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2003 Reader Survey inserted in this issue

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Return-to-work programs benefit workers, workplace, ACOEM says

Lack of credentials, training may be the rule, not the exception

Return-to-work (RTW) programs are seen as such an integral part of occupational medicine that it would never occur to most observers that there are a number of physicians who are ill-prepared to appropriately address RTW issues. But the current situation apparently is of enough concern to the Arlington Heights, IL-based American College of Occupational and Environmental Medicine (ACOEM) that it has issued a position statement on the subject.

"The Attending Physician's Role in Helping Patients Return To Work After Illness or Injury," recently published on the organization's web site (www.acoem.org/guidelines/article.asp?ID=55), offers physicians guidance in developing and implementing RTW plans **(see highlights on p. 39)**.

In setting forth its rationale, ACOEM states that it recognizes:

• that a fundamental purpose of medical care is to restore health, optimize functional capability, and minimize the destructive impact of injury or illness on the patient's life;

• that prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical, and social well-being;

• that a return to all possible functional activities relevant to the patient's life as soon as possible after an injury or illness has many beneficial effects;

Smallpox vaccination: Is your plan in place?

With the escalating threat of biological warfare against the United States, hospitals must be prepared to treat the victims of such attacks while protecting their employees and patients at the same time. To respond to this need, American Health Consultants offers **Smallpox Vaccination of Health Care Workers: The Real-World Experience**, an hour-long audio conference on Wednesday, March 26, from 2-3 p.m., EST.

Whether you are just beginning or are expanding your smallpox vaccination program, this audio conference will provide the latest strategies and information you need to ensure the smooth management of your program.

(Continued on page 46)

• that physicians positively affect the likelihood and rapidity of healing by setting clear expectations for recovery with patients.

But why now?

Given the general consensus that RTW programs are important and limiting absences and lost productivity are essential components of occupation health practice, the questions still arises: Why now? What makes the issue so pressing today?

"We clearly see a growing employer interest in maximizing productivity and minimizing unnecessary absence; there's a fairly large movement in industry in the area of realizing the potential connection between health and productivity," says **Jennifer Christian**, MD, MPH, chair of ACOEM's work fitness and disability section.

But there's an even more pressing issue, she adds. "As occupational doctors, we work in a variety of settings; some as corporate medical directors, some in private practice and some in consulting, and we often end up in the position of looking at the process of care for many companies and seeing how their physicians handle the process of return to work," Christian notes. "We see that they are often not clear on what their role is or on how to perform it, and there are actually a lot of unfortunate outcomes."

David Randolph, MD, MPH, a member of ACOEM's RTW Process Improvement Committee, is equally concerned. Randolph, who is a past president of the Chicago-based American Academy of Disability Evaluating Physicians (AADEP), notes that the organization shares a number of members with ACOEM. "When I first joined the ranks of AADEP, there were very few professionals who had credentials in both arenas," he notes. "I found a lot of physicians were not particularly knowledgeable in the area of disability or did not understand what transpires in this arena. They may not be up to date on treatment, such as for back pain, or causes, like those for carpal tunnel syndrome. They may make erroneous presumptions and just proceed to disable the worker. There's an awful lot of ignorance."

This ignorance is of even greater concern given the current regulatory atmosphere, says Randolph. "What we have in front of us is a looming disaster," he charges. "Our society has been experiencing a burgeoning of people applying for and receiving disability benefits, sometimes for more statutory than practical reasons. For example, you can be granted Social Security disability benefits simply by meeting certain requirements; if you have clinical ridiculopathy and you are 52, you can be considered disabled."

The wrong message

Randolph says the General Accounting Office (GAO) issued a report in August 2002 indicating that in 2001, Veterans Affairs and Social Security paid out a total of $90 billion in disability benefits. He fears we will follow the path of Europe, where roughly 47% of their population currently receives disability benefits. "This would not only result in a horrendous financial load on those not receiving benefits, but more important, it would give the wrong message to a huge percentage of the population; that they can't work. And since our society values work, it's a tremendous statement for medicine to make."

Christian couldn't agree more. "There's a sort

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of pathetic condition we call iatrogenic [caused by the healer] disability. It may not be a perfect word; it's not *just* what the doctor did, but it also involves the patient's interaction with the disability system," she explains. "The system can cause a worker to be disabled functionally much more than their biologic condition would require. As an extreme example, I've seen a man out of work for two years with an injured big toe."

