


[Home](#)   [Career Center](#)
[Join Now](#)


[Member Login](#)

[Donate](#)
[Community Forum](#)

Welcome to the WOEMA WINDOW. This e-newsletter is sent to members by email on a monthly basis. The e-newsletter provides links to this page. Below are the items that appeared in the September 2019 issue.

- [WOHC 2019 Was a Smashing Success: See the Photos!](#)
- [FREE CME Webinar: Thursday, October 31, at 12:00 PM PDT](#)
- [The IME Handbook – Part 4](#)
- [It's Not Burnout, It's a Three Alarm Fire](#)
- [Meet the WOHC 2019 Resident Scholars](#)
- [WOHC 2019 Award Recipients](#)

### Latest News

---

### Upcoming Events

---

No events

[View Full Calendar](#)
[View Religious Calendar](#)

### WOHC 2019 Was a Smashing Success: See the Photos!

The 2019 Western Occupational Health Conference (WOHC) took place September 11-14 at the Sheraton Hotel & Marina in San Diego, CA. The conference planned by a committee of over 30 WOEMA members chaired by Dr. Akbar Sharip. Over 200 occupational medicine physicians and other health professionals attended WOHC's plenary and post-graduate sessions, worksite tours, board exam review course, networking events and the Signature dinner event "Fiesta By the Bay." The conference speakers and topics at WOHC were outstanding. Click on the link below to see the photos from various WOHC events!

[\[PHOTO GALLERY\]](#)



## FREE CME WEBINAR

THURSDAY, OCTOBER 31, 12:00 PM PDT

### WEBINAR TOPIC: IMPLEMENTING THE NEW 2019 CDC GUIDELINES ON TB SCREENING OF HEALTHCARE PERSONNEL

**Speakers: Warner Hudson, MD, FACOEM, FAAFP; Wendy Thanassi, MD**

This webinar will be a review of the May 2019 CDC MMWR Guidelines on TB screening of US healthcare personnel as well as cover key items discussed in the soon to be published companion paper on implementing these new guidelines, with a focus on practical approaches, what's changed, LTBI treatment and case reviews.

Learning Objectives – After this webinar participants will be able to:

- Implement the new CDC guidelines for TB screening of US healthcare personnel
- Treat LTBI using new approaches
- Adapt the new guidelines for your TB screening program

**Dr. Warner Hudson** is Associate Clinical Professor of Occupational and Environmental Health at UC Irvine. Prior to this he was Medical Director of Occupational and Employee Health for UCLA Health System and Campus where he implemented and directed large TB surveillance programs for healthcare personnel, researchers who worked with live TB, animal workers, and travelers. He was a voting member of the IBC there for 7 years. He has numerous publications on biosafety subjects including tuberculosis and has been a co-leader of the working group to develop the companion paper to the 2019 CDC guidelines on TB screening of US HCP. His is past president of ACOEM and WOEMA.

**Dr. Wendy Thanassi** is the Chief of Occupational Health at the Palo Alto VA and Clinical Assistant Professor in Emergency Medicine at Stanford Medical Center. She completed her medical education at Stanford University School of Medicine, her internship and residency at Yale – New Haven Hospital, CT, and is board certified in Emergency Medicine by the American Board of Emergency Medicine. Her particular interest is in infectious diseases. Dr. Thanassi has worked all over the world, including in TB hospitals in South Africa. Her extensive experience using IGRAs helps her to explain patterns and anomalies in serial testing of healthcare workers to help others make evidence-based decisions regarding testing and treatment of LTBI in the nation's workforce.

[\[REGISTER\]](#)



## THE IME HANDBOOK

### PART 4 IN A SERIES BY DR. STEVE FEINBERG

Dear fellow WOEMA members, some of you may be interested in performing independent medical legal evaluations (referred to as an IME) in addition to evaluations done within the workers' compensation system. WOEMA presented a symposium at the WOHC 2017 Maui annual meeting in which Dr. Christopher Brigham and I provided a copy of our book, The IME Handbook. This is installment part 4 from that book. As always, I am personally available to you via email to answer any questions ([stevenfeinberg@hotmail.com](mailto:stevenfeinberg@hotmail.com)). This 4th installment will cover the cover IME assessment, case summary, clinical impression & analysis, causation and apportionment, prognosis, maximal medical improvement, impairment, work ability, appropriateness of medical care, recommendations and disclosures.

