

# NECOEM *Reporter*

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## Upcoming Events!

*OEM Conference at Rutgers Univ*

Oct 18-19, 2014

Sponsored by

OEMNJ, NYOEMA and POEMS

Dec 4-5, 2014

*“Innovations and Challenges in OEM*



2014 NECOEM/MaAOHN  
ANNUAL CONFERENCE

Marriott Newton, Newton, MA

New for 2014: Scholarships  
available for reduced conference  
registration for poster presenters

[www.necoem.org](http://www.necoem.org)

## FMCSA

### Medical Examiner Training

NECOEM sponsors training on:  
October 11, Waterbury CT, and

December 6 at Newton

Wellesley Hospital, MA

[www.necoem.org](http://www.necoem.org)

## MANAGING CHRONIC HEALTH PROBLEMS AT WORK:

### New Study Assesses Strategies to Address Functional Issues Proactively

William S. Shaw, Ph.D., Glenn Pransky, M.D., M.Occ.H., and Bob McLellan, M.D., M.P.H.

One significant and growing problem in occupational health and safety is the increasing number of employees reporting chronic health conditions. This is explained by a combination of factors: the aging workforce, rising obesity rates, more life-saving medical treatments, and an increase in the population prevalence of several common chronic diseases. Now, nearly one-third of the US workforce reports one or more chronic health conditions affecting their ability to work, and this percentage is likely to increase [1-2]. This is an important worksite wellness issue

that can easily fall between the cracks of injury prevention, health promotion, traditional disease management, and disability benefit systems, so occupational medicine practitioners may increasingly find themselves being asked to address this problem of “walking wounded” employees through new worksite programs and policies. As a result, we have been pursuing a line of research to understand the nature of this problem better and to offer potential solutions.

**What kinds of problems do workers with chronic ill-**

**nesses report?** Besides the obvious problems of scheduling healthcare visits around a busy work schedule and avoiding sickness absence, focus groups with affected workers have identified other problems they can experience while at work [3]. Pain and other symptoms, especially fatigue, represent a distraction from job tasks and make it difficult to keep up. Complaining about chronic pain and discomfort can lead to friction with co-workers, supervisors, and customers. Another problem

*(Continued on page 2)*

## Where Occupational Medicine Goes, So Goes the Nation's Health

By Karen O'Hara

Medical professionals, academics and employers are wondering how to best cultivate a new crop of physicians to meet the nation's anticipated demand for occupational and environmental medicine (OEM) physicians. At its recent annual conference in San Antonio, Texas, members of the American College of Occupational and Environmental Medicine (ACOEM) asked the

question: “Where will our expert practitioners come from?” The answer seems to depend to a considerable degree on the ability to heighten awareness of the specialty and better articulate its value.

Phyllis Gerber, M.D., a consulting occupational physician and co-chair of ACOEM's Council on Academic Affairs, said the college is exploring a

number of ways to promote the specialty. These include mentorship programs, training opportunities for mid-career professionals and messaging to help members “pitch” their practice. “We have to start spreading the word: 250 million people need to know what we do,” Dr. Gerber said.

*(Continued on page 3)*

(Continued from page 1, *Chronic Health Problems*) is that work activities and work schedules don't always provide the level of leeway



and flexibility they feel is necessary to stay on the job. Lastly, recurrent symptoms and medical complications can lead workers to experience negative feelings of worthlessness and self-doubt.

**How are workers able to continue working despite having a chronic illness and being symptomatic?** Most workers report that informal worksite processes, especially informal job accommodations and flexibility, are their key to survival at work [3]. Some, but not all jobs offer enough flexibility and leeway so that employees can modify work activities, pace their work, and adopt a work style that is more comfortable. Having an advance plan to deal with setbacks and symptom flare-ups is another coping strategy frequently described by workers. Communication with co-workers and supervisors about health problems are helpful to obtain assistance and support, but workers caution that this should be done judiciously and take into account worksite rules and structures. Positive self-talk and other cognitive strategies can also be helpful to get through symptom flare-ups at work. Though many employers currently offer disease management programs through their healthcare insurers, these programs are more likely to focus on symptom management, encouraging healthy lifestyle, and managing healthcare utilization than on functional issues at work. Thus, there is a gap between the problems faced by chronically

ill workers and the programs and resources available to them.

