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INSIDE: 1998 SALARY SURVEY RESULTS

INSIDE

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Here's reassuring news: Most lawsuits under the ADA are won by employers

But charges still can be costly — don't relax policies

Employers win almost all lawsuits involving the Americans with Disabilities Act (ADA), according to a recent analysis. The study suggests that the ADA is not nearly the problem that employers and occupational health providers thought it would be, and some observers suggest that it also means employers and providers are adhering to the law so well that only weak cases are taken to trial.

The numbers are remarkably lopsided. Employers prevailed in 92% of all court decisions in ADA cases filed since the first in 1992, according to an analysis conducted by the American Bar Association in Washington, DC. That figure applies to cases that have gone through the appeals process and not been overturned as of March 31, 1998. The result is consistent with another analysis by the federal Equal Employment Opportunity Commission (EEOC), which showed that employers prevailed in 86% of the administrative complaints resolved by the EEOC. The EEOC oversees the ADA.

Of 1,200 ADA case decisions on file with the American Bar Association (ABA), one party prevailed in 760 (63.3%). In 440 cases (36%), no final decision had been made at the time of the analysis. The discrimination issue was decided on the merits in only 528 (44%) of the 1,200 cases. Of the 760 cases with one party prevailing over the other, employers prevailed in 92.11%, leaving employees to prevail only 7.89% of the time.

Those numbers involve only the cases actually taken to litigation. The EEOC statistics show that there have been 83,158 complaints resolved

EXECUTIVE SUMMARY

Employers have won 92% of all court decisions regarding the Americans with Disabilities Act (ADA). The numbers are encouraging and they suggest:

- The ADA isn't the terrible burden for employers that some feared, at least in terms of final court awards.
- Current efforts to comply are meeting with courts' approval.
- You can't let your guard down with ADA compliance.

from 1992 to 1997, and 86.4% were resolved in the employer's favor. Only 13.6% were resolved in the employee's favor.

Numbers show there's little to worry about

The American Bar Association analysis shows that all the hand wringing and whining by employers about the ADA in the past years were unjustified, says **John Parry**, JD, director of the ABA's Commission on Mental and Physical Disability Law and the main analyst. The ABA had been saying for years that it appeared employees were at a distinct disadvantage when pursuing ADA lawsuits, but doubts from outsiders resulted in the group conducting the formal analysis. The results were not unexpected, but Parry says he did not realize the analysis would show employers winning a whopping 92% of the cases.

"This runs against what most people were thinking," he tells *Occupational Health Management*. "Attorneys for employers have been making arguments that the ADA is extremely burdensome to their clients, but I just don't think you can make that argument anymore. These numbers show that just isn't true."

Parry says the difference between the 92% of cases won judicially by employers and the 86% won administratively is minor, and the employee is very unlikely to win either way. He says the results indicate that the ADA is written, or interpreted by the EEOC and the courts, in a way that makes it almost impossible for a disabled person to prove his or her case.

The biggest hurdle for a claimant is the definition of disability, Parry says. While the seemingly broad definition is intended to cover almost anyone who might suffer job discrimination as the result of a disability, he says the definition is full of Catch-22s that often result in automatic dismissals before the cases can be heard on the merits. Employees usually lose their cases because of these six facets of the ADA:

- ❒ substantial limitation;
- ❒ otherwise qualified;
- ❒ collateral estoppel;
- ❒ the definition of "employer";
- ❒ the burden of proof;
- ❒ undue burden.

The fundamental Catch-22 of the ADA is that it requires the claimant to prove that the disability is substantially limiting, yet it also requires the claimant to prove that he or she is able to carry out the essential job functions. While that may not be such a major hurdle in the workplace, it becomes a huge obstacle when trying to prove a claim administratively or in court. Parry also says the doctrine of collateral estoppel is a major problem because several courts have denied claims of disabled employees because they applied for federal or state disability benefits. The application requires the person to declare that he or she is unable to work, and so the courts sometimes conclude on that basis that the person is not otherwise qualified to carry out the essential job functions.

"The result is that people sometimes have to decide whether to file a discrimination suit, which can take a long time to resolve and they won't have any income in the meantime, or file for disability income and risk losing their discrimination claims," Parry says.