The disability becomes emotional as well as physical, she continues. "I, myself, got very interested in disability prevention in the mid-'80s, when I saw people out on workers' comp for two or three years, and you'd meet these shattered hulks of people who had previously been skilled workers with self-respect. They had turned into whining, depressed people whose lives had fallen apart," she recalls.

Christian came to realize in her own practice that fairly shortly after someone stops working, they become unsure about whether they can return to work. "If you do not get back on that horse quickly, the devil of doubt will creep back into your mind," she notes. "And if you get benefits only when you're sick, you need to prove yourself sick to keep those benefits safe."

Randolph agrees. "It's a major mental health issue — and if it wasn't before, it will be in the future."

Awareness must increase

One of the benefits of the ACOEM position statement is that it will increase awareness of the problem, says Christian. "Even in occupational medicine there has been little awareness that disability is created by withdrawal from work," she notes. "You create an invalid simply by having the disability system and by not getting people back to work soon enough."

In her occupational medicine residency, she did not learn much about workers' comp and learned nothing about preventing disability, Christian notes. "That's not unusual — it's not part of regular medical school education or even an occ-med residency, which is more about occupational disease, rather than musculoskeletal problems and a variety of other common injuries."

Not much has changed since then, she says. "About five years ago, a guy who had recently graduated with an occ-med residency was working for me," she recalls. "He still had books on his shelf from that residency, so I suggested we look up disability and see what was there. In all the books, we never found one reference to it, other than sample cases. It's in a blind spot."

In med school today, she says, students receive a total of five hours on occupational medicine. "That doesn't include the impact of medical conditions on work," she notes.

Still, says Randolph, in terms of actually treating patients, "these are skills that are taught from day one. These doctors have the requisite knowledge; it's not rocket science."

One of the keys may lie in better communication. For example, Randolph suggests, you might send the ACOEM position statement to attending physicians who seem to be unreasonably delaying return to work.

"In general terms, this means the individual physician who is involved in primary care — it could be an occupational physician, the family doctor, an internist — anyone on the frontline

ACOEM's RTW Statement Highlights

Developing return-to-work plans:

- Early in the course of treatment, the physician should discuss with the patient expected healing and recovery times as well as the positive role of an early, graduated increase in activity on physical and psychological healing.
- The physician should be familiar with the family and community support systems available to the patient. The physician should also be aware of the patient's general responsibilities at home and specific responsibilities at work.
- The physician should facilitate the patient's return to work and activity at home by encouraging communication between the patient and his or her employer early in treatment or rehabilitation.
- The physician should identify and address potential obstacles to the recovery of function and return to work as soon as possible.
- When the physician believes that the patient has recovered sufficiently and can return safely to some form of productive work, the patient/employee should be clearly informed of this judgment and advised that despite continuing symptoms, resuming normal activities is an important part of the rehabilitation process.
- The physician should counsel the patient and the employer about protective and preventive strategies to use at work, when appropriate. ■

assessing the worker's ability to perform his daily living or work activities," Randolph explains.

Randolph has a number of opportunities to assess the work of such physicians. "Sometimes I'll be asked [for my opinion] by a third-party insurance company or by a law office," he says. "I'm handed a stack of information and asked, 'Should this person be off work?'"

Just recently, he says, he saw the records of a woman on short-term disability since last May. "In the record, her physician kept giving her excuse notes month after month, and the reason behind the notes was never clearly provided," he asserts. "The disability was just maintained because the notes were presented that said she couldn't work."

A significant number of physicians will bend the rules to allow their patients to stay off work, Randolph asserts. "Technically, that's fraud," he says. "When I call them and ask why the patient is out of work, they often just say, 'She says she can't work; she is not feeling well.' I'm all for confronting these physicians."

Of course, many physicians might get defensive in such situations. Recognizing this, Randolph suggests you establish a good rapport with the attending physician first. "Invite them to the plant for an inspection," he suggests. "Discussing the ongoing clinical problem may help. Everyone has to trust you are not there as a hired gun, but rather to try to make things work better."

The use of independent evaluators can be priceless to doctors at plants, Randolph says. "The treating physician may say one thing; the occ-doc may see things differently, so you send out for another opinion. What's critical is keeping open the lines of communication with the treating physician."

