**Opioids: From Scourge to a Big Dig-Like Solution**

Peter Rousmaniere, MBA

The worst man-made epidemic

A prominent expert on opioid use in the workers’ compensation field, Gary Franklin MD, says that prescribed opioids, such as OxyContin and Fentanyl, comprise “the worst man-made epidemic in modern medical history.”

The medical director of Washington State’s monoplistic state fund, Gary Franklin and colleagues tracked deaths of injured workers from complications of opioid treatment since 2001. They were the first to sound the alarm in the workers’ comp industry.

Many doctors still prescribe these drugs, but the tide of research and practitioner opinion has turned against using these painkillers, especially for long-term care.

The expansion, halt and pullback of opioids in workers’ comp is a dark story involving perhaps 2,000 unintentional deaths and, over the years, upwards of one hundred billion dollars in claims payouts.

The workers’ comp industry was victimized by opioids and their well-resourced purveyors and ardent advo-

(Continued on page 6)

**The Pregnant Worker**

**Safety and Health in the Workplace**

Joseph Charlot, MD, MPH, FACP

Are pregnant workers and the children they are carrying safe in today’s workplace? The team of experts who strive to assure their safety may include: the occupational medicine provider, obstetrician, industrial hygienist, occupational health nurse, lactation consultant, audiologist, radiation health specialist, toxicologist and certified safety professional. The occupational medicine provider plays a pivotal role in working with these other experts to help companies ensure a safe work environment for pregnant workers and their unborn children. Federal laws pertaining to pregnant workers that occupational medicine providers should be aware of include: 1) Americans with Disabilities Act; 2) Pregnancy Discrimination Act of 1978; 3) Family Medical Leave Act; 4) Health Insurance Portability and Accountability Act; 5) Fair Labor Standard Act.

Prevention of reproductive hazards is important. OSHA states: employers must furnish

(Continued on page 2)

**Legal Aspects of Workplace Reproductive Hazards**

Carolyn Langer, MD, JD, MPH

With over 57% of women participating in the workforce, females continue to enter nontraditional or male-dominated occupations, such as construction, manufacturing and agriculture. Moreover, 62% of women who have had a birth within the past twelve months are in the labor force—or approximately 48 births/1,000 women in the workforce. Given the prevalence of women of reproductive age in both male and female-dominated professions, occupational medicine professionals are often consulted about developing policy, assessing potential risks to the pregnant woman and to her developing fetus, and assisting with accommodation requests. It is therefore beneficial for the occupational medicine provider to be familiar with the legal framework addressing workplace reproductive hazards in order to ensure protection of the rights of pregnant workers and to minimize the possibility of gender discrimination. Irrespective of the law, occupational medicine providers are encouraged to engage

(Continued on page 5)
AMA Guidelines for Continuation of Various Job Tasks during Pregnancy.

