AMERICAN HEALTH CONSULTANTS®

Occupational Health Management™

A monthly advisory for occupational health programs

IN THIS ISSUE

OCTOBER 2002
VOL. 12, NO. 10 (pages 109-120)
NOW AVAILABLE ON-LINE!
www.ahcpub.com/online.html

For more information, call: (800) 688-2421

Special Series: Where Have We Been, and Where Are We Going?

Has corporate influence limited occ-med docs?

Most docs unable to advocate on behalf of workers

(Editor's note: Our cover story this month is the first in a two-part series on the field of occupational health. In this first article, we will discuss a controversial article published in the American Journal of Preventive Medicine *that paints a bleak picture of the industry, attributing current failures to practitioners. In next month's cover story, we will take a look at the prospects for the future of the profession and the megatrends that will help shape that future. As always, we are anxious to hear from you. E-mail us at alison.allen@ahcpub.com to let us know how you feel about the comments your colleagues make on our pages and the challenges you are facing in your own professional endeavors.)*

With an ominously titled treatise on the fate of occupational medicine, a physician at the University of California, San Francisco (UCSF) School of Medicine has engendered a flood of comments in electronic communities across the country. "The Rise and Fall of Occupational Medicine in the United States,"[1] published in the April issue of the *American Journal of Preventive Medicine,* asserts, among other things, that:

- "Industry money and influence pervade every aspect of occupational medicine";
- "In this financially charged environment, it is difficult to find an occupational physician with the temerity to speak out on behalf of workers."

The author, **Joseph LaDou**, MD, of UCSF's division of occupational and environmental medicine,

Continued from cover page

presents. It's a segment of the employee population we can't afford to ignore, warns Jonathan Chang, MD, FACSM, clinical assistant professor at the University of Southern California in Los Angeles. Not only are these workers subject to any number of acute injuries that can keep them out of work for weeks, but even relatively minor problems can cut into their effectiveness at work. . . . 114

Changing work force will impact employee training
With the proportion of Hispanic workers in the U.S. work force expected to increase by more than one-third by 2008 and the number of Asian workers expected to rise by about 40%, employers must make sure employees *understand* their health and safety training — not just that they receive it, according to occupational health experts. This may include providing written materials in the employees' native language, using an interpreter during training sessions, and considering culture and literacy 115

PAs, some physicians happy with their jobs
Not all health care workers are unhappy with their jobs. While recent surveys indicate that low levels of job satisfaction are one of the keys to the current nursing shortage, studies of physicians and PAs offer some encouraging news. Both of them show relatively high levels of job and career satisfaction — for physicians, those levels are higher in certain specialties and lower in others, while for PAs it's big smiles across the board 117

COMING IN FUTURE ISSUES

- What does the future hold for occupational health professionals?
- Making a science out of proving your contribution to the organization's bottom line
- How to develop a medical surveillance program to detect potential health problems
- Report says better protection is needed for disaster rescue workers
- The unique workers' comp, disability challenges of a unionized workplace

paints a picture of a profession that experienced rising hopes in the 1970s as governmental agencies sought to transform occupational medicine into a major clinical specialty, but now must deal with the reality of a promise unfulfilled.

Among LaDou's other claims:

• "For the most part, occupational physicians . . . are not coming together to plan a future for a specialty that is failing to thrive."

• The other occupational health team members generally consider the occupational physician the most expendable member of the team.

• Occupational health nurses are gradually taking over industry positions formerly held by occupational physicians.

• The small number of new board-certified specialists (fewer than 100 a year) "is far below that which would be required merely to replace the loss by retirement of older board-certified physicians."

Whether they agree or disagree with the key points LaDou makes in his paper, occupational health professionals say the dialogue inspired by its publication is good for the profession.

"He has definitely raised the flag on some important issues," says **Deborah V. DiBenedetto**, president of the Atlanta-based American Association of Occupational Health Nurses (AAOHN). "It's a good, thought-provoking article. It opens up the opportunity for dialogue and demonstrates that we can develop a common voice on how to go forward."

As to her own thoughts on LaDou's paper, DiBenedetto notes that "there are kernels of truth in what he says, but he has taken his points to the extreme."

William B. Patterson, MD, MPH, FACOEM, chair, medical policy board at OH+R, Hingham, MA, agrees with DiBenedetto that "it is absolutely healthy in general for us to have this dialogue." Upon reviewing several e-mails to electronic communities in which he participates, Patterson notes "there were some occupational health nurses who felt he was too negative, others who felt his predictions of the demise of occupational medicine were premature and that new avenues will open up."

A mixed reaction

Patterson's reactions to LaDou's claims that occupational health is dominated by corporate America are decidedly mixed. "My first reaction is that he is absolutely correct that the number of

physicians working for corporations has dropped dramatically. Everybody knows that," he says.

However, he adds, "From a specialty point of view, that is potentially good. What that means is that practicing occupational physicians are less dependent than they used to be on one employer. I think he is quite correct to point out that since corporations control the vast majority of the money spent in occupational medicine, there is a tremendous pressure upon practicing occupational health professionals to work cooperatively with corporations."