Christian concurs, suggesting that you can send the ACOEM statement to treating physicians as a matter of course. "They may find it useful in terms of laying out of a paradigm, and an approach or method to thinking about having employees stay at work and return to work sooner," she says.

There are really two options, she declares: To send the statement to a doc in a problem case where he seems to be particularly unaware of certain key issues, or to be more proactive — to reach out to treating physicians with whom you regularly interact. The latter approach may help avert defensiveness on the part of the treating physician.

In those communications, it should be emphasized that staying at work is equally as important as returning to work, Christian notes. "With an aging work force, we can predict declines over time. Staying at work is an example of anticipatory management, while returning to work is reactive management," she observes. "Using the position statement can not only help get employees back to work sooner, but hopefully, they maybe not have to leave work at all."

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Though vaccinations lag, Connecticut forges ahead

State leads in volunteer smallpox inoculations

Although the response to the Bush administration's voluntary smallpox vaccination has been underwhelming **(see article, p. 41)**, one northeastern state is moving ahead with its program undeterred.

Connecticut, which claims to have both the first civilian public health official to be vaccinated as well as the first state program initiated, has taken delivery of 6,000 doses of the smallpox vaccine and has begun implementation of its vaccination program with the inoculation of a core team of health care workers from the UCONN (University of Connecticut in Farmington) Health Center.

A genesis team of 15 health care workers received the initial doses, and then proceeded to inoculate others at the state's 32 hospitals.

"By end of today [Feb. 14], we expect to have 90-plus people vaccinated," says **William Gerrish**, spokesman for the Connecticut Department of Public Health in Hartford. "We were the first in the nation to start the program, and we are very pleased with our progress to date."

The state's goal is to establish core teams in acute care hospitals in the state, thus creating a core group ready to respond in case of a smallpox outbreak in the state.

Jim Hadler, MD, the state epidemiologist, has been identified as the first civilian public health official publicly vaccinated since the announcement of the government's voluntary inoculation program.

"On both counts — from a personal perspective and in terms of the statewide program — I didn't

Vaccination plan still meeting resistance

The enthusiastic response of states such as Connecticut notwithstanding, national leaders concede that the actual numbers of health care workers volunteering to be vaccinated is relatively small.

Centers for Disease Control and Prevention (CDC) director **Julie Gerberding,** MD, acknowledged as much during a Feb. 5 press briefing, noting that concerns expressed by health care groups regarding compensation in the federal voluntary smallpox program might be the cause of limited numbers of persons being vaccinated.

Gerberding said she was aware that compensation issues have health care providers concerned they may "fall through the cracks," and reported that although the CDC had shipped 204,600 doses of smallpox vaccine to 40 states and counties, a total of only 687 health care personnel had been vaccinated. (As of this writing, the total is slightly more than 1,000.) No adverse events have been reported, she said, but added that as the vaccinations increased, "we know we're going to see side effects."

Meanwhile, the Washington, DC-based American Public Health Association (APHA) has recommended additional protections to ensure safe and effective implementation and renewed its call for a measured, deliberate approach.

"It is prudent for us to begin vaccinating the first 500,000 emergency health workers," said **Georges Benjamin**, MD, FACP, executive director. "This is an important step to further improve our public health preparedness efforts. However, civilian responders at the federal, state, and local level require and should be provided the same treatment as military participants in any smallpox vaccination program."

APHA identified several elements of the program that need to be addressed:

- Adequate federal resources must be allocated to state and local health departments, hospitals, laboratories, and other organizations that are coordinating this program, and funds should not be diverted from other public health resources.
- Liability protections must be granted for organizations and persons who participate in the vaccination program.
- A national program must be established to compensate workers and others who suffer complications associated with the vaccine.

APHA also urged that access to treatment must be guaranteed for those who participate in the program; adequate education and training must be provided to all participants; medical screening should be provided prior to vaccination; ongoing surveillance for side effects and evaluation is required; individuals who participate or choose not to participate should not be discriminated against and their privacy rights ensured; the Food and Drug Administration should approve bifurcated needles for the smallpox vaccine; and sufficient doses of vaccinia immune globulin should be made readily available. ■

feel any reluctance to roll out the program and encourage hospitals to participate," says Hadler. "We wanted every hospital to at least offer the vaccinations. For me as an individual, I felt the risk I was taking was very, very small, and of course in my job, I have the potential to be exposed to smallpox so it was worth doing. But everyone must make the decision for themselves."

