

NECOEM *Reporter*

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Upcoming Events

May 10: Alternative Modalities in Returning Veterans with PTSD to the Workforce, Candace Green, Portland, ME, www.necome.org

May 15: Workplace Sleepiness and Sleep Disorders, Steven Lockley, PhD, Farmington, CT www.necoem.org

June 10-12: Preventing and Treating Biological Exposures, Cambridge, MA www.eagleson.org/OCCHEALTH

Fall 2012: Aerospace Medicine, location TBD, www.necoem.org

NECOEM/MaAOHN Annual Conference 2012 November 29 and 30
 Newton Marriott Hotel,
 Newton, MA

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Unexpected Exposure on a Farm

by Karen Huyck, MD, PhD, MPH

A retired teacher living in a rural area presents to the occupational medicine clinic with a six-month history of episodic panting, dyspnea, burning of the nose, decreased taste, dysphagia, headaches, dizziness, ataxia, poor balance, facial droop, and decreased concentration and memory. She had an extensive medical work up through her primary care provider that was negative for underlying neurologic, pulmonary, or rheumatologic disease. She also had noticed increased sensitivity to many substances including solvents, cleaning solutions, detergents, synthetic fragrances, laminated

flooring, and particle board. Wearing of an organic vapor mask decreases or prevents the symptoms, as does being away from her house or if she is at the house being in rooms closed to outdoor air.

She reported no prior allergies and past medical history is otherwise unremarkable. She is a former smoker and does not drink alcohol. Physical exam at the time of visit was largely unremarkable. She noted living with her spouse in a single family farmhouse for the past 20 years located in an agricultural area. Her residential history revealed no

concerning exposures other than a bathroom containing moldy areas and water damaged wallboard. She has no livestock, she does keep indoor pets, and she uses no unusual chemicals. The house water is from a private well with a two year-old pump, but she does not drink the water because of concern for high metal content (no test results were available).

The exterior of the home, however, is notable for actively tilled earth including about 100 acres of hay and corn fields, nearby trees, wild-

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Temporary Worker Effect

by Marcy Goldstein-Gelb

For ten hours each day, Juan C. peeled fruit at a multi-national food production plant on the south shore of Massachusetts. In 2011, while carrying a large bucket of fruit, Juan fell, fracturing two discs in his back. What would normally be a textbook workers' compensation case

quickly became a nightmare when Juan discovered a surprise: he wasn't working for the plant after all, but instead for a temporary [staffing] agency.

While workers' compensation can be difficult for any worker to navigate, for Juan and thousands of other temporary

workers in Massachusetts, trying to reach the temporary agency to find out the name of the provider is nearly impossible. In Juan's case, the only human voice at the temporary agency was an answering machine. For other temporary workers, their

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Farm Exposure (Continued from page 1)

flowers, silos (unspecified contents), as well as neighboring farms and livestock barns. The grounds are often damp due to nearby streams. Further questioning revealed a neighboring farm across the river and upwind from the property has approximately 1200 head of cattle. She states she discovered that formaldehyde was being used on the farm to treat hairy warts on the cattle's feet. The formaldehyde was stored in 55 gallon drums labeled as 37% formaldehyde, and the workers using it were not wearing any personal protective equipment. By her report, some of the workers noted occasional symptoms such as tremors. It was also reported that the waste from the disinfectant treatment was poured into the manure pits, which was then sprayed onto fields. The fields that were being sprayed at the time of onset of her symptoms had just been switched to hay from corn, which is notable because reportedly hay requires more frequent spraying. A home testing product for formaldehyde was purchased, reportedly showing levels of $0.8\text{mg}/\text{m}^3$ (0.65 ppm) inside the patient's house, and the manure from the neighboring farm was off the chart for the colorimetric test. State and federal authorities had been contacted, but it was unclear what if any investigation had been undertaken.