<table>
<thead>
<tr>
<th>Job Task</th>
<th>Week of Gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretarial and light clerical</td>
<td>40</td>
</tr>
<tr>
<td>Professional and managerial</td>
<td>40</td>
</tr>
<tr>
<td>Sitting with light tasks:</td>
<td></td>
</tr>
<tr>
<td>Prolonged (more than 4 hours)</td>
<td>40</td>
</tr>
<tr>
<td>Intermittent</td>
<td>40</td>
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<tr>
<td>Standing:</td>
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<tr>
<td>Prolonged (more than 4 hours)</td>
<td>24</td>
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<tr>
<td>Intermittent</td>
<td>32</td>
</tr>
<tr>
<td>More than 30 minutes per hour</td>
<td>40</td>
</tr>
<tr>
<td>Less than 30 minutes per hour</td>
<td></td>
</tr>
<tr>
<td>Stooping and bending below knee level:</td>
<td></td>
</tr>
<tr>
<td>Repetitive (more than 10x per hour) Intermittent</td>
<td>20</td>
</tr>
<tr>
<td>2 to 10 times per hour</td>
<td>28</td>
</tr>
<tr>
<td>Less than 2 times per hour</td>
<td>40</td>
</tr>
<tr>
<td>Climbing:</td>
<td></td>
</tr>
<tr>
<td>Vertical ladders and poles:</td>
<td></td>
</tr>
<tr>
<td>Repetitive (4 or more x per 8 hour shift) Intermittent</td>
<td>20</td>
</tr>
<tr>
<td>Intermittent (less than 4x per 8 hour shift)</td>
<td>28</td>
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<tr>
<td>Stairs:</td>
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<tr>
<td>Repetitive (4 or more x per 8 hour shift) Intermittent</td>
<td>28</td>
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<td>Intermittent (less than 4 x per 8 hour shift)</td>
<td>40</td>
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<tr>
<td>Lifting:</td>
<td></td>
</tr>
<tr>
<td>Repetitive:</td>
<td></td>
</tr>
<tr>
<td>Less than 25 lb.</td>
<td>40</td>
</tr>
<tr>
<td>25-50 lb.</td>
<td></td>
</tr>
<tr>
<td>More than 50 lb.</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: American Medical Association Council on Scientific Affairs, "Effects of Pregnancy on Work Performance"

Pregnancy Safety (Continued from page 1)
a place of employment free from recognized hazards. This requires employers to evaluate the conditions of work and take steps to eliminate any physical or dangerous material hazards that could put an employee or her unborn infant at risk. Employers are responsible for training and protecting their workers; they must inform employees about hazards through training, labels, alarms, color-coded systems, chemical information sheets and other methods (OSHA’s Hazard Communication Standard). Employees are responsible for learning about the hazards in their workplace, using personal protective equipment and following proper work practices.

The approach to the evaluation and management of the pregnant worker by the occupational medicine provider should be systematic. First, a thorough medical, occupational and environmental history; second, a hazard evaluation of the agents to which the pregnant worker is exposed; third, exposure assessment of hazards (usually performed by an industrial hygienist); fourth, risk characterization of hazard; fifth, risk communication of hazard to the pregnant worker; finally, risk management of hazards.

Reproductive hazards do not affect every woman or every pregnancy. Whether a woman or her baby is harmed depends on how much of the hazard they are exposed to, when they are exposed, how long they are exposed and how they are exposed.

Some specific potential reproductive hazards include the following:

**Ionizing radiation.** Deleterious consequences of ionizing radiation for the pregnant worker can be divided into four categories: 1) pregnancy loss (miscarriage, stillbirth); 2) malformation; 3) disturbances of growth or development; 4) mutagenic and carcinogenic effects.

Radiation risks should be discussed with the pregnant worker, including an explanation of the background population risk for miscarriage, congenital anomalies, genetic disease, and growth restriction (approximately 20, 4, 10, and 10 percent, respectively). Studies of atomic bomb survivors exposed to acute radiation doses and solid cancer incidence rates were used to develop ionizing radiation exposure limits for the embryo/fetus. Exposure for the embryo/fetus shall not exceed 500 mrem (0.5 mSv) for the term of the pregnancy and should not exceed 50 mrem (0.5 mSv) per month in any month for the remainder of the pregnancy. Medical radiography, research, industrial radiography and the nuclear energy industry are occupations with greater potential for exposure.

**Pesticides.** Agricultural workers and crop dusters are most likely to be affected. Their associated risks include: infertility, miscarriage and poor fetal growth.

**Second hand smoke.** Workers in bars and (Continued on page 3)
Pregnancy Safety (Continued from page 2)

I and the planning committee are delighted to extend our invitation to our annual conference on December 3 and 4 in the Boston area. The conference this year promises to be as exciting and informative as in previous years. One look at the program agenda and you will find that it encompasses a variety of areas and topics in occupational and environmental health. It is our hope that each of the conference attendees will have some nugget of wisdom to take away to their own professional lives. The title is apt: “Tips, Tools and Pearls for the OEM Professional”. The second day has two tracks, both in the morning and afternoon sessions, which allows for a greater choice of offerings! Clinical sessions include occupational dermato-logy, cardiovascular issues and return to work and reproductive and pregnancy health. Another session not to be missed is on Infectious Disease Issues in Occupational Health by Jack Ross, MD, from Hartford Hospital, scheduled on Day One of the conference. Listen to Glenn Pransky, MD, this year’s Harriett Hardy awardee, as he speaks on preventing work disability.

