inclusivity, what other initiatives would you like to share with our readership?

Bill: Collaboration is my other big focus. It sounds a lot like inclusivity. We have various committees, sub committees, task forces and special interest sections. What I am looking for is more collaboration between these different entities. And, it is happening. For example, a council working on a specific project at times reaches out to a section, say Medical Center occupational health, to get their expertise. Or, for example, the Council of Public Affairs relied on a paper by the Council of Scientific Affairs to advise the State of Michigan on their appeal to Michigan OSHA to revise their lead standards. So, that’s my goal – to improve internal communication between different ACOEM entities, resulting in a better outcome, a better “product”.

AK: Excellent! During your inaugural address as ACOEM’s new president, you spoke about energy plateaus and transitions. Can you comment briefly on those?

Bill: We all have day jobs; we are essentially volunteers here. Just as US Presidents change with terms but the State Department stays the same, similarly the ACOEM core staff stays the same but leadership changes. We have a new CEO. It takes about a year to learn, grow and set new policies. During Dr. Yarborough’s term as President, we were in a plateau state with all the changes. Now, I have the pleasure to see the changes “blossoming”. Bill Bruce, our new Executive Director, has tremendous energy and our staff are excited and engaged. We are going to see some significant changes in ACOEM in the next year or two with fresh ideas and fresh blood. So that’s why I am excited to see the possibilities unfold.

AK: You gave an example of thermal physics where ice changes to water and water to steam. I guess what you are essentially saying is that those energy plateaus are inevitable but an essential part of change to get on to the next growth phase.

Bill: Yes, and the adjustments that go along with that are essential to move ahead again. I am not saying that we have gone backwards, certainly not. We continue to grow. Our expansion into the federal realm has been enormous; that’s due to our man in Washington DC – Patrick O’Connor; his contributions and his connections are a big help. It used to be that we had to go to Congress and appeal to them to listen to us, now they come to us and are asking for our input and advice. This is a total reversal. We are not a large organization by any means, but they recognize that we have the expertise and that this is not what a lot of physicians do, in the regulatory realm and they are recognizing that.

AK: So, we are being heard, more....

Bill: Yes, we are!

AK: That’s very good. This kind of ties into my next question. We talk about challenges all the time, but I wanted to ask you to comment on a few positive things that you as the president or ACOEM as an organization have been involved in, such as, you just mentioned, increased visibility in Washington, DC.

Bill: Today, here, we had orthopedists speaking at this conference referring to the thousands of shoulder replacements they have performed. Most of medicine deals with one patient at a time. Occupational medicine organizations like us have the opportunity to move the needle for entire populations, not just one individual at a time. That is the beauty of this - you develop a position paper to change a statute or change an OSHA standard and that is a contribution on a national / population level. This is very satisfying....to use your medical training and expertise to really make a difference in the health and safety of workers in the country. There isn’t another specialty that can say things like that.

AK: I agree. Moving on......I am going to ask you to comment in a few words on the following categories as they pertain to ACOEM:
Collaboration (I think we already addressed that): Essential

Innovation: Painful but inevitable. Dr. Joe Fanucchi helped develop a model for the first ACOEM website and at that time, the BOD rejected it, not once but repeatedly, year after year. To even think that was a good idea at that time was laughable.

Information Technology: Again painful (think EMRs!) but transformative. We have to realize what it can do once it starts working well.

Membership / Member engagement: Members are our lifeline. The biggest issue now is to define what our membership means. Who are our members? That is where inclusivity comes in.

International engagement / leadership / collaboration: In just the past 5 years, with our International Occupational Medicine Society Collaborative, this has opened the eyes of our members with regards to what goes on in the rest of the world. For me, one of the most enriching things is to represent ACOEM internationally.

Partnership (with our brethren, across related disciplines): We have to rebuild some of those relationships. For example, we have common interests with, and we need industrial hygienists as our partners. We have no ties with the Osteopathic Occupational Medicine association - why? This needs to change.

AK: What would you want to say to medical students, OEM residents and the newest members of our profession?

Bill: Keep your eyes open. There is a whole range of opportunities in medicine. Even if you start out in one field / one specialty, consider the fact that there are opportunities to do something else, to collaborate.

AK: Lastly, anything for our NECOEM members.....

Bill: “Keep the home fires burning”. I believe that NECOEM is the flagship component that some other components can look to. Some other components are merging and NECOEM and its members are great examples to show how valuable it is to collaborate!