Mitsubishi settles $3 million lawsuit

Even though the numbers are overwhelmingly in favor of employers when it comes to ADA complaints, that does not mean employers and occupational health providers should let their guard down. Quite to the contrary, some observers suggest that the employers prevail so often because they are taking the necessary steps to comply with the ADA, leaving only baseless claims to be argued in court. Relaxing your standards would only increase the chances that legitimate ADA claims would be filed.

And even though the study results suggest

COMING IN FUTURE MONTHS

■ Workers comp payable for day-off injury?

■ Courts clamp down on firing after return to work

■ Respirator rule changes may ease burden

■ Expanding your services: What to offer

■ On-site testing ideas that work

SOURCES

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that employers are likely to win an ADA case, a single case can hit an employer very hard. That was the lesson learned by Mitsubishi Motor Manufacturing of America, which recently settled a lawsuit for $3 million. The settlement was the largest of its kind since the ADA was introduced in 1992, according to information supplied by the EEOC.

The lawsuit was filed by 87 job applicants who thought the company's Normal, IL, plant violated the ADA by screening out some applicants with disabilities such as diabetes and asthma. Mitsubishi spokeswoman **Gael O'Brien** tells *OHM*, "We believed we were in compliance with the ADA. Where we were not, we have agreed with the EEOC to ensure that we fully comply."

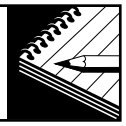
In addition to the $3 million payment to the workers, Mitsubishi agreed to revise its policies and procedures for hiring. O'Brien declined to provide more information on what changes would be made.

Sears uses hotline for ADA complaints

On the other side of the issue, Sears is being lauded for its efforts to improve ADA compliance. The giant retailer, based in Chicago, has what the ABA calls a progressive, proactive program for reporting possible ADA violations through a hotline that employees can use. Called the "Ethics Assist Line," the hotline is promoted to all Sears employees as a way to report, and seek help with, possible violations of the ADA and other regulatory or ethical matters. Even companies that do business with Sears can use the hotline to report possible violations, says **Paula Davis**, a spokeswoman for Sears. The line has been in operation since 1994 and receives up to 18,000 calls a year from Sears' 300,000 employees, plus vendors.

"When they call the line, advisors will take the information and recommend next steps or ways to further research a concern," Davis says. "They can report the information anonymously if they wish, but we try to put them in touch with local management or with someone at the corporate office." ■

GUEST COLUMN



What now? Try remote OHS development

By **Mike Grosh**
President
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Even if you are proud of your program, sooner or later, every successful occupational health program will face the question: What now? There are always new clients to be secured, new businesses developing in the marketplace, and new incremental services that should be integrated relative to regulatory changes and consumer need. But when utilization is at or near capacity and revenue and profits meet or exceed targets, it's generally time to consider the "What now?" question.

Most such successful, mature programs are led by aggressive market-oriented management teams with a history and culture of new business development. In the highly competitive environment now facing most health care organizations, it's hard to imagine suitable justification for simply resting on one's laurels. Stagnation is not an option. Should the occupational medicine program go forward in different markets? Or with new products and services? Or should the program's excess resources be reallocated to other parent programs that may benefit from the energy, momentum, and experience represented by that group?

The answer often is that you should look at expanding your services into another location. There are several strong arguments in favor of

adjacent occupational health service development in this instance. Generally, the parent organization's service area encompasses and far exceeds the service area of the initial occupational health program development. Therefore, secondary benefit to the parent, such as referral to specialists and inpatient/outpatient services, can be enhanced nearly as well in a remote occupational health program development as in the case with the first development. Also, in many instances, significant relationships with employers and payers originally secured through the successful initial development can be leveraged easily in the subsequent development in adjacent markets.

Clients may benefit from a second location

Client employers may have other locations or associations through trade groups and professional organizations with operations of a similar kind in the new market. Payers who have enjoyed a positive relationship with the initial occupational health program may themselves have employer/clients who could benefit from well-managed occupational health resources in their local markets. Likewise, marketing information management and financial management systems, which were initially developed to support the primary operation, will transfer easily to subsequent operations.