**Can employee coping efforts be improved?** To address this workforce challenge, researchers at the Liberty Mutual Research Institute for Safety and their collaborators are launching a randomized controlled trial of an employer-sponsored group self-management program for dealing with chronic physical health conditions while on the job. The intervention is designed around the principles of pain and chronic illness self-management that have been shown to improve function and well-being in general, but have never been studied in the workplace context [4]. The program involves 10 hours of on-site, facilitated group workshops for employees. The content of the program focuses on communication, problem solving, job modification, and cognitive-behavioral strategies. The study design is a randomized controlled trial of 300 employees recruited from several participating employers.



One important distinction is that this study focuses on *preserving* function at work rather than restoring function or facilitating return-to-work after a period of disability or prolonged sickness absence. In this way, this intervention program represents a proactive strategy for employers to prevent disability before it occurs. Also, the group workshops in this study are being offered within existing EAP provider frameworks and with a standardized provider manual, so the program could be easily adopted by other employers if shown effective in this randomized trial. Introducing such pro-

grams in the workplace may be one way to expand occupational health to address broader issues of worker health affecting productivity, turnover, and healthcare costs.

If you know of an employer who might be interested in this novel wellness strategy, please contact Glenn Pransky at (508) 497-0253 for more information about the study. The methodological details of the study design are posted at [www.clinicaltrials.gov](http://www.clinicaltrials.gov) (NCT01978392). The intent of this research is to focus more attention on the functional difficulties of workers with chronic health conditions, who represent a growing proportion of the US workforce. The essential premise is that affected employees may be more functional at work if they are encouraged to self-manage their workplace challenges through pacing, problem-solving, thoughtful communication, and an appropriate use of job flexibility and leeway. This study addresses an important gap in worksite wellness activities and represents a possible new direction in occupational medicine practice.

#### References:

- [1] Ward BW, Schiller JS. Prevalence of multiple chronic conditions among US adults: estimates from the National Health Interview Survey, 2010.
- [2] Burton WN, Pransky G, Conti DJ, Chen CY, Edington DW. The association of medical conditions and presenteeism. *J Occup Environ Med.* 2004;46:S38-S45.
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- [4] Shaw WS, Tveito TH, Geehern-Lavoie M, Huang Y-H, Nicholas MK, Reme SE, Wagner G, Pransky G. Adapting principles of chronic pain self-management to the workplace. *Disabil Rehabil.* 2012;34(8):694-703.

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*Glenn Pransky is the Director of the Liberty Mutual Center for Disability Research.*

*Bob McLellan is the Medical Director and Section Chief of OEM at Dartmouth Hitchcock Medical Center.*

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## We Need You!

On any given day, about one-third of the U.S. population is working, making the workplace a prime setting for health interventions. “We cannot fill the need for trained occupational medicine specialists,” said Arch Chip Carson, M.D., Ph.D., associate professor and program director at the University of Texas Education and Research Center, UT School of Public Health in Houston. “There is more clinical work in occupational health than we can handle. So, we have to share that task with others who are not specifically trained in occupational medicine principles and practices.”

According to Dr. Carson, an estimated 4,000 physicians who are either board-eligible or board-certified are practicing OEM in the U.S. Approximately 10,000 more physicians (e.g., internists, family and emergency medicine, general surgeons) have “substantial” OM practices. There also are related sub-specialists such as physiatrists, neurologists, ophthalmologists and orthopedic surgeons, as well as occupational health nurses and nurse practitioners, physician assistants and other allied professionals making significant contributions.