AK: Thank you Bill!

Bill: Thank you.

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Early return-to-work after musculoskeletal conditions: A pilot intervention program (RETAIN-CT) in Connecticut

Contributed by William S. Shaw, PhD, George V. Moore, MD MSc FACPM FACOEM, Michael Erdil, MD FACOEM, University of Connecticut Health Center; Adam Seidner, MD, MPH, The Hartford

The Disability Problem. The problem of work disability is well known to professionals in the occupational health arena. With an aging U.S. workforce, a higher rate of disabling chronic conditions, and a high demand for skilled and experienced workers to fill needed positions in industry, the burden of work disability has never been a more pressing issue for policymakers and government institutions. Federal spending for Social Security Disability Insurance (SSDI) has more than doubled since 2000, and 1 in 4 Americans in their 20s can now expect to be receiving SSDI disability benefits before age 67.

Of additional concern, unemployment is associated with increased risks for affected individuals of cardiovascular and mental health disorders, cancer and overall mortality. In the State of Connecticut, the number of workers on SSDI disability benefits has shown a sharp increase from 53,815 to 81,330 since 2000 (a 50% increase), while the State population grew by only 5 percent. This outpacing of disability recipients relative to the entry of new workers to
The RETAIN-CT system-level Return to Work (RTW) intervention program in Connecticut. To address the problem of growing CT workforce disability, the State made a successful bid for Federal funding to adopt a State-level intervention program (RETAIN-CT) designed to improve long-term RTW/Stay-At-Work (SAW) outcomes for workers with acute musculoskeletal disorders. This project represents a new multi-stakeholder coordinated effort among several State agencies, health care providers and insurers. The plan is to train CT DOL regional occupational health clinic providers, and for these clinics to become RETAIN-CT Training and Consultation Centers which will in turn, provide specialized training to community health care providers. Coordination through private insurers will allow the use of additional RTW resources, new project-specific billing codes for early RTW planning and to collect work disability outcome data. In the Phase I study, 500 disability insurance claimants from The Hartford insurance company will be studied, with half receiving care from a trained RETAIN-CT provider, and RTW coordinator services will be offered as an adjunct to conventional medical care. The challenges of returning to work after musculoskeletal pain. Like many other medical conditions, an episode of low back pain (LBP), upper extremity pain, or other musculoskeletal conditions can create a need for individuals to adjust habits and lifestyles temporarily while trying to maintain basic physical, social, and vocational activities. If pain persists, successful adaptation may require a clearer understanding of the pain vs. function, attention to coping and self-care strategies, learning to overcome functional problems, and utilizing available supports and resources wisely. Interventions that promote worker self-efficacy by improving coping strategies, identifying more options through problem-solving, engaging the support of employers, and involving workers using participatory methods, are likely to result in improved sense of confidence, well-being, early and sustainable RTW and better long-term health and occupational outcomes.

What are the elements of the RETAIN-CT initiative? The RETAIN-CT initiative is modeled after the successful Washington Department of Labor and Industries Centers of Occupational Health and Education (COHE) program. At the individual level, the RETAIN-CT program is guided by personal behavior change principles with an emphasis on self-efficacy beliefs related to pain, function and work. RETAIN-CT key system-level elements include existing resources (e.g., organizational capacity within CT State government, occupational health clinics, local clinician expertise, and strengths of the local insurance and disability systems) and new RETAIN-CT resources (e.g., financial incentives for providers to participate in RTW planning, technical support, clinician training; and availability of additional RTW specialists). Providers will ensure best medical practice and be more involved and supported in RTW planning efforts. Insurance case managers will act as early telephonic RTW coordinators and provide proactive lost time tracking and employer coordination in the first few weeks of the claim, and RETAIN-CT field-based RTW coordinators will be called upon to provide a more individualized and participatory approach to job modification and RTW after one month of work absence.