Consequently, unless the initial occupational health program exists in an island market, such as in some rural settings, sufficient opportunity exists to support developments of a remote cookie-cutter representation of the primary occupational health program. From a pure investment standpoint, subsequent developments enjoy an existing robust set of resources that you can leverage for expeditious and economical development in subsequent operations. Therefore, initial capitalization and return on investment should be significantly enhanced as compared to the original development.

Also, strategic and tactical advantage is gained for both the occupational medicine program and its parent organization in many instances through subsequent occupational health program development. Assuming that initial development took place in close geographical proximity to the parent hospital or health care system, subsequent development will further that system's outreach into adjacent markets. Similarly, the remote occupational health program will provide a buffer to development by competition.

Consider the scenario in which two major health care systems are operational in a large metropolitan area, with primary hospital facilities positioned approximately 25 miles apart. Each has developed successful occupational health services on the main campus. Each program serves employers in a 10-mile radius around the occupational health facility. Each, then, has the opportunity to take a position in the adjacent market, which will both support the continued success of the initial occupational health program and secure a competitive outpost in the relatively underserved area that exists beyond the primary markets of both operations. Clearly, the first developer of subsequent facilities would realize strategic and tactical gain.

In another scenario, a rural hospital serving a community of some 50,000 individuals has developed an occupational health program intrinsic to its emergency department that services virtually all the employers in its community. The next closest small community is some 50 miles away and is serviced by a similarly configured community hospital and occupational health program. Little would be gained by the subsequent development of secondary occupational health resources by either institution in either market.

Location is key to success

Where should subsequent development take place? The late Tip O'Neill, former speaker of the House, said that "all politics is local." The same could be said for occupational health services. Therefore, one should appropriately apply the old real estate maxim: "location, location, location." In our experience, something on the order of 80% of employers surveyed across the country indicate that they use occupational health resources within a three-mile radius of their facilities.

Thus, one primary consideration when looking at location for subsequent development are the demographic conditions of the adjacent markets. Seek markets with a high concentration of employment. Distribution of that employment should favor density in the higher utilization industries such as manufacturing and transportation. Survey employers regarding their levels of satisfaction with current providers and perceived need for new resources. Profile and analyze existing competition.

Finally, give careful consideration to the parent organization's development plans in its adjacent

market. Are there plans for outpatient medical facilities, outpatient surgery centers, or additional rehab locations? Is the organization pursuing a primary care or other managed care network? Are existing insurance products offered by the parent institution, which may support certain geographical locations over others?

In the final analysis, the formula for site location is simple: Look for locations that offer maximum access to desirable populations, maximum visibility, optimal proximity to the desired market, minimal competitive threat, and optimal coordination with other parent organization outreach initiatives.

New facility may need to be more aggressive

So what will the subsequent operation look like as compared to the initial occupational health program development? Generally, the further away from the parent facilities, the more independent and robust the operation will need to be.

Where the original facility may have been able to support market need through limited hours of operation and coordinated use of the emergency department, a subsequent development may need to look at more extended hours or even a 24-hour availability.

Where the initial entity may have been able to coordinate physical therapy and diagnostics with local hospital-based resources, the subsequent and remote operation may need to integrate those services within the locus of the primary care operation.

Where possible, this manner of support services can be secured through close coordination with other system outpatient resources. But where no such opportunity exists, the occupational health program needs to consider carefully its ability to deliver a full-service, one-stop resource to the remote market. In some instances, systems for information management and billing will need to be developed for the first time in subsequent operations, where the initial development relied upon parent organization resources in its first iteration.

Additionally, occupational health program directors may be, for the first time, finding themselves dealing with more prosaic issues of housekeeping, security, laundry, and other matters. You will need to address these issues in planning as necessary resources to a secondary and remote operation.

Importantly, the dynamics of the occupational health program will change considerably with subsequent development as well. Marketing now needs to develop business relationships in environments that may not be as familiar with the parent organization and the associated occupational health program.

The medical director now faces the challenge of recruiting and supervising other physicians and health care professionals in a manner that will deliver a consistent and seamless program under the professional service of a variety of individuals.

So who should drive subsequent development in these instances? Clearly, the existing management staff in a successful occupational health program have great insight into all the salient issues that would come to fore in the consideration and planning of subsequent operations. They know their market, they know their competition, they know their capacities, and they know their program.