Patterson adds that the substantial majority of corporations with whom he has worked have been interested first in quality medical care and second in an honest opinion. "If I give an employer an honest opinion that will stand up to scrutiny, I'm doing them a favor," he asserts. "If I give them a slanted opinion that could be overturned by a physician advocating for the employee, I'm not doing them any favors."

This is not to say that some corporations don't exert undo pressure on occupational health professionals. In his article, LaDou cites the example of David Kern, MD, an occupational physician at Brown University and physician at The Memorial Hospital, both in Providence, RI. Kern investigated interstitial lung disease occurring in nylon flockers at Microfibres, a Pawtucket, RI-based multinational corporation. Microfibres and hospital administrators tried to block Brown's presentation of his findings in 1997, but he continued his efforts and brought NIOSH into the investigation.

Although he ultimately received a Health Achievement award from the American College of Occupational and Environmental Medicine (ACOEM), Kern was relieved of his position as head of the Brown occupational medicine program, the clinic was closed and he was ultimately dismissed.

"Yes, there are clients like Microfibres," says Patterson. "There are unfortunately individual managers in some companies who exploit workers or explicitly seek opinions favorable to the employer. My own approach, and what I recommend for our company's providers, is to stick with your own opinion. If it becomes intolerable, you need to refuse to provide services to that client."

Seeking compliant providers?

There are some areas of the discussion of corporate domination where Patterson parts company with LaDou. "I disagree with him when he says industry will continue to hire the most compliant and most cost-effective health care providers," he says. "I say it's reasonable to hire cost-effective practitioners who provide good care and get employees back to work quickly. I would distinguish between corporate relationships and compliant relationships."

DiBenedetto concedes that the tendency for companies to look for the most cost-effective providers has helped occupational health nurses and hurt physicians, at least in the workplace. "A nurse with the right training and experience can play a different role, for a better price and be more cost-effective, but will also know when to call in a physician," she explains.

Nurses are replacing doctors, but providing a different service — not as clinicians but as occupational health professionals, she continues. "We can do absolutely everything a physician can do except practice medicine. With the outsourcing of a lot of services, you don't need the clinician in-house. Companies are looking more for a practitioner with the management and business skills to manage programs."

Which gets us back to cost-effectiveness. "Doctors and nurses are in the business of providing hands-on care. All of us are advocates for patient and safety welfare," DiBenedetto says. "Businesses recognize it's to their advantage to keep employees healthy and productive, but they don't want to hear the bleeding-heart side of things. They want to see cause and effect, return on investment, and [its linkage to] keeping employees productive, healthy, and on the job."

Occupational health professionals have to advocate for patients appropriately and based on a business perspective, DiBenedetto continues. "You have to speak the language of business so that the corporations understand and see the value of what you are doing," she observes. "Sure, we don't want anyone hurt, but how do you quantify that? How do you avoid the increased cost of health and safety risks? Of absenteeism? We can definitely advocate for health and safety by showing the cost-benefit of putting in our programs."

But even a strong business case may not be enough, says Patterson. What might really be needed is an attitude adjustment on the part of corporate leaders. "One thing that bothers me is that occupational physicians ought to be more vocal in calling for training in ethical standards for corporate leaders, businessmen, and managers," says Patterson.

"Probably the best example is ergonomics," he

continues. "Employers have resisted standards from OSHA, despite the fact that ergonomics programs have proven to be cost effective."

Employers, he explains, often measure manager effectiveness by the number of recordable injuries that occur in the workplace. "Sometimes, pressure is put on docs to withhold prescription-strength anti-inflammatories so the event will not be OSHA-recordable. Or, they may assign people to restricted duty, which *is* recordable, without recording it. This is an example of a poor corporate practice that occupational physicians should be vocal about. They should be seeking more training of safety managers and human resource managers in this area. They have an ethical duty," Patterson asserts.

Changes in the wind

Patterson takes issue with LaDou's charge that physicians are not coming together to ensure a better future.

"ACOEM has made tremendous strides in the last five or six years," he says. "They have reached out to government and encouraged physicians to lobby and organize." He notes that there were "some administrative difficulties" at ACOEM that hurt its ability to take some actions it should have, but that these have been resolved.

Still, notes DiBenedetto, who joined ACOEM in the 1990s, 80% of the organization's membership were corporate physicians. That number now is only 15%-20%. "And fewer than that are pure occ-med docs," she says.

One positive sign, she notes, is a growing number of occupational health physicians going back to school to get their MBAs. "As nurses and physicians, we don't receive basic business skills as part of our professional training," she explains. "More and more docs are now looking at how to apply business knowledge within their practices. This will put them in a better position to advocate for their patients."

Patterson agrees. "To the degree that physicians use their education to advocate for effective health and safety measures, that's a positive," he says.

