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NIOSH doctor dismissed; says he was fired for protecting patients

His research links Navy jobs to silicosis

In a case that evokes every occupational health provider's worst nightmare, a physician with the National Institute for Occupational Safety and Health (NIOSH) in Morgantown, WV, has been fired from his job.

The dismissal occurred after a longstanding and volatile dispute over thousands of Navy veterans who may have undiagnosed silicosis related to their military work. The doctor says he was fired for trying to protect his patients, but others suggest that perhaps he did not handle the dispute as diplomatically as he should have.

Regardless of the clinical outcome, the experience may hold a lesson for other occupational health providers who, inevitably, will face a similar situation at some point in their careers. Such disputes always are difficult, but a careful approach can help you get your patients the help they need.

The NIOSH case concerns **Philip Jajosky**, MD,

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MPH, a 23-year veteran of the U.S. Public Health Service. He recently was ordered to leave his post as a public health researcher with NIOSH in what the institute calls "an involuntary retirement."

The dismissal came two months after closed hearings in Rockville, MD, in which a panel determined that Jajosky had defied the NIOSH chain of command and performed poorly.

NIOSH officials did not return calls seeking comment on the dismissal, but Jajosky has plenty to say about it. He is adamant that NIOSH fired him for doing the right thing for his patients, and says the government has nefarious motives for getting rid of him.

He makes repeated comparisons to the notorious Tuskegee experiments of 1932, in which the federal government promised 400 poor black men in Macon County, AL, free treatment for syphilis. The Tuskegee Study, which lasted until 1972, actually had nothing to do with treatment. The public health service was using the men to study the long-term effects of untreated syphilis, and the incident has since become known as one of the worst failings of health care providers to protect their patients.

"I see a direct comparison to Tuskegee," Jajosky says. "We should tell the veterans with sarcoidosis that they might have work-induced lung disease, and the others who did dusty jobs that they might have work-induced lung disease. We have medical information that they do not have, and that's the way it was with the Tuskegee incident. The government knew and didn't tell them."

Navy work may be tied to silicosis

Jajosky entered the dispute in 1992, 17 years after a Navy veteran initially approached NIOSH to suggest that his lung disease might be tied to the work he did in the Navy, specifically his work in grinding the rough surface off of aircraft carrier decks. NIOSH had said there was no evidence to support a connection between his Navy work and the lung disease he was suffering years later, but then the dispute came to Jajosky's attention. He immediately thought there was merit to the veteran's claim.

"I thought somehow I could handle the situation," Jajosky says. "I was very excited and optimistic in the beginning, but at the same time, I had a sick feeling about the controversy. There were 17 years of conflict between the U.S.

Research suggests link between Navy and silicosis

There is little equivocation in the conclusions of the key research by **Philip Jajosky**, MD, MPH, the former public health researcher who was ordered to leave his post as a public health researcher with National Institute for Occupational Safety and Health (NIOSH) in Morgantown, WV. Jajosky concludes that there is a direct link between dusty work on Navy ships and the subsequent sarcoidosis diagnoses of military veterans.[1]

In a point that seems certain to inflame Jajosky's superiors, he concludes that lay veterans of the Navy are reliable sources for identifying work-related risks for lung disease and can be relied upon to "propose disease-related research hypotheses." That is a direct contradiction to NIOSH's refusal to pursue the course suggested for years by a Navy veteran convinced he had found a source of occupational lung disease.

Jajosky conducted the research after the Navy asked NIOSH to determine if Navy work environments have been associated with lung diseases — some of which may have been reported as sarcoidosis. He used a case-control approach involving the modern personnel database of the Naval Health Research Center, and he also computed sarcoidosis rates using total Navy manpower data. He says previously published military data from the 1940s and 1950s were juxtaposed with current findings to gain a broader historical perspective.

The study describes sarcoidosis as "a diagnosis of exclusion, which is to be assigned only after known causes of sarcoidosis-like disease have been carefully eliminated. This is difficult when the typical clinical manifestations caused by a fibrogenic agent like silica are modified by the presence of other materials in mixed-dust exposures." In general, the study says, some sarcoidosis diagnoses may represent new work-related diseases whose causes are yet to be identified, or diseases whose causes are already known but were not carefully ruled out or were never considered.