Formaldehyde is a colorless, flammable, strong-smelling chemical that is used in building materials, including pressed-wood products (such as particleboard, plywood, and fiberboard), glues and adhesives, permanent-press fabrics, paper product coatings, and certain insulation materials. In addition, formaldehyde is commonly used as an industrial fungicide, germicide, and disinfectant. Formaldehyde is also a product of combustion, released by the burning of materials such as natural gas, wood, gasoline, kerosene, or tobacco. Formaldehyde is classified as a volatile organic com-

pound (VOC), and is quickly broken down in the air, usually within hours. Formaldehyde evaporates from shallow soils, and in water may be broken down by bacteria or other microorganisms. Formaldehyde in small concentrations is a normal part of our environment. According to a 1997 report by the U.S. Consumer Product Safety Commission, formaldehyde is normally present in both indoor and outdoor air at low levels, usually less than 0.03 parts of formaldehyde per million parts of air (ppm). Outdoor air levels are typically between 0.0002 to 0.006 parts per million (ppm) in rural and suburban areas.

Formaldehyde is a highly reactive molecule that can be directly irritating to tissues with which it comes into contact. The odor of formaldehyde gas can be recognized at concentrations as low as 0.03 ppm. When formaldehyde is present in the air at levels exceeding 0.1 ppm, some individuals may experience adverse effects such as watery eyes, burning sensations in the eyes, nose, and throat, coughing, wheezing, difficulty in breathing, nausea, fatigue, headaches, dizziness, skin rash or irritation. Irritation of the eyes, nose, and throat is the most common health effect. Exposure to formaldehyde at 10 ppm causes severe irritation of the upper respiratory tract, with a burning sensation of the nose and throat, coughing, choking and vomiting. Exposure to 50 ppm or higher may lead to inflammation of the lung (pneumonitis) or to a potentially fatal accumulation of fluid in the lungs (pulmonary edema). Symptoms of pulmonary edema (chest pain and shortness of breath) can be delayed for up to 24 or 48 hours after exposure. High concentrations also may trigger attacks in people with asthma. Formaldehyde may cause occupational asthma, but this is quite rare and seems to occur in susceptible individuals, probably through irritation of the airways. There is evidence that

some people can develop a sensitivity to formaldehyde leading to severe allergic reactions of the skin, eyes, and respiratory tract. Once a person is sensitized, contact with even a small amount of a formaldehyde solution can cause outbreaks of dermatitis characterized by redness, rash, itching and swelling that can spread from the hands or arms to the face and body. It is estimated that 3 to 6% of the population responds positively to patch testing with 2% formaldehyde. Up to 20% of individuals are very sensitive to formaldehyde and may react acutely to formaldehyde at very low concentrations (below 0.1 ppm), whereas others have no reaction to the same level of exposure, and the health effects of formaldehyde exposure vary from one person to another.

Human eyes are especially sensitive to formaldehyde. Many people describe the eye irritation as a burning sensation much like when cutting an onion or when you get soap in your eyes. The threshold for mild eye irritation may be as low as 0.01 ppm. Light to medium eye irritation has been observed after five minutes of exposure at 0.2 ppm, and medium to severe irritation at 0.6 ppm. Exposure to 0, 0.25, 0.5, 1 or 2 ppm formaldehyde gas for 90 minutes resulted in irritation of the eyes at all concentrations with severity increasing with concentration. Formaldehyde also is corrosive to the eyes and can cause severe eye damage with permanently altered vision or blindness. There are several case reports of eye injury occurring when formaldehyde solutions were accidentally splashed into the eyes. Characteristically, formaldehyde eye injuries are immediately painful but can leave the eye looking normal for at least an hour or two after exposure. Over the course of the next 12 hours,

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very severe eye damage becomes apparent.

Formaldehyde solutions are toxic if ingested, causing corrosive burning of the mouth, throat and digestive tract with vomiting of tissue and blood, metabolic acidosis from conversion to formic acid, damage to the liver and kidneys, and in severe cases, convulsions, central nervous system depression, and death. The fatal dose of formaldehyde in a 70 kg person is estimated to be about 60 to 90 mL of 37% formaldehyde.