A detailed plan

Connecticut was particularly well positioned to respond to the call for voluntary vaccinations, because it had already been developing bioterrorism and smallpox response plans. Under its Stage I smallpox plan, the state will offer the vaccine to designated health professionals identified by hospitals, local health departments, and the state Department of Public Health who have volunteered to make up the first-response teams. The plan was based on guidance from and ultimately approved by Atlanta-based Centers for Disease Control and Prevention (CDC).

"From our perspective, we know we don't have a dedicated smallpox facility; a person could show up in any acute care facility, so we asked all acute care facilities to identify response teams and have protocols in place," Hadler explains. "Then the issue becomes this: We also want you to offer the vaccine to people who would be part of your

smallpox response team."

The Stage I plan:

• involves approximately 6,000 health care and public health response workers;

• includes full involvement and support of the state's 32 acute care hospitals;

• includes full involvement of the state's 98 local health departments and districts;

• establishes 32 hospital-based smallpox medical care teams with a full contingent of inpatient and emergency room health care worker teams, including various clinical specialists, nurses, technicians, mental health professionals, and housekeeping staff. Each hospital-based team would include approximately 140 volunteers per hospital for a total of approximately 4,600 hospital-based volunteer statewide;

• establishes smallpox field response teams (1,400 volunteers) in the event Connecticut needs mass-vaccination clinics;

• The University of Connecticut Health Center serves as the genesis team to be the primary vaccinator of the smallpox medical care and field response teams.

One of the major reasons such a plan is needed for health care workers is because a smallpox outbreak "would be an occupational health problem, especially for people in emergency departments," says Hadler.

"That's the common pathway," he explains. "It may take up to six days before someone can look like they may have smallpox. "It might take two days for the rash to develop and three or four more to positively identify smallpox. So by then it may be too late to vaccinate [health care workers]." That's why, he notes, in addition to recommending vaccinations, specific additional protocols are required, such as masking all staff who care for patients with fevers and rash.

"In Europe in the '50s and '60s, there was no smallpox, but people would travel to India and return with the disease, and it would be transmitted to others," Hadler notes. "More than 50% of the transmissions were to health care workers. This argues in favor of having the vaccination, or at least, offering it to those who want it."

And to whom will it be offered? In general, the state is looking for response teams to include personnel in hospitals who might first come in contact with an infected patient, as well as those public health personnel who would be assigned to investigate cases, track contacts, vaccinate people, and institute measures to control the spread of disease.

"We are working with representatives sent from the hospitals," says Hadler. "With the basic team, there should be a fair degree of protection in the ED — all the doctors and at least one-third of the emergency technicians. On the inpatient side, you need people who can take care of patients in the ICU for seven days while the others get vaccinated. This can include ICU nurses and docs, infectious disease specialists and a smattering of other specialists. If you do this and follow the right infection control protocols, you should be well protected."

After putting out its guidance on response team composition to every hospital, the department then provided a three-hour statewide training session about smallpox for the teams members that had been selected. The topics included a wealth of information about smallpox and how to control it — all from an occupational health perspective. "For people in a certain type of work, this *is* an occupational disease, and it is preventable if you are vaccinated," Hadler asserts.

The Connecticut plan is ahead of schedule, according to Gerrish. "One factor in our success has been our collaborative approach — the team that has been working all along on bioterrorism is now working on this initiative," he observes. "Plus, a very strong partnership has developed between Connecticut's hospitals and their local health partners."

Details on the Connecticut plan may be found at: www.dph.state.ct.us.

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Health professionals trusted in wellness

Survey: Employees favor on-site nurses, consultants

Employees seeking wellness advice or program leadership are most comfortable placing their trust in health care professionals (on-site nurses or outside consultants), according to a recent survey commissioned by the Atlanta-based American Association of Occupational Health Nurses (AAOHN). The study was designed to:

• assess the current primary sources of health information;

• evaluate perceptions of health and safety

Key findings of AAOHN/ brand survey

- Nearly 60% consider health and wellness program offerings from employers a viable incentive to stay at their current job.
- Health care professionals (health care consultants and on-site nurses) are the most trusted sources for employee wellness program information (61%).
- Fifteen percent of respondents ranked company human resources staff as a trusted source, right behind pamphlets and brochures (18%).
- Respondents claim that one of the top reasons they don't participate in their company's wellness program is because they prefer to obtain health/wellness information from a more credible source — someone in the health industry.
- More men than women commented that the source needs to be more credible.
- Men and women indicate similar levels of participation (of those polled who have access to health/wellness programs).
- The 18-34 age group is less likely to participate in a health/wellness program than the 35-44 age group.
- More than three-quarters of respondents (78%) would take advantage of an employee wellness program if it was readily available to them.
- Nearly 80% of respondents feel their overall health would improve with the availability of a health/wellness program.