Project timeline and contact information. Phase I of the RETAIN-CT study will be conducted over an 18-month period starting October 1, 2018. If the pilot phase of the study shows a high level of feasibility, engagement of stakeholders and positive outcomes for workers to facilitate early RTW, then the State will compete for a Phase II effort that would involve roll-out of the project with multiple insurers across all regions of the State. For more information about the study, please contact Karen Quesnel at the Connecticut Department of Labor (karen.quesnel@ct.gov; 860-263-6527) or William Shaw at the University of Connecticut Health Center (wshaw@uchc.edu, 860-679-8946).
Acknowledgements. The cooperative agreement for the RETAIN-CT study is fully funded by the United States Department of Labor, Office of Disability Employment Policy in the amount of $2,111,269.00 under Cooperative Agreement No. OD32541187549. This document does not necessarily reflect the views or policies of the U.S. Department of Labor, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The authors are faculty members in the Division of Occupational and Environmental Medicine at the University of Connecticut Health Center.

Recommended websites on related topics:  
https://www.dol.gov/odep/  
https://www.dol.gov/odep/return-to-work/  
https://www.rtwmatters.org/  
https://askjan.org/  
https://www.choosingwisely.org  
https://blogs.cdc.gov/niosh-science-blog/2017/04/12/worker-recovery/  
https://www.iwh.on.ca/workplace-disability-management  

Recommended journal articles:
- Jurisic M et al. ACOEM Position Statement. The Personal Physician's Role in Helping Patients With Medical Conditions Stay at Work or Return to Work. JOEM 2017

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**Ron and Jay's Truck Stop, or Go? February 2019**

By Drs. R. Blum and J. Poliner

To all our Commercial Driver Medical Examiners … this column is for YOU! Have an interesting question or problem case to share in a future newsletter? Do you have any other thoughts or opinions about these cases presented in this article? Send them to Newsletter Editor, Susan Upham, MD, MPH at supham@roadrunner.com.

**Case 1:** A driver presents for a DOT exam and reports on his history that his chronic pain is controlled with methadone. The CDME does not pass him and advises that he seek a medication change from his personal physician. He returns in a few weeks, having been changed from methadone to Percocet. However, when the treating physician is presented with the new CMV Driver Medication Form [MCSA-5895], he refuses to complete it. Without this documentation, the CDME does not pass the driver, and the driver accuses him of depriving him of his livelihood.

**Ron and Jay:** The CDME acted appropriately. Note that it is important to document the basis for decision making at each step. The recommendation should indicate that a medication change should be to a non-imparing alternative. Furthermore, one should establish the clinical basis for the use of strong analgesic medication, as the underlying condition may be potentially disqualifying. Lacking supportive documentation from the treating physician, the CDME would be ill advised to clear the driver. Even with supportive documentation, the CDME must make an independent determination. This driver’s recent use of strong opioids, and the natural history of such use, suggests that this driver is likely to continue using these products.

Thanks to our faculty colleague, Robert Swotinsky MD, who opines that in such a situation, “It's not unreasonable to expect some evidence of abstinence before issuing the card.”

**Case 2:** A 17-year-old student presents for an FMCSA examination, as it is a prerequisite of his CDL training class. As he is only seventeen, he is too young to drive for the DOT (minimum of 21 years of age for Federal
Ron and Jay: There are several qualifying parameters for drivers stipulated by the DOT regulations, including age (21 or over for Federal qualification), ability to speak and understand English, comprehension of traffic signals, ability to safely operate a commercial motor vehicle, and to pass a road test, for examples. None of these are medical issues. Their assessment is the responsibility of the employer, not the CDME.

As clinicians, our role is limited to determining whether the applicant is medically qualified to perform the functions of a commercial driver. Thus, it is perfectly appropriate to perform the examination on one who may not be qualified for reasons other than medical and establish whether they are clinically qualified. In fact, it is not unusual for CMV driver candidates to obtain medical clearance before they have acquired a CDL. As you deem it appropriate, you may choose to notify an employer of your concern regarding an applicant’s non-clinical qualifications, but you are under no obligation to do so.

ADVISORY: Update on National Registry of Certified Medical Examiner Refresher Training

By Ron and Jay

NECOEM members who are CMEs have inquired about the refresher training that was to be completed five years after initial certification. The FMCSA has recently released the following advisory:

“The rollout of the required refresher training has been delayed. FMCSA is working with a course trainer for the development of the material. The material will be provided online, through your National Registry account, and there will be no charge to take this training. The ME will be able to complete the training over several sessions (it does not need to be completed all at once). The current Training Organizations (such as NECOEM) will not be performing this refresher training.

The National Registry system will identify certified Medical Examiners that meet the rulemaking requirement for this refresher training. When the ME is eligible to take the training and the ME logs into their account, the system will provide a navigation link to this online training. Once the training is completed, the ME record in the NR will automatically be updated with this refresher training. Reminder emails will be sent by FMCSA prior to the deadline.