In today’s digital era, the opening session on the second day, the William B. Patterson Memorial Lecture on Excellence featuring Mobile Medical Apps for OEM Professionals – Survive and Thrive in the 21st century by Constantine Gean, MD, FACOEM, will be another “pearl”. Other sessions cover mold, workplace violence, “heartsink patients” and a cervical spine lecture with physical exam techniques and more.

The conference has been approved for 10.75 CME credits and an equivalent number of MOC credits, 2 hours of Risk Management Credits for the MA Board of Registration in Medicine, 10.75 AAOHN, CCMC and ABIH credits. The President’s Dinner Reception and Poster Session at 5PM on December 3 offer ample opportunities for networking. One highlight of this year’s conference is a pre-release showing of the film “An Introduction to Occupational and Environmental Medicine” at 7:30 PM on December 3rd. Vendor exhibits will be on display highlighted by the “Badges” exhibit—a memorial tribute to Asbestos Workers that honors the legacy of Dr. Irving J. Selikoff.

Looking forward to seeing you all, our readers, in December, for a wonderful learning and networking experience while enjoying all that Boston has to offer!
suggestions for pregnant employees include: lifting aids; temporary reassignment of duties; reserved parking to shorten walking distances; stools; ergonomic chairs; temporary reassignment to less physically demanding jobs; alternate workstations; flexible arrival time; more frequent rest, food, water and bathroom breaks; telecommuting; a less physically demanding shift; limited overtime; flexible use of leave. Every October, Working Mother magazine publishes a list of the best 100 companies for working mothers. Some benefits offered by most companies on the list are: 1) flextime; 2) telecommuting; 3) on-site lactation room; 4) fully paid maternity leave.

There are potentially difficult legal issues for pregnant workers and their employers – especially when there is the potential for increased risk to the unborn child from the mother’s occupational environment. Please see the accompanying article by Carolyn Langer. Pregnancy is a normal experience. As occupational medicine providers, let us work with the patient and employer safety team to promote a safe pregnancy and a healthy child.

Dr. Joseph Charlot is Medical Director at Saint Francis Center for Occupational Health in Torrington, CT. jcharlot@stfranciscare.org

3. NIOSH Publication No. 99-104, The Effects of Workplace Hazards on Female Reproductive Health
5. NIOSH Publication No. 99-104, The Effects of Workplace Hazards on Female Reproductive Health
16. NIOSH Publication No. 99-104, The Effects of Workplace Hazards on Female Reproductive Health
25. (October/November 2014) Best versus the Rest. Working Mother Magazine. 54-62
Pregnancy, Legal (Continued from page 1) in an individualized, interactive process with employees—both male and female—who are seeking accommodation and to promote a workplace that is safe for all employees.

OSHA Regulations

Established in 1970, OSHA’s core mission is to “ensure so far as possible every working man and woman in the Nation safe and healthful working conditions.” OSHA has specific standards that regulate the following chemicals in part for their reproductive effects: lead; 1, 2-dibromo-3-chloropropane; and ethylene oxide. These protections may include medical surveillance and mandatory removal protection. However, because very few substances are regulated for their reproductive hazards, we look primarily to legislative and case law for guidance on employers’ obligations to pregnant workers and on practices that constitute employment discrimination.