He's in accord with LaDou on another key strategy for strengthening the profession. "I completely agree with him in his support for alternative pathways for board certification," he says. "With the closing of occ-med residencies and a continued attraction of occupational medicine for mid-career physicians, the alternative pathways should be strengthened, not weakened. I think there will be a continued interest in occupational medicine by experienced family practitioners and emergency physicians who are looking for a change of lifestyle. Many come from strong clinical and good educational backgrounds, and there should be a way for them to become board-certified."

Many hospitals have such programs, he notes, "and for our part, we prefer to hire those physicians with formal [occupational medicine] training."

DiBenedetto sees an ongoing challenge for both occupational health nurses *and* physicians, noting that doctors and nurses both face marketplace challenges. "When I think of the shift of the marketplace, yes, physicians have definitely lost out [in terms of corporate positions], but we have, too, because we perform staff functions," she says. "It's more a result of the baby boomers deciding to do other things with their lives."

Finally, notes Patterson, some things are simply out of the hands of occupational health professionals. "Occupational medicine — more than any other specialty — is sensitive to the winds of political change," he observes. "For example, the current emphasis on bioterrorism is good for occupational medicine, but if we don't have a government that's supportive, we won't have support for research and residencies. Unfortunately, occupational medicine represents working people who lack political power, and you often get less support in Washington, DC, and in the state houses for common occupational injuries and illnesses than you do for rare cancers and rare diseases."

Reference

1. LaDou J. The rise and fall of occupational medicine in the United States. *Am J Prev Med* 2002; 22(4):285-295.

[For more information, contact:

• ***William B. Patterson**, MD, MPH, FACOEM, Chair, Medical Policy Board, OH+R, 175 Concord St., Suite 36, Hingham, MA 02403. Telephone: (781) 741-5175, ext. 234. Fax: (781) 741-5499. E-mail: bpatterson @ohplus.com.*

• ***Deborah V. DiBenedetto**, MBA, RN, COHN-S, ABDA, American Association of Occupational Health Nurses, 2920 Brandywine Road, Suite 100, Atlanta, GA 30341. Telephone: (770) 455-7757. Fax: (770) 455-7271. Web site: www.aaohn.org.]* ■

On-site pharmacy offers easy access, lower costs

Facility seen as natural adjunct to wellness program

When you've already got an extensive health-and-wellness program in place for your employees, what can you do to take your health-related services to the next level?

One option would be to follow the lead of StorageTek, a Louisville, CO-based company that delivers a broad range of storage solutions for digitized data. This past May, StorageTek marked the opening of an on-site pharmacy for its employees.

StorageTek management anticipates that the new facility will save employees money on their prescriptions, provide much easier access to prescription and pharmaceutical advisory services, and ultimately contribute to improved employee health.

"As you know, pharmaceutical costs are increasing at double-digit rates annually," notes **P.J. Hollister**, MSHA, manager of wellness services. "We saw this as an opportunity to enhance employee benefits and reduce costs."

The pharmacy is operated for StorageTek by CHD Meridian Healthcare, a Nashville, TN-based health care management company that designs, implements, and manages employer-sponsored medical centers, pharmacies, and occupational health programs at the workplace. It is open five days a week and is staffed by a fully licensed pharmacist and support staff.

StorageTek employees who use the pharmacy receive a 10% discount on their copayment or coinsurance, as well as additional personalized care, both clinically and from a cost perspective. "We have a mail-order plan as well as retail sales, and the on-site pharmacist will work with employees to show them which will be better in a given case," Hollister explains.

The next logical step

The pharmacy seemed like the next logical step for a company that already provided its 2,000 employees with a wide range of health and wellness services. "We started to think about it about two years ago, when we were approached by CHD Meridian," Hollister recalls. "We already had a wellness center that included on-site child care, an extensive fitness facility with free weights, Nautilus equipment, a lap pool, basketball, a three-mile outside track, volleyball, softball fields, lots of leagues, and stress-management and nutrition classes, and wellness coordinators who conduct personal profiles."

In addition, she notes, StorageTek has an on-site medical clinic, four full-time family medicine providers, chiropractors, an optometrist, physical therapy services, a dental hygienist, and a mental health counselor. "The core clinic staff are employees — the PAs, nurse practitioners, and support staff — while the rest are independent contractors," Hollister explains.

StorageTek is self-insured for its medical plan. "At the time we built our facility in 1992, we had a more manufacturing-oriented operation and we were more geared toward workers' comp, with the motivation being controlling costs," Hollister explains. "Now, 10 years later, workers' comp is less than 5% of the business, and we've grown the practice as a family practice for internal medicine to enhance the well-being of employees and to create savings on our medical plan. We have a PCP [primary care provider] in our point-of-service [POS] network, so 40% of the employees have chosen us."

With an extensive occupational health program and facility already in place, the pharmacy had a ready-made home. This makes the StorageTek operation even more unique. "For most of their clients, CHD Meridian runs an occupational health and/or family practice plus a pharmacy. We are one of the few where only a pharmacy needed to be carved out," Hollister says.