Dr. Brigham has a [website devoted to IME education](#). While you will have access through the WOEMA Newsletter to the full IME Handbook in installments, the [full IME Handbook PDF is available on his website as well](#). There is a cost associated with Dr. Brigham's materials.

#### Assessment

Based on the findings from the history, review of medical records and other documents, physical examination and clinical studies, the evaluator responds to the specific questions asked by the client.

The evaluation physician cannot base opinions solely on only the basis of "education, training and experience." Rather, the evaluator must provide a clear description of why a conclusion has been reached, including reference to the facts and current science and best practices.

Opinions are stated clearly and explicitly using terminology such as “based on a reasonable degree of medical probability.” This means “more likely than not”, i.e., that there is a probability greater than 50%. All opinions should be supported with a detailed explanation to justify those opinions.

Credibility issues should be discussed and explained. Do you believe the examinee is malingering (lying) or you find evidence of symptom magnification/exaggeration related to her chronic pain syndrome?

### **Case Summary**

Provide a succinct summary of the history and physical examination followed by opinions (when requested) on the specific issues requested by the client.

### **Clinical Impression**

List the diagnostic categories and/or the differential diagnoses. Typically, this is done as a numbered list. Also, include the basis for your impression – findings in medical records, labs, imaging, current exam findings, etc.

### **Clinical Analysis**

It is essential to provide a clinical discussion of the problems in a manner that is clearly understood by a non-medical reader. Your opinions must be supported by the facts in the case and evidence-based medicine. As appropriate, provide specific references to the medical literature.

### **Causation and Apportionment**

Causation and apportionment are often critical issues. The evaluator must determine whether the problem, impairment and/or disability was preexisting or was caused by an event or occurrence. There may be multiple factors, including occupational and non-occupational, that contribute to the development of a clinical problem. Causation must be based on the facts and current science. Legal standards for causation may differ from medical standards and may vary by jurisdiction.

Many clinicians focus on aspects of clinical care for their patients, i.e., what is appropriate evaluation and treatment, and may not be formally trained in causation analysis or epidemiology, nor may they be familiar with the most current science. IME physicians must understand the current science and the process of determining whether a condition is injury-related. In the AMA *Guides* series of publications, the *Guides to the Evaluation of Disease and Injury Causation* provides guidance on the process of causation and apportionment analysis.<sup>[1]</sup> This publication provides guidance on understanding work-relatedness, methodology, causality examination, and provides chapters dealing with specific regions.

Causality requires determination that each of the following has occurred to a reasonable degree of medical certainty:

- A causal event took place.
- The patient experiencing the event has the condition (e.g., impairment).
- The event could cause the condition.
- The event caused or medically contributed to the condition within medical probability.

It appears that some physicians opine that certain injurious events caused or aggravated a condition based on a temporal relationship, without a scientific basis to support these conclusions, and these opinions are accepted by fact finders without further analysis. This results in faulty decisions on these cases and a failure of the examinee to understand the true nature of the condition.

In 1965, the English statistician Sir Austin Bradford Hill proposed a set of nine criteria to provide epidemiologic evidence of a causal relationship between a presumed cause and an observed effect or simply an association. This causation analysis checklist is sometimes referred to as the Bradford Hill criteria.[2]

The list of the criteria is as follows:

1. Strength (effect size): A small association does not mean that there is not a causal effect, though the larger the association, the more likely that it is causal.
2. Consistency (reproducibility): Consistent findings observed by different persons in different places with different samples strengthens the likelihood of an effect.
3. Specificity: Causation is likely if there is a very specific population at a specific site and disease with no other likely explanation. The more specific an association between a factor and an effect is, the bigger the probability of a causal relationship.
4. Temporality: The effect has to occur after the cause (and if there is an expected delay between the cause and expected effect, then the effect must occur after that delay).
5. Biological gradient: Greater exposure should generally lead to greater incidence of the effect. However, in some cases, the mere presence of the factor can trigger the effect. In other cases, an inverse proportion is observed: greater exposure leads to lower incidence.
6. Plausibility: A plausible mechanism between cause and effect is helpful (but Hill noted that knowledge of the mechanism is limited by current knowledge).
7. Coherence: Coherence between epidemiological and laboratory findings increases the likelihood of an effect. However, Hill noted that "... lack of such [laboratory] evidence cannot nullify the epidemiological effect on associations".
8. Experiment: "Occasionally it is possible to appeal to experimental evidence".
9. Analogy: The effect of similar factors may be considered.