However, to ensure a full visibility of the forest as well as the trees, we strongly recommend utilizing outside resources to assist in feasibility study and planning site location to ensure a truly objective evaluation of the concept and optimal configuration of any such development.

Quick returns on your investment

To summarize, if the initial program has truly reached its stride and enjoys a state of excess capacity, it usually makes sense to consider subsequent development in adjacent markets. One must carefully analyze that development in terms of the opportunity, both to the occupational health program and its parent organization, and carefully plan the subsequent development on the basis of employer demographics, existing competition, and other critical, strategic, and tactical components.

When the conditions are right and the appropriate planning ensues, in all likelihood, subsequently developments will result in operations that require less capitalization and result in quicker return on investment than the initial developments.

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Reader Question

Slow days signal need to change marketing tactics

Question: Despite being established, having a very good marketing person, and being part of a network, our occupational health clinic is just not busy enough 20% of the time. Naturally, there is some variation in the workload so that some days are quite busy, but these slow days are hurting our bottom line. How could we increase business on these slow days?

Answer: First, you need to identify the underlying cause for why you're not busy 20% of the time. That step will make all the difference when you to try to fix the problem, says **Georgia Casciato**, a health care business development consultant in Downers Grove, IL.

Is the problem cyclical? That is, do you consistently have 20% slow days? Or do the slow days fall into more of a seasonal or daily pattern? Seasonal patterns can be related to the type of employers you serve, and the daily factors — such as every Monday being a slow day — can be traced to a number of problems, including poor scheduling by your staff. To look at seasonal patterns, Casciato suggests a review of at least one year and preferably several years of business.

"Some industries are very seasonal, like the construction business, and there isn't much you can do to stop that," she says. "But if you see that there are regular times of year when you can expect business to fall off, that might be a good opportunity to use some of your existing staff for other programs to serve your customers. That's the time to do those things you otherwise don't think you have time to do."

EXECUTIVE SUMMARY

No matter how good you think your marketing staff are, there's something wrong if you have slow days. Consider these factors:

- exactly when slow times occur;
- whether your marketer is devoting appropriate time to new accounts and existing customers;
- how aggressive your marketer is.

She cautions that customer service is not just a spare time activity. Waiting for patients to come in the door with a broken arm is only part of occupational health; your staff must be working constantly to drum up new business from existing clients. And of course, your sales staff should always be working aggressively to bring in new clients.

"If there's not enough business coming in, you have to ask whether you have enough customers to support your program," Casciato says. "And if you do have enough, you need to ask whether you work your customers well. Do you stay in front of them in the absence of injury care with flu shots, work site health screenings, work site walk-throughs, and other ways you can serve your customers?"

Assuming you have a reasonable number of clients signed onto your program, your best bet for increasing business is to increase utilization of the clinic by your current customers. One tactic is to look for additional decision makers in the organization, besides the contact person you deal with on a regular basis. Don't just go around that contact person, but find out who else is in a position to send business your way. If your contact does not handle work site health promotions and executive physicals, for instance, ask who does. And if the company does not provide executive physicals, suggest that they start.

You also might want to look at the overall goal of your program before solving the problem of slow business, Casciato says. If your goal is to stand alone and make a profit, your solution might be different than if your goal is to break even while bringing in high ticket revenue streams to your parent hospital.

The problem might lie with your sales staff. Even if you think your sales staff are doing a great job, it might be worthwhile to take a closer look. How do you do that? Casciato offers these suggestions:

- **Conduct an audit of sales activities.**

The audit can be internal, or you can bring in an outside auditor. This would involve taking a close look at the number of sales calls made in a day, whether the person is contacting true decision makers and scheduling appointments instead of just dropping in.

- **Look at the salesperson's organization.**

This step can be telling about how efficient and aggressive an employee is in seeking new clients and servicing existing customers. Take a look at whatever scheduling system the sales staff use.

SOURCES

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See how many appointments are scheduled, and how many things are on the "to do" list.

• **Check for aggressiveness in making sales calls.**

On average, a salesperson can be expected to make four in-person sales calls per day. Lots of factors can offset that, but four per day is realistic. Also, check to see if the person is calling on the right people. Is he or she calling on the best new prospects and the customers who can offer the most business? Or is the salesperson calling on the people who are just easier to deal with and less of a challenge?