When a Medical Examiner Administrative Assistant (MEAA) connects to an ME that is eligible to take this training, this information will appear in the MEAA account. However, the MEAA will NOT be able to take the training on behalf of the ME.”

A Special Event

Our newest Board of Directors member, Dr. Shilpa Gowda, shares her experience as a delegate to the American Medical Association (AMA)
As a newly elected representative from the ACOEM Residents and Recent Graduates (RRG) Section, I had the pleasure of attending the AMA’s House of Delegates annual meeting in June 2018, held at the Hyatt Regency in Chicago, IL. Additional members in attendance from the ACOEM RRG section included Major Brian Shiozawa, MD, currently an occupational medicine resident at the Uniformed Services University of Health Sciences in Bethesda, MD, and Allison Jones, MD, past president of ACOEM RRG section, chair of ACOEM’s RRG Section Outreach, and the first ever elected delegate to AMA-YPS to represent ACOEM within the house of medicine. This was my first time attending this meeting and I knew little of the typical proceedings of such events. I had scarcely known that the policies and stances of the AMA were decided at such meetings, but felt fortunate to participate in the proceedings, in however modest of a capacity. Due to clinical responsibilities, I arrived a little late to the first day of the meeting. However, Allison had attended these meetings before and was armed with a stack of policies for me to review. We spent that first evening focusing on sixteen of these, as ACOEM section delegates to the AMA, and determined what our positions should be.

Examples of resolutions for discussion were Deferred Action for Childhood Arrivals (DACA) and parent-child border separations, policies for International Medical Graduates (IMGs), as well as important public health topics such as newborn screenings, FDA regulations, and cancer treatments. Interestingly, one resolution discussed inclusion of individuals with disabilities in graduate medical education programs. Dr. Shiozawa was in attendance during the discussion of this resolution. He noted that several audience members came forth in support of inclusion of individuals with disabilities in residency training. However, he took an opposing stance, noting the potential impact on patient safety. Although I was not present for this resolution, I noted how Brian’s stance highlighted the special role that occupational medicine physicians play. While his stance might be perceived as "cold hearted", as occupational medicine physicians we must weigh such priorities against public safety concerns. Notably, this resolution was referred for further study after deliberation.

An AMA Interim meeting was subsequently held in November 2018 at the Gaylord Hotel in National Harbor, MD, which I was not able to attend due to clinical responsibilities. Dr. Shiozawa attended however, and noted that 11 resolutions were of relevance, many related to current events at the national level. One sought to relabel the term “physician assisted suicide” as “medical aid in dying,” perhaps legitimizing the controversial practice in circumstances of terminal illness. Another sought to define gender as a spectrum rather than a binary assignment, an issue that has been on the national stage. Others discussed issues relevant to physicians and physicians-in-training, such as burnout and financial burdens. I think that all physicians can probably relate to such topics on some level, and I am currently working with my medical director, Dr. Kenji Saito, on tackling...
some of these concerns. Another resolution discussed the delegation of informed consent. One resolution proposed increasing rural resident rotations. I find this resolution interesting as a physician who currently serves patients in rural areas. As someone who completed medical school and residency training primarily in urban areas, except for a rural community medicine rotation at Block Island, I recognize that my current practice of caring for patients in rural areas requires diagnostic and triage abilities as well as awareness of slightly different patient needs than does caring for patients in urban areas. I think that more physicians should be trained in rural areas particularly given the shortage of rural area physicians, which may only increase over the coming years. Perhaps there should be greater incentives for physicians to practice in rural areas. Another interesting resolution discussed related to increasing discussion of nutrition in medical encounters. Brian reported that he spoke in favor of this resolution on account of the importance of nutrition to health; however, others opposed it on account of lack of time in medical encounters and delegation of nutrition instruction to nutritionists. Ultimately, AMA’s Reference Committee voted against the resolution because of an existing AMA policy recommending nutrition education. Personally, I support a discussion of nutrition in relevant medical encounters. Myths about nutrition are prevalent, especially in this age in which we are told to follow various diets and given conflicting information about what is “good” and “bad” for our health. I recall a recent Grand Rounds presentation at my hospital employer advocating the ketogenic diet, and another advocating the Mediterranean diet. Based on my personal research, the most important nutritional principles are variety, moderation, and whole foods. It is the duty of the physician to help patients navigate the plethora of nutritional advice in current circumstances and to make execution feasible given their access to resources. Better yet would be promotion of efforts to increase access to food on a large scale, which is something that my medical director and I have tried to do, particularly for those in rural Maine, working on a grant through our hospital for a “food garden.” I think that all physicians, as leaders in health, can play a key role in their communities. In this era of widely prevalent rates of obesity and related chronic diseases, the role of nutritional education is ever more apparent.

Other topics of public health relevance addressed at the Interim Meeting included contraception for female inmates and contraception coverage for postpartum women through Medicaid, typically in underserved populations with reduced access to birth control resources. Additional topics included the opioid epidemic and electronic health records. Another topic discussed was gender and minority disparities in medicine, a topic that has turned out to have personal relevance. One “hot button” topic was the implementation of artificial intelligence in healthcare; how can we use it artfully to enhance our capabilities rather than replace us?

The 2019 annual meeting of the AMA HOD will be held again at the Hyatt Regency in Chicago, IL from June 8 through June 12. I hope to be in attendance for this meeting, representing ACOEM. I think that this representation is particularly important if we want OEM to be increasingly recognized as a medical specialty. Besides being a voice for occupational medicine providers, I hope to be a voice for young women physicians of minority races. Additionally, I hope to immerse myself in the positive, ambitious vibe that I found so captivating and comforting last year and to continue to weld personal connections across different medical specialties. In this era of division and controversy, it is a good reminder that at the end of the day, we are all on the same team and that OEM physicians play an important role in the team. We can and should therefore work together collaboratively to further human health.

Shilpa Gowda, MD, MPH, is board certified in OEM and currently works at Workplace Health in Maine. She is on the Medical Staff at Maine General Health. Dr. Gowda was elected to the NECOEM Board of Directors in 2018.
William C. “Bill” Bruce has been the Executive Director of ACOEM for a year and a half. I had the privilege of recently interviewing him while attending NECOEM’s Annual Conference on 11/29/18.

**The challenge of evolving technology** We reviewed some of the initiatives that have taken place which enhance ACOEM’s website. He reports that the biggest challenges have been “distance recovery” and catching up with technology to remain up-to-date. Along with this comes some additional good news! He does not expect membership dues to increase as a result of the upgrade, as the funding for the upgrade has been obtained from ACOEM’s reserves.

**Website undergoes major upgrade** Bill is optimistic about this upgrade. The ACOEM board has been extremely enthusiastic and supportive. This has involved the input of 40 members. The new website is up and running, and all are encouraged to visit it at [https://acoem.org/](https://acoem.org/). The new website is user-friendly, and he is confident that members will like it.

The largest effort to date involved focusing on digital transformation and technology of the site, which had not been updated for several years. The most noticeable changes are the new platform, as well as modification of the membership database and the “My ACOEM” portal. This overhaul uses new “group” icons, including a new physician directory and one for non-members and employers. Also, there is a “path” for exploring the website by non-members and employers. It is mobile responsive and has an associated mobile app. This will make communicating with other members easy! It also integrates with the AOHC app and makes the process for claiming CME extremely easy. It also includes member promotion activities.

**Membership feedback is welcome!** Of course, there could be some glitches in the system. As such, feedback from our members is welcome and necessary changes will be implemented as needed.
Khaul Khatlani, MD, MSc

Profile: Dr. Khatlani is a first year Clinical Fellow at Yale Occupational and Medicine Program. She completed her medical education from DOW Medical College, Karachi, Pakistan with honors. She decided to pursue training in Epidemiology at Johns Hopkins under the prestigious Fogarty Fellowship in Trauma and Injury Prevention. During her Fellowship, she conducted a community-based study on “Intimate Partner Violence”, in rural areas of Pakistan. After completion of her Fellowship, she continued working at Johns Hopkins School of Public Health as a Post-Doctoral Fellow in International Health, focusing on injury prevention among children in Bangladesh. Her passion for public health led her to pursue a Preventive Medicine Residency at Griffin Hospital-Yale School of Medicine, CT. Her exposure to Occupational and Environmental Medicine (OEM) in residency intrigued her to work towards the prevention of workplace injuries. She enjoys clinical OEM because it allows her to interact with a unique patient population and apply her investigative skills in examining complex epidemiological issues.