The evaluator must be able to distinguish between an aggravation and an exacerbation. An aggravation results from an event or injury causing a permanent worsening, hastening or deterioration of a pre-existing condition. An exacerbation is a temporary increase in the symptomatology of a pre-existing condition; in some jurisdictions, this is referred to as a temporary aggravation. It is important to understand the use of appropriate terminology in the jurisdiction/context in which you are working.

Medical apportionment is an estimate of the extent to which two or more probable factors caused an injury or disease. When apportioning responsibility for an injury or disease, one must first consider all potential causes and then determined whether each is probable or possible. A compensable injury or disease may exacerbate or aggravate a pre-existing condition, but may also be temporarily or partly worsened by subsequent trauma or exposure. Many illnesses are multifactorial in etiology.

Physicians must be aware of the current medical literature to determine the causes for a condition, including occupational and non-occupational causes and the significance of these causes.

It is also important to recognize that the definition of apportionment depends on the jurisdiction.

### **Prognosis**

Determine prognosis based on the clinical problems and probable future clinical course.

### **Maximal Medical Improvement (MMI)**

The evaluator assesses whether a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment. Synonyms include: fixed and stable, permanent and stationary and stable and ratable.

### **Impairment**

Impairment evaluation is the acquisition, recording, assessment and reporting of medical evidence using a standard method such as that described in the *AMA Guides to the Evaluation of Permanent Impairment*. The appropriate Edition of the *Guides* should be used, based on the jurisdiction. The evaluation and reporting must comply with the standards provided in the *Guides*.

### **Work Ability**

Work ability is defined by consideration by of three factors: risk, capacity and tolerance.[3] The IME physician needs to assess each of these factors in opining on work ability. Risk refers to the chance of harm to the examinee, co-workers, or to the public, if the examinee engages in specific work activities. Substantial harm means an objectively worsening in the examinee's condition, and not merely an increase in previously present symptoms, like pain or fatigue. Capacity refers to concepts such as strength, flexibility and endurance. These are measurable with a fair degree of scientific precision. Current capacity may increase with exercise or the passage of time. Tolerance is a psychopathologic concept that refers to the ability to tolerate sustained work or activity at a given level. Symptoms such as pain and/or fatigue are what limits the ability to do task(s) in question. Tolerance is dependent on the rewards available for during the activity in question.

### **Appropriateness of Medical Care**

When requested, the appropriateness of medical care should be evaluated using evidence-based medicine and recognized practice guidelines, such as the American College of Occupational and Environmental Medicine Practice Guidelines and/or Official Disability Guidelines – Treatment Guidelines.

**Recommendations**

The client may request recommendations on further medical care and/or steps to facilitate recovery. Some IME physicians may provide cost estimates but typically a separate Life Care Planner works with the IME on future medical care costs.

**Disclosures**

IME physicians commonly provide disclosures at the end of their reports, such as:

The above analysis is based upon the available information at this time, including the history given by the examinee, the medical records and tests provided, the results of pain status inventories, and the physical findings. It is assumed that the information provided to me is correct. If more information becomes available later, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation.

My opinions are based upon reasonable medical probability. Medicine is both an art and a science, and although an individual may appear to be fit for work activity, there is no guarantee that the person will not be reinjured or suffer additional injury. If applicable, employers should follow the processes established in the Americans with Disabilities Act, Title I. The opinions on work capacity are to facilitate job placement and do not necessarily reflect an in-depth direct threat analysis. Comments on appropriateness of care are professional opinions based upon the specifics of the case and should not be generalized, nor necessarily be considered supportive or critical of, the involved providers or disciplines.

Any medical recommendations offered are provided as guidance and not as medical orders. The opinions expressed do not constitute a recommendation that specific claims or administrative action be made or enforced.