• **Make sure there is a customer service plan for existing accounts.**

A formal system allows the salesperson to continually get in front of the customers to upsell them. The customer service plan is where you will get most of your utilization because getting a customer to commit to your program is only the beginning of the game. "When they commit to you, that gives you permission to play the game. Now you've got to play," Casciato says. "The ones who think the game is done at that point are the ones losing business to other programs."

Remember that health care sales is a specialty profession. Make sure you have someone on board who has the training and experience to do the job, not just someone who got thrown into the position as the occupational health program grew. It also is possible that your program has grown so much that your salesperson is too busy servicing existing customers to aggressively solicit new ones. That's not the case in most programs, but if you find that is the problem, it's time to hire another sales professional.

Remember that the sales staff must be good, but they also must be prolific. Doing an excellent sales job with just a few clients won't do you much good. "Quality is good, but without the quantity balance you're just not going to get enough volume in your clinic," Casciato says.

(Editor's note: Do you have a question you would like to see answered in an upcoming issue? Please use the reader question form enclosed in this issue to send us your questions.) ■

Survey shows most discourage back belts

The results of the 1998 *Occupational Health Management* Reader Survey show that back support belts are falling out of favor rapidly, and Internet use is now a standard part of most practices.

OHM surveyed approximately 800 readers in April 1998. The results give a glimpse into the changing face of occupational medicine. Here are a few highlights:

✔ Sixty percent of the respondents "discourage" the use of back support belts for the prevention of back injuries. Another 24% said they were undecided about whether to recommend the belts. None said they "recommend" the belts, but 2.7% "strongly recommend" them.

✔ Ergonomics consulting is a "small part" of your program for 63% and a "major part" for 34%.

✔ For 55% of the respondents, small companies make up most of their clients. For 22%, large companies make up most of their clients, and 19% say their clients are equally divided.

✔ Most of the respondents (55%) have more than 300 clients, 18% have 151 to 300 clients, and 21% have 51 to 150.

✔ The great majority of respondents have access to the Internet. Thirty-two percent say they have Internet access both at home and at work, 27% have access at home, and 27% have access at work. Only 13% say they have no Internet access.

✔ Massage therapy is popular among occupational health programs, with 40% saying they offer it or plan to within the next year. Twenty percent offer or plan to offer chiropractic care, and 10% say the same about acupuncture. No one reports offering or planning to offer herbal medicine. ■

OSHA ergonomic standard may be released in '99

A federal ergonomics rule might be published in summer 1999, according to **Charles Jeffress**, PhD, administrator of the Occupational Safety and Health Administration (OSHA) in Washington, DC.

The rule will be released only if Congress does

not stand in the way, as it has done in recent years. OSHA has worked on a comprehensive ergonomics rule for American workplaces since 1992, and it came close to releasing a rule in the past few years. But Congressional leaders smacked OSHA sharply on the hand and threatened to eliminate nearly all federal funding for OSHA if it released the rule. With such a strong rebuke, OSHA backed down.

But in a recent speech to the safety and health committee of the National Turkey Federation and the National Broiler Council in Washington, DC, Jeffress said OSHA plans to publish an ergonomics rule in the summer of 1999. He noted that Congress has not forbidden OSHA to publish the ergonomics rule next summer but still could block it by threatening the OSHA budget again, according to a transcript of the Jeffress speech obtained by *Occupational Health Management*.

Congress blocked the rule in the past because industry leaders complained that it was unnecessary, not supported by research, and would be cost prohibitive. Jeffress' comments were made to poultry industry representatives because their workers are considered among the most at risk for repetitive motion injuries. He mentioned that a recent OSHA investigation found high risk for repetitive motion injuries in the poultry industry, but that back injuries accounted for 40% of injuries.

He urged the safety representatives to make simple, "common sense fixes." Reducing slips and falls would greatly reduce the number of back injuries, he said. High-traction boots are one good preventive measure. Another Jeffress recommendation: Keep that chicken fat off the floor. ■

AAOHN encourages TB surveillance by OH nurses

The American Association of Occupational Health Nurses (AAOHN) in Atlanta is encouraging the Occupational Safety and Health Administration (OSHA) in Washington, DC, to require surveillance programs for tuberculosis (TB) in the workplace, but without requiring physician oversight.