Pregnancy Discrimination Act (PDA) of 1978

The PDA prohibits discrimination based on pregnancy, childbirth, or related medical conditions. Specifically, the PDA requires that “women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes...as other persons not so affected but similar in their ability or inability to work.” Employers must treat pregnant women the same as non-pregnant individuals with regard to all aspects of employment, including, but not limited to, hiring, compensation, fringe benefits, job assignments, training, promotion, and layoff/termination. The PDA not only applies these protections to currently pregnant workers, but also to those of reproductive capacity. Under Title VII of the Civil Rights Act of 1964, employers may discriminate on the basis of sex only in those instances in which sex or pregnancy actually interferes with the employee’s ability to perform the job—the so called Bona Fide Occupational Qualification (BFOQ) exception. For example, airlines may remove pregnant flight attendants at various stages of pregnancy to ensure the safety of passengers in the event of an emergency.

The Johnson Controls Case: The PDA’s prohibitions against pregnancy discrimination were further reinforced by the landmark U.S. Supreme Court Case, International Union, UAW v. Johnson Controls, Inc. Johnson Controls, a battery manufacturer, excluded women without proof of medical sterility from jobs with potential lead exposure. The U.S. Supreme Court invalidated Johnson Control’s fetal protection policy because it did “not apply to the reproductive capacity of the company’s male employees in the same way” as it applied to that of the females. In other words, male employees were not required to furnish proof of medical sterility, even though lead is also a known male reproductive hazard. The Court further determined that the company’s fetal protection policy was not justifiable as a BFOQ because the BFOQ exception would only apply if pregnancy had an adverse impact on female employees’ job performance. The Court noted that while lead is potentially harmful to the unborn fetus, there was no evidence that lead exposure diminished the female employees’ ability to perform the duties of the job. The Court concluded that “decisions about the welfare of future children must be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire those parents.”

Young v. United Parcel Service: The Johnson Controls case centered on an employer’s mandatory exclusion based on a women’s reproductive status. However, perhaps a more common scenario is employee initiation of a request for voluntary job transfer or modification due to concerns of an adverse reproductive outcome. Prior to the U.S. Supreme Court case’s decision handed down in the UPS case earlier this year, there were very limited protections for women with uncomplicated pregnancy seeking such accommodations. In the UPS case, a pregnant employee submitted a medical note from her obstetrician with a 20 pound lifting restriction. UPS denied her request, indicating that the ability to lift up to 70 pounds was an essential function for all drivers, and that UPS policy only offered light duty to employees with work-related injuries. The U.S. Supreme Court ruled that UPS violated the PDA by failing to accommodate Ms. Young’s pregnancy-related lifting restriction. The Court added that the employer must treat pregnant women the same as it treats any other temporarily disabled employee and must accommodate her request if the employer accommodates others “similar in their ability or inability to work.” That is, an employer that offers temporarily disabled workers light duty, temporary reassignment, or disability leave with or without pay must provide the same benefits to an employee temporarily disabled by pregnancy.

The Americans with Disabilities Act Amendment Act (ADAAA) of 2008

Title I of the ADA, which applies to private and state and local government employers with 15 or more employees, prohibits employment discrimination based on disability. The ADA further requires employers to make reasonable accommodations for employees and job applicants, provided that such accommodations do not cause undue hardship. Pregnancy per se is not a disability under the ADA because it is not considered an impairment. However, the definition of “disability” was expanded in 2008 (the ADAAA) to include certain temporary impairments if they substantially limit one or more major life activities. As a result, certain pregnancy-related impairments, such as gestational diabetes,
Opioids (Continued from page 1)

Had insurers kept their eye on the real problem, claims payers would today be more successful in preventing chronic pain and aiding recovery, and the medical community in New England and elsewhere would be better recognized, financially and otherwise, for its efforts. I’ll get to this towards the end of this article.

**Impact on workers’ comp costs**

Claims costs are human misfortunes with the tears wiped off. Within workers’ compensation, the financial burden of opioid use cannot be easily separated from the burden of other pain interventions. Insurers have conventionally not reported, even internally, how costs vary depending on characteristics of a workers’ comp claim. As a result, the financial impact of opioids was largely disguised.

