UNITED STATES HOUSE OF REPRESENTATIVES
HOUSE EDUCATION AND LABOR COMMITTEE HEARING

"Hidden Tragedy: Underreporting of Workplace Injuries and Illnesses"

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Representing the American College of Occupational and Environmental Medicine

Good Morning. I am Robert McLellan, an occupational medicine physician and the Immediate Past President of the American College of Occupational and Environmental Medicine, known as ACOEM. I serve as the Chief of the Section of Occupational and Environmental Medicine at Dartmouth-Hitchcock Medical Center and as Associate Professor of Medicine and Community and Family Medicine at Dartmouth Medical School. ACOEM represents more than 5,000 physicians and other health care professionals specializing in the field of occupational and environmental medicine. Founded in 1916, ACOEM is the nation's largest medical society dedicated to promoting the health of workers through preventive medicine, clinical care, disability management, research, and education.

ACOEM welcomes this opportunity to provide our organization's perspective on OSHA recordkeeping. Our interest in this subject stems from our role as physicians with a dual mission; we provide direct care to workers in the clinic and we serve as public health officers for employed populations. As clinicians, we have an obligation to provide the best, evidence-based care to workers. As a specialty of preventive medicine, we also have a responsibility to use epidemiological tools such as the OSHA log to design population-based preventive interventions.

In my position as President of ACOEM, I had the opportunity over the last year to tour the country and visit with occupational physicians and allied health providers working in a variety of settings. A concern reported to me during these visits was that some employers exerted pressure on occupational physicians to alter treatment and/or return to work statements in ways likely to minimize OSHA recordability. Based on the frequency of this report, I suggested that ACOEM convene a special session on OSHA recordkeeping at ACOEM's annual meeting known as the American Occupational Health Conference, this year held in New York City, In addition to this session, ACOEM recently established a forum on its website to gather additional perspectives from our members on their experience with OSHA recordkeeping. In the coming months, we look forward to participating in a survey of our membership to be conducted by the Government Accountability Office, at the request of Chairman Miller and Representative Woolsey, and Senators Kennedy and Murray, in an exploration of the issue of reporting of work-related injuries and illnesses. We expect to publish a position paper in the upcoming months, but not before our College has had the opportunity to more fully explore options as to how best to further the goal of valid and reliable recordkeeping that supports preventive health and evidence-based medical care. My testimony today therefore represents the results of preliminary exploration of this issue by our College.

From the public health perspective, the OSHA Log was created as *a* tool to describe the burden of occupational injuries and illnesses on society. This data drives occupational health and safety resources. It is also used to target interventions to address industries and processes that carry the greatest risk. When followed over time, the log can help evaluate the

effectiveness of these interventions. However, the OSHA log can only support these functions to the extent that it is valid and reliably maintained. Most importantly, society's interest in preventing work-related injuries and illnesses is foiled when our picture of the true burden of work-related injuries and illnesses is distorted.

Limitations of the OSHA log in serving these basic public health functions have long been recognized. Several peer-reviewed articles in the scientific literature have concluded that for many reasons, the annual BLS survey of employer logs results in substantial under-reporting of the full extent of work-related injuries and particularly illnesses (Azaroff, Levenstein, et al 2002, Boden and Ozonoff 2008, Rosenman, Kalush et al, 2006). With reference to other data bases and changes in the recordkeeping rules (Friedman and Forst 2007), some researchers have questioned whether the apparent decline in injuries and illnesses is a true reflection of reality. These conclusions do not mean that most employers are not in good faith doing their best to accurately comply with the recordkeeping rule. Rather, multiple factors are at play.

The OSHA log was never designed to serve as a single, comprehensive metric of occupational health and safety at either the national or employer level. By prescription of the OSH Act itself, the recordkeeping standard has always excluded first aid cases. As well, several sectors of workers are excluded; a problem which is growing with the burgeoning number of contingent workers, a workforce estimated in a recent article in the Journal of the American Medical Association as representing nearly a third of the American workforce (Cummings and Kriess 2008). The OSH Act also did not supersede workers' compensation law, which often defines compensable injuries and illnesses somewhat differently than the OSHA recordkeeping standard. In fact, since the turn of this century, the Council of State and Territorial

Epidemiologists has promoted the use of a suite of 19 different occupational health data bases in an effort to capture a more valid picture of work related injuries and illnesses (Council of State and Territorial Epidemiologists 2008).