Comments submitted to OSHA by AAOHN indicate that the occupational health nursing organization supports a standard that would protect employees from exposure to tuberculosis "through effective TB surveillance conducted by competent, qualified health care professionals." OSHA is reviewing comments on its proposed standard.

In supporting the promulgation of a tuberculosis standard, AAOHN states that it "urges OSHA to recognize the differentiation between health surveillance activities and medical treatment and follow-up in this and all future health standards." The statement goes on to say, "AAOHN strongly opposes any changes that would require physician supervision of TB surveillance programs and the independent practice of occupational health nurses, which would only serve to restrict employers' and employees' access to all qualified health care providers."

AAOHN also recommends that OSHA clarify the definition of "work-related exposure" in the final standard. The association says that employers should bear the burden of showing that an exposure was not work-related or incur the costs of medical removal of employees suffering occupational exposures.

A survey conducted recently by AAOHN indicates that in 71% of the work sites surveyed, occupational health nurses hold overall responsibility for health surveillance. ■

Traffic accidents increase 20% over 5 years

On-the-job traffic accidents have increased nearly 20% over the past five years and are the No. 1 cause of death in the workplace, according to new analysis of data released by the National Safety Council in Itasca, IL.

Workplace injuries and deaths overall have remained stable in the past five years despite an expanding economy. The National Safety Council analyzed figures from the Bureau of Labor Statistics in Washington, DC. Those figures show that 6,218 people died on the job in 1997, and 6,217 died on the job in 1992.

Fatal injuries to women and workers 45 and older have increased. Nonfatal injuries decreased from 6.8 million in 1992 to 6.2 million in 1996. The construction industry had the greatest increase in deaths in the five-year period, which is possibly the result of the growing economy. ■

Egg processor agrees to fines, improvements

A large egg processor in Ohio has agreed to pay $425,000 fines and to make several significant safety improvements at its work sites, following charges from the federal Occupational Safety and Health Administration (OSHA).

After inspecting the AgriGeneral Company's facility in Croton, OH, OSHA cited the company on Aug. 18, 1997, for willful violations of the general duty clause and temporary labor camp standards, along with serious violations of the standards on bloodborne pathogens, confined spaces, hazard communications, and agricultural equipment standards. The proposed penalties initially totaled $1.07 million. The 7,000-acre Croton facility, now operating as Buckeye Egg Farm, employs 365 workers in producing, processing, and distributing about 4.5 million eggs daily from almost 10 million chickens. A similar facility in nearby Mount Victory was not included in the original inspection but will be included in the promised safety improvements.

The violations involved overexposing employees to ammonia and organic dust, including failure to have an effective respirator program, machine guarding deficiencies, fall hazards, bloodborne pathogens, and confined space hazards. The company has agreed to correct those deficiencies and also to conduct semi-annual safety and health inspections through December 2000. Extensive employee education programs are part of the agreement, along with an improved respirator program and a commitment to provide migrant workers with safe drinking water. ■

OSHA changes rule on methylene chloride

Recent changes in the federal safety rule on methylene chloride may make it much easier for employers to comply. Some deadlines for compliance have been extended, and changes may make it possible for some employers to avoid respirator use.

The Occupational Safety and Health Administration (OSHA) recently amended the 1997 methylene chloride standard, largely in response to a request by the United Auto Workers union. One modification adds temporary medical removal benefits for employees who are temporarily removed or transferred to another job because of a medical determination that exposure to methylene chloride may aggravate or contribute to the employee's existing skin, heart, liver, or neurological disease.

The rule affects 92,000 firms employing about 250,000 workers. Methylene chloride vapors can cause cancer and worsen cardiac disease.

Other changes involve the start-up dates by which some employers using methylene chloride must achieve the permissible exposure limits by using engineering controls. As originally enacted, the rule required companies with fewer than 20 employees to complete installation of engineering controls by April 10, 2000. Larger employers originally had earlier deadlines, but now the rule has been revised to allow some employers with 20 to 49 employees to also wait until the April 10, 2000, deadline.

