



Medical Mismanagement: Should OSHA Dictate How to Practice Occupational Health?

Before OSHA accuses anyone of medical mismanagement, shouldn't it define its qualifications for passing judgment?

I recently spent four days being deposed by Department of Labor attorneys because I had agreed to serve as an expert for a company facing a much-publicized ergonomics citation. The citation's initial charges included a series of alleged deficiencies falling under OSHA's rubric of "medical mismanagement." Although OSHA has repeatedly promised to stay out of the practice of medicine, this and earlier citations illustrates OSHA's foray into the regulation of occupational health practice.

At a recent National Advisory Committee for Occupational Safety and Health meeting, attendees raised concerns about the apparent lack of quality occupational health care for musculoskeletal disorders (MSDs) and the need for guidance through agencies such as the National Institute for Occupational Safety and Health. Dr. Linda Rosenstock, director of NIOSH, recently announced grant funding availability to train health services researchers in occupational safety and health. NIOSH's stated goals are to improve access to occupational health care and the quality and efficiency of that care, and to increase practitioners' participation in preventing workplace injuries and illnesses.

OSHA previously had limited its regulation and enforcement of occupational health practice to medical examination aspects of various chemical exposures for employee placement, monitoring and surveillance, and medical removal

in circumstances where potential for exposure existed and actual overexposure or adverse effects of it had occurred. In addition, the concern in many quarters, including OSHA that workplace physical (ergonomic risk) factors may cause or contribute to MSDs has apparently led the agency to carve out new territory for inclusion in its standard-setting activities.

If OSHA doesn't want to designate the practice of occupational health, why evaluate it?

Few occupational health professionals (OHPs) would argue that certain musculoskeletal disorders are not work-related to some extent. Certainly, once an MSD is present, various work and nonwork activities may temporarily exacerbate the symptoms and potentially affect the underlying pathology. But there is limited information as to the combination of physical factors and the levels of those factors required to produce or aggravate specific MSDs. The relative contribution of such factors to the development of an MSD also is uncertain. Likewise, we don't know the overall influence of physical factors on MSD development or on MSD-like symptoms. It is this lack of specificity which potentially makes the objective MSD etiology and enforcement of an eventual OSHA ergo/MSD standard difficult.

No one is against making work easier, more productive and safe, but the latter, not the former, is the legislative province of OSHA. In addition, the influence of myriad psychosocial factors increasingly reported to be highly associ-

ated with musculoskeletal symptoms precludes the exclusive use of symptoms such as those identified under Bureau of Labor Statistics data or surveillance definitions to identify *bona fide* MSDs. An exhaustive search for definitions, criteria and scientific basis for identifying and classifying medical mismanagement reveals little of scientific merit. Discussions with former OSHA officials indicate that, while the term "medical mismanagement" has been employed by OSHA, documentation enabling unbiased enforcement by OSHA compliance officers has reportedly not been provided for their use. In fact, that aspect of the citation that I analyzed ultimately was not pursued by OSHA.

Nevertheless, it is critical for all OHPs to become intimately involved in any governmental or consensus standards-setting where professional occupational health care judgment will be judged. It could be as simple as OSHA saying that companies must follow the specific recommendations of qualified OHPs in determining an employee's working status. However, NIOSH and OSHA appear poised to take a much broader role.

Clinical activities provided by physicians, nurses and other health care professionals depend on the scope of practice for each profession, as established by individual states. However, these activities have fallen exclusively under medical monitoring and surveillance requirements. The following overall functions comprise the majority of care in occupational health practice, both preventively and after an injury or illness has occurred: medical determination for job placement (*e.g.*, restrictions), medical monitoring and surveillance, diagnosis, treatment, rehabilitation, causal determination, recordkeeping and impairment determination. Activities such as hazard recognition and communication and health promotion also are important.

The American College of Occupational and Environmental Medicine doesn't define medical mismanagement, but brought significant structure to occupational health practice through the development of its 1997 *Occupational Medicine Practice Guidelines*, which provide a framework for diagnosis, treatment and other areas for general and specific body systems. Recommended time frames for disability are provided, but the guidelines do not specify, for example, nerve conduction velocity test values for diagnosis of nerve entrapment syndrome (*e.g.*, carpal tunnel syndrome). On the other hand, there still is no consensus among occupational health practitioners that such testing is essential for diagnosis of carpal tunnel syndrome.

There is also no precise framework for determining restrictions, but the guidelines significantly advance the process of structuring high-quality, consistent occupational health care delivery. Electrodiagnostic testing is not used in most surveillance activities, and OSHA citations have based in-

creased carpal tunnel syndrome levels on poorly defined criteria without benefit of electrodiagnostic confirmation.

Referrals and Revisits

Local practitioners had standing orders for on-site nursing staff that referral to a physician should occur if there is a lack of improvement after 10 days of a specific care regimen. However, OSHA's meatpacking guidelines from the 1990s, which have not been updated, specify a shorter time frame.