Top work-related health concerns:
- Stress at work (15%)
- Muscle strains/injuries (11%)
- Exposure to harmful substances (10%)
- Personal injury (5%)
- Deteriorating vision due to computers (3%)
- Workplace violence (3%)

Top-rated topics for a health and wellness program:
- Stress management (85%)
- Fitness (84%)
- Screening programs (84%)
- Health insurance education (81%)
- Disease management seminars (80%)
- Nutrition seminars (71%)
- Stop-smoking seminars (67%)

concerns in the workplace;

• gauge the availability of and participation in wellness programs, as well as reasons for nonparticipation;

• assess the importance of health and wellness programs in the workplace;

• identify the aspects of an ideal wellness program and trusted sources of information.

The survey included men and women who were employed full time. Of those responding, 61% said health care professionals were the most trusted sources for employee wellness program information. **(See other highlights of the survey findings, left.)**

A tradition of trust

These results were not surprising to **Jennifer J. Lim**, RN, MSN, COHN-S/CM, FAAOHN, national manager/health services for Comprehensive Health Services (CHS) in Westminster, CO. She manages 21 clinics throughout the United States for CHS, one of the largest providers of occupational health services in the world, with more than 9,000 affiliate health professional faculty.

"Recent surveys show firemen to be the most trusted profession, and the second is nurses," says Lim. "Before 9/11, it was always nurses."

Occupational health nurses, many of whom run wellness programs as part of a wide range of responsibilities, are integrated into the corporate or business environment and are viewed as partners. "They see employees every day — not just when they come in for a wellness activity," Lim notes. "They see them for workers' comp issues, physicals, and so on, so a relationship is established."

The occupational health unit, she explains, is seen as a neutral place — a one-stop shop for employee health. "For a lot of employees, it's the only place they go for regular screenings and the like," says Lim. "They trust the staff, and the department is readily accessible. Employees trust that confidentiality will be maintained and that any information they share will not impact their job in a negative way."

One interesting finding of the survey was that outside consultants were trusted slightly more than on-site nurses. Lim says she can explain that finding.

"Consultants don't have any ties at all to the business," she observes. "If an employee had any concern at all that a manager might find out about say a mental health problem or prostate cancer, they'd have a lesser concern with someone outside the company."

So in this case, she says, more trusted does not necessarily mean more qualified. "It's just that in some cases the employee may feel more

comfortable sharing confidential information," Lim declares.

So if you manage an in-house occ-health program, who should you favor to run your wellness program — an on-site nurse or an outside consultant? "An in-house person is more ideal because they know the work environment they are in, and they can customize the program," she says. "You may want to do certain screenings, such as mammography, based on the average age of your female employees. Or when designing a diet, you would likely base it on the kind of work the employees do."

A money-saving priority

Though CHS offers a wide variety of services, "We make wellness a priority," says Lim. Looking at another survey result, it's easy to see why: Nearly 60% of the respondents consider health and wellness program offerings from employers a viable incentive to stay at their current job.

"If a company shows that they care for the well-being of the employee as a whole person [work-life programs, benefits, etc.], those employees will be more inclined to stay with the company," she says. "Also, studies show that wellness programs will produce so much more in terms of employee morale and retention."

Lim uses the example of flu shots to illustrate her point. "In the last few years, there has been a shortage of flu shots," she observes. "Employees of companies who have purchased the shots and offered them free of charge say to themselves, 'My company really cares about me.'"

Not only does such an attitude aid retention, but it can provide an impressive financial return as well, says Lim. "For every day an employee is out, you have about four times the cost of a day's salary in terms of workers' comp and other back costs," she observes. "You need a backup worker, and there's an impact on productivity, as well as on morale. Yet the flu shot only costs about $15."