The findings suggest the link that NIOSH had denied for years. An unexplained peak of military sarcoidosis rates appeared in the 1960s and the 1970s, along with a decline in the black / white ratio of these rates from 17:1 to 6:1. The research also revealed a decreased risk for sarcoidosis diagnoses among men who worked only on "clean ships," those with few jobs that involved grinding or other tasks creating a dusty environment. The sailors did not use respiratory protection.

Jajosky writes that "these findings are consistent with the original hypothesis that preventable, environmental exposures may cause [or increase one's susceptibility] to sarcoidosis-like disease in naval settings." The study is the first to find work environment associations for sarcoidosis in a military setting, he says.

"The historical progression from descriptive sarcoidosis studies to detection of military work environment associations should be extended to include clinical studies of those veterans still living who are at high risk for lung disease, particularly generations of veterans with high rates of sarcoidosis," he concludes.

Jajosky goes on to conclude that "workers with firsthand experience are well suited to identify work-related hazards and propose disease-related research hypotheses."

Reference

1. Jajosky P. Sarcoidosis diagnoses among U.S. military personnel: Trends and ship assignment associations. *Am J Prev Med* 1998; 14:176-183. ■

government and this black Navy enlisted man."

Jajosky contends that there is a racial element in the government's refusal to admit a connection between the man's Navy work and his lung disease. He adds, however, that the main motivation for NIOSH refusing the claim is to avoid a precedent that would change the way future claims are made.

NIOSH and the Public Health Service both operate on a policy that, essentially, requires the military veteran to prove his or her claim that military service led to an occupational disorder, Jajosky says. Since the veteran in this dispute came to NIOSH with his suspicions, NIOSH officials do not want to confirm them and set a precedent in which future claims would have to be investigated and possibly confirmed as the responsibility of the government.

Jajosky also says the government does not want to be responsible for the thousands of potential cases of silicosis that would be uncovered by the response he contends is necessary. NIOSH officials have stated publicly in the past that there is no such motivation and that Jajosky's superiors merely disagree with him about what the clinical evidence shows.

There is no disputing that thousands of veterans worked in dusty conditions that now would be considered a risk for silicosis, and NIOSH does not deny that many of those men were diagnosed previously with sarcoidosis, a granulomatous disorder of unknown cause. Jajosky says his research proves that many, if not most, of those diagnoses should be changed to silicosis induced by their work in the Navy. **(See article on p. 15 for more on Jajosky's research.)**

"By and large, the veterans who may have been misdiagnosed don't know it and can't be expected to make that connection on their own."

"Sarcoidosis, by definition, means we have no idea what caused your lung disease," he says. "We have known from the 1940s that sarcoidosis diagnoses have been some of the most important sentinel events for lung disease in American workers. That is the initial diagnosis, and then you find the real cause."

NIOSH refuses to consider the sarcoidosis rates among Navy veterans in dusty jobs as a sentinel event and to follow up with all those who might be suffering from silicosis, he says.

"By and large, the veterans who may have been misdiagnosed don't know it and can't be expected to make that connection on their own," he says. "It's just like the Tuskegee experiment. If you tell a veteran he has sarcoidosis, he thinks it has meaning and you're telling him it's not work-related. That's not necessarily true."

Jajosky says it seems that "even in the post-Tuskegee era, the government wants to preserve a system in which the burden of proof is on the veteran. That is contrary to everything I was taught as a military physician."

A prominent occupational health leader says Jajosky's dismissal raises disturbing questions about the issue of silicosis diagnoses. The issue may need further study, says **Robert McCunney**, MD, MPH, director of environmental medicine at the Massachusetts Institute of Technology in Boston and president of the American College of Occupational and Environmental Medicine (ACOEM) in Arlington Heights, IL.

While he says he cannot weigh in on whether Jajosky or NIOSH ultimately is right about whether to pursue the silicosis diagnoses with the veterans, he tells *Occupational Health Management* that the case is a good study of what happens when an occupational health provider butts heads with an employer or client.

McCunney says he is skeptical of Jajosky's claims that NIOSH flatly turned down his efforts to pursue the silicosis diagnoses and wonders how well he handled the dispute. It is entirely possible that Jajosky is right about the research but failed in the diplomatic aspects of his job, McCunney says.