The OSHA log has grown to serve many purposes beyond that for which it was designed. When a single metric becomes the focus of safety efforts, it can become distorted by a wide variety of pressures. For example, OSHA's preamble to the recordkeeping rule cites a stakeholder, who commented that "Today, many owners are selecting contractors on the basis of the contractors' rates for lost work days and total recordables." At its best, this concentration results in intensive efforts to improve safety. At its worst, however, the spotlight on the log produces efforts to make the log look good, rather than placing attention on reducing risks that lead to injury and illness. ACOEM members report that various incentive programs to produce a "good" OSHA log can distract safety programs from the primary goal of prevention. When workers or managers are promised a valuable prize to avoid recordable injuries, they may pressure each other to under-report. One ACOEM member reported that a worker came directly from the job to the clinic with a very recent, significant laceration. In contrast to obvious appearances however, the worker reported that the injury had occurred the night before at home and in passing stated that to claim otherwise would risk that his fellow workers would lose a steak dinner. In another case, the entire plant was told that if they had a recordable injury, the whole workforce would lose its bonus. When managers' bonuses are dependent on a "clean" log, they may make efforts to reduce reporting, whether it be by discouraging reporting by employees, shifting medical care costs to group health insurance or inappropriately intruding on the doctor-patient relationship.

Although physicians and providers do not have a regulatory obligation under the standard, we have an ethical obligation to correctly diagnose, report, and treat injuries. The rule allows business to use a physician of its choice in the final determination of causation, treatment, and work restrictions. At its best, this provision allows employers to select knowledgeable physicians. At its worst, this provision can lead employers to select physicians not for their competence, but for their reliability in declaring that an injury is not work related.

**ACOEM Members' Perspectives**

ACOEM has not conducted its own systematic research. The following comments represent perspectives and anecdotes collected from our members.

- Some ACOEM members have observed a wide variability in employers' understanding and application of the recordkeeping standard.
    - Many employers make every effort to comply assiduously to the letter of the standard. In these settings, reporting is encouraged and the general rule is to "treat the patient, not the log." The log is used to stimulate interventions that improve safety. Unfortunately, in some cases, this careful compliance can result in the industry being targeted for OSHA inspection because of incidence and severity rates that *appear* above comparable businesses.
    - Some employers, in the spirit of training, ask physicians if they can make minor alterations to their treatment, if medical outcomes are not compromised, to take advantage of regulatory distinctions between first aid and medical treatment.

- Some, particularly smaller employers, find the rule inordinately complex and confusing, and complete the log incorrectly through ignorance of the rules.
- Some employers work closely with in-house or outsourced physicians to coordinate administrative functions of recordkeeping with the medical providers who best understand the circumstances of the worker's health problem. In other cases, an employer's recordkeeper has little contact with knowledgeable providers.

- Some of our members point out that the OSHA log is a lagging indicator of safety; no matter how accurate, it counts past events. These members encourage employers with whom they work to use a broad set of metrics to evaluate and promote the health and safety of a workplace, such as first aid and near misses, workers compensation data, and hazard assessments. Noting that any injury, no matter how minor is an indicator of a hazard, several members would rather declare all first aid incidents as "recordable." They reason that efforts should be devoted to prevention rather than arguing about recordkeeping rules.
- Some of our members complain that distinctions that the standard make between first aid and medical treatment are nonsensical and can drive bad medical practice.
  - For example, using a cotton swab to remove a foreign body from the eye is considered first aid. Unfortunately, use of a swab may damage the cornea. The appropriate tool for the same purpose is a needle like tool, called an eye spud, used by a trained health care provider. Use of this tool, however, is considered medical treatment.