In broader programs, such as smoking cessation or weight control classes, the benefits can be even greater. "They can impact a person's entire sense of well-being — their work/life balance, their stress level, their whole quality of life," says Lim. "They become a happier person, and they recognize their company did that for them. And again, if you can stop one person from smoking or if you find one diabetic, the cost savings are astounding. You can pay for your entire wellness program for 10 years."

Occupational health nurses are well qualified to facilitate wellness programs because wellness education "is inherently in their training under prevention," she says. Many more of them function as in-house wellness professionals, rather than as outside consultants. "It's usually tied to one of their many jobs," says Lim.

Despite the training, however, it's important to bear in mind that the world of wellness is constantly changing and expanding. "Take 9/11," Lim posits. "An occupational health nurse would have studied signs and symptoms of exposure to specific chemicals or diseases, but prior to that event, they would never have had much education on bioterrorism. It's a constant evolution."

The AAOHN survey can be viewed at www.aaohn.org.

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The big picture counts in mental health, too

The entire company could be impacted

EAPs (employee assistance programs) and similar services are available in many organizations to help employees with mental health issues, but not nearly enough attention is paid to mental health at the organizational level, says **Jeffrey P. Kahn,** president of New York City-based WorkPsych Associates. And just as mental health issues can impact the productivity of an individual, they also can impact overall productivity and the performance of an organization.

"Everybody has seen the effects of emotional problems on productivity — from the depressed worker who can't concentrate on the job to the guy with marital problems who ends up arguing with the boss, too," notes Kahn, whose services, which include individual and corporate consultation, policy development, prevention programs and management training, are designed to complement existing management and mental health programs. "What people don't realize is that what is obvious on a small scale is just as real on a large scale, too."

In other words, mental health issues do not occur in a vacuum. "Employees who are happier people tend to be more productive workers.

Everybody knows that on the micro side, but not surprisingly it's equally important on the macro side," Kahn explains.

Organizational problems

There are a variety of ways to look at mental health, ranging from individual problems to organization problems — from bad office politics to dilemmas of organizational change, notes Kahn, who is co-editor of a new book called *Mental Health and Productivity in the Workplace: A Handbook for Organizations and Clinicians* (Jossey-Bass, San Francisco). Common organizational issues can include:

- issues of ethics;
- workplace violence;
- leadership and organizational structure;
- organizational change;
- emotional crises in the workplace;
- executive distress;
- job loss and uncertainty;
- working abroad;
- office politics

"All of these can leave workers unhappy and not as effective as they might want to be," says Kahn, adding, "What happens at the top makes a huge difference in terms of corporate culture."

To maximize the productivity at your company, you need pay attention to a number of different potential problem areas, he says. "For example, you need to look at the corporate culture — if the company is seen as fair or whether people feel trusting in that environment."

It's very important to look at management leadership style, Kahn adds. "Managers who act like [General] George Patton can certainly get things done well and quickly, but only at great emotional cost to employees, and in a situation where it's not easy for them to quit," he points out. "For instance, some unhappy workers on Wall Street are paid an enormous amount of money, so they feel they cannot quit."

Understand your people

In the long run, the most effective and productive approach is to try and understand what makes your people tick and what works for them, Kahn says. "From an occupational medicine perspective, if people turn up in your department, there's a high likelihood that an emotional problem is one of the reasons," he asserts.

The emotional component is even important for people with physical medical problems, Kahn asserts. "One recent study shows that if you tried to predict the length of disability for workers with back problems, the best predictor is the level of stress and anxiety they're experiencing," he observes.

Thus, he says, it's useful to keep in mind when certain health issues turn up in the workplace that you may need to understand the psychiatric aspects that can be associated with those illnesses — for example, absenteeism, violence in the workplace, or critical incidents.

Kahn also is a strong advocate of what he refers to as quality mental health care. "It's important to front-load the system with the most skilled clinicians you can for initial diagnosis," he says. "Most companies do the opposite and use a low-level approach. Often, employee/patients get lost in the shuffle, not getting the help they need, or getting it much later than they should."

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Over half of WTC workers have health symptoms

Preliminary analysis reveals that more than 50% of the screened responders to the World Trade Center (WTC) 9/11 disaster have experienced pulmonary, ear, nose, or throat (ENT), and/or mental health symptoms, according to the Mount Sinai-Irving J. Selikoff Center for Occupational and Environmental Medicine at Mount Sinai Medical Center in New York City.