Reduced costs anticipated

Hollister says her company is expecting the pharmacy to help reduce costs based on the pro formas presented by CHD Meridian. "The essence is the lower ingredient cost," she says. "We're a closed-door pharmacy model — the pharmacy can only sell to us. In terms of what we pay pharmaceutical companies for the drugs, it [price schedule] is one of the lowest you can find."

The result, she says, "should be pretty good savings, even though we're incurring additional operational expenses."

The CHD Meridian pro forma shows that at different thresholds of utilization StorageTek will save different amounts of money. "After one year, we are projected to see a return on investment," says Hollister. "One of the reasons is we already had a facility; we just had to do a little remodeling."

The new pharmacy will offer the opportunity

for a number of health benefits, says Hollister. "Hopefully, there will be increased compliance, as well as people taking their meds correctly and an increased awareness of potential drug interactions. There will be a more personalized opportunity to check on things like that," she says. "Also, the pharmacist is able to work directly with our providers for the medical visits that we do here. It's a kind of unique arrangement that could translate into an additional health benefit."

Hollister says she and her colleagues have had numerous discussions about whether having the on-site pharmacy will actually improve compliance. "We'd like to think that's the case," she says. "We've only been open since May 15, and our pharmacy manager says that so far the amount of prescriptions not picked up is about same as at a normal pharmacy. However, the pharmacist does more follow-up calling than usual, and we will be measuring how many employees use their prescriptions."

An added advantage in terms of communication with employees is the fact that StorageTek is a high-tech company, says Hollister. "We have some great access to web sites for additional information. Our pharmacist can use them to further educate our employees, which is an added service."

So far, employee participation has been good. "It's what we had hoped for — for the first year, we estimated 50%," says Hollister. "The number of prescriptions filled in a day is moving in the right direction, and we have a lot of happy customers. The convenience and cost savings have translated into an enhanced benefit — something the company has done for its employees. Our whole wellness center conveys that message to the employees as well. To see a company investing in employee wellness at a time when the economy is not doing so well sent a nice message."

[For more information, contact:

*• **P.J. Hollister**, MSHA, Manager of Wellness Services, StorageTek, One StorageTek Drive, Louisville, CO 80028-0030. Telephone: (303) 673-3506.]* ■

Weekend warriors sport Monday-morning injuries

Even those who don't miss work can be affected

The term "weekend warrior" is catchy and perhaps even a bit humorous, but there's nothing funny about the impact their activities can have not only on their health but also on their work performance.

Just what is a weekend warrior? "My definition is someone who is normally fairly sedentary during the week because of work or other commitments, and then on the weekends cuts loose with an excess of physical activity," says **Jonathan Chang**, MD, FACSM, clinical assistant professor at the University of Southern California, Los Angeles, and Western University in Pomona, CA. Chang also is a member of the Olympics Sports Medicine Society.

These individuals tend to pay the price for their sporadic sports activities in terms muscle soreness, joint aches and pains, and frequent sports injuries that show up in the doctor's office, he adds.

"Beyond the usually significant aches and pains, the other conditions that may show up in the office are acute injuries, because these people are out of shape or too fatigued [to participate in sports properly]," He adds. "These include ligament sprains, cartilage tears, some fractures, rotator-cuff problems in the shoulder area, and all of the overuse syndromes we tend to get in every other part of our bodies."

Impact can vary

So the impact on a weekend warrior's work life can vary widely, but none of it is insignificant. "For someone who does the same activity every day, such as sitting at a desk, and decides to play in a volleyball tournament on the weekend, that kind of person can't get out of bed the next day," notes Chang.

How much work can they miss for minor injuries? "It's kind of injury-specific," he allows, "but for those people who have more active jobs that require lifting or who are on their feet a lot, if they are not in shape and participate in weekend athletic activities in the way we're describing, they will often miss one or two days of work depending on the injury."

And even if an employee is not actually out of work, their weekend activities still can impact their performance and productivity. "Let's just take a warehouse worker who has to lift 40- to 50-pound boxes all day long. If he plays a lot of basketball on the weekend, how much will he be able to lift?" Chang posits. "The effects could last for several days."

Despite the media attention that has been devoted to weekend warriors, the number of employees who continue this type of activity does not seem to be decreasing, he says. "There's a lot of information out there warning people of its evils, but either they don't take advice very well or they really are that busy."

Some of these individuals can be reached if you simply offer some kind of preventive program, says Chang. "If you have an in-house program, you have a better opportunity," he notes. "If your company or hospital takes physical fitness seriously, a gym is a very proactive way to do it."

He notes that with the cost of health care rising once again, large companies are doing all they can to keep employees healthy. "See if your company will apply preventive measures that can result in a healthier, more efficient and more productive work force," he offers.

With company programs, you have a little more control than if you simply relied on the individual employee, Chang says. "Inside a company, you can use peer pressure as well — particularly if your boss is participating," he explains.

Some employers, especially warehouse companies, have told employees that if they participate in a half-hour supervised, timed workout, they will be paid for that time. "This is a win-win situation," he says.

Stretching programs also can help, but they are a tough sell. "Everyone is so rushed in this country that they just don't want to do it, even though as we get older, everyone gets stiffer," Chang observes.