The conventional way insurers report claims costs is by presenting the average cost of claims. The average cost of a lost time compensable claim ranges among states from the low $20,000s to the mid $30,000s.

Note, however, the huge impact when opioid–related claims are isolated. The following table shows claims data obtained in a few minutes from the Official Disability Guidelines’ claims cost estimator for a 42-year-old worker in a job of medium physical demands and with a rotator cuff syndrome.

<table>
<thead>
<tr>
<th>State</th>
<th>Without opioids</th>
<th>With opioids</th>
<th>% difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>$24,859</td>
<td>$73,468</td>
<td>296%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$26,958</td>
<td>$70,047</td>
<td>260%</td>
</tr>
</tbody>
</table>

The effect of opioids is even more extreme when one looks at the most expensive 5% of claims. The next table, also from the Official Disability Guidelines, shows, for temporary total disability claims, “best practice,” the average cost excluding the 5% most costly, and the 5% most costly.

<table>
<thead>
<tr>
<th>State</th>
<th>Best practice</th>
<th>Excludes 5% most costly</th>
<th>5% most costly</th>
<th>5% with opioids and smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>$15,377</td>
<td>$21,244</td>
<td>$29,612</td>
<td>$135,737</td>
</tr>
<tr>
<td>California</td>
<td>$16,706</td>
<td>$30,779</td>
<td>$42,742</td>
<td>$156,302</td>
</tr>
<tr>
<td>Indiana</td>
<td>$13,843</td>
<td>$18,623</td>
<td>$26,950</td>
<td>$131,361</td>
</tr>
<tr>
<td>New York</td>
<td>$16,497</td>
<td>$29,370</td>
<td>$40,936</td>
<td>$156,358</td>
</tr>
</tbody>
</table>

Then, at the far right, is the claims cost among the 5% most costly when the claimant receives opioid treatment for 30 days or longer and is a smoker. I included two states regarded as high cost (California and New York) and two states regarded as low cost (Arizona and Indiana). Note the skewed results in every state.

**Opioids in history, 1800s to 2000**

The modern history of painkillers in medicine began in the 19th century with successful attempts to produce opioids from opium. Morphine, heroin and codeine were created in the 19th century; methadone and oxycodone, in the early 20th century. The impetus behind these developments was a desire to offer a more precise and less addictive form of pain relief.

Opium and opioid production and use were virtually unregulated worldwide in the 19th century, even though scientists and medical practitioners warned about addictive risks. One out of 400 Americans were estimated to be opioid addicts (mainly morphine) in 1911. Public health officials in leading countries induced governments to assert control. The first international commission was founded in 1909. In the United States, the federal government and most states enacted laws in the 1910s which eliminated opioids from consumer products.

In the 1980s and 1990s the medical and regulatory communities in the United States moved to approving opioids outside narrow and extremely time-limited pathways, such as palliative care and post-surgery. A Scientific American article of 1990 sent an urgent message in favor of broader and on-going use. The author, Ronald Melzack, encouraged a “more humane way to treat pain,” which was to maintain a patient on a constant, ongoing regime of opioids.

Broader recognition of a pain relief imperative launched many expansions of medical care. Between 1994 and 2004, lumbar spine MRIs quadrupled. The frequency of spinal fusions for degenerative conditions more than quadrupled between 1988 and 2000, doubling in the last two years of this period. Opioid use took off after Purdue Pharma introduced OxyContin in 1995. As opioid sales quadrupled, opioid-related overdoses and related fatalities multiplied. Prescribed opioid-related deaths of all patients, work related or not, rose from 1999 through 2011 by 420% to 16,917.

Fatalities were just part of the picture. Patient misuse, abuse, and addiction also factored in. A 2008 study estimated a 3.27% addiction rate for prescribed opioid patients. That’s three times the 1% figure cited by Purdue Pharma sales staff to doctors. After accounting for all “aberrant drug-related behaviors,” such as not taking prescribed drugs or taking illicit drugs at the same time, a 2008 report implicated some 11.5% of all patients and 20.4% among chronic pain patients.