"The high prevalence of pulmonary, ENT, and mental health symptoms among WTC site workers some 10 months to a year following the Sept. 11 terrorist attacks is alarming," says **Robin Herbert**, MD, who also serves as medical co-director of the center. "Our preliminary findings clearly demonstrate the need for the immediate screening of WTC responders, as well as the provision of medical follow-up.

Free and confidential medical screening examinations are being offered to all WTC workers, as well as referrals for follow-up medical care and occupational health education.

"Our findings are consistent with the findings

Smallpox conference

(Continued from cover)

Learn about adverse sides effects of the vaccine, how hospitals are dealing with compensation and liability issues, and about screening issues for those health care workers who have immunocompromised family members.

The program will be moderated by **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville, TN. An award-winning epidemiologist who has seen actual cases of smallpox and is overseeing a volunteer smallpox vaccine study at Vanderbilt, Schaffner began his career as a medical detective in the Centers for Disease Control and Prevention's (CDC) Epidemic Intelligence Service.

Other program speakers include:

- **Kathy Emanuelsen**, MEd, RN, director of occupational health services for Hartford (CT) Hospital, an 800-bed acute-care facility. Emanuelsen and her staff were among the first in the nation to create a smallpox vaccination clinic. She will share how they started the program, briefed staff, counseled volunteers, and successfully managed difficult clinical and administrative issues.
- **Allen Craig**, MD, is state epidemiologist and director of communicable and environmental disease for the state of Tennessee in Nashville. He will discuss vaccination efforts in his state, the education for health care workers and facilities, and steps to take for vaccinees before, during, and after inoculation.

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from a number of related health studies, including government-funded analyses, all of which support the urgency of providing appropriate health services for these workers," adds Herbert.

Major findings of the preliminary analysis include:

- 78% of participating emergency responders reported at least one WTC-related pulmonary symptom that first developed or worsened as a result of their WTC-related efforts;
- 46% of the sample still experienced at least one pulmonary symptom in the month before the screening examination;
- 88% reported at least one WTC-related ENT symptom;
- 52% of the sample still experienced at least one ENT symptom in the month before the screening examination;
- 52% reported mental health symptoms requiring further mental health evaluation.

In addition, approximately one in five of the sample reported symptoms consistent with post-traumatic stress disorder.

Most striking is the fact that a large proportion of this sample showed evidence (either symptoms or abnormal test results) of respiratory disease 10 months to one year after Sept. 11, 2001. Approximately 73% of the sample had either ENT symptoms or abnormal physical examination findings or both. Similarly, 57% of the sample had either pulmonary symptoms or an abnormal pulmonary function test or both.

The data presented were analyzed on a random sample of 250 WTC Program participants selected from the first 500 WTC responders to participate. To date, more than 3,500 WTC responders have been screened as part of the existing one-year program, scheduled to conclude in July 2003.

Public-private effort

The program is being coordinated by the Mount Sinai-Irving J. Selikoff Center, with the support of the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC), and offered to workers and volunteers exposed to hazards of the WTC site and/or Staten Island landfill in New York City in the aftermath of Sept. 11, 2001 in the course of their efforts in rescue and recovery, restoration of essential services, cleanup, and/or debris removal.

The $12 million in initial federal funding was secured for the one-year screening program through the efforts of Sen. Hillary Clinton with the support of Sen. Charles Schumer, New York's congressional leaders in the House, and labor leaders.

Only about one-third of the sample participants had received any prior medical care for their symptoms and conditions before participating in the screening program, emphasizing the critical need for medical screening. To date, federal funding has been received to support a total of 9,000 medical screening examinations, one each for 9,000 of an estimated 40,000-plus responders who have been estimated to have participated in post Sept. 11 efforts at Ground Zero.

Kenneth Berns, MD, CEO and president of Mount Sinai Medical Center and WTC Program directors Herbert and **Stephen Levin**, MD, released the findings, at a major press conference at Mount Sinai.

"These preliminary results demonstrate the importance of the screening program, given the documented persistent effects on the physical and psychological health of the WTC workers and volunteers," said Levin, who also serves as medical director of the Mount Sinai-Irving J. Selikoff Center. "The findings also point to the need for treatment resources and for short- and long-term follow-up. The earlier these WTC-related illnesses are detected and treated, the more likely that treatment will prevent long-term illness and disability," he said.