## Challenges Abound

OEM physicians share a desire to provide excellent care, save lives and improve the health of working populations. However, they are subject to a number of challenges, starting with the nature of the health care delivery system as a whole. “We have a health care system run amok,” Dr. Carson said. “The system we have created essentially eats 60 to 90 percent of the resources we put into it, leaving the rest for actual care. This is a shameful situation and one that I hope we are beginning to correct.”

Other challenges for medical professionals cited by Dr. Carson include:

- Increased regulation by governmental entities, insurers and “risk-shy” institutions
  - An ongoing need to justify treatment recommendations to obtain reimbursement
  - Litigious practice environments
  - More strict licensure and certification requirements
- Challenges specific to OEM include:
- Low specialty recognition
  - Insufficient output of new trainees
  - Fewer opportunities to expand practice into traditional preventive medicine areas, the roots of the specialty
  - An estimated 200 to 500 positions for physicians available each year at organizations that would prefer to employ individuals with formal training in OEM, corresponding with lack of funding for recruitment-related activities

## Residency Training Conundrum

While the need for trained specialists continues unabated, occupational medicine residency program numbers are shrinking. There were 47 OEM residency programs in 2000; today there are 27 producing 54 to 61 graduates a year. Consequently, a growing number of medical schools have added OEM training competencies to some residency programs in an effort to provide “rudimentary knowledge,” reports Jeff Levine, M.D., M.S.P.H., who is affiliated with the University of Texas Health Science Center in Tyler, Texas.

Dr. Levine said that the Accreditation Council for Graduate Medical Education (ACGME), the leading accrediting body for allopathic physicians, has made some important changes in preventive medicine and OEM residency requirements over time. “The council’s goal is to train physicians, and there needs to be a clear demonstration of the traditional medical model – individual physicians taking care of individual patients,” Dr. Levine said. However, “the residency review committee recognized the need for a population health component, so they have worked hard to ensure a balance. Some significant changes have been made through some greater clinical requirements as the house of medicine sees it. Fundamentally, occupational medicine is more than just a workers’ compensation or injury management specialty. Without a

population and injury prevention focus, we sort of disappear into the other specialties across the board.”

He said changes in preventive medicine residency requirements effective July 1, 2014, reflect a shift to a more outcomes-based approach in terms of how residents are trained and residency program performance is measured overall. Periodic progress reports featuring information obtained through an accreditation data system are among the requirements. “The days of old when review was every five years have gone away; we are now developing dashboards for the accrediting body to evaluate annual performance based on certain milestone metrics and competencies,” Dr. Levine said.

Areas targeted for increased emphasis include hours on duty, alertness management and fatigue mitigation; care transitions; supervision; professionalism and personal responsibility; and patient safety.

“We don’t do this in isolation. It requires working with disciplines outside of medical practice to do excellent work,” Dr. Levine added. “There have been workforce changes over time that affect practice and training, and there is an increasing emphasis on social-behavioral factors that influence risk.”

Tee Guidotti, M.D., M.P.H., an international consultant in OEM and former chair of the Department of Environmental and Occupational Health in the School of Public Health and Health Services at George Washington University, believes universal adoption of a five-year OEM residency would help ensure longevity for the profession. “One thing that could basically be done overnight would be to declare that occupational medicine is a five-year residency,” he said. “Why? Because everyone gets about five years of training anyway. Another option would be to declare it as

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(Continued from page 3, *Occ. Med. Goes*)

a fellowship rather than as a residency. A rigorous training program attracts people who want to achieve and excel. If it's flimsy, you attract less qualified candidates."

### A Global Perspective

Visiting from the University of Pompeu Fabra in Barcelona, Spain, another speaker at the conference, Consol Serra, M.D., Ph.D., former chair of the harmonization committee for residency training in the European Union, said that the committee has been focused on "harmonizing practice and training across countries so free movement of doctors can occur while maintaining quality."

"To have both a clinical and social perspective of health, we need competencies other than clinical – we need to be counselors and participants in skill development," she said. "There is growing evidence that work is good for you, provided that the working conditions are acceptable. We need to use the bio-psychosocial model of health."

She noted that OEM gets little mention in four leading journals (*Lancet*, *New England Journal of Medicine*, *Journal of the American Medical Association* and *BMJ*), suggesting that most physicians "get a very limited view of the evolution of knowledge" in the specialty. Meanwhile, she said there is "no common strategy to deal with training in occupational medicine," nor are the concerns and expectations of customers consistently taken into consideration. She referred to a Scottish study which found employer and employee perceptions of necessary competencies for OEM physicians differed from the perception of the doctors themselves in some important ways. This suggests "there is a need to rethink training programs to meet the expectations of customers," she said.

### Put on Your Shades

The future may not be so bright that physicians have to don sunglasses, but there are a number of reasons to feel encouraged about the prospects of the specialty, several speakers said. First, there appears to be renewed interest in corporate medical practice – both occupational and personal health management-related – following an era of outsourcing. In a related trend, recruiters say jobs for younger physicians are opening up as older physicians take payouts and early retirement. "This trend will likely continue in the near future," Dr. Carson said. "In the past two years I have seen more requests for occupational medicine practitioners to enter positions in corporations than I have in the last 15 years. Practitioners are returning to practice in large corporations that understand medical in-house consultation is critically important to their business model. There is still a huge number of businesses that have not yet received the message, but they will. They will see their competitors doing it, and they will start doing it, too."

Second, there are emerging opportunities for OEM physicians to respond to prevention provisions in the Affordable Care Act in collaboration with employers who are interested in population health management and worker wellness initiatives. "The ACA has elevated prevention services to a level equivalent to other medical provider services," Dr. Carson said. "We can now get paid for things we used to do for free. We can also take advantage of our skills to create centers of excellence for illness prevention in schools, communities and workplaces so it has to be considered for reimbursement. Wellness promotion flows naturally from that. Research and evidence is beginning to pour out now – some from ACOEM's own health and productivity group – that every dollar spent through a properly designed program returns a larger amount of cost savings in the future. Our problem in the past has been how to present those numbers and make them understood."

Third, Dr. Levine points to positive aspects associated with working in a field as dynamic as OEM. He alluded to topics on the National Occupational Health Research Agenda, for example, and said that researchers at the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health (NIOSH) and academic institutions are investigating serious public health threats (e.g., potential terrorist attacks, natural disasters, pandemics). NIOSH also supports Total Worker Health, a strategy aimed at integrating occupational safety and health protection with health promotion.

Fourth, Dr. Carson mentioned that while the much-anticipated transition from ICD-9 to ICD-10 coding has been delayed in the U.S., ICD-11 is already on the horizon in some other parts of the world where ICD-10 is in use. "It will hit here eventually," he advised, "and it has specific sections built into it for coding (and billing) of occupational health services and population health practice activities that have never been included in that coding system before."

Fifth, surveys show that compensation and job satisfaction rates are higher than average in OEM when compared to other types of medical practice. "We do better (salary-wise) than most primary care physicians, and we still mostly have a better lifestyle, so that's very attractive," Dr. Carson said.

In summary, he offered this advice to his colleagues: "Our future is what we make of it. Every OEM physician should stretch his or her comfort zone to some extent." For example:

1. Stay in touch with developments. Learn a new occupational medicine skill. Begin a new area of practice.
2. Engage a stakeholder in an educa-

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# Summary: NECOEM NRCME training courses

The Federal Motor Carrier Safety Administration (FMCSA), US Department of Transportation now requires that all commercial (truck and bus) drivers operating in interstate commerce whose current medical certificate expires on or after May 21, 2014 must be examined by a certified medical professional listed on the National Registry of Certified Medical Examiners (NRCME). NECOEM has offered 13 in-person training courses in New England to its members and interested non-member healthcare providers so that they could meet the training requirement for NRCME certification.

Our NECOEM faculty – Drs. Ron Blum, Robert Swotinsky, and myself - have provided training to 754 healthcare professionals at NECOEM training courses. As of May 21, 2014, 68 of 754 course attendees (9%) are current NECOEM members and 455 of 754 (60%) have become NRCME certified medical examiners (MEs). NECOEM has provided training for 34% of certified MEs in New England states. The two tables below summarize attendance and certification by state and profession.