Education is key

Ironically, he says, the most important element is also the most difficult. "Education is the first thing you should do," Chang says, while noting that participation in such programs is often low. "Still, I'm not saying you shouldn't make the attempt," he advises. "You will reach some people. In occupational health, the more a program is pushed by the employers, the more employees you get — it has to come from the top."

In terms of interventions, they should be company-specific, says Chang. "For telecom companies — since most everyone at the worksite sits on their butts — you tend to get carpal tunnel syndrome and tennis elbow," he observes. "These companies want to emphasize more upper extremity stretching, rather than endurance training or strength training."

If you have a warehouse company, however, your employees need bigger, stronger muscles, as well as increased endurance. "These people need weight rooms and barbells," Chang says.

If, despite your best efforts, a weekend warrior comes down with an injury, occupational health professionals can still make a bad situation better, says Chang. "Yes, you can shorten the natural history of an injury if the employee is given anti-inflammatory meds, and their work is modified so as to not aggravate the injury," he notes. "And physical therapy modalities can improve the pain they are having. It's similar to the whiplash you get in car accident; if it is treated correctly, it all goes away. Instead of being out four to six weeks, the employee can be out two to three weeks."

{For more information, contact:

*• **Jonathan Chang**, MD, FACSM, 500 N. Garfield Ave., Suite 204, Monterey Park, CA 91754. Telephone: (626) 571-6658.]* ■

Keeping up with changing work force is essential

Language, literacy gaps may affect training

As hospitals hire growing numbers of foreign-born workers, occupational health professionals are facing an unprecedented challenge to adapt health and safety training.

The proportion of Hispanic workers in the U.S. work force is expected to increase by more than one-third by 2008, and the number of Asian workers will rise by about 40%, according to the Bureau of Labor Statistics. Overall, about one in 10 Americans was born in a foreign country, according to a recent U.S. Census report.

While some workers, such as Filipino nurses, are well educated and highly proficient in English, low-wage foreign-born employees may struggle with literacy even in their native language. The bottom line: Employers must make sure employees *understand* the health and safety training — not just that they receive it, experts stress.

That may include providing written materials in the employees' native language, using an interpreter during training sessions, and considering cultural and literacy issues, says **Sherry Baron**, MD, MPH, medical officer and co-team leader of special populations at risk for the National Institute

of Occupational Safety and Health (NIOSH) in the Cincinnati division office.

"No matter if the employees' first language is English or not, you must have training that they can understand," emphasizes **Sandra Elias**, RN, OHN, occupational health and workers' compensation consultant at St. Jude Heritage Occupational and Environmental Health Services in Fullerton, CA.

A lack of comprehension

New employees may be so agreeable that they nod politely when asked if they understand the information in a training session, but the consequences of that gentle evasion can be significant.

Piedmont Hospital in Atlanta hired a group of young men from Sudan who had been dubbed "The Lost Boys," because of their traumatic experiences after their villages had been destroyed. The men had high-school educations, and some had even attended college. While they speak English, "some of them understand better than others," says **Joyce Geddie**, RN, former manager of the hospital's employee health clinic. Their native language was an unusual African dialect that was not available from translation services.

As new employees in environmental services, they received the standard orientation as well as specific training in bloodborne pathogens. They acted as if they understood everything, even nodding during the training session, Geddie says.

But when one employee was observed pushing down on the trash with a gloved hand, Geddie realized the training would have to be repeated, this time with feedback focused on determining whether the employees understood.

"You need to be prepared for all the extra [things] you need to do," she says. Piedmont also has a large Hispanic work force and has conducted some training in Spanish. The Material Data Safety Sheets also are in Spanish, she says.

Web sites have Spanish versions

As hospitals and other employers recognize the importance of training geared toward immigrant workers, more resources are becoming available.

The U.S. Occupational Safety and Health Administration (OSHA) announced efforts to improve safety for Hispanic workers and launched a Spanish-language web site. Employees now can file OSHA complaints in Spanish.

The NIOSH division office in Morgantown, WV, just launched a Spanish-language web site with links to other health and safety information in Spanish. The web site includes about 25 NIOSH documents that have been translated into Spanish, as well as some documents from OSHA. **(For more information, see editor's note, at the end of the article.)**

"It was really in response to a large demand from employers and from our own discussions with people in industry and labor. There was a big need for [material in the] Spanish language," says **Marie Haring Sweeney**, PhD, chief of the document development branch in the education and information division.

The Centers for Disease Control and Prevention (CDC) in Atlanta has published Vaccine Information Statements (VISs) for DTaP, hepatitis B, and pneumococcal conjugate vaccines in 12 languages, and has information on hepatitis A, B, and C in Spanish and Turkish. The CDC also has developed a Spanish-language web site.

Meanwhile, employers sometimes hire translators for specific orientation materials. "I am not bilingual," says Elias, so she sometimes works with a translator as she conducts a session. Even if the employees seem to have good English skills, it may be helpful for them to have printed material in their native language, she says.