- The difference between a laceration of only a few millimeters, for which a bandaid is sufficient, and a laceration of a few centimeters needing sutures is luck, not safety.

- Some members indicate that several parties including some workers, employers, and insurance companies try to influence occupational medical treatment in ways that may result in medical harm to a worker or in other cases, excessive costs to employers. We do not know how extensive this problem is, but anecdotes are common enough to be a concern. Let me note parenthetically that it is clear some employees may demand inappropriate time off or medical treatment and that some physicians may comply with those requests, in this case resulting in over-reporting rather than under-reporting. However, since the focus of this hearing is on under-reporting, we will focus our testimony on anecdotal evidence from ACOEM members illustrating how some employers, supervisors or safety professionals act in ways that are driven primarily for the purpose of minimizing OSHA recordability.
  - Some employers willfully misinterpret the "routine functions" criteria of OSHA to define cases as not recordable. Some employers have asked clinicians to write "Work as tolerated" on the Return to Work form in order to manage the restrictions themselves and avoid a paper trail of recordability, for example.
  - One member reported an instance where a safety team at a site without an on-site medical office, inappropriately controlled access to health care providers in the context of plant incentive programs that rewarded the absence of recordable injuries. She intervened when she learned that after a worker was exposed to

vinyl chloride, the safety team had applied a hazardous chemical (potash) to the worker's skin since they had read that the chemical could be used to neutralize environmental spills.

- Some employers send supervisors to the clinic with the expectation that they accompany the worker into the exam room to contribute to the evaluation of an injured worker.
- Some employers send messages to be attached to medical charts directing the physician to opine that the injury was not work-related.
- Some employers ask occupational health professionals to prescribe "exercise" instead of physical therapy or to employ athletic trainers instead of therapists to minimize recordability.
- Some employers have been known to question the clinician's decision to sew up a wound or they have requested Steri-Strips (a type of bandaid) in order to prevent recordability.
- Occupational health professionals are asked to review treatment by other clinicians to determine if the prescription was "really necessary" in an effort to avoid recordability, clearly in violation of OSHA's own interpretations.
- Some of our members report that employers have diverted injured workers to other physicians in a community who are apparently more willing to comply with an employer's directives to alter care to minimize recordability.

**Conclusions and Recommendations**

Let me conclude by saying that we believe most physicians and employers are trying to do the right thing when it comes to OSHA recordkeeping. But we find anecdotal examples of distorted reporting troubling, suggesting a process and a system in need of review because of the potential for causing both medical harm and flawed statistical results.

No single party is to blame for under-reporting: As often is the case, it is a complicated mix of pressures that range from workplace practices to health provider policies and government regulations. ACOEM has developed strong relationships with multiple constituencies, including workers, employers and regulators, and has partnered with NIOSH to further the protection of the workforce. It is not our intention to point fingers, but rather to seek solutions that are based on doing what's right for the patient and that are grounded in good science and best practices.

Our advocacy on this issue is quite straightforward:

- **Number one**: Physicians must always do the right thing for the patient. Although physicians and providers do not have a regulatory obligation under the standard, they do have an ethical obligation to correctly diagnose, report, and treat injuries. This obligation also extends to avoiding unnecessary treatment and disability. These principles are built into our Code of Ethics and adhering to them must always remain as a key goal. This will be our overriding priority in all of our discussions of the issue.

- **Number two**: We believe that OSHA must encourage a better understanding of the requirements contained in the recordkeeping standard and the various interpretations and uses surrounding the standard. Providing employers with electronic decision-

making tools that incorporate rule interpretations, for example, could reduce the variability in recordkeeping.

- **Number three**: It may be time to update the current OSHA recordkeeping standard and its enforcement to minimize under-reporting.
- **Number four**: OSHA might undertake a special emphasis program to increase the number of medical records reviewed as part of OSHA's Audit and Verification Program of Occupational Injury and Illness Records (CPL 02-00-138).
- **Number five**: ACOEM supports efforts to broaden the suite of occupational health indicators used at a national, state, and facility level in order to improve the quality of the data necessary to prevent work related injuries and illnesses.

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