That deadline change applies to employers using methylene chloride in these instances:

- ❒ furniture refinishing;
- ❒ aircraft paint stripping;
- ❒ formulation of products containing methylene chloride;
- ❒ use of methylene chloride-based adhesives for boat building and repair;
- ❒ recreational vehicle manufacturing;
- ❒ van conversion or upholstering;
- ❒ construction work involving the restoration and preservation of buildings;
- ❒ painting and paint removal;
- ❒ cabinet making;
- ❒ floor refinishing or resurfacing.

OSHA also is granting shorter extensions of the existing engineering control deadlines for certain larger employers. Most of these changes allow employers 12 to 24 months more time than was given in the original standard.

Another modification defers the requirement to use respirators to achieve the eight-hour time-weighted average permissible exposure limit of 25 ppm until the engineer control deadlines have passed. This is a very important change because it will enable some employers to avoid respirator use entirely. The only respirators effective against methylene chloride are supplied air respirators, which are relatively expensive. OSHA says it is better for employers to use their limited resources on permanent engineering controls.

In the interim period, employers must meet the short-term exposure limit of 125 ppm over a

15-minute period by using some combination of engineering controls, work practice controls, and/or respirator use. They also must institute feasible work practices to lower exposure levels. ■

Andersen RE, Franckowiak SC, Snyder J, et al. **Can inexpensive signs encourage the use of stairs? Results from a community intervention.** *Ann Intern Med* 1998; 129:363-369.

The addition of simple signs encouraging stair use can significantly increase physical activity in the workplace, according to this study from The Johns Hopkins University School of Medicine and The Johns Hopkins Weight Management Center, both in Baltimore.

Health professionals have long advocated walking and taking the stairs as modest but effective ways to increase physical activity and overall health. To determine how easy or difficult it is to change people's habits with regard to stairs, the researchers studied 17,901 people in a shopping mall in which escalators and stairs were adjacent. The stairway consisted of 10 stairs, a 6-foot landing, and 10 more stairs.

The authors first studied stair use as a baseline. They found that, overall, 4.8% of shoppers used the stairs instead of the escalator. Those under 40 years old were slightly more likely to use the stairs, and men and women used the stairs at about the same rate. With shoppers who did not appear overweight, 5.4% used the stairs. But only 3.8% of overweight shoppers used the stairs. Race had some effect, with 5.1% of white shoppers and 4.1% of black shoppers using the stairs.

Then the researchers placed a 22-inch by 28-inch sign on an easel beside the escalator and stairs. It featured a caricature of a heart and the caption, "Your heart needs exercise. Use the stairs." After a month of watching shoppers again, the authors found that stair use increased significantly to 6.9% overall.

To study the effects of a weight loss message rather than a general health message, the researchers replaced the first sign with one featuring a caricature of a woman at the top of set of stairs. She wore pants that were too large for her thin waistline, and the caption read, "Improve your waistline. Use the stairs." With that sign, stair use increased significantly to 7.2%.

There were some interesting differences in the way people reacted to the signs. Shoppers over age 40 responded by taking the stairs more often than younger shoppers, and women responded more than men to the health benefits sign. They responded almost equally well to the weight loss sign. Overweight people were more likely to take the stairs after seeing the weight loss sign than the general health sign.

One result was particularly troubling to the researchers, and they have no explanation. Stair use among blacks actually decreased from 4.1% to 3.4% with the health benefits sign, as stair use among whites increased from 5.1% to 7.5%. With the weight loss sign, blacks increased use of the stairs modestly from 4.1% to 5%, but whites went from 5.1% to 7.8%.

The researchers conclude that simple, low-cost signs can significantly increase stair use, but they say educating blacks is an additional challenge. ▼

Chang MH, Chiang HT, Lee SS, et al. **Oral drug of choice in carpal tunnel syndrome.** *Neurology* 1998; 51:390-393.

Steroids are more effective than other drug choices in treating carpal tunnel syndrome (CTS), according to these researchers in Taiwan.

They studied the most commonly used oral medications for CTS, using diuretics, nonsteroidal anti-inflammatory drugs (NSAIDs), and steroids. A prospective, randomized, double-blind, placebo-controlled study included patients with clinical symptoms of CTS confirmed by standard electrodiagnosis.

The baseline assessments included a standardized symptom questionnaire in which the patient rated five categories of symptoms on a scale of 0 to 10. The total score in each of the five categories was used as the global symptom score.