The effects of long-term exposure are not well known. Long-term exposure to high levels of formaldehyde has been shown to cause nasopharyngeal cancers. The United States Environmental Protection Agency (EPA) has listed formaldehyde as a probable human carcinogen, while The Department of Health and Human Services (DHHS) and the International Agency for Research on Cancer (IARC) have classified formaldehyde as a human carcinogen based on studies of inhalation exposure in humans and laboratory animals. There is strong but not sufficient evidence for formaldehyde causing leukemia. Firm conclusions cannot be drawn about the potential nervous system effects of long-term formaldehyde exposure as studies have been confounded by exposure to other solvents. Other studies have failed to find any significant neurological effects in large exposed populations. Impaired learning and changes in behavior have been observed in rats after exposure to high concentrations of formaldehyde. In terms of respiratory effects, occupational exposure studies indicate that formaldehyde exposure causes temporary, reversible decreases in lung function, but no long-term effects. Although recent studies suggest that irreversible effects are possible.

Formaldehyde does not accumulate in the body. It has a half-life in

the blood of about 90 seconds and is (1) rapidly metabolized to formic acid and excreted in the urine, (2) converted to carbon dioxide then exhaled, or (3) used by the body to make proteins and nucleic acids. Formaldehyde cannot be reliably measured in blood, urine, or body tissues following exposure because formaldehyde is produced in the body and would be present as a normal constituent in body tissues. Antibodies to formaldehyde-bound proteins can be found in the blood of people exposed to formaldehyde; however, this test cannot be used to determine the extent of exposure or the kind of health effects that might develop from exposure.

The most common guideline for acceptable formaldehyde levels is 0.10 ppm. Few people will have health problems at levels below 0.10 ppm. However, some people are sensitive to formaldehyde and may experience health effects at levels below 0.10 ppm. If you have levels of formaldehyde that exceed 0.10 ppm it is recommended that you take steps to reduce the levels by removing the source if feasible and increase ventilation. The EPA has determined that lifetime exposure to 1 ppm formaldehyde in drinking water is not expected to cause any adverse effects. The legal limit set by OSHA for formaldehyde exposure in air averaged over an 8-hour work day is 0.75 ppm. The short-term exposure limit (STEL) is 2 ppm, which is the maximum exposure allowed during a 15-minute period. The action level, which is the trigger for increased industrial hygiene monitoring and initiation of worker medical surveillance, is 0.5 ppm when calculated as an 8-hour time weighted average. (See OSHA Standard 1910.1048 for details.) OSHA considers concen-

trations of 100 ppm immediately dangerous to life and health (IDLH), whereas The National Institute for Occupational Safety and Health (NIOSH) considers 20 ppm of formaldehyde to be IDLH. The NIOSH recommended exposure limit (REL) is 0.016 ppm time weighted average and 0.1 ppm 15 minute ceiling. The Department of Housing and Urban Development (HUD) standards for formaldehyde emissions in manufactured housing are less than 0.2 ppm for plywood and 0.3 ppm for particle board. The HUD standards are designed to provide an ambient level of 0.4 ppm or less in manufactured housing.

In this case, treatment was aimed at presumed formaldehyde exposure (avoiding exposure, appropriate respirator with organic vapor cartridge, ENT evaluation for possible nasopharyngeal effects) and aimed at mitigating the hypersensitivity response, including addressing hypersensitive glottal reflex, heightened olfactory response, and exposure-related anxiety symptoms (such as capsaicin swish, anxiolytics, gabapentin, olfactory retraining, intranasal lidocaine or ipratropium nasal spray).

Karen Huyck is a Physician at the Dartmouth Hitchcock Medical Center, Department of Occupational & Environmental Medicine and a member of the Board of Directors of NE-COEM.

References accessed December, 2011:

<http://www.epa.gov/iaq/formalde.html>

<http://www.atsdr.cdc.gov/phs/phs.asp?id=218&tid=39>

http://www.ccohs.ca/oshanswers/chemicals/chem_profiles/formaldehyde/health_for.html

<http://www.cancer.gov/cancertopics/factsheet/Risk/formaldehyde>

http://www.osha.gov/OshDoc/data_General_Facts/formaldehyde-factsheet.pdf

<http://www.cpsc.gov/cpsc/pub/pubs/725.pdf>

<http://www.health.state.mn.us/divs/eh/indoorair/voc/formaldehyde.pdf>

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10075

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Temporary Worker (Continued from page 1)

“temporary agency” was a van driver who picked them up and drove them to their worksite, which can range daily from fish processing plants to construction sites.

There have been some studies addressing the relation between temporary employment and occupational injuries. A recent revision has reported that seven of 13 relevant studies show a consistent increased risk of occupational injuries among temporary workers. [http://www.ncbi.nlm.nih.gov/pubmed/15737968] In that revision, it is suggested that the association among temporary workers may be related to their greater inexperience and lack of safety training at the workplace, although the association may be biased by confounding related to occupation.

Last year, Juan C. and other temporary workers joined a coalition being spearheaded by the Massachusetts Coalition for Occupational Safety and Health (MassCOSH) that seeks legislative reforms to address a growing problem of hard-to-track “shadow” temporary agencies. Known as the REAL Coalition (Reform Employment Agency Law), the group includes a diverse contingent of workers, occupational and public health professionals, community members, attorneys, labor representatives, faith leaders and even business owners, tired of being undercut by temp agencies that aren’t paying into comp.

According to a June 2011 report produced by UMass Amherst, over one-third of temp agency workers in the Commonwealth are low-wage industrial and service sector employees. These low-wage temporary employees are sent off to work in some of the most dangerous and difficult jobs in the state: residential construction, landscaping, fish and meat

processing, recycling, rock cutting, cranberry harvesting, cleaning and janitorial services. With little experience and often no safety training, temporary workers are at elevated risk of injury and even death.

The Employment Agency Reform bill (House 1393) filed by Rep. Dorcena Forry and Senator Jack Hart addresses a gap in Massachusetts law that excludes temporary agencies from state regulation. The bill allows the state’s Department of Labor Standards to regulate temporary agencies and carry out inspections when needed. It also requires temporary agencies to provide non-professional employees with basic written information about their job, such as the name of the employer, the wage rate, and the workers’ compensation provider: critical information that would have helped Juan C. after his fall. The bill has already received a favorable report by the Joint Committee on Labor and Workforce Development and was endorsed by the state’s Attorney General, the Governor’s Labor Department, and the Massachusetts Bar Association

“The Massachusetts Bar Association’s overwhelming support for the Employment Agency Reform Bill makes complete sense for many reasons,” said Doug Sheff, Vice President of the Massachusetts Bar Association. “First, it protects the most vulnerable workers in the Commonwealth from abuse, even serious injury and death. But it also protects law-abiding businesses from being undercut by fly-by-night temp agencies.”

Concerned by the lack of access to medical treatment for temporary workers, the Massachusetts Medical Society approved a resolution in May 2011 supporting the provision of the bill pertaining to workers’ compensation. It supports “legislative efforts to ensure provision of written information to temporary workers

within 72 hours or fewer of hire detailing required personal protective equipment for the job and all information necessary to access workers’ compensation benefits in the event of a workplace injury.”

“We’ve seen a groundswell of support for this bill,” said Jonny Arevalo, MassCOSH’s Worker Center Educator who is helping to spearhead the REAL Coalition. “I think it’s because this bill is not only common sense, but will help thousands of people who work in the shadows of the economy and are so vulnerable to abuses.”

At a recent hearing on the bill, Dr. Robert Naparstek, a Fellow of the American College of Occupational and Environmental Medicine told the legislature that the bill was long overdue: “As a doctor, I have witnessed this horror many times. When an injured worker cannot rightfully access workers’ compensation they inevitably receive late and sub-standard medical care.”

“Having occupational professionals testify, meet with and send letters has been critical in helping legislators understand how this bill impacts the safety and access to medical treatment for some of the state’s most vulnerable workers,” said Arevalo of MassCOSH. Referring to the recent vote to favorably move the bill out of the committee, he added, “We’ve achieved a first milestone – but we still have several critical steps to ensure the bill’s passage.”

Looking to learn more about The Employment Agency Reform bill? Contact Marcy Goldstein-Gelb at mary.gelb@masscosh.org for more information and how you can get involved.

The Henry Ingersoll Bowditch Award for Excellence in Public Health- A Local Public Health Perspective Can an Occupational Medicine Physician get involved?

by Phil Adamo, MD, MPH, FACOEM

Recently, the Massachusetts Medical Society presented me the Henry Ingersoll Bowditch Award for Excellence in Public Health. I am humbled as the recipient and wanted to become familiar with this 19th century physician. Dr. Bowditch was an active, passionate abolitionist and clinician. Although these two passions seem to be at opposite ends of the spectrum, once you read about his life you can understand his contributions to society. He graduated from Harvard College and Harvard Medical School and spent time in Europe advancing his medical education. He was among the first American physicians to become proficient in the use of a stethoscope and upon his return to America published books and articles on cardiac physical diagnosis. As his career advanced, he became more interested in the public health movement in America. He became impressed with the importance of sanitation in preventing the spread of disease. He became the first president of the Massachusetts State Board of Health and in 1877 was elected president of the American Medical Association. Ironically, he died of tuberculosis in 1892 at the age of 84.

My colleagues suggest my career emulates Dr. Henry Bowditch's. While my experience cannot match the great success of Dr. Bowditch in his time, there are similarities. Obtaining a Masters in Public Health and working both in the field occupational medicine and the public health arena have given me a sense of professional satisfaction. However, I have not worked alone to achieve this success. When you surround yourself with passionate and good people, they lift you higher and motivate you to be the best you can be. During my journey of pub-

lic health advocacy I have been surrounded by great people.

My public health advocacy efforts have spanned from the local level, to state, and further into the Massachusetts Medical Society. First, as a 10 year volunteer on the Massachusetts Department of Public Health Sharps Injury Prevention Advisory Committee which was promulgated by the Department of Public Health after signing it into law in 2000 by Governor Mitt Romney. Later, at the Mass Medical Society in the Occupational and Environmental Committee under the leadership of Dr. Bill Patterson where we spearheaded many environmental and health issues such as childhood asthma. These experiences prepared me for the future challenges of public health advocacy on the local level.

Creating the Pittsfield Board of Health was a vision of one of our city counselors that blossomed into a collaborative effort to include Mayor Ruberto during his first term. With the help of the city solicitor, the Board of Health was established on October 12, 2004. I was selected by the board members to become the first chairman of the Board of Health, a position that I retain to this day. The diverse experience of the membership is what makes this an important community board. To-

gether, with the director of the department we meet the challenges of the community.

As chairperson, one of the most pressing issues involved PCB's near a community school, along with the ensuing remediation. This was a result of a consent decree signed by the previous Mayor of Pittsfield with General Electric. As you know, the PCB problem is highly emotional and political and the science is very controversial. There was poor risk communication between the remediation companies and the citizens resulting in a lack of trust. My first challenge was to gain the trust of the community through education and establishing bi-directional lines of communication while acknowledging the community concerns surrounding PCB's. I also had to ensure that the proper protocols were followed during the remediation. I remember at times going to meetings and anticipating it would get highly charged and wishing that there was police protection available because some threats had been made against me. I remember leaving the school building through a side door and looking over my shoulder to make sure that no one had followed me out. I wanted to make sure that I was quoted properly in the newspaper so that this did not become a media

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Farm Exposure (Continued from page 3)

<http://www.epa.gov/iris/subst/0419.htm>

<http://www.gpo.gov/idsys/pkg/BILLS-111s1660enr/pdf/BILLS-111s1660enr.pdf>

<http://ehs.okstate.edu/links/FORMALD.HTM>

Neghab, et al. Respiratory morbidity induced by occupational inhalation exposure to formaldehyde. Industrial Health. 49:89-94, 2011.

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Rhode Island Occupational Happenings

Narcotic Prescriptions are very much in the spotlight for all prescribers in the Ocean State. The Board of Discipline and Licensure has published its “Rules of the Road” to remind physicians “...to preserve the ethical imperative to unself-interested advocacy (and) ...do no harm.” Three persons die each week from a prescription drug overdose with the bulk reflecting OxyContin abuse. **Chronic pain management** is no stranger to the occupational health practice and offers particularly challenging clinical decision-making.

This came into sharp focus for my practice last year. I rented space within an Urgent Care facility. In June the owner of the facility received notice from the Board that his license was “summarily suspended” and he was to cease all physician work at once. He was being investigated by the Medical Board, the Pharmacy Board,

the Attorney General and the Federal Department of Drug Enforcement. He had been provided a “pharmacy” by a proprietary company that dispenses medications to “work injured” patients. It was alleged that the narcotics in that pharmacy were ending up on the streets and that he was receiving the bulk of the income from the street sales.