**Response in the workers’ comp system, 2000 - 2015**

Many will agree with one pain expert’s observation that “Washington State really did the yeoman’s work on alerting not just the workers’ comp industry but the country to opioid safety problems.” Much of the credit goes to Franklin, since 1988 the medical director of the state fund, Labor
Opioids (Continued from page 6)

and Industries, the exclusive source of workers’ compensation insurance in the state.

In the early 2000s, Franklin and his colleagues began to examine closely why injured workers died, even years after their injury. They found that in a significant number of cases, opioids prescribed for their work injury were a contributing factor. When I extrapolated their findings for the nation as a whole, it appears that over 2,000 injured workers died this way through 2010.

Medical experts conceived the notion of proposing a dosage threshold, above which risks such as overdoses appeared to be much more costly. Washington State’s inter-agency task force published the nation’s first dosage advisory in April, 2007. The 2010 edition of Washington’s opioid guidelines recommended a 120 mg/day morphine equivalent dose (MED) threshold, above which the physician was to consult with a pain specialist. Six other states followed Washington in imposing dosage guidelines.


State controls over opioid prescribing expanded greatly since 2010: databases of prescribing; prescribing guidelines; educational mandates; formularies. By 2014 there existed at least 13 opioid treatment guidelines endorsed by states or professional bodies. Most recommended a daily threshold of MED, a written prescriber-patient treatment agreement, and urine drug testing.

Starting in 2012, pharmacy benefit managers begin to report a tapering of or actual decline in use of opioids in workers’ compensation.

Conservative care: workers’ comp “Big Dig”

Claims payers need to bring their strategies for chronic pain into better balance. This includes addressing prevention as well as recovery, and embracing a full array of available interventions. I use the term conservative care, when the technically more accurate term would be evidence-based medicine, because “conservative care” resonates more successfully with the non-medical specialists who run workers’ comp insurers and corporate risk management departments.

Conservative care puts primary emphasis on behavioral, psychological, and alternative types of treatment. Without in any way blaming the patient, it sets its goal for the patient to be an active partner in recovery - to acquire long-lasting skills at self-management.

The workers’ comp industry has a special relationship with conservative care. Workers’ comp, in contrast to group health insurers and government-run health plans, focuses far more on musculoskeletal conditions, the type which conservative care is well suited to address. Thus, workers’ comp claims payers are directly responsible for ensuring access to good conservative care programs, through how they support these services.

The workers’ comp industry’s travails with chronic pain invites comparison with the city of Boston’s struggle to modernize its downtown traffic flow through the immensely ambitious and costly Central Artery/Tunnel Project, also known as the “Big Dig”.

Both are super big-ticket challenges. The Big Dig project went from ground breaking in 1992 to official but not final completion in 2006. It reorganized 160 lane miles of surface and below-surface roads and bridges, with additional subway and bus system alterations.

What makes the analogy with the chronic pain challenge in workers’ comp informative is that challenges of this scale demand an extraordinary degree of collaboration distributed over a large number of parties. It’s a massive systems engineering challenge. The Big Dig required close, frank, and accountable collaboration of hundreds of contractors, public agencies, and other actors. It proved an astounding success with respect to one risk: there was only one work-related death reported.

The goal of the Big Dig was to improve the livelihood of the Boston metropolis – more than reworking traffic flow. The goal of a chronic pain initiative is to keep workers productive – more than managing drugs. Claims payers need to share more information about their experience with what works – and does not – in prevention and recovery. Presently there is virtually no sharing of experience among claims payers; nor is any research group engaged in collecting and distilling this experience.

Service providers need to share results as well, among managed care organizations, medical providers, and an increasing array of nonmedical coaching, return-to-work, injury prevention, and other interventions. Huge data coordination investments are called for.


He is a journalist and consultant in the field of risk, with a special focus on work injuries. Peter is an award-winning author of some 200 articles on many aspects of workers compensation. He is a columnist for WorkCompCentral. Holding an MBA from Harvard Business School, Peter has been in the workers’ compensation field for 25 years. He resides in Woodstock, VT. Email: prfroumaniere.com.