"That certainly is a dim view of the situation he has, and I'm not sure that's reality," he says. "I would be surprised if NIOSH would stonewall his efforts like that, and I'd be shocked if they stonewalled because of the money involved."

McCunney says he is sympathetic to any occupational health provider who has to fight an employer or client to do the right thing for patients, and he says it is not at all a rare occurrence. Most providers will encounter such a problem more than once in a career, he says.

"Absolutely, I can relate to that problem," he says. "I'm aware of situations in which physicians were fired for being overzealous, or sometimes just for being accurate and trying to do the right thing. Unfortunately, it's not a rare situation for physicians in this specialty."

McCunney says he is a bit surprised to hear of such allegations against a federal agency because he would expect them more from private industry, where the effort to save money on medical care is more intense. He says the Jajosky situation makes him wonder if perhaps Jajosky somehow did not react well to the dispute, even if he was right about the clinical facts.

"He may have been right on the science and sincere about helping the patients, but sometimes that's not the whole story in terms of getting things done," he says. **(See article on p. 17 for McCunney's advice on dealing with similar disputes.)**

Jajosky says he eventually went over his bosses' heads because he felt the information had to be released, making another allusion to how the Tuskegee experiment was not stopped until it was revealed in an article in *The New York Times*.

Now that he's out of a job, Jajosky says he was outmaneuvered by a powerful government agency.

"I actually thought things were going to work better; I guess I was delusional there," he says. "When the Surgeon General explained [in a public ceremony] that it was *The New York Times* that stopped the withholding of medical information from the Tuskegee participants, I just couldn't get that out of my mind. I thought that if we released the information, we'd do a lot of good.

"I still feel I did the right thing. There's no doubt in mind about that."

[For more information, contact:

• American College of Occupational and Environmental Medicine, 1114 N. Arlington Heights Road, Arlington Heights, IL 60004. Telephone: (847) 818-1800. Fax: 847/818-9266. Web site: http://www.acoem.org.] ■

Utilize diplomacy to get what's best for patient

When an employer or client resists good occupational medicine, providers may have to become diplomats to get things done, suggests **Robert McCunney**, MD, MPH. McCunney is director of environmental medicine at the Massachusetts Institute of Technology in Boston and president of the American College of Occupational and Environmental Medicine (ACOEM) in Arlington Heights, IL.

First, he recommends following the guidance of ethical codes provided by ACOEM and the American Association of Occupational Health Nurses in Atlanta. Those codes require physicians and nurses to protect their patients' interests even when the employer resists. And McCunney suggests that you can even use the ethical codes to bolster your position.

"You can show them that, as an occupational health professional, you're bound to this code of conduct that requires you to do the right thing for the patient," he says. "Sometimes that defuses the argument some by showing that it's not just you against the company. You don't have any choice but to do this for the patient."

It also can be helpful to just explain some of the practical aspects of the situation to the employer, such as the likelihood that the worker will appeal a workers' compensation denial and eventually receive coverage anyway. Employers often do not understand that you only have to prove a likelihood that a disorder or injury is work-related, not that it is an absolute certainty, he says. When you explain that, the employer may understand that there is no need to fight the diagnosis, McCunney says.

"You can explain that they will eventually pay for it anyway, so they might as well take the high road and do the right thing," he says. "That way they can gain whatever benefits there are from that. That's better than paying the money on appeal and looking like you didn't care."

The physician's ultimate responsibility always is to the patient, McCunney says, no matter what that means financially for the employer or client. But he cautions against an adversarial approach in which you insist on one course of action simply because you are the medical professional.

"That's a prescription for failure, definitely not the best approach to take, especially in a non-medical environment," he says. "You clearly have a unique perspective, but being highhanded can just alienate people. It's tempting to do that when you're sure of the diagnosis and don't want to back down, but sometimes you have to be able to work with the employer without backing down."

McCunney says you have to find "productive ways to do what's right for the patient within the framework of the employment situation." ■

Osteopathy docs can play role in occupational health

Doctors of osteopathy (DO) are not well known by either the public or other health care providers, but recent research suggests that they can play an important role in occupational health care.