If you have workers who actually are employed by an outside contractor, such as food services or security personnel, you are not absolved from responsibility to make sure they were properly trained, Elias notes. "I'd ask for their training documentation and an outline of their training," she says. "I'd also watch and see what they're doing."

Language isn't the only barrier that can affect comprehension of training material. Sometimes cultural differences may affect how employees interpret policies.

"Trainers may take for granted information about disease or disease causation, but it may be very different in another culture," Baron says.

In one case, researchers observed that farm workers weren't washing their hands after working in the fields. After some discussion with workers, they learned that the workers mistakenly believed that they could get arthritis or other conditions from washing with cold water.

Low-wage earners who are recent immigrants also may have lower literacy levels, Baron says. Training methods should take that into account.

"Some training methods that may be more participatory, involving the use of lots of drawings and explanations and activities, probably work

well for everybody, but [they work] particularly well for individuals who come from backgrounds where they're not as attuned to reading documents," Baron points out.

It may seem like a new burden to provide foreign-language materials or training, but keep in mind that foreign workers usually represent a growing segment of the community served by the hospital, she says. "You'll be hiring people as part of an ever-increasing size of some ethnic community."

(Editor's note: The Spanish-version OSHA web site is at www.osha.gov, and the NIOSH web site is available at www.cdc.gov/spanish/niosh. The Spanish-version CDC site is at www.cdc.gov/spanish/default.htm. Information on AIDS/HIV is available in Spanish at www.natip.org and www.aidsinfonet.org/infored.html.) ■

PAs, some physicians happy with their jobs

Certain specialties have higher satisfaction rates

While recent surveys cite low job satisfaction as one of the causative factors of the growing nursing shortage, the job satisfaction picture is not nearly so dire in other areas of health care. In fact, in some areas the picture is quite the opposite.

In two recent surveys, physician assistants (PAs) and physicians in selected specialties indicated a relatively high level of satisfaction.

Researchers at the University of California, Davis (UC Davis) School of Medicine and Medical Centers conducted a study of more than 12,000 physicians representing 33 medical disciplines and found that more than 70% were "satisfied" or "very satisfied" with their careers, while about 20% were dissatisfied.

And in a survey conducted by the Alexandria, VA-based American Academy of Physician Assistants (AAPA), 86% of the respondents said they would become a PA if they had to choose their career over again.

Not all specialties equal

In the UC Davis study, one of the more interesting findings was the difference in satisfaction levels between physicians in various specialties. For example, specialties reporting a relatively high level of career satisfaction include pediatrics, perinatal medicine, neonatal care, geriatric internal medicine, and dermatology. High levels of dissatisfaction were more commonly reported in obstetrics/gynecology, ophthalmology, orthopedic surgery, internal medicine, and otolaryngology.

"These findings have important implications for physicians, their professional organizations, residency directors, managed care administrators and students selecting a specialty," notes **J. Paul Leigh**, professor of epidemiology and preventive medicine at UC Davis and lead author of the study, which appeared in the July 22 issue of the *Archives of Internal Medicine.*

Other factors also figured into job satisfaction for physicians. For example, high levels of career satisfaction were linked to higher incomes, living in the Northeastern and West North-Central regions of the United States, practicing in a rural area or small town, and having little involvement with managed care.

Happy across the board

By contrast, PAs across the board expressed high levels of satisfaction. Asked if they would become PAs if they were to choose their careers today, 50% said they "definitely would," and 36% said they "probably would."

"We've sliced and diced the data by specialty, age, geography — you name it," says **Steve Crane**, PhD, AAPA executive director, "and it's virtually no different in any subcategory. It's a study we've done over a three-year period, and it's been virtually the same over the past three years. It's a truly a uniform result — it's not just occupational medicine PAs, or those in some other area of specialty who are happy."

There are a number of reasons for these high satisfaction levels, says Crane. For one thing, PAs are broadly trained in primary care, but learn the basic elements of medicine all the way through surgery, so they can function in a wide variety of settings. "If you end up somewhere you don't like, you can easily move because of your primary-care base of training," Crane explains.

In fact, on the average PAs will work in three different specialty areas over their career, says Crane, while most nurse practitioners and most physicians end up working in a more limited area. "PAs can use their training to find an optimal position," he explains.

In addition, he notes, the way the profession is structured is critical. "PAs always work with

Clinical trials harmed by lack of informed consent

The mention of clinical trials often triggers a silence between physician and patient, usually because neither one knows much about the subject. Nearly 80% of physicians admit they would like to know more about clinical trials so they can help their patients make an informed decision before volunteering to participate.

"Most subjects enrolled in clinical studies have a meager understanding of what they have gotten into," says **Alan Sugar**, MD, chairman, New England Institutional Review Board and professor of medicine at Boston University School of Medicine. "Informed consent has largely focused around the signed form and has not practically become the continuous process that it needs to be. As a result, a subject's misunderstandings largely go unchallenged."

