New Developments in Workers' Compensation Law

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The basic purpose of workers' compensation legislation is to provide the prompt payment of specified benefits to an injured worker, regardless of the question of fault. The workers' compensation laws of the individual states vary considerably in content and scope, especially as they apply to occupational diseases.

The Occupational Safety and Health Act of 1970 established the National Commission on State Workmen's Compensation Laws. The Commission was directed "to undertake a comprehensive study and evaluation of state workers' compensation laws to determine if such laws provide an adequate, prompt, and equitable system of compensation." The Commission presented its report to the President in July 1972. The Commission's report called for liberalization and some degree of uniformity of the state acts.[1]

In the years since the Commission's report several changes have been made in the individual states' workers' compensation acts; however, a lack of uniformity in the individual state acts persists. The greatest difference between state acts exists in the area of occupational disease, which is usually defined as an industrial disease contracted independent of an accidental injury and arising out of employment. The occupational disease discrepancy in the state acts is complicated by the fact that the occupational disease may be delayed in onset; in fact, the development of occupational disease may be spread over many years and over several employers.[2] The compensability of the occupational disease is further complicated by the additive or synergistic effect of the environment external to the workplace and individual lifestyle, as well as genetic factors.

The report of the National Commission on State Workmen's Compensation Laws served as a stimulus for the revision and improvement of several state acts. It was, however, not the first attempt at reforming state workers' compensation acts, as substantial reform had taken place in New York, California, Oregon, Maryland, Idaho, and Pennsylvania prior to the Commission's Report.[3]

The differences in the workers' compensation acts of the individual states were increased with the publication in 1983 of the "Suggested List of Ten Leading Work-Related Disease and Injuries" by the National Institute for Occupational Safety and Health. This list included: (1) occupational lung diseases, (2) musculoskeletal injuries, (3) occupational cancers, (4) severe occupational traumatic injuries, (5) occupational cardiovascular diseases, (6) disorders of reproduction, (7) neurotoxic disorders, (8) noise-induced loss of hearing, (9) dermatologic conditions, and (10) psychologic disorders.[4]

Many of the state workers' compensation acts do not have provisions that accommodate these conditions. Since 1983, we have observed a movement of reform by some states to accommodate these conditions. For example, effective

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July 1, 1987, amendments were made to the state workers' compensation law in Montana. These changes included the following:

(a) exclude from coverage injuries from emotional or mental stress and disease not caused by an accident;

(b) make heart attacks compensable only if they are the primary cause of physical harm; and

(c) change the definition of occupational disease to exclude physical or mental harm arising from emotional or mental stress or from a nonphysical stimulus or activity.[5]

Political, social, and economic pressures are constantly increasing benefits to keep pace with the rising cost of living. We note activity in some states to implement reform that would accommodate health care cost containment and case management. The most consistent thing about the individual state workers' compensation act is change.

I propose that there is a need, more than ever before, for a national scheme, built from the ground up, to deal with workers' compensation. The present individual state laws handle occupational disease poorly, at best. There is a need for a formula determining disability based on impairment, environmental influence, lifestyle influence, hereditary influence, and workplace exposure. There is a need for a formula to prorate the liability among contributing employers.[2] I feel that physicians and attorneys have not performed well in the current system. Much of the data to support the reward is based on subjective, as opposed to objective data, and once the reward is determined, not enough of it reaches the worker. There is a definite need for more scientific objectivity and less adversarial negotiation. There is a need for more documented exposure, as opposed to assumed exposure.

I propose that it is time to consider the development of a national board (please note, I did not say a federal board but a national board [not under federal control]) with equal representation from labor and industry that would: (1) develop and control rules and regulations of workers' compensation for the nation, (2) oversee regional boards, and (3) accept or reject appeals for evaluation of regional board decisions.

The regional boards would accept or reject a request for an evaluation of a claim submitted by the worker. The regional boards would also have equal representation from labor and industry.