Poster: Evaluating Parkinson’s Disease Risk in a Retired Military Petroleum Specialist: A Scoping Review by Khaul Khatlani, MD, MSc, Brian Linde, MD, MPH & Raphael Lefkowitz, MD, MPH.

A 78-year-old male veteran, recently diagnosed with Parkinson’s Disease (PD), with no known risk factors, presented to our clinic to evaluate his occupational exposures for potential causality. The veteran served in the U.S Army and was deployed in Germany from 1962-64 as a Petroleum Specialist, whereby he had extensive exposure to jet fuels. Although several occupational and environmental exposures are implicated in the etiology of the disease, there are no studies on jet fuel exposure and PD specifically. Therefore, we performed a detailed literature search to evaluate the relationship between hydrocarbons, the main constituent of jet fuels, and PD.

Overall, the evidence was mixed. Although a handful of studies demonstrated a positive association between hydrocarbons and PD, there were important limitations in study design (case reports and case control mainly), sample size, and heterogeneity in the exposure measurement. Given the limitations in the existing evidence regarding the association between hydrocarbons and PD, there is a need for large epidemiological studies with accurate assessment of long-term hydrocarbon exposure to comprehend the mechanism of hydrocarbon toxicity. It is pertinent that occupational medicine physicians thoroughly evaluate veterans for all possible occupational and environmental exposures and also be aware of the limitations in scientific literature.
NECOEM AC Poster Presenter: Justin Yang, MD, MPH

**PROFILE:** Justin (Chih Chao) Yang, MD MPH is a graduate of Harvard Chan School Class of 2012 and now is in his second year at the Harvard TH Chan School of Public Health Occupational and Environmental Medicine Residency. He completed his internal medicine residency at Tufts/Steward St. Elizabeth's Medical Center in June 2017 and is Board-Certified in Internal Medicine. For the past 7 years, he has worked with Dr. S. Kales and co-authored several publications related to cardiovascular health among firefighters. Throughout the years, he also received several trainee awards, including Best Poster and Excellence in Teaching, from the American College of Physicians, Tufts Medical School and Harvard.

**POSTER:** **Push-ups as a predictor of future cardiovascular events and functional capacity: a 10-year retrospective cohort study.** Robust evidence associates increased physical fitness with a lower risk of cardiovascular disease (CVD) events and improved longevity; however, few have studied simple, low-cost measures of fitness assessment. We conducted a retrospective cohort study (2000-2010) among occupationally active career firefighters and evaluated the association between push-up capacity and subsequent CVD. During the ten-year period, 37 CVD-related outcomes (8,601 person-years) and 224 composite outcome events (8,668 person-years) were reported. We found significant negative associations between increasing push-up capacity and CVD and composite events. Participants able to complete >40 push-ups had a 96% reduction in incident CVD event risk (IRR 0.04, 95% CI: 0.01–0.36). This 10-year study demonstrated the utility of using push-ups, a low-cost and simple measure, in predicting future cardiovascular events and functional capacity.

This study was published on JAMA Network Open on February 15th, 2019 and received significant media attention globally. ([https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2724778](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2724778))
PROFILE: Justine Lazatin is a third-year medical student at the University of New England College of Osteopathic Medicine. Awarded the Humanism in Medicine Scholarship and inducted into the Gold Humanism Honor Society, Justine is distinguished for her demonstration of excellence in clinical care, leadership, and dedication to service. With an undergraduate degree in Biology and Dance from SUNY Geneseo (2015), her passions for both the sciences and the arts have led her to develop a special interest in medical student, resident, and physician well-being. In pursuing her clinical rotations at Maine General Medical Center, she learned about the field of Occupational and Environmental Medicine when she met her mentor Dr. Kenji Saito. As they began commiserating over the burnout epidemic in the health care field today, she knew that the NECOEM conference would be the perfect venue to begin exploring research-based methods for developing resiliency in medicine.