"Clearly, Mount Sinai's findings demonstrate the value of this NIOSH-funded screening program for identifying, characterizing, and addressing the chronic health problems experienced by some WTC workers," added NIOSH director **John Howard**, MD. "The preliminary data also will help inform ongoing research and recommendations to protect emergency responders and others from hazards associated with catastrophic incidents."

Mt. Sinai representatives said further follow-up of affected workers also is clearly indicated to monitor the chronic nature and severity of these health problems and to assure that proper treatment is received.

[Editor's note: WTC Program services are provided by a consortium of occupational medicine centers in the New York metropolitan region and nationwide under the auspices of Mount Sinai's Center for Occupational and Environmental Medicine working in conjunction with the Association of Occupational and Environmental Clinics. Workers and volunteers interested in obtaining more information or registering for the program are asked to call the WTC Program phone bank at (888) 702-0630.] ■

AHA issues clarification on smallpox vaccination

The American Hospital Association (AHA) has sent Disaster Readiness Advisory #10 to all U.S. hospitals, updating them on the national smallpox vaccination program for hospital workers. In the advisory, AHA said that it had worked with the administration and Congress to clarify an earlier, narrower interpretation of Sect. 304 of the Homeland Security Act. This section was intended to provide liability protection for hospitals, health care workers and others who participate in the vaccination program.

The advisory noted that the new interpretation, which the Department of Health and Human Services (HHS) issued in a guidance document Jan. 16, "moves closer to the intent of Sect. 304," by clarifying that a participating hospital in the vaccination program is a covered entity, regardless of where its smallpox response team is vaccinated. But the advisory, signed by AHA president Dick Davidson, said the association still has concerns about the voluntary program.

"Both the guidance and the declaration [which HHS Secretary Tommy Thompson issued to launch the program] continue to reference that coverage is provided only while 'acting within the scope of employment'; that is, potentially

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limiting protection for vaccinated persons who inadvertently spread the infection caused by the smallpox vaccine's virus outside the participating hospital," the advisory said.

The declaration also does not address the AHA's concern for nonparticipating hospitals, which should be protected when using health care workers who have been vaccinated as part of a state or federal plan. On Jan. 27, according to the advisory, AHA sent Thompson a letter responding to his declaration and addressing these two outstanding liability protection issues. The advisory is posted at www.aha.org, under "What's New." ▼

Frist working on laws to help vaccinated workers

Senate Majority Leader **Bill Frist**, (R-TN) said he would work to develop legislation providing funding to those injured by smallpox vaccinations and affirmed his willingness to consider legislation to address liability concerns.

Speaking before the Senate Committee on Health, Education, Labor, and Pensions, Frist said that while Sect. 304 of the Homeland Security Act provides some liability protections, "we must explore how this law interacts with state workers' compensation laws as well as with state product liability laws in formulating the correct and most effective policy in this area."

William Schuler, CEO of Portsmouth (NH) Regional Hospital, testified that state public health departments may need additional funding to enable them to play a greater role in education, screening, and vaccination site care, which would ease the staffing issues to be shouldered by hospitals. Schuler noted that vaccinations could further exacerbate staff shortages due to time off. ▼

Liability, ethics among AOHC conference issues

This year's American Occupational Health Conference (AOHC) will be held May 2-9, 2003, in Atlanta. The conference will be held in the World Congress Center.

Topics will include case management, return to work, ethical concerns, regulatory and liability issues, ergonomics, business, and safety. Among the featured speakers will be John Henshaw, Assistant Secretary of Labor for OSHA, who will address the AAOHN/ACOEM joint session scheduled for Wednesday, May 7.

For registration information, visit the AAOHN site at www.aaohn.org, or call (770) 455-7757. ▼

Stress at work linked to risk for back pain

A paper in the *American Journal of Industrial Medicine* (2003; 43:179-187) says that a stressful psychosocial work environment increases the risk for back pain.

The study, performed by the Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, Division of Safety Research in Morgantown, WV, and researchers from the University of Pittsburgh, looked at more than 6,000 workers in 160 newly opened retail stores.

The material handlers were interviewed at the outset of the study and then approximately six months later. After adjusting for history of back problems and work-related lifting, the researchers found that the risk of back pain was moderately increased among employees who reported high job intensity demands, job dissatisfaction, and high job scheduling demands. ■