Regional medical centers should be identified to evaluate each case for which a claim is submitted to the board. Where possible, these evaluation centers could be located in the educational resource centers. Testing would be performed by specialists to develop objective data. Work hardening centers could be used to evaluate rehabilitation data and assist in preparing the claimant for return to the worksite. Funding of the board could be made on the basis of cost-plus for claims settled. The employers could continue with the current system of insurance to support the payment of their claims either through private insurance carriers, self-insurance, or a special fund provided by the regional board. The settlement of compensation claims could still be handled through four basic methods[1]: (1) the formal agreement method, (2) the direct settlement, (3) formal claim petition, and (4) the hearing method.

The payment for temporary total disability, permanent total disability, permanent partial disability, and death could continue as it is at the present time; however, there would be one uniform scale throughout the nation. Individual employers would be required to maintain a list of panel physicians for selection by the injured for treatment. The national board would be advised to establish and

maintain minimal requirements for claim submission and the regional boards would be advised to accommodate those who need help with reading, writing, and claim preparation. Serious effort would be made to provide easy access to the system and to accommodate scientific data submitted by the treating physician, the evaluating panel physician, claimant, and employer. Flexibility of the system would be maintained to accommodate changes in the scientific literature.

I feel that such a system would provide fair and uniform compensation with maximum reward for the claimant on a national scale.

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DISCUSSION OF THE PAPER

JOHN CHONG (*McMaster University, Hamilton, Ontario, Canada*): I am concerned about the recognition of occupational disease. This is a central issue in any health care or public health system or workers' compensation system throughout the world. Without a category of health professionals trained in occupational health, it is not possible to recognize the work-related disease. Underreporting is a frequent result. The key issue you have identified is that of training all health professionals at the undergraduate, postgraduate, and continuing educational levels.

At McMaster University, we have tried very hard to target our educational reforms at all levels. Undergraduates are trained in occupational health, as well as in a specific area. But many barriers need to be overcome to implement this program. Some problems stem from underrecognition of the importance of occupational and environmental causes of disease.

I would like to ask how we can succeed in getting students' attention early. How can we transform the very constrained medical model, the diagnosis and treatment model, which is already ingrained in a high proportion of students when they enter medical school, to a more prevention-oriented effort? Without that change in orientation, many of the concepts that we have discussed will never reach fruition.

FISHER: You have made a good point. As occupational physicians, we must be represented on medical schools' curriculum committees because that is where the decisions are made. Medical schools are not preparing physicians for dealing with cost-containment or with quality-of-care issues. They are not developing physicians who are prepared to think about preventive medicine.

Another thing you can do is to encourage local industries and medical schools to collaborate to bring their students into industrial facilities. I just spoke at the

medical school of the University of Medicine and Dentistry of New Jersey in Stratford, New Jersey addressing the students and the residents in the field of occupational medicine. They need exposure to the concept of preventive medicine; it is foreign to them.

If we are going to get good data and good scientific programs, physicians have to be the bottom line in the system. No matter what you do within the plant, that patient has contact with the physician outside the plant, and that physician has to recognize occupational disease.

You are right: There is a big job ahead of us. There are not enough of us to do it, but we can try.

ALAN ENGELBERG (*American Medical Association, Chicago, Ill.*): Many medical specialty groups from orthopedists to emergency physicians are tripping over each other trying to get into occupational medicine. Internists tried to say they were the only ones who could do it. In this context, I would like to ask you, Dr. Fisher, whether, when you were President of the American Occupational Medical Association, you tried to bring in some of these specialty groups to meet with your Board of Directors. Did you broach the idea of anything like specialty centers in occupational medicine? If you did, how was that accepted by these other specialties who are now trying to get into the practice of occupational medicine?

FISHER: I did broach it, and they were not keen on it. I have no problem with the internists or the orthopedists or anyone else wanting to practice occupational medicine. The more the better. My problem is that most of them tend to look only at the acute case, but do not follow up. When a doctor treats a patient, he does not look at the cause of the exposure. He does not come down on the employer or go into the worksite.

That is the problem. The occupational physician cannot practice occupational medicine in the closet. He must go into the workplace to see the exposures. That is where the patient is located, and it is there that you have got to stop the future exposures.

Treating the acute case of carbon monoxide poisoning today does not stop the process. You have got to get to the source. That is my concern with this business of every doctor wanting to practice occupational medicine, while wanting to stay in his white coat and office. You cannot do it.