Much of health practice depends on knowing the nature and history of the patient's complaints. Part of that is understanding each patient and how he approaches work, as well as his psychosocial factors, symptoms and diagnosis, in guiding such medical management activities as referral time frames. Thus, designation of medical mismanagement based solely on work complaints cannot be justified. Each type of health problem requires its own time frame for referral. At the same time, patients whose condition is worsening need re-evaluation. It

has been proposed that workers may fear employer retaliation for seeking medical care, but this claim has not been scientifically validated. Ethnicity, gender, labor-management relations and other factors also can influence patient self-referral patterns.

Restrictions

Activity-specific medical restrictions are an essential component of work resumption for injured or ill employees. Except for functional capacity testing, there is little hard, published science on which to base precise restrictions. Ideally, restrictions should be structured on a progressive resumption of function, with progress documented through objective testing for strength, range of motion, aerobic capacity and other factors. However, to successfully meld employer and medical return-to-work actions, further analysis and criteria must be developed, including job tasks, job-specific medical standards, a systematic job-specific restriction matrix, reasonable accommodations and

restriction-consistent modified duty.

All of these can be accomplished by using different scientific approaches and quantitative ascertainment. However, for OSHA to select one approach over another without a solid scientific evaluation is clearly not in anyone's best interest. If only objective results from functional evaluations on individual workers could be used to set restrictions, setting evaluation criteria potentially could be achieved. What was really surprising was OSHA's expectation that workers with complaints and restrictions should be placed in modified duty specifically determined not to pose an MSD risk. NIOSH, in its 1997 assessment, and the finding of the First National Academy of Sciences Ergonomic Conference acknowledged that specific dose-response parameters for the development of specific MSDs cannot be set, based on current data. Thus, how could medical mismanagement be judged on the basis of MSD incidence or prevalence, given the current state of the art? Further, when such symptoms as pain are considered

in the restriction-setting process, along with a basic lack of quantitative knowledge on physical factor-MSD relationships, establishing a set group of modified jobs without MSD risks in a given workplace is not possible.

The basic state of the art for setting restrictions is just that, an art. Restriction-setting requires evaluation of objective and subjective factors. For OSHA to state that one approach is medical mismanagement, while accepting another, is not based on adequate scientific foundation.

OSHA also alleged that medical mismanagement, in general, potentially increased the risk of developing, or severity of, MSDs. Assessing this relationship includes answering such questions as: How long does it take for an MSD to develop? How long can someone with an MSD continue to perform an activity before additional pathology manifests? What risk level is provided by returning a worker with tendinitis, for example, to a job with low force, but frequent motion? Why can one worker be placed in modified duty without developing

symptoms yet another cannot?

The bottom line is that predicting risk in these areas is difficult, at best. Employers with or without occupational health advice cannot create so-called no-risk jobs or no-risk modified duty.

Other Issues

It is important to note the breadth of OSHA's medical mismanagement concerns:

- Workers were not afforded sufficient opportunity to become conditioned to the work;
- Minimal information was given to OHPs, or OHPs did not sufficiently encourage employees to report musculoskeletal complaints;
- Medical records were incomplete;
- OHPs didn't follow up with employees who returned to work;
- In-house OHPs failed to appropriately refer employees to physicians;
- Inappropriate job accommodation was provided for workers returning from medically directed time off;
- Tracking and follow-up of employ-

ees with MSD complaints was inappropriate or inadequate;

- Treatment was inappropriately conservative; and
- Medical protocols lacked definition and precision.

If OSHA doesn't want to designate the practice of occupational health, why evaluate it? How much definition and precision should there be in medical protocols before allegations of medical mismanagement arise? How should OHPs encourage employees to report symptoms early? Should workers report a few twinges in the same location over the last few days or over several weeks?

Is there adequate scientific basis from which to judge the optimum limits of these questions? What would be adequate? When should failure to meet these standards become medical mismanagement?

The American Association of Occupational Health Nurses (AAOHN) and the American College of Occupational and Environmental Medicine (ACOEM) have set forth guidelines and recommended practices for a range of topics. Neither

has set a bar upon which a specific infraction of medical mismanagement could be established. If OSHA wants to enter this arena, it first should study state laws and licensing boards for specific statutes and regulations. Then look at the history of disciplinary actions in these areas from licensing boards and at the specific criteria used by professional specialties. Considerable study and research in all areas of health care lately have concentrated on evidenced-based practice approaches in which practice protocols are investigated to ascertain the ones with the highest efficacy, safety and cost-effectiveness. Research must also address, if possible, the potential risk from medical mismanagement in terms of the development and exacerbation of actual disorders, not symptoms, along with a determination of quality, cost-effective occupational health care. This is of paramount concern for all types of practitioners, professional societies and state and federal governments.

If OSHA desires to join ranks with AAOHN, ACOEM and others to study and determine proper medical management

of work-related injuries and illnesses, it should do so within its congressional mandate, the 1970 OSH Act. NIOSH, on the other hand, is an institute with the congressionally legislated duty to research a broad array of occupational health issues, including occupational health care.

A state-of-the-art discussion sponsored by the various governmental and professional organizations is a good place to start. OSHA insists it does not want to regulate medical practice. Then why investigate and enforce medical mismanagement? How much more involved can you be in determining appropriate medical practice than evaluating the definition and precision of medical protocols when no one has scientifically established the boundaries? To paraphrase an esteemed jurist, "I can't define medical mismanagement, but I know it when I see it." Occupational health professionals, employers and workers deserve better. OH

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