The Channel 10 news truck appeared immediately in front of our building just as an online article appeared in the *Providence Journal*. The impact was immediate: the urgent care ceased operations, the radiology service left the building, the lab left the building and drug salespersons were instructed by their employers to cease visiting. All the other tenants felt that their own reputations had been dirtied. I nearly lost my practice.

Rhode Island, like the Commonwealth of Massachusetts, is requiring documentation of CME in opioid use for license renewal. The Department of Health reminds us that use of opioids requires a higher level of care and documentation. They want to see a “pain agreement/contract” and careful monitoring of outcomes and adverse effects. They recommend referral to “pain management clinical experts.”

--Steven G. McCloy MD

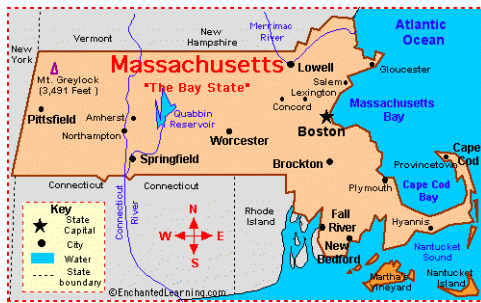
Excellence in Public Health (Continued from page 5)
frenzy. I created a grass-roots task force that involved teachers from the school, residents from houses in the area, government agents from local government, the department of public health, the Environmental Protection Agency and the Massachusetts Department of Environmental Protection. It took close to a year to gain the trust of the citizens in the area. In public health, there is often compromise and although in the ideal world, one would want the toxic waste sites to be totally removed, but where and at what risk. My message was that this was the best alternative to making this a superfund site.

The Pittsfield Board of Health has taken on the challenges beyond non-compliant homeowners and restaurant inspections. We have also been involved with emergency preparedness, the H1N1 epidemic, healthy food initiatives, improving community housing conditions, regulating the practices of body artists and also touching on the issues of child-

hood obesity. Through Mass in Motion, the citizens have access to healthier foods and resources to improve exercise habits. We have witnessed a decrease of cigarette sales to minors but improvement is still needed as challenges remain. Through our passionate and good public health advocates in our community, the Pittsfield Board of Health is revising the regulation of youth demographic marketing of products. Our local regulation has become a benchmark for other Massachusetts communities. It is the board’s belief that community involvement improves outcomes and compliance. Dr. Bowditch advocated for the prevention of spread of disease. Just as he addressed sanitation standards, we have addressed sub-standard living conditions in neighborhoods. Such apathy and dilapidation of housing can lead to increased illness. We developed a system that gives citizens, home

owners and landlords an opportunity to improve living conditions before receiving penalties. We believe that education of citizens helps them to understand regulations and make changes for better health. Public health and prevention is the key to a healthy community. I have surrounded myself with passionate and good people that have helped propagate community wellness. I can have it all, a passion for the occupational world and public health – a professional place that I intend to stay with the goal of continuous improvement!

Phil Adamo is the President of NECOEM and Medical Director of Employee Health, and Occupational Health/Injury Care at UMass Health Systems and Medical School



Massachusetts Occupational Happenings

The Massachusetts Medical Society Committee on Environmental and Occupational Health is currently accepting applications for membership on the committee. The committee provides advice and counsel to the Massachusetts Medical Society on issues relating to environmental and occupational health, and works to improve the health of the public by promoting professional understanding of and involvement in environmental and occupational health issues.

The committee is active on a range of issues, determined by the members and the organization. Some recent committee activities include:

- Recommending policy for MMS and the state regarding influenza immunization for health care workers
- Hosting a regional scientific and policy symposium on wood biomass for heat and power to educate government officials from the northeast states about

health impacts and regulatory measures to mitigate those impacts.