POSTER: Justine presented her literature review findings at the annual NECOEM conference. “Medical Student and Physician Burnout: Overcoming the Demands of Medical Practice with Resiliency” co-authored by Dr. Saito, MD, JD and Erin Landry, BS. The latest research shows that up to 50% of physicians and medical students meet burnout criteria, which is associated with an increased risk for all-cause sickness absence, depression, and suicidal ideation. Furthermore, current data suggest that physician burnout negatively affects patient health outcomes with possible broad economic implications. While the culture of medical practice certainly contributes to physician burnout, encouraging data suggest that burnout can be combatted with resiliency, a learned skill through training and practice. Data suggest that physicians who participated in a CME program on mindfulness showed improvements in measures of well-being and the delivery of patient centered care. Still, in a poll that captured responses from 1,052 various health-care related organizations, only 14% reported having an engagement program for all staff to reduce burnout. Burnout among healthcare workers is unsustainable and directly impacts the health of the patients we care for. Further research on the efficacy of resiliency training for all staff in the health care field is crucial for the well-being of providers and our future patient populations.
ANSWER TO LAST ISSUE’S “WHAT IS IT?”

**Solvent (Chemical):** Carbon disulfide, used in the manufacture of viscose rayon. Rayon is the oldest “manufactured” fiber, although the source (cellulose) is plant based.

The retinal image shows microaneurysms which are thought to be characteristic of CS2 induced microangiopathy which is also postulated to be the mechanism that results in nephropathy.

The following members sent in correct responses:

**Jonathan Borak, MD**
**Teresa Allen, MD**
**Glenn Pransky, MD**

Congratulations!!

“What/Who Is It” features a series of trivia, facts, figures, etc. related to the field of occupational medicine. If you have any such interesting or fun-filled material, please e-mail Dr. Karandikar at dr_abhik@yahoo.com. All material should be related to the specialty of occupational and environmental medicine and have an educational, inspirational, historic or other relevant value.

Diagram credits:
https://www.textileflowchart.com/2015/05/flow-chart-of-viscose-rayon.html
http://www.madehow.com/VOLUME-1/RAYON.html
http://textilelearner.blogspot.com/2013/06/viscose-rayon-manufacturing-process.html
http://plastiquarian.com/?PAGE_ID=14338
https://www.researchgate.net/figure/retinal-fundus-image-containing-dr-lesions_fi2_261037783

Memorium

**Dr. Joshua Schia Schwartzberg**
3/21/46 – 1/10/19

The NECOEM membership as well as family and friends mourn the recent passing of our colleague, NECOEM member, and former board member (2015-2016) Dr. J. Schwartzberg. He established and practiced occupational medicine at the Champlain Medical Urgent Care Center in S. Burlington, Vermont. Many NECOEM members fondly remembered him:
• “Very sad news indeed. Having interacted with him during Board meetings and later, over the phone, you could not miss his enthusiasm and love for his clinical practice and his clinic and all things life…” – A. Karandikar

• “Very sad. I think the paragraph from his obituary (copied here) is inspiring for all of us. The following is an excerpt from the January 24, 2019 Adirondack Daily Enterprise.

  “Dr. Joshua Schia Schwartzberg, “Doc Josh,” was born after World War II in Munich, Germany, on March 21, 1946. He died Thursday, Jan. 10, 2019... Josh would not want flowers, or a donation given to any particular cause in his name; instead he would ask that anyone reading this obituary strive to live a life that consistently gives back to others through careers, actions and relationships. His email footer reads, “Life is not about waiting for the storm to pass ... it’s about learning how to dance in the rain.” He spent every day living like it was his last, and even after he received his pancreatic cancer diagnosis, he continued to live his life how he always had: seeing patients, spending time with family and friends, fishing, cooking, taking care of his plants and taking time every day to stop and smell life’s roses.” - D. Berube

• “I was very moved by the obituary. I enjoyed meeting him and recall having dinner with him at the NEOCOEM meeting a few years ago. He loved commuting in his plane across Lake Champlain to his office in Burlington. Just so sad, but inspiring words here too.” - D. Sparhawk

• “So sorry to learn of the inevitable. Josh never accepted defeat, always displaying a positive outlook. When he was diagnosed and left the Board, I offered to help him in his practice, and while VT credentialing proved formidable and he was able to secure alternate assistance, it led to our spending a week together that summer, between chemo treatments, with him flying us to a remote lake in eastern Quebec for some great scenery, comradery, and trout fishing. I wasn’t able to join him on a repeat performance he scheduled last spring, but as recently as this past December, he acknowledged he was still working and while the chemotherapy was a burden, he was forging ahead. He was a kindred spirit and I will miss him.” - R. Blum

• His full obituary can be found at http://www.adirondackdailyenterprise.com/obituaries/2019/01/dr-joshua-schwartzberg/

Good bye Josh – Shalom