JAMES CONE (*University of California, San Francisco, Calif.*): Our problem has been in dealing with the American Board of Preventive Medicine in regard to occupational medicine. We need to examine the performance of the Board in the field. Is it advancing or retarding the field?

Our experience suggests it may be retarding the interests of occupational medicine. Therefore, we should examine the original rationale for founding the Board, which was to raise the performance and standards in the field and to promote the education of physicians in occupational medicine. Too often the Board seems to create obstacles.

FISHER: From the standpoint of the American Occupational Medical Association, we would like very much to establish an independent board in occupational medicine. The problem now is that such a proposal has to be voted upon by all the other existing board representatives. The American Board of Preventive Medicine covers general public health, aerospace medicine, and occupational medicine. I think that there is a need for an independent occupational medicine board separate from the other two. Occupational medicine is a specialized area, and the lack of a separate board is a shortcoming.

VALERIE WILK (*Farmworkers' Justice Fund, Washington, D.C.*): I would like to call your attention to the fact that when we are talking about reform of workers' compensation, we should remember that agricultural workers are not even cov-

ered by workmens' compensation laws in half of the states. When you are talking about only 1200 board-certified occupational medicine physicians in the U.S., how many of those are based in the cities as opposed to rural areas? I was pleased to hear Dr. El Batawi acknowledge earlier the agricultural component of the workforce.

FISHER: One of the amendments to the Gaydos Bill on the House floor was to exempt agricultural facilities that have seasonal workers who work fewer than six months a year from notification. That is a real problem.

TEE L. GUIDOTTI (*University of Alberta, Faculty of Medicine, Edmonton, Alberta*): In Canada a free-standing board was, in fact, established—the Canadian Board of Occupational Medicine. It has had a wonderfully salutary effect on the primary certification agency, the Royal College of Physicians and Surgeons, leading eventually to breaking up the logjam and to the establishment of occupational medicine as an independent specialty apart from what had previously been the general area of community medicine. Now, there are, in effect, two pathways to certification in Canada—a direct path, and an indirect path, which is eminently suitable for the lateral transfer of specialists from other areas into occupational medicine. This is a very interesting development, but one of the major benefits of the alternate pathway was its effect on the primary board specialization pathway.

FISHER: Similarly, in this country, most of the practicing occupational physicians and many of those who are board-certified are the result of mid-career conversions.

MITCHELL R. ZAVON (*Agatha Corp., Lewiston, N.Y.*): As someone certified in everything including industrial hygiene, I agree with virtually everything you have said, but one huge area has been overlooked: Most workers are not seen by doctors. They are seen by nurses. Most plants are not visited by doctors. If the workers are lucky, they are visited by a qualified, competent industrial hygienist.

We live in an age of specialization. Although I have taught that the physician should get out in the plant so that he knows what the worker is exposed to, a busy physician in private practice has to be extremely dedicated to do that.

We depend on the specialist, the industrial hygienist, or the safety engineer, to describe the situation to a physician or to a nurse who is knowledgeable. We should not ignore the fact that the nursing component of the occupational health team is more critical than is the physician, and that the industrial hygienist is more important in cleaning up the work environment than is the physician.

We need the concept of the team to be reinstated. During the 38 years I have practiced occupational medicine, I have seen the team sundered by one specialty area after another opting to get out from under the umbrella. In some industries these specialists do not even report to the same people.

One last comment on workers' compensation laws. Having spent many years in Ohio, I am not at all sure that that state-run model is one that we should emulate. I was not successful within that system in inculcating the notion of prevention. My advice fell on deaf ears in a state-run "nonprofit" system, which has been profitable for the politicians and the political process within the state.

FISHER: A major problem I see is that many facilities do not have a full-time hygienist. They use an insurance carrier to provide hygiene services. A related problem is that the plant manager or production manager, both of whom are lay persons, are typically given the responsibility for knowing when the hygienist has to be called in. In the last year I have visited 39 of our facilities with that very purpose in mind—to sensitize the nurses to finding the exposures and to knowing when to call the hygienist.