- Reviewing and providing comments on draft guidelines promulgated by the Health Care Services Board at the Department of Industrial Accidents.
- Advocating for clean air and water
- Participating with academic institutions on with coalitions to protect residents from occupational and environmental hazards.
- Planning of the Massachusetts Medical Society / Harvard School of Public Health Leadership Forum on Energy and Health which brought together experts from medicine, government, public health, academia and business to discuss the relationship between the environment, individual health, and human health, and to identify action steps for individuals, physicians, policymakers, and the Society to promote environmental and human health

The committee typically holds one evening meeting every other month at Massachusetts Medical Society headquarters in Waltham, with the option to connect remotely.

If you are interested in learning more about the committee, or applying for membership, please contact Robyn Alie, ralie@mms.org, John Burress, Vice Chair (john.burress@bmc.org), or David Dietz, Chair (David.Deitz@LibertyMutual.com)

A Personal Experience of Mentorship, Professional Development and Public Service

Some years ago, Bill Patterson informed me (i.e., subtle arm twist) that I should become a member of the Massachusetts Medical Society Committee on Environmental and Occupational Health. Bill articulated a rationale that resonates as clearly today for others as it did for me then. That rationale, for the OEM Physician, includes:

- *Balance your professional life via adding to “E” aspect of OEM*
- *Opportunity to “give back” via assisting with public health initiatives, policy development, and education*
- *Advance your career via demonstrating constructive advocacy to your peers*
- *Glean insight into topics that impact our specialty*

- *Appreciate machinery of Mass Med, AMA, and state governance*
- *Enjoy collegial interactions with leaders in our field.*

Dr. Patterson saw Mass Med CEOH as a logical progression from involvement locally to a statewide sphere of interest/influence. My experience has confirmed Bill’s assessment; my professional life has been enriched by serving on this committee and I would strongly encourage each NECOEM member to consider doing so.

John W. Burress, MD, MPH, FACOEM

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NECOEM

NECOEM is a not-for-profit, regional component society of the American College of Occupational and Environmental Medicine, the pre-eminent organization of occupational and environmental physicians, associate and affiliate clinicians.

NECOEM has over 240 physician, associate and affiliate members and is dedicated to preventing and treating occupational injuries and illnesses. NECOEM provides continuing medical education for its members and other clinicians in order to enhance the care that they provide to men and women in the workplace. NECOEM is an advocate for workplace safety, occupational health research, raising public awareness of occupational and environmental health issues, providing guidance on public health policy, and recognizing outstanding achievement by individuals in occupational and environmental health.

The editorial board welcomes letters to the editor. Write or email to NECOEM at the above address. The editor reserves the right to edit letters for publication purposes.

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Bread and Roses Centennial

One hundred years ago, in January, 1912, textile workers in Lawrence, Massachusetts organized and staged a "walkout" in what became known as the "Bread and Roses Strike." The strike was so named because protesters could barely afford loaves of bread to feed their families ("bread") and women played an integral part in the strike ("roses").

Conditions were already difficult in the textile mills, but a recent statute passed in 1911 by the Massachusetts' state legislature mandated a shorter work week of 54 hours, down from 56 hours. The primarily European immigrant and female workforce was upset because mill owners tried to cut their pay by the two lost hours, despite their already paltry \$8 a day or less salary. Conditions for a strike were ripe with recent union organization by a local chapter of the Industrial Workers of the World. With the union's support, the workers staged a walkout despite resistance from the city



Local militia surrounding protesting workers during 1912 Bread and Roses Strike.

and the presence of local and state militia (see photo). Parades and public gatherings, though prohibited, were held throughout the strike. Workers persisted with their strike despite fear of reprisals while the union organized economic and medical help for the striking workers. Women played a key role in helping send organizers' and strikers' children out of the city to strike supporters in other cities so that the children would be safe and cared for during the strike. The police, after learning of these child evacua-

tions, attempted to stop one at a train station by brutally attacking the women and children. The United States Congress however learned of this episode through the press and held hearings which drew national attention to the strike and generated significant negative publicity for the mill owners. The owners eventually gave in to the workers' and union's demands after 8 weeks of striking, providing pay increases for the workers and agreeing to meet with grievance committees. Although the victory was only local, the Bread and Roses Strike paved the way for workers to organize and advocate for better conditions throughout New England.

Submitted by Matt Lundquist Source:
<http://womhist.binghamton.edu/teacher/DBQlaw2.htm>