I have reviewed the excerpts and entire outline if provided and taken my own history, made additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

I declare under penalty of perjury that the information contained in this report and its attachments is true and correct, to the best of my knowledge and belief, except as to information that I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted in this report, that I believe to be true.

Certain jurisdictions may require other disclosures.

The next installment (part 5) in the upcoming WOEMA Newsletter will cover IME quality assurance, functional capacity evaluations, post IME and post case closure issues, fee and payment policies, testimony: defending your IME report, IME liability issues, marketing, and IME training and certification.

[1] Melhorn JM, Talmage JB, Ackerman WE, Hyman MH. AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition, AMA 2014.

[2] Hill, Austin Bradford (1965). "The Environment and Disease: Association or Causation?". Proceedings of the Royal Society of Medicine. 58 (5): 295–300. PMC 1898525 Freely accessible. PMID 14283879.

[3] Talmage JB, Melhorn JM, Hyman MH. AMA Guides to the Evaluation of Work Ability and Return to Work. Chicago, IL: American Medical Association, 2011.

[\[Part 1\]](#)

[\[Part 2\]](#)

[\[Part 3\]](#)



## IT'S NOT BURNOUT, IT'S A THREE ALARM FIRE

*an editorial by Troy Ross, MD, MPH, WOEMA Newsletter Editor*

I recently [read](#) a compelling piece, written by two physicians, who identify physician burnout as a misdiagnosis – what we call burnout is instead moral injury. I've run across another interesting examination of the system that we all operate within. Here a practicing surgeon [calls out](#) the "medical system" for being rigged to extract resources from everyone who takes part. He sees it as the next Big Short.

Not only are both observations on target, but I see them being connected. Now what am I, what are we, going to do with those revelations? I know what I have been doing in the past. I've worked around the margins and tried to avoid entanglement with the worst parts of the whole mess. I'm fortunate. In the OEM world that has been an easier task than in other areas of medicine. Hence the often advertised statistic that we have the lowest burnout rates in the medical community.

I conclude that more needs to be done – that I need to do more. I'm still deck side, enjoying the fresh breezes that remain, but the Medical Titanic is sinking.



Think globally, act locally- here's my commitment:

- 1) I will make a conscious effort to educate my patients before I treat them. I'm not talking about a simplified presentation of the pathophysiology behind the low back pain. I want them to understand their lifestyle choices that impact the need to see a doctor for back pain.
- 2) Take on the pharmaceuticalization of our world. Opioids are just the tip of the iceberg. There is no "pill for every ill". When my medical assistant brings me a list of 14 prescription medications that her 78 year old mother has accumulated after being a good patient and following her multiple doctor's orders, I call bullshit. I helped her find a committed primary care doctor, who immediately halved the list. I now look for every opportunity to help people see past [band aid drugs](#) to look for solutions.
- 3) In Don Quixote fashion I will continue to fight against the mechanization of my profession. For years I have refused to sit at a keyboard or with an electronic device, when I talk with my patients. As the business side of medicine tries to wrap everything up in a nice little EMR package I will continue to push back. My notes are *my* thoughts, *my* way of communicating to others. I don't communicate with drops downs, or radio buttons, or ICD-9/10/ or 11 codes (and yes ICD-11 is [just around the corner](#)).
- 4) Most importantly, but without a firm execution plan yet, I will work on connecting my patients to [community](#). The individual that I see in the exam room is not the same person that lives with his family or works with his group of colleagues or recreates with his friends. Drug abuse, suicide, physician burnout – I see those problems and more as a fundamental lack of belonging to and having meaning within a community.

Would you like to help me add to the list?



## MEET THE WOHC 2019 RESIDENT SCHOLARS

WOEMA invited nine residents from across the U.S. to attend WOHC as scholars and to participate in the annual Resident Poster Competition. **Nnenna Okoyoe, MD, MPH** won the 2nd prize (\$125) for her poster on *"Examining Perceptions on the B Reader Among Current Radiology Resident Physicians: Results of a US Survey"* and 1st prize was awarded to **Neesha Mody, MD** for her poster: *"Mental Health and Cardiovascular Disease Risk in Los Angeles Bus Drivers"* Check next month's issue where we will be featuring the 1st prize winner's abstract!



**Oluseyi Awodele, MD**  
University of California, Irