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OSHA AND THE HEALTH SYSTEM PART 2 WINTER 1975

Introduction

Part I of the Fall, 1974 CCAHS Quarterly described the history, functions and programs under the Occupational Safety and Health Act (OSHA) of 1970. A brief history of occupational safety and health dangers, as well as legislative attempts to ameliorate such dangers and the particular problems affecting the greater New York City work force were also summarized.

Under OSHA, the U. S. Department of Labor (DOL) is charged with enforcement of basic safety and health standards at the workplace. These standards are based on the recommendations from the National Institute of Occupational Safety and Health (NIOSH) which is under the jurisdiction of the U.S. Department of Health, Education, and Welfare (HEW). Both agencies attempt to collect up-to-date statistics on deaths and injuries traceable to unsafe working conditions. Although primary responsibility for data collection resides with the DOL, to date, it has relied wholly on industry records and limited review of workmen's compensation records. These sources of data, used to make objective assessment of the effects of unsafe working conditions, are of questionable value. The 1974 Senate Oversight Hearings indicated gross governmental negligence in the collection of data on industrial work-related injuries and deaths. Several figures which are normally used and accepted as a definitive of the extent of the problem include: 15,000 to 25,000 deaths each year caused by industrial accidents and over 100,000 deaths each year from industrial disease exposure. The latter figure is attributed to former Secretary of Health, Education and Welfare, Elliot Richardson.

The most startling occupational hazard figures involve cancer, the nation's prime killer. The World Health Organization and others have asserted that most cancers are related to environmental and occupational exposures. Thus, these cancers can be prevented or greatly reduced by correcting our environment. Data like this show that occupational safety and health is not an isolated area of labor legislation, but is of concern to all Americans.

Workers, until the 1970 OSHA, had no national legislative act to create and enforce work-site safety or to correct hazardous working conditions. Despite this, health care professionals, institutions and workers are only beginning to see the relationship between unsafe work conditions and their health problems.

A recent American Public Health Association Journal editorial by Dr. Henry Howe, representative of the American Medical Association, stated that, "Medical surveillance of the health of working people, even under NIOSH and OSHA regulations, will increasingly involve the whole medical care delivery system, including the services of laboratory personnel, public health nurses, radiologists, epidemiologists, mental health professionals, dentists, community health planners, environmentalists, health educators, veterinarians, social workers and new professionals." Dr. Howe has come to realize the

interrelationship between workers' safety and health, and the responsibilities of the health care system in helping workers achieve safe working places.

Effective involvement of health professionals to minimize work related health problems requires the development of:

(1) a data collection network which would provide DOL with complete and accurate statistics on occupational safety and health problems faced by workers;

(2) a screening program to detect occupationally related diseases; and,

(3) a program of medical surveillance, treatment and prevention of occupationally related disease and injury.

Such proposed programs could then help translate OSHA into a more effective piece of legislation, and also reinforce the available health care delivery system with a strong emphasis on preventive medicine.

Today there is no specific legislative mandate, health code or other public health law requiring hospitals, medical professionals and other health care workers to monitor occupationally related diseases and disability.

The U. S. Senate Oversight Hearings on OSHA concluded in 1974 that there is a need for improved reporting mechanisms and aggressive adminstrative action to insure complete data collection. Workers and their unions who will benefit from more accurate records, are now lobbying for stronger legislation requiring better reporting. Once accurate data is collected, follow-up procedures and preventive measures can be established.

Incorporating occupational safety and health surveillance responsibilities into the job description of hospital workers will facilitate OSHA data collection at those institutions.

Of course, strong legislation which ties existing State and City Public Health Laws to OSHA is urgently needed. This will fill the vacuum between the federal, state and city levels. Although improved legislation is one immediate goal, interim programs should be immediately initiated to fill the gap.

Threat of Medical Malpractice Provides Incentives for Change

Recently, the U.S. Supreme Court ruled that a $79,000 award given to the widow of an insulation worker who died of asbestos inhalation be left standing. An effective medical surveillance program by that company's medical department might have saved the worker's life, thereby eliminating a sizeable court award and related legal expenses.

In another ruling, a retired steelworker has recently been awarded $30,000 in damages from the U.S. Steel Corporation in a landmark civil lawsuit in which the man claimed his hearing was impaired by excessive noise in the steel mill.

In yet another case, a Californian asbestos worker was awarded a $350,000 settlement in a malpractice suit against a company-employed doctor. Although the worker had been diagnosed three times by that doctor as having asbestosis, on no occasion was the worker informed about his illness. The doctor's defense stated that the company was his client and not the worker, and that nothing could be done about the disease anyway. The court ruled that the doctor did have an obligation to inform the worker. The court also recognized that the early detection of asbestosis could have been a basis to advise the worker to stop smoking and adjust other aspects of his life style. These actions could have lengthened the worker's life.

The defenses taken by most companies are usually adequate to protect them against adverse judgments. The rulings in those cases are exceptional in that the rights of workers were upheld. These cases may become landmark decisions which will force employers to improve working conditions or face large malpractice awards or other financial penalties.

A Hypothetical Case

It has been known since the late 1890's that aniline dye is carcinogenic. An aniline dye plant worker complained of excessive exposure to dangerous chemicals. A concerned nurse and physician, after talking with the patient, came to the conclusion that a serious health problem existed for the workers. The physician contacted the worker's union and in a few weeks spoke before workers from aniline manufacturing plants. During the discussion the workers realized that many physical illness complaints that they had could be related to their working conditions. A program was developed to have the workers put through a medical program to detect work related illnesses. The union instituted action to make the workplaces safer. This hypothetical case was posited to help answer these questions:

1. Did the MD have a moral or legal obligation to take any action?

2. If the hospital administrator had been informed, what steps would the administrator have to take? Was there a moral or legal obligation to do anything?

3. Can the patient's doctor (or the hospital) be sued for negligence for not protecting and informing other workers at the plant?

4. Should the doctor/hospital seek to force the company to institute safer working conditions (to minimize exposure to aniline dye)?

5. Should OSHA and public health laws be improved to ensure that health institutions and professionals take steps to correct occupationally-derived disease and injury?

Under present law and social practice, medical professionals, health institutions, and other health care workers have no legal obligation to identify and correct occupational health hazards. Despite the lack of legislative mandate, there is still an ethical and moral dimension to correct work related health problems faced by employees.

Needed: Consumerist Approach

OSHA enables workers, unions and public interest groups to correct occupational hazards. The worker is on the front line when occupational hazards exist. Workers often have the best information on workplace deficiencies. Consequently, their involvement in reporting these deficiencies is vital to the OSHA program. Many workers are deeply concerned about the effects an employer sponsored and controlled program can have on uninterrupted employment and promotions. But unless there is a strong union and worker participation, occupational safety and health programs may be suspect among employees.

Guarantees of privacy and confidentiality of the participants is essential. Without these guarantees, the best OSHA programs may falter due to worker fear, disinterest and non-participation.

The four year experience under OSHA, thus far, has shown that without the concerted action of workers, unions and local community representatives, OSHA would have had little impact on workplace health hazards. The combination of workers, as potential medical patients and community board activists, as users of available community services, can provide a sufficient political base to pass more effective occupation and safety health programs. This political base itself will greatly strengthen the enforcement of any legislation to improve workplace conditions. Specially tailored educational programs for community boards will create a better understanding of OSHA and exert pressure on local health facilities to develop occupational programs.

A First Step: Comprehensive Screening

Monitoring programs can identify safety and health problems faced by workers. Large-scale screening programs can determine whether workers are being exposed to excessive amounts of toxic substances which pose a serious threat to their health. Landmark programs have been inaugurated with the United Auto Workers, Local 259, which screened its members for asbestos exposure to brake linings. Tunnel workers were screened for exposure to silicosis; Textile Workers Union members were screened for exposure to poly-vinyl chloride. Other such programs, such as the screening of Bridge and Tunnel Officers for exposure to carbon monoxide, has been performed recently at St. Vincent's Hospital by Dr. Steven Ayers.

Programs like these are excellent examples of how cooperation between workers, employers, and health professionals can result in increased screening and early diagnosis of occupationally related diseases. But this is just the first step.

The next step is the linking of screening programs with comprehensive programs to diagnose, treat and prevent occupational disease and disability. In the Fall 1974 CCAHS Quarterly, these programs and those initiated by Dr. Irving Selikoff, of Mt. Sinai Environmental Sciences Laboratory, were briefly described. The remainder of this Quarterly briefly outlines where occupational safety and health programs can be linked to existing health care services.

The Out-Patient - Ambulatory Care System

Every day workers enter emergency rooms overcome by chemical fumes or excessive exposure to dangerous substances, or with work-related injuries or illnesses. Hospital-based outpatient and ambulatory care services, however, have few programs to detect or report unsafe or unhealthy working conditions. Since large numbers of people use these hospital based ambulatory services for primary, as well as for emergency treatment, the incorporation of occupational health and safety services would be extremely beneficial, reduce health costs and improve the lives of workers. Hospitals can become one data collection center to identify the sources of work related health problems. The unsafe work locations, once identified, can be inspected and a timetable for correction of unsafe conditions can be established.

For more chronic conditions, specialty clinics could routinely monitor workers for occupationally related diseases. Careful follow-up and "preventics" could help reduce the risk to uninfected co-workers. Better communications and coordination of OSHA programs between hospitals and local factories should be developed for continuous comprehensive medical detection programs to protect workers, prevent disease and minimize occupational hazards. These programs, developed within the OSHA guidelines, must maintain active involvement of workers, unions and community boards in policy making decisions.

Ambulatory care services can play a major role in occupational safety and health programs. For instance:

Obstetrics Gynecology (OB-GYN)

Pregnant workers should never be exposed to toxic substances. It has been established that carbon monoxide, lead and mercury, to name a few, can impair the fetus. Obstetrics-Gynecology departments should apprise patients of these dangers. Proper follow-up on pregnant workers can help lower birth defect and death rates and increase the chances for a normal delivery.

Pediatrics Clinic

Pediatrics clinics should be closely linked to OB-GYN. Some pediatric clinics now monitor for lead poisoning and drug addiction. Pediatric programs should be expanded to include infants exposed to ambient toxic chemicals. A careful medical history designed to identify any past occupational conditions which the mother may have been exposed to and which might have affected the fetus or the child is vital.

Pulmonary Function Clinic

Many industrial substances can adversely affect the lungs and respiratory systems of workers. OSHA-oriented pulmonary function clinics can catch the pulmonary problems of workers at an early stage. Once detected, workers can obtain professional advice to prevent further deterioration and be advised of the aggravation of their occupationally-derived pulmonary problems by such ordinary life-style habits as smoking.

Dermatology Clinic

The skin can manifest many signs of unsafe working conditions. Rashes, itching and other apparently minor dermatologic irritations, can be an early warning to dermatology clinic staff that workers are in contact with dangerous substances. Preventive programs can be developed to detect and correct health related dermatological problems.

Mental Health Facilities

Mercury, noise and carbon tetrachloride are just a few of the environmental substances found in factories as being identified as possible sources of mental distress. Pressures of various kinds at work can also cause severe mental stress. Exposure to chemicals inimical to the human nervous system can cause severe mental and nervous system disorders. Community mental health programs should be integrated into OSHA programs. These programs should be expanded to include detection and treatment services for occupationally caused mental disorders.

Occupational Safety and Health Clinic

Occupational safety and health clinics do not exist in any hospital or related health facility now. When developed, an OSHA clinic would collect and analyze data and follow-up on the occupational causes of disease or injury. In addition, it would serve as a screening and diagnostic center for other specialty clinics. Labor and management groups could receive training about occupational problems. Health professionals would also be trained to detect occupationally-related diseases and injuries. These clinics would serve as a central contact to the local health departments.

The Emergency Room

The Emergency Room (ER) can become a vital link to OSHA for workers, unions, management, and the Department of Labor inspectors. ER personnel could perform "Imminent Danger" inspections for the DOL or report imminent danger situations to the DOL. The Act requires an inspection of a workplace within 24 hours by the DOL when an imminent danger exists. Emergency rooms designated by the DOL as centers could report potentially dangerous conditions, request imminent danger inspections, and provide valuable medical and technical expertise to DOL inspectors.

In addition to the ambulatory services, in-patient services can be utilized to detect and correct occupational safety and health hazards.

Hospital In-Patient Programs

Occupational health programs to be implemented on an in-patient basis would closely follow those outlined for specialty clinics. In-patients are more available for in-depth interviews about working conditions.

Health care workers (nurses and social workers) in closer contact with in-patients would be invaluable information gatherers.

Hospital Pathology

Hospital pathology departments have personnel trained to find the origins of disease. Developing a relationship to detect and report occupational related diseases with the DOL, health department and this department is needed.

Medical Record and Related Certificates

New modernized methods of taking a medical history and recording treatment and the patient's progress have been introduced recently. The present medical record (chart) format needs further revision to include data on the patients' (or family) occupational history, potential work hazards faced, etc.

Another important medical document used to determine the causes of death is the death certificate. Present death certificate format makes it practically impossible to record causes of death related to work. The death certificate needs to be revamped to allow for the recording of occupational causes of death.

The birth certificate could also be adjusted to include health problems of the newborn which can be traced to the mother and other family members. Modification of the birth certificate would probably be more difficult to accomplish but appropriate revision would be invaluable to epidemiologists.

Health Science Schools and Training

OSHA's effectiveness requires concerned and knowledgeable health professionals and workers. Several areas outlined below can be points where the educational process can begin.

Medical Schools

According to recent figures, there are only 2,624 full-time doctors in the U.S. in occupational medicine and only two medical schools providing full programs in occupational medicine. Medical school curricula has to be expanded to train more physicians for occupational medicine.

Schools of Nursing

Nursing school curricula should be expanded to train more nurses for occupational health services.

Schools of Public Health

Occupational medicine courses exist in most schools of public health. Expansion of courses, plus upgrading of course content and staff would

attract a wider range of health professionals.

Schools of Social Work and Allied Fields

Adding occupational health and safety course content to school curricula will prepare their students to detect occupational diseases. In addition, students in physician-assistant, nurse-practitioner, para-medical and similar programs would benefit from training in occupational safety and health, since many innovative health programs have increased the medical responsibilities of these workers. The suggested expansion and additions of program do not require radical modifications in course curricula.

Training Present Health Care Personnel

The training and education of present health care workers is needed. Professional health associations might offer courses on occupational safety and health for members. Health worker unions also might run classes for members on occupational safety and health issues.

Local Government Health Agencies

Local government health agencies have a responsibility to make the workplace safer for workers and the health system more responsive to the health needs of workers. For instance, in New York City, the City Health Department currently inspects restaurants to ensure that minimal standards are met. A similar program to inspect work conditions would protect employees. The City Health Department would inspect work sites to see that OSHA standards are being met; the results made available to the unions, the public, and workmen's compensation insurance companies.

Another program started by New York City and copied throughout the country is the Poison Control Center. Anyone seeking information about poisons can call. The Center expanded, to include an up-to-date roster on substances found in factories, etc. would be helpful to workers and unions.

Also administered by the City Health Department is the "Ambulatory Care Program," (see Health Perspectives, "Ambulatory Care Program - Role For the Consumer," Jan-Feb, 1975) which governs the spending of public monies in the ambulatory care programs located at participating non-profit voluntary hospitals. The addition of occupational safety and health programs to the Ambulatory Care Program contract would greatly expand life-saving and cost-producing services at those institutions. Community Boards, as on-the-spot monitors of this added program, would ensure responsiveness to community and worker needs.

Summary

The OSHA legislation had raised hopes that the workplace would be a place to support life, not to shorten or cripple it.

This hope can only be fulfilled if present legislation is expanded to

include guarantees that data will be collected on occupationally-derived illness and injury, and that, this data will quickly lead to preventive and corrective measures.

OSHA's dream can be fulfilled only if workers and unions are full participants in programs designed to protect them against peril. That method will be more successful if health care providers, as well as City and State health agencies provide professional, technical back-up for all occupational safety and health programs. This in turn requires a more compassionate, concerned and educated provider.

Once these elements are merged, successful OSHA programs, more readily accessible to workers, will reduce health and safety hazards at the workplace.