(Continued on page 8)
Pregnancy, Legal (Continued from page 5)

Preeclampsia, and sciatica, might be considered “disabilities” that merit protection under the ADA, including reasonable accommodation.

**Conclusion**

Despite the emergence of new statutory and case law over the past couple of decades, occupational medicine providers must appreciate that limitations in the legal framework for addressing potential exposures to workplace reproductive hazards persist. Notwithstanding, the following risk management principles may be helpful in approaching these complex situations:

- Do not exclude females from the workplace based on their gender or reproductive status
- Include information on reproductive hazards as part of annual hazard communication training
- Do not discourage or use coercion on employees, for example, by providing female workers, but not male workers, with information about reproductive risks
- Do not require employees to sign waivers absolving the employer of liability in the event of an adverse reproductive outcome
- Offer pregnant women the same benefits (e.g., light duty, disability leave) as those offered to other temporarily disabled workers
- Engage in an individualized, interactive process with employees who are seeking accommodation
- Encourage input from and dialogue with employees’ treating clinicians

Particularly given that pregnancy is a temporary condition, parties can often engage in informal processes to accommodate pregnant employees and to safeguard the health of both male and female employees planning for the birth of a child. Above all, focus on minimizing/eliminating exposures and making the workplace safe for all employees.

Carolyn Langer is the Chief Medical Officer of MassHealth, an Instructor in Occupational Medicine at the HSPH, and an Associate Professor at UMass Medical School.


**Opinions (Continued from page 7)**

[a] Callahan T, Rousmaniere P. Opioid deaths in workers comp. Presented to New Hampshire legislative task force on opioids. September 2013

**Opioids (Continued from page 5)**

**Answer to last issue’s “Who Is It?”:**

Bernardino Ramazzini (1633-1714).

Dear Dr. Karandikar,

I believe the quote “For the common maxim ‘Nothing in excess’ is one I excessively approve” can be attributed to Bernardino Ramazzini around the 18th century (with regard to reducing the risks of job exertion). I cannot recall the original Italian phrase!

Thanks, and look forward to reading NECOEM Reporter.

Best regards,
Richard A. Manfready
Tufts University School of Medicine (MD’17)
richard.manfready@tufts.edu

Congratulations to Mr. Richard A. Manfready, medical student, for sending the correct answer!

Bernardino Ramazzini, called the Father of Occupational Medicine, authored the De Morbis Artificum Diatriba [Diseases of Workers], a highly regarded contribution to the field of occupational medicine, where he focused on workers’ health problems in a systematic and scholarly way. Generally, he recommended moderation in working, especially, of hard work, for example, periodic interruption of hard working activities. It is this moderation in taxing work that he advises when he comments on “Nothing in excess is one I excessively approve!”

If you have any such interesting or fun-filled material, please email 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.
NECOEM Welcomes Four to the Board

NECOEM has been fortunate to welcome four new elected members to our Board of Directors:

**Dana Sparhawk, MD, MPH** is a board-certified occupational and environmental medicine physician who has been practicing occupational medicine in a variety of settings for nearly 30 years. His early experience was in the Air Force, followed by private clinic settings, most of which was in Rhode Island as Regional Medical Director and Medical Policy Board member for Occupational Health and Rehabilitation, Inc. In 2009, he joined Lifespan, a group of four hospitals in Rhode Island where presently he is Director of Employee and Occupational Health Services. At Lifespan, he is in charge of their self-funded workers’ compensation program, employee health services, leave of absence programs, and health and wellness promotion programs for over 14,000 employees. He is also on the faculty at the Alpert Medical School of Brown University and is involved in medical student teaching. He very much enjoys his current position as, along with his administrative responsibilities, it also allows him to continue to see patients, as well as spend much more time doing preventive medicine and public health, which was his original reason for pursuing a career in medicine. Dana has been a member of NECOEM for 25 years and has always enjoyed and benefited from his association with his occupational medicine colleagues.