The study comes from **Gunnar Andersson**, MD, PhD, and others at Rush-Presbyterian-St. Luke's Medical Center in Chicago. Andersson is chairman of the department of orthopedics. His research found that manual therapy by an osteopath is as effective at relieving chronic lower back pain as more conventional medical care, and the patients need fewer drugs and less therapy.[1]

"I wouldn't say it's an endorsement of

(Continued on page 19)

DOs practice medicine, give comprehensive care

*(This description of osteopathic medicine is provided by the American Academy of Colleges of Osteopathic Medicine in Chevy Chase, MD, and **Boyd Buser**, DO, associate dean for clinical affairs at the University of New England College of Osteopathic Medicine in Bieddeford, ME.)*

Osteopathic medicine is a distinct form of medical care based on the philosophy that all body systems are interrelated and dependent upon one another for good health. Osteopathic physicians use all the tools available through modern medicine, including prescription medicine and surgery.

Physicians licensed as doctors of osteopathic medicine (DOs), like their medical counterparts (MDs), must pass a national or state medical board examination in order to obtain a license to practice medicine. DOs provide comprehensive medical care to patients in all 50 states and the District of Columbia.

Currently, there are approximately 37,000 DOs practicing in the United States. Reflecting the osteopathic philosophy of treating the whole person, 57% of DOs serve in the primary care areas of family medicine, general internal medicine, and general pediatrics, often establishing their practices in medically underserved areas.

Another 43% are found in a wide range of medical specialties including surgery, anesthesiology, sports medicine, geriatrics, and emergency medicine. Still others serve as health care policy leaders at the local, state, and national levels. In addition, increasing emphasis on biomedical research at several of the osteopathic colleges has expanded opportunities for DOs interested in pursuing careers in medical research.

Beginning in the late 1800s

Andrew Taylor Still is known as the father of osteopathic medicine. After the Civil War and following the death of three of his children from spinal meningitis in 1864, Still concluded that the orthodox medical practices of his day were frequently ineffective, and sometimes harmful. He devoted the next 10 years of his life to studying the human body and finding better ways to treat disease.

His research and clinical observations led him to believe that the musculoskeletal system played a vital role in health and disease and that the body contained all of the elements needed to maintain health, if properly stimulated.

Still believed that by correcting problems in the body's structure, through the use of manual techniques now known as osteopathic manipulative treatment, the body's ability to function and to heal itself could be greatly improved. He also promoted the idea of preventive medicine and endorsed the philosophy that physicians should focus on treating the whole patient, rather than just the disease.

Hands-on treatment

Osteopathic manipulative treatment (OMT) is a system of treatment developed by Still, based on his recognition of the role that the musculoskeletal system plays in the body's continuous effort to resist and overcome illness and disease. Still believed that manual manipulation was useful in stimulating the body's ability to fight disease and in restoring health.

OMT is composed of a spectrum of manual techniques that today's osteopathic physicians may use to alleviate pain, restore freedom of motion, and enhance the body's own healing power. Often these techniques are used in conjunction with more conventional forms of medical care, such as prescribing medication and performing surgery.

Some of the most commonly used manipulative procedures include:

- articulatory techniques;
- counterstrain;
- cranial treatment;
- myofascial release treatment;
- lymphatic techniques;
- soft tissue techniques;
- thrust techniques.

[For more information, contact:

• The American Academy of Colleges of Osteopathic Medicine, 5550 Friendship Blvd., Suite 310, Chevy Chase, MD 20815-7231. Telephone: (301) 968-4100.] ■

osteopathy, but it supports the idea that it can be a valuable adjunct to other treatment methods," Andersson says.

The study was not able to put a dollar value on the different outcomes, but Andersson says osteopathy could be a useful option for patients who have difficulty taking medications, for instance. He suggests incorporating osteopathy as one option among many for patients with lower back pain.

"It's not going to be right for everyone, but there seems to be reason to consider it," he says. "Some patients don't like being manipulated, though. It can be a forceful manipulation and some patients just don't like that."

As an orthopedic surgeon, Andersson says he was interested in exploring the benefits of osteopathy because he had heard so many patients say they got better from either osteopathic care or chiropractic manipulation, a somewhat similar modality that involves manipulation. **(See article on p. 18 for more on how osteopathy works.)**

Andersson says there is a role for osteopathic physicians in an occupational health program, but only as an additional option, not as a replacement for any currently offered treatment modality or staff.