The 73 patients were randomized to one of four treatment protocols: four weeks of placebo, four weeks of diuretic, four weeks of slow-release NSAID, or two weeks of 20 mg prednisolone daily and then two weeks of 10 mg daily. During and after the treatment, the patients' global symptom scores were compared to their baselines.

The researchers found that after two weeks of treatment, the steroid group had a significantly greater reduction in the average global symptom

score than the placebo, NSAID, and diuretic groups. After four weeks of treatment, significant reduction in symptoms continued only in the steroid treatment group. Four weeks of steroid treatment caused the patients' global symptom scores to decrease from an average 27.9 to 10. The placebo, diuretic, and NSAID groups had no significant reduction from their baseline scores after four weeks.

"For patients with mild to moderate CTS who opt for conservative treatment, corticosteroids are of greater benefit," the researchers conclude. ▼

Smith JM, Conwit RA, Blumenthal PD. **Ulnar nerve injury associated with removal of Norplant implants.** *Contraception* 1998; 57:99-101.

The removal of Norplant contraceptive implants can cause an ulnar nerve injury that might be misinterpreted as a cumulative trauma disorder, according to this study from The Johns Hopkins University School of Medicine in Baltimore.

The authors report the case of a 23-year-old woman who underwent what should have been a routine procedure to remove her Norplant implants. They had been inserted 3.5 years earlier with no complications, and she had experienced no pain, paresthesias, or weakness in the arms, hands, or fingers. The implants were directly over the most anterior aspect of the triceps muscle, with the lower end of the implants lying approximately 5 cm from the medial condyle of the elbow.

The woman's gynecologist prepared to remove the implants in the standard fashion by first injecting the site with 3 ml of 1% lidocaine. The patient immediately complained of a sharp pain shooting down the medial aspect of the lower arm to the fourth and fifth digits. After incising and exploring for obvious nerve injury and finding none, the doctor removed the implants.

At the end of the procedure, the patient reported a slightly painful tingling sensation. She returned four days later with persistent pain, definite weakness of the ulnar-innervated muscles of the right hand, and numbness over the hypothenar eminence and especially the fourth and fifth digits. A clinical neurologic evaluation was consistent with an ulnar nerve injury. Nerve conduction studies revealed normal ulnar motor conduction velocity but reduced compound muscle action potential amplitude.

Her condition improved over a two-month follow-up. The traumatic injury was traced to improper placement of the implants, leading to damage to the neurovascular structures at the time of removal. The authors note that significant symptoms may not appear for up to eight days after removal and can mimic other injuries involving the ulnar nerve. "If nerve injury is suspected, immediate nerve conduction studies appear to be warranted because they establish a baseline for comparison," they say. "We conclude that if pain, paresthesia, or anesthesia persists four to six weeks after the injury, repeat nerve conduction studies may be of prognostic significance and may help outline a plan for rehabilitation." ▼

Sokejima S, Kagamimori S. **The effect of working hours on the incidence of myocardial infarctions.** *British Medical J* 1998; 317:775-780.

Both unusually short working hours and unusually long working hours appear to increase male workers' likelihood of having acute myocardial infarctions, according to this research from Toyama

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(Japan) Medical and Pharmaceutical University.

The researchers studied the work schedules of 200 men ages 30 to 69 who had been hospitalized for acute myocardial infarction, along with 300 male controls with similar ages and occupations. The analysis revealed that men working less than seven hours a day were 3.07 times as likely to have suffered a heart attack than those working seven to nine hours per day. Those spending more than 11 hours a day on the job were 2.44 times more likely to have had heart attacks than those working seven to nine hours a day.

The risk associated with longer working hours was easier to explain than with shorter hours. "A possible biological explanation for long working hours eliciting an acute myocardial infarction might be changes in the activity of the autonomic nervous system," the researchers say. They also suggest that changes in average working hours could affect the circadian rhythm of autonomic nerve activity and failure of the autonomic nervous system to adapt adequately to the change could increase the risk of myocardial infarction.

To account for the risk associated with shorter hours, the researchers theorize that the men may have had premorbid conditions and may have experienced unemployment during the study period. They note that other studies have shown that the risk of myocardial infarction increases during unemployment. ■