**Abhijay Karandikar, MD, MPH, FACOEM** is a board-certified occupational and environmental medicine physician. After completing an internship in general surgery at the University of North Dakota, he pursued and completed his occupational medicine residency at the University of Illinois at Chicago, where he also served as the faculty-appointed chief resident. He received the C. C. Clayton Award for Distinguished Excellence in Advanced Degree Training while pursuing his Master of Public Health (MPH) degree at the Virginia Commonwealth University Medical Center in Richmond, Virginia. Dr. Karandikar was recently elevated to fellow status in the American College of Occupational and Environmental Medicine (ACOEM). He served as an alternate in the House of Delegates for ACOEM’s Work Fitness and Disability Section for two years and was elected to serve as their delegate at the AOHC Annual meeting in Baltimore, Maryland, this year. Dr. Karandikar is chair of the 2015 NECOEM Annual Conference committee and has been an associate editor of the NECOEM Reporter since 2014 where he initiated the trivia section “Who Is It?”. Dr. Karandikar has served as a medical director at ConnCare/Backus Hospitals in Norwich, Connecticut, for the past two months. Prior to this, he worked for seven years at a multispecialty multi-clinic health center in northern Maine, providing clinical and consulting services in occupational medicine. In his spare time, he enjoys spending time with his family, movies and traveling. He lives in Rocky Hill, Connecticut, with his wife and two children.

**Josh Schwartzberg, DO, ABFP** is owner and Medical Director of Champlain Medical Urgent Care (CMUC) in South Burlington, Vermont. Josh has 4 decades of private clinical practice experience and has practiced occupational medicine in Vermont since 2001. He is a certified MRO, IME and Senior FAA Medical Examiner. He opened his current practice in 2013 and provides a blend of primary care, urgent care, and occupational medicine services to the northern Vermont region. In the short time it has been open, CMUC has developed relationships with over 250 occupational medicine clients, including the City of Burlington and the University of Vermont. CMUC has earned the respect of both workers and employers by providing timely and convenient access, excellent diagnostics and dedication to quality care. Dr. Schwartzberg is board-certified in family practice and has held numerous academic faculty positions. He is an instrument-rated private pilot, owns and operates a small farm near Burlington, is married with three sons, and is an avid fisherman and gourmet cook. Josh is looking forward to bringing his depth and breadth of clinical, academic, and business experience to the NECOEM board where he is delighted to represent Vermont.

**Susan Upham, MD, MPH** is a board-certified, fellowship-trained occupational and environmental medicine physician. Prior to completing the University of Massachusetts Medical School (UMMS) OEM program, she completed the UMMS Fitchburg Family Practice residency and was a family practitioner for two years. She has been practicing occupational medicine in Portland, ME since 1993. She is a founding member and a co-owner of Bayside Employee Health Center, which is the only woman-physician-owned OEM clinic in Maine and which has recently celebrated its 15th anniversary. She is a certified MRO and CDME. Over the years, she has enjoyed OEM teaching through programs provided to the students at the University of New England Medical School, residents at Maine Medical Center and to various employers and other interest groups. She has a particular interest in health issues related to indoor air quality and has consulted with numerous employers and employee groups related to this problem. She is an associate editor of the NECOEM Reporter and will be acceding to the editor position with our next issue. Susan is married to Paul Upham, MD, Medical Director of WorkWell at Southern Maine Medical Center, (Biddeford, ME) and has one college age son, Matthew. She enjoys boating, singing in a choir, gardening, and spending time in the White Mountains. WorkWell at Southern Maine Medical Center, (Biddeford, ME) and has one college age son, Matthew. She enjoys boating, singing in a choir, gardening, and spending time in the White Mountains. Southern Maine Medical Center, (Biddeford, ME) and has one college age son, Matthew. She enjoys boating, singing in a choir, gardening, and spending time in the White Mountains.
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.

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