Properly informing patients is not only ethically necessary, say clinical trials experts, but it also ensures better trials and data. Last year, more than 17 million people seriously thought about participating, but only a few million actually completed their trials. And even among them, many gave their consent without a thorough knowledge of the facts. Indeed, patients can be so daunted by questions and lack of information that they simply decide not to volunteer.

"There's a simple ethical mandate that you don't ordinarily do dangerous things to people without their knowledge and consent," says **Dale E. Hammerschmidt**, MD, FACP, associate professor of medicine and director of Education in Human Subjects' Protection for the University of Minnesota Medical School in Minneapolis. "From a more pragmatic perspective, a well-informed subject is likely to cooperate better with the trial and is more likely to report potential problems. The quality of the data and the safety of the trial are both enhanced when the subjects really know what's going on."

A new resource, written for doctors and clinical trial participants, can help answer some of these tough questions. Boston-based CenterWatch, the leading publisher of clinical trial news and information, now offers *Informed Consent*, a guide to the risks and benefits of volunteering for clinical trials.

Informed Consent is a step-by-step guide that begins with a history of the clinical trials industry, explores the drug development process, and how a new drug makes its way to the marketplace. It also details why people decide to participate, how to find clinical trials, how to research clinical trials and evaluate their risks, how to ensure proper informed consent, what the vulnerable populations are, and what to do when things go wrong. Cost is $16.95, and can be ordered from CenterWatch at (800) 765-9647, or by faxing (617) 856-5901. It also can be ordered through www.centerwatch.com; www.amazon.com; and www.barnesandnoble.com. ■

physician supervision, and their scope of work is dictated by what is delegated to them," he observes. "As they grow in knowledge and experience, the physicians usually give them more to do, so the job, if you will, is never the same. Its scope expands steadily."

Then there are lifestyle issues. People choose the profession because they want to practice medicine with physician supervision, and they can get their training in a two-year period instead of eight, yet they can still get the same satisfaction in terms of patient/physician relationships. "PAs work on the average 44 or 45 hours a week so they can still have a life," adds Crane.

PAs also appreciate what they see as a very high level of respect shown to them both by physicians and by patients, as well as from other health workers, says Crane. "Pay levels are also good; the average salary is $71,000 nationwide, with entry level pay at about $58,000," he says.

It also is a young profession. The average age of a practicing PA is 41, and in the last seven years, the number of PA programs has more than doubled. In addition, 45% of the profession has graduated in the last five years. At present, 53% of PAs are women and 47% are men. "The profession had been male-dominated," says Crane, "But in our schools today, 67% of the students are women and 33% are men."

The profession also is a diverse group, with 12% of all PAs being minorities. Occupational medicine, says Crane, is one of the fastest-growing areas. "The demand for the profession is strong, and we see a bright future," he concludes.

[For more information about the AAPA survey, contact:

• ***Nancy Hughes**, Vice President — Communications and Information Services, American Academy of Physician Assistants, 950 N. Washington St., Alexandria, VA 22314-1552. Telephone: (703) 836-2272, ext. 3505. Fax: (703) 684-1924.* E-mail: *nancyh@aapa.org.* Web site: *www.aapa.org.]* ■

NEWS BRIEFS

ACOEM: Don't restrict HIV+ employees

Health care workers who are HIV-positive should not face restrictions on their practice as no procedures have proven to be "exposure-prone" related to transmission of the virus, the Arlington Heights, IL-based American College of Occupational and Environmental Medicine (ACOEM) stated in a recently released guideline.

"You can look back at 20 years of the epidemic, during a time when there have been many HIV-positive surgeons practicing surgery," says **Mark Russi**, MD, MPH, chair of ACOEM's occupational infectious disease committee. "There has been one case of a surgeon transmitting HIV, if you leave out the cluster [of cases related to] the Florida dentist.

"With no more evidence than [that] of transmission of HIV from health care workers to patients, it's difficult to justify restricting them from carrying out their profession," he says, who is associate professor of medicine and public health at the Yale University School of Medicine and director of occupational health at Yale-New Haven (CT) hospital.

Instead, ACOEM recommends that HIV-infected health care workers who perform invasive procedures should double-glove and "minimize to the extent possible digital palpation of needle tips and blind probing in poorly visualized or highly confined anatomic sites."

Exposure-prone hard to define

In a case that is still largely unexplained, six patients of an HIV-infected Florida dentist acquired the disease in the late 1980s.[1] In 1992, a French orthopedic surgeon transmitted HIV to a patient on whom he had performed a 10-hour surgical procedure.[2]

Yet as of June 2001, there have been more than 23,000 health care workers with HIV in the United States, according to data from the Centers for Disease Control and Prevention (CDC).

Such a low risk of transmission makes it impossible to identify procedures that are particularly "exposure-prone," as the CDC advised in its HIV guideline released in 1991,[3] Russi says.

The CDC said that procedures were exposure-prone if "a needle tip was digitally palpated in a body cavity, or . . . a health care worker's fingers and a needle or other sharp instrument or object are simultaneously present in a poorly visualized or highly confined anatomic site."