Members should be aware of some recent changes in the NRCME program:

The NRCME homepage URL has been changed to: <https://nationalregistry.fmcsa.dot.gov/NRPublicUI/home.seam>

There is one PDF file for the entire ME Handbook (260 pages): <http://nrcme.fmcsa.dot.gov/documents/FMCSAMedicalExaminerHandbook-2014MAR18.pdf>

NRCME has a map of the locations of all 21,373 certified MEs throughout the US:

<https://nationalregistry.fmcsa.dot.gov/NRPublicUI/ResourceCenterMELocations.seam>

Certified MEs are required to complete an online database entry for each exam performed (Form 5850) at least monthly, or indicate that they have not performed a CDL exam in the past month.

There are now three training organizations offering the certification exam to healthcare professionals who have completed the training course and are eligible for certification: PSI Online, Comira Testing, and Prometric.

At this time two additional courses are planned for 2014: Waterbury, CT in October and Newton, MA in December. Details are available on the NECOEM website. Information about the certification process can be found in the "Complete Guide to Medical Examiner Certification" at [https://nationalregistry.fmcsa.dot.gov/NRPublicUI/documents/Complete\\_Guide\\_to\\_ME\\_Certification\\_revised\\_032513.pdf](https://nationalregistry.fmcsa.dot.gov/NRPublicUI/documents/Complete_Guide_to_ME_Certification_revised_032513.pdf).

Our faculty offers special thanks to:

Deborah Halbach, Executive Director of the Maine Academy of Family Physicians, for her efforts in partnering with NECOEM for the 4 training courses in Maine. We are pleased that 64% of certified MEs in Maine have attended our NECOEM courses.

Dianne Plantamura, NECOEM Executive Director, for her key role in arranging these successful courses as well as her tireless and cheerful responses to questions from

NECOEM members and course attendees.

- Safe driving! Jay Poliner, MD, MPH, FACOEM, West Hartford, CT

TABLE 1	Training course attendees					NECOEM members	
	DO/MD	APN/NP	PA	TOTAL	% states	Total	mbrs %
CT	152	15	40	207	27%	18	9%
ME	88	32	34	154	20%	10	6%
MA	109	75	30	214	28%	29	14%
NH	15	17	13	45	6%	7	16%
RI	25	5	2	32	4%	2	6%
VT	5	3	5	13	2%	1	8%
NY	44	11	18	73	10%		
Other	12	1	3	16	2%	1	6%
<b>TOTAL</b>	<b>450</b>	<b>159</b>	<b>145</b>	<b>754</b>	<b>100%</b>	<b>68</b>	<b>9%</b>
<b>% profession</b>	<b>60%</b>	<b>21%</b>	<b>19%</b>	<b>100%</b>			

TABLE 2	Course attendees who have certified					All certified M.E.s	
	DO/MD	APN/NP	PA	TOTAL	% states	Total	NECOEM %
Connecticut	86	9	28	123	27%	357	34%
Maine	36	22	17	75	16%	118	64%
Massachusetts	63	49	22	134	29%	374	36%
New Hampshire	9	12	9	30	7%	135	22%
Rhode Island	15	4	2	21	5%	93	23%
Vermont	3	3	4	10	2%	71	14%
New York	32	8	9	49	11%		
Other	9	1	3	13	3%		
<b>TOTAL</b>	<b>253</b>	<b>108</b>	<b>94</b>	<b>455</b>	<b>100%</b>	<b>1148</b>	<b>34%</b>
<b>% profession</b>	<b>56%</b>	<b>24%</b>	<b>21%</b>	<b>100%</b>			

## MEET NECOEM'S NEW BOARD OF DIRECTORS MEMBERS



**Peter C. Lee, MD, MPH, FACOEM**

Dr. Peter Lee is the Global Occupational Health and Wellness Leader for General Electric. In this capacity, Peter leads on-site clinic innovation and management, develops globally responsive medical policies and drives advancements in travel medicine, crisis management, and disease management. He also supports GE HealthAhead (culture of health initiative) to ensure population health and wellness programs are evidence based. He serves as GE's public health liaison. He also currently serves as an occupational medicine residency advisory committee member at the Yale School of Medicine. Prior to GE, Peter served as Chief Strategy Officer and Corporate Medical Director of a Boston-based occupational medicine delivery and consulting firm. Peter received his MD from the University of Vermont College of Medicine and is a graduate of the University of North Carolina at Chapel Hill and the Harvard School of Public Health. His post graduate training encompasses an internship in general surgery, fellowship in healthcare quality and residency training at the Harvard Occupational and Environmental Medicine Residency program where he also served as chief resident. Peter's research interests have included the development of effective influenza vaccination strategies and novel center of excellence care models. Peter has been recognized by various professional societies including the American College of Medical Quality (ACMQ) for his leadership and research. He is board certified in Preventive Medicine and a Fellow of the American College of Occupational and Environmental Medicine (ACOEM). He enjoys teaching, learning, fundraising, mentoring, running, and golfing. He resides in Fairfield, Connecticut.

Congratulations Peter for your appointment to the Board of Directors!



**Thomas (Tom) Luna, MD, MPH, FACOEM, FASMA.**

Dr. Luna is board certified in occupational medicine and in aerospace medicine and is a fellow in ACOEM and in the Aerospace Medical Association. Dr. Luna has played multiple roles throughout his career – as a clinician both in civil and aerospace medicine arenas, as an educator, as a leader and as a researcher, to name a few. He practiced occupational medicine for 21 years in the US Air Force, serving as the military equivalent of a corporate medical director, a residency director and as a director of medical education. Tom's research background is in shiftwork and fatigue. Dr. Luna also practiced aerospace medicine for 21 years in the U.S. Air Force. In that capacity, Dr. Luna coordinated the medical and human factors investigations of more than 100 aircraft accidents, was featured in a Discovery Channel special on crash investigations, presented papers at numerous international scientific meetings and logged more than 1200 flying hours as a crewmember in 20 different aircraft. He has worked in settings and locations such as Korea, the Loring Air Force Base in northernmost Maine, Delaware, Texas, etc. He has many honors and awards to his credit including military medals/decorations and is a recipient of the Aerospace Medical Association Eric Liljencrantz Award, 2012, which is awarded annually to honor excellence as an educator in aerospace medicine.

Dr. Luna currently divides his time between charitable work in Portland, Maine with refugees and at a local soup kitchen, clinical occupational medicine with MaineGeneral's Workplace Health, and independent occupational medicine practice – mostly in service to Professional Disability Associates. Tom served as coordinator, moderator and one of five guest speakers for NECOEM's mini-conference on aerospace medicine in September 2012 and serves NECOEM as the editor of the NECOEM Reporter. He was recently selected to help represent NECOEM in the ACOEM House of Delegates.

Congratulations Tom for your appointment to the Board of Directors!

**ANSWER TO "WHAT IS IT?"**

The settlement shown in the Spring issue's "What Is It?" is the Hull House located in the near west side of Chicago. Dr. Alice Hamilton, a pioneer in occupational medicine was one of its notable residents.

Congratulations to Joan Balkus RN, COHN-S, CCM and Jay R. Poliner, MD, MPH, for correctly identifying the structure!

*"What Is It?" is a section on trivia, facts, figures, etc. related to the field of occupational medicine. If you have any such interesting or fun-filled material, please e-mail it to the associate editor at dr\_abhik@yahoo.com. All material should be related to the specialty of occupational and environmental medicine and have an educational, inspirational, historic or other relevant value.*

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**Congratulations to the new  
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The new fellows from  
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**Bernard M. Bettencourt, Jr, DO, MPH;  
Michael D. Lappi, DO, PHD;  
James E. Mazo, MD, MS;  
Ben Hur P. Mobo, Jr, MD, MPH;  
Rick Snyder, DO, MPH;  
Marcelo Targino, MD, MPH.**



(Continued from page 4, Occ. Med. Goes)  
tional dialogue to explain and promote occupational medicine as a value-added specialty.

3. If you are not already, consider becoming board eligible.
4. Routinely collect numbers that demonstrate value to yourself and others. (ACOEM and NECOEM can help facilitate this.)
5. Be part of efforts to reach a common consensus on individual contributions and the role of OEM, in general. "As we increase our recognition, and as we move forward as a group and as individuals, this is where our expert practitioners will come from," Dr. Carson said.

*Karen O'Hara is Director, Marketing and Communications, at WorkCare, Inc., the nation's largest physician-owned and managed occupational health care company.*

*Her previous positions include Managing Editor and Communications Specialist at UL Workplace Health and Safety, and Senior Vice President and Editor-in-Chief, RYAN Associates and the National Association of Occupational Health Professionals. Based in Santa Barbara, Calif., she has specialized as an industry journalist, consultant and curriculum planner in occupational health since 1990.*

Related resources:

1. American College of Occupational and Environmental Medicine (ACOEM) 10-point advocacy Agenda for Change; <http://www.acoem.org/AdvocacyAgendaForChange>
2. Marketing Healthcare Services to Employers: Strategies and Tactics; Frank H. Leone; <http://www.naohp.com/menu/publications/mhse/>
3. Occupational Health Services: A Practical Approach; Tee Guidotti, ed.; Routledge, 2013.
4. Occup Environ Med. 2005 Jun;62(6):406-13. *Required competencies of occupational physicians: a Delphi survey of UK customers.* Reetoo KN1, Harrington JM, Macdonald EB.

**Tony Tannoury, M.D.**  
*Minimally Invasive Spine Surgery*



**In Collaboration with Dr. Tony Tannoury,  
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- Observe and meet patients before and after surgery
- Learn the complex process involved in workers' compensation cases

**For More Information:**

Please visit [www.bostonmis.com](http://www.bostonmis.com)

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## NECOEM

The New England College of Occupational and Environmental Medicine is a not-for-profit regional component society of the American College of Occupational and Environmental Medicine. The mission of the New England College of Occupational and Environmental Medicine is to support the optimal health and safety of workers and workplace environments through educating our members and other health care professionals, encouraging research, workplace safety, and high quality practice, guiding public policy, and promoting the specialty of Occupational and Environmental Medicine.

*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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### *Letters to the Editor:*

Hello, Dr. Karandikar

The Hull House in Chicago was the intermittent residence of Dr. Alice Hamilton, a pioneer in occupational medicine in the US as well as a strong support of the settlement house movement. Her experiences as a resident of Hull House, especially those with the health hazards faced by immigrant workers, were instrumental in her decision to pursue a career in occupational medicine. Among Alice Hamilton's many professional accomplishments was her appointment as the first female faculty member at Harvard Medical School. She also had many ties to Connecticut: a graduate of Miss Porter's School in Farmington, CT, she retired to a house in Hadlyme, CT with her older sister Edith Hamilton, a classics scholar. I encourage any NECOEM members not familiar with her professional life to read "Exploring the Dangerous Trades," an autobiography first published in 1943. Many thanks for adding this "trivia quiz" to the REPORTER!

Best regards – Jay Poliner

Dear Dr. Karandikar,

Hull House was founded by Jane Addams and Ellen Gates Starr. Jane Addams served as the first woman president of the National Conference of Social Work. Because of the work of Alice Hamilton, I always considered Hull House as a symbol of the union of my two careers - social work and occupational health. Check out the history of Hull House at its official site:

[www.uic.edu/jaddams/hull/hull\\_house.html](http://www.uic.edu/jaddams/hull/hull_house.html)

Thank you for choosing this historic site for the first "What is it."

Dianne Plantamura, CSS, MSW