The research was lauded by osteopathic physicians, who say they have long sought acceptance among more traditional medical care. **Boyd Buser**, DO, associate dean for clinical affairs at the University of New England College of Osteopathic Medicine in Bieddeford, ME, says the key point of the study is that osteopaths achieved equal results with less medication and fewer therapy sessions.

"The medication issue is very important because you have not only the cost of the medication, but also the potential for adverse effects, which are pretty prevalent with a lot of the medications," he says. "It's also clear that DOs treat patients for a shorter period than physical therapists or chiropractors. We don't say from the outset that you need a certain number of treatments and then we'll assess your progress. With the osteopathy model, we treat and determine the need for further treatment on a visit-by-visit basis."

Doctors of osteopathy only make up about 6% of all physicians in the country, with a higher concentration in the Midwest and few on the West Coast, Buser says. The biggest challenge for osteopaths is the lack of understanding about who they are and what they do, he says.

"The general public is very poorly informed about osteopathic medicine, with some data showing that about 80% of Americans can't tell you what a DO is or how they differ from an MD," he says. "Health care professionals have a little better idea, but there still is a real lack of understanding about manipulative medicine and how it can benefit patients."

[For more information, contact:

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• Boyd Buser, DO, Associate Dean for Clinical Affairs, University of New England College of Osteopathic Medicine, 11 Hills Beach Road, Bieddeford, ME 04005. Telephone: (207) 283-0171.]

Reference

1. Andersson GB, Lucente T, Davis AM, et al. A comparison of osteopathic spinal manipulation with standard care for patients with low back pain. *N Engl J Med* 1999; 341:1,426-1,431. ■

CDC warns of forklifts as source of CO poisoning

Carbon monoxide (CO) poisoning usually is associated with cars or faulty furnaces, but warehouse workers may be at risk as well. Forklifts used in manufacturing plants may spew out the deadly, odorless gas, possibly poisoning workers in poorly ventilated warehouses or adjoining offices, according to a recent warning from the federal Centers for Disease Control and Prevention (CDC) in Atlanta.

For occupational health providers, there is a particular challenge because the symptoms of CO poisoning — headaches, nausea, and dizziness — often masquerade as other illnesses and it may be misdiagnosed. CO is a colorless, odorless gas released as a byproduct of incomplete fuel combustion.

In one case in 1998, 75 workers at a plastic manufacturing plant suffered from headaches, dizziness, and weakness. (*MMWR* 1999; 48:1,121-1,124.) Of the 10 who went to emergency rooms for treatment, many were misdiagnosed — some

with migraines, others considered to have had a fainting episode.

The cause of the outbreak was determined to be high levels of CO emitted by forklifts, compounded by a malfunction in an exhaust fan.

Proper diagnosis is important for providing treatment. People exposed to CO can be treated in a hyperbaric chamber if their illness is recognized, according to the CDC report. "CO poisoning associated with indoor combustion sources has long been recognized but continues to be a problem in the United States.

The events described in this report illustrate factors that result in failure to adequately prevent CO poisoning and to promptly recognize such incidents when they occur." ■

Dry ice produces carbon dioxide in freezer

Dangerous levels kill repairman

The federal Occupational Safety and Health Administration has cited two Boston employers — Dick's Last Resort of Boston, a restaurant, and BALCO, a refrigeration and heating, ventilation, and air conditioning repair company — for alleged serious violations of the Occupational Safety and Health Act following the death in June of a BALCO repairman.

The repairman was overcome by carbon dioxide while repairing a walk-in freezer at the restaurant.

OSHA has proposed a total of $77,000 in penalties against the two employers. According to **Brenda Gordon**, OSHA area director for Boston and southeastern Massachusetts, a restaurant employee discovered the repairman unconscious in the closed walk-in freezer on June 12, 1999. Nine 55-pound blocks of dry ice had been placed in the freezer to lower temperatures and help preserve food while the freezer was being repaired. As the blocks evaporated, dangerous levels of carbon dioxide built up in the closed freezer and overcame the repairman, who died the next day.

The citations address each employer's alleged failure to adequately protect its own employees against excess levels of carbon dioxide.

"The inspection found that both companies allowed their employees to enter an atmosphere that posed an immediate danger to life and health due to excess carbon dioxide levels inside the freezer and that they allowed the workers to do so without appropriate respiratory protection, without adequate training to recognize the hazard posed by the dry ice and carbon dioxide, and without stationing an employee outside the freezer to monitor and provide assistance to the worker inside," Gordon says.

"In addition, the restaurant was also cited for not posting a danger tag on the freezer, lack of a hazard communication program, and failing to address how outside contractor employees would be informed of hazardous materials and conditions and appropriate safeguards," she adds.

Ventilation and monitoring required

Gordon noted that feasible methods of addressing these types of hazards can include mechanical ventilation of the work space; the use of respiratory protection by employees; continuous atmospheric monitoring of the work area; and continuous visual, voice, or signal monitoring of employees in the work space.

"A case such as this shows in the strongest terms why safety standards are important and why it is necessary that they be followed," she says.

The specific citations and alleged failures are:

❒ **Dick's Last Resort** of Boston faces $49,000 in proposed penalties for seven alleged serious violations:

1. failure to provide a place of employment free from recognized hazards likely to cause death or serious physical harm in that an employee who entered the freezer was exposed to carbon dioxide gas in excess of the immediately dangerous to life and health concentration of 40,000 ppm;
2. failure to supply the employee with an appropriate respirator;
3. failure to ensure that a second employee was stationed outside the freezer whenever an employee entered it, in order to monitor, provide assistance and maintain communication with the first employee;
4. failure to post a danger tag on the freezer;
5. lack of a written hazard communication program;
6. failure to address how outside contractor employees would be informed of on-site hazardous materials and conditions and necessary precautionary measures;

7. failure to train employees were not trained on how to recognize and protect themselves from carbon dioxide hazards.

❒ **BALCO** faces $28,000 in proposed penalties for four alleged serious violations:

1. failure to provide a place of employment free from recognized hazards;

2. failure to supply the employee with an appropriate respirator;

3. failure to ensure that a second employee was stationed outside the freezer whenever an employee entered it, in order to monitor, provide assistance, and maintain communication with the first employee;

4. failure to train employees to recognize and protect themselves against the hazards of carbon dioxide gas and vapor.

A serious violation is defined by OSHA as one in which there is a substantial probability that death or serious physical harm could result, and the employer knew, or should have known, of the hazard. ■

Man dies because pump not grounded at plant

The death of a repairman at a chicken processing plant has led the federal Occupational Safety and Health Administration to cite B.C. Rogers Processors for safety violations and to propose penalties totaling $74,250 for safety violations at the company's Morton and McComb, MS, plants.

According to **Clyde Payne**, OSHA's Jackson, MS, area director, an inspection was begun after an employee was electrocuted at the Morton plant on June 18, 1999.

During the inspection, OSHA determined that the plant's liver pump, which moves chicken parts through the plant for processing, was not electrically grounded.

Electrical dangers high on hazard list

Payne notes that electrical hazards are one of the top four workplace hazards, so OSHA urges employers to take great care in protecting workers who are exposed to electrical equipment or wiring.

The Morton plant was fined $19,200 for one serious citation, which included several hazards involving electrical equipment, problems with defective gaskets on flip seals, and flip seals that were not closed on weatherproof receptacles. Also cited were deficiencies in lockout procedures, which ensure that hazardous energy is controlled during maintenance operations. In this case, personal lockout devices were not used by individual workers involved in group maintenance details.

An additional penalty of $47,500 was assessed against the Morton plant for one repeat violation involving unlabeled circuit breakers and exposed live parts in circuit breaker cabinets and for using flexible cords instead of fixed wiring at fixed motors and other equipment.

Complaints led to OSHA inspection

OSHA's inspection of the McComb plant was the result of a complaint about the company's failure to properly record occupational injuries and illnesses and its refusal to allow injured employees to see the plant's occupational health physician.

The McComb inspection, which began Sept. 14, resulted in one repeat citation against the company for failing to log all work-related injuries and illnesses. The citation carries a $7,500 penalty.

B.C. Rogers Processors employs 1,000 workers at the Morton plant and another 500 at the McComb plant. ■

Several employers cited for fall hazards

Several employers around the country have been cited for hazards related to fall protection recently, including a Dublin, GA, company, cited after a worker fell from a 911 communications tower.

Raymond Finney, the Atlanta-East area director for the federal Occupational Safety and Health Administration, reports that an employee of CSSI fell to his death from the top of a 600-foot 911 tower near Covington, GA, which he had free-climbed to troubleshoot its strobe lights. The citations carry penalties totaling $18,400.

Building and maintaining communication towers, the work that CSSI performs, is a high-growth

industry, Finney notes. According to the Labor Department's Bureau of Labor Statistics, 93 fatalities associated with this type of activity were reported from 1992 to 1997.

OSHA's safety inspection in response to the fatal accident revealed three serious violations:

• A cage or ladder safety device was not used when employees climbed over 20 feet on the tower.

• Employees did not use a safety harness and tie off with a lanyard when free-climbing the tower.

• Employees used tools that were not insulated or designed for live electrical work.

In another case, OSHA cited two Manchester, NH, contractors — Exterior Designs and Airtight — for alleged violations of the Occupational Safety and Health Act at a Manchester work site and has proposed combined penalties against the two companies totaling $39,900.

David May, OSHA area director for New Hampshire, says the alleged violations were discovered during an inspection conducted Oct. 7, 1999, at a building renovation project located in Manchester and chiefly concern the lack of adequate fall protection for employees. Exterior Designs was performing stucco work on the outside of the building and had 13 employees working on-site at the time of the inspection; Airtight, the renovation project's general contractor, had four employees working on-site.

Special emphasis on fall protections

The citations came as the result of an OSHA inspector noticing the hazards by happenstance.

"An OSHA compliance officer who was passing by this job site observed employees working on the second and third floors of this building without any visible fall protection, a situation which exposed these workers to potentially fatal falls," May says. "In line with OSHA's special emphasis program on fall protection, an inspection was opened immediately and these citations and fines are the result of that inspection."

OSHA's inspection found employees of both contractors exposed to a variety of fall hazards, in particular, potential falls of up to 50 feet through unguarded exterior wall openings on the second through fifth floors of the building.

Workers for Exterior Designs also were exposed to additional hazards involving the erection and use of scaffolding, including employees erecting scaffolding without fall protection; an employee working in an aerial lift without fall protection; employees accessing the building's third floor by jumping from the scissors lift through a wall opening; improperly installed scaffolding support posts; employees not adequately trained nor knowledgeable about scaffold erection; and scaffold erection not supervised by a competent person.

Spot inspections used to reduce falls

Noting that 28 New England workers fell to their deaths on the job in 1998, May explained that OSHA is seeking to reduce that number through a New England-wide special emphasis program that combines employer education with active enforcement. One element of that program includes unannounced spot inspections when OSHA inspectors observe employees working more than 10 feet above the next lower level without any apparent fall protection.

"So far this year, New Hampshire has been spared any fatal workplace falls, but employer and worker alike cannot and should not be lulled into a false sense of security because of that," he says. "Fall prevention is not a product of good fortune. Rather, it's the result of knowing, providing, and utilizing clear, basic and required worker safeguards."

Exterior Designs faces a total of $33,900 in proposed penalties for nine alleged serious violations. The company previously had been cited by OSHA for substantially similar violations in citations issued April 6, 1998, following an inspection at a Portsmouth, NH, work site.

Airtight faces $6,000 in proposed penalties for four alleged serious violation. ■

Falling pipe kills man in trench

The federal Occupational Safety and Health Administration has cited Fiore Construction Co. for alleged willful and serious violations of the Occupational Safety and Health Act and has proposed penalties totaling $57,800.

This marks the third time in 1999 that OSHA has cited the Leominster, MA, contractor for alleged trenching safety violations on an Exeter water main installation project.

David May, OSHA area director for New

Hampshire, says the alleged violations were discovered during an inspection initiated Oct. 14, 1999, in response to reports of an accident in an excavation in Exeter, where Fiore was installing water mains for the Town of Exeter. A Fiore employee was injured when a section of pipe that was being lowered into an unprotected trench slipped and pinned him against the trench's sidewall.

"The inspection found that the trench in question, which was 6 feet to 8 feet in depth, lacked any form of cave-in protection to prevent a collapse of its sidewalls onto anyone working in that trench," May says. "Collapse protection is essential since the sides of a trench can collapse with great force and without warning, stunning and burying workers beneath tons of soil before they have a chance to react or escape. Though no collapse occurred in this case, that in no way relieves an employer of the responsibility of providing this baseline, well-known, and required safeguard."

No protective system to prevent cave-ins

May explains that OSHA's excavation safety standard requires that excavations 5 feet or deeper must have a protective system in place to prevent cave-ins. Such protection can be supplied by shoring the trench's sidewalls or by sloping those sidewalls at a shallow angle. He notes that neither safeguard was in place or in use in the excavation at the time of the inspection.

"Of special concern is the fact that this is the third time this year OSHA has cited this contractor under this standard on this project," he says. "OSHA has no choice but to categorize the trenching citation as willful, its most severe category. Willful citations are issued only when OSHA believes, based on its inspection, that the employer knew what measures were required to protect workers yet apparently elected to ignore them."

Specifically, the citations and proposed penalties from this latest inspection encompass one alleged willful violation, with a proposed penalty of $55,000, for employees working within a trench that was not adequately sloped or shored against collapse. There also was one alleged serious violation, with a proposed penalty of $2,800, for a damaged synthetic web sling that was not removed from service.

Previously, OSHA issued a willful trenching safety citation, with a proposed fine of $55,000, to Fiore on June 14, 1999, following its inspection of a trench and a serious trenching safety citation with a $1,000 proposed fine issued to the contractor on Aug. 16, 1999, following an inspection of another trench.

Both citations are currently under contest. ■

Injuries and illnesses hit all-time low since 1970s

The latest federal statistics on workplace injuries and illnesses show that the rate for 1998 was the lowest since the Bureau of Labor Statistics (BLS) in Washington, DC, began reporting this information in the early 1970s.

A total of 5.9 million injuries and illnesses were reported in private industry workplaces during 1998, resulting in a rate of 6.7 cases per 100 equivalent full-time workers, according to a survey by the BLS.

Employers reported a 4% drop in the number of cases and a 3% increase in the hours worked compared with 1997, reducing the case rate from

7.1 in 1997 to 6.7 in 1998.

Within the service sector, the highest incidence rate was reported for transportation and public utilities (7.3 cases per 100 full-time workers), followed by wholesale and retail trade (6.5 cases per 100 workers).

About 2.8 million injuries and illnesses in 1998 were lost workday cases; they required recuperation away from work or restricted duties at work, or both.

The incidence rate for lost workday cases has declined steadily from 4.1 cases per 100 full-time workers in 1990 to 3.1 cases per 100 workers in 1998.

The rate for cases with days away from work has declined for eight years in a row and, at 2.0 cases per 100 full-time workers in 1998, was the lowest on record. By contrast, the rate for cases involving only restricted work activity rose from 0.7 cases per 100 workers in 1990 to 1.2 cases in 1997 and remained at that level in 1998.

The latter types of cases may involve shortened hours, a temporary job change, or temporary restrictions on certain duties (for example, no heavy lifting) of a worker's regular job. In 1998, the rate in manufacturing for days-away-from-work cases was lower than the rate for restricted-activity-only cases — 2.3 for days-away-from-work cases and 2.5 for restricted-activity-only cases. In all other divisions, the rate for days-away-from-work cases was higher than the rate for restricted-activity-only cases.

Injury rates generally are higher for midsize establishments (those employing 50 to 249 workers) than for smaller or larger establishments, although this pattern does not hold within certain industry divisions. Eight industries, each having at least 100,000 injuries, accounted for about 1.5 million injuries, or 28% of the 5.5 million total. All but one of these industries were in the service sector.

There were about 392,000 newly reported cases of occupational illnesses in private industry in 1998. Manufacturing accounted for three-fifths of these cases.

Disorders associated with repeated trauma, such as carpal tunnel syndrome and noise-induced hearing loss, accounted for 4% of the 5.9 million workplace injuries and illnesses. They were, however, the dominant type of illness reported, making up 65% of the 392,000 total illness cases.

Seventy-one percent of the repeated trauma cases were in manufacturing industries. ■

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