However, the agency never issued any further parameters or lists of exposure-prone procedures. ACOEM's position is "within the intent and spirit of the CDC guideline," Russi says. "We have another 10 years of experience, and there's only been one transmission."

ACOEM did note that a greater risk of transmission exists for health care workers who are hepatitis B e-antigen positive. Further, in light of recent reports of transmission of hepatitis C from health care workers to patients, ACOEM will consider a

Occupational Health Management™ (ISSN# 1082-5339) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Occupational Health Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours: 8:30-6:00 M-Th; 8:30-4:30 F.

Subscription rates: U.S.A., one year (12 issues), $465. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $372 per year; 10 to 20 additional copies, $279 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 755-3151. World Wide Web: http://www.ahcpub.com.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Steve Lewis.**
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@ahcpub.com).
Production Editor: **Nancy McCreary**.

Copyright © 2002 by American Health Consultants®. **Occupational Health Management**™ is a trademark of American Health Consultants®. The trademark **Occupational Health Management**™ is used herein under license. All rights reserved.

THOMSON
AMERICAN HEALTH CONSULTANTS™

Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

separate position statement on that disease, Russi says. "It's clearly an area that we need to address," he says.

In other HIV-related issues, ACOEM stated:

• Employees with HIV infection or AIDS qualify for protection under the Americans with Disabilities Act (ADA) and the Family and Medical Leave Act (FMLA).

Under the ADA, employers must provide reasonable accommodations and are prohibited from discriminating against employees because of their disability. The FMLA provides a 12-month unpaid leave to employees with "serious health conditions" who have at least one year of service.

• Although ACOEM doesn't support restrictions on HIV-positive health care workers, it noted that courts have not considered such policies to be discriminatory.

In May, the U.S. Supreme Court declined to hear the appeal of a dental hygienist who sued under the ADA when he was reassigned to a lower-paying clerical position after his employer learned he was HIV-infected. In *Waddell v. Valley Forge Dental Association*, the 11th Circuit Court of Appeals upheld a dismissal of his case, stating that it did not constitute discrimination because of the potential risk to patients.[4]

• A source patient may harbor resistance to antiretroviral medication, complicating the decision about post-exposure prophylaxis.

While treatment should begin as quickly as possible, the medication may be adjusted after consultation with infectious disease experts, ACOEM says. Because of possible toxic side effects, those on prophylaxis regimens should be closely monitored.

• Occupational health physicians should be involved in the development of policies regarding AIDS and HIV in the workplace and should design educational programs.

References

1. Centers for Disease Control and Prevention. Update: Transmission of HIV infection during an invasive dental procedure — Florida. *MMWR* 1991; 40:21-33.

2. Lot F, Seguier J-C, Fegueux S, et al. Probable transmission of HIV from an orthopedic surgeon to a patient in France. *Ann Intern Med* 1999; 130:1-6.

3. Centers for Disease Control and Prevention. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. *MMWR* 1991; 40(RR08):1-9.

4. *Waddell v. Valley Forge,* No. 00-14896, 11th U.S. Circuit (Dec. 21, 2001). ▼

EDITORIAL ADVISORY BOARD

Consulting Editor:
William B. Patterson,
MD, MPH, FACOEM
Chair, Medical Policy Board
Occupational Health + Rehabilitation
Hingham, MA

Judy Colby, RN, COHN-S, CCM
Past President
California State Association of Occupational Health Nurses
Occupational Health Specialist
Southern California Orthopedic Institute
Van Nuys, CA

Annette B. Haag,
RN, BA, COHN
Past President
American Association of Occupational Health Nurses
President
Annette B. Haag & Associates
Simi Valley, CA

Virginia Lepping,
RN, MBA, COHN
Executive Vice President
Providence Occupational Health Services
Granite City, IL

Charles Prezzia,
MD, MPH, FRSM
General Manager
Health Services and Medical Director
USX/US Steel Group
Pittsburgh

Pat Stamas, RN, COHN
President
Occupational Health and Safety Resources
Dover, NH

Melissa D. Tonn,
MD, MBA, MPH
President & Chief Medical Officer
OccMD Group, P.A.
Dallas

Financial aid for nurses, others for homes, tuition

The state of Florida has introduced low-cost home and educational loan programs to help health care providers recruit and retain nurses and other health care professionals. The HealthCare Worker+ initiative, which is a partnership with Fannie Mae (The Federal National Mortgage Association), will help nurses and others obtain funding for a home by using just 1%, or $500 of their own funds, according to Florida Gov. Jeb Bush. The loans are available to full-time RNs, licensed practical nurses, licensed vocational nurses, certified nursing assistants, unlicensed assistants, and accredited physician assistants as well as medical technicians, technologists, and therapists. The student loan program, a partnership with Medsouth, will provide low-interest loans to Florida-licensed nursing professionals and students to help them repay their college loans. Florida has 9,800 vacant nursing positions and expects to need 34,000 additional RNs by 2006. ■

Newsletter binder full?
Call **1-800-688-2421**
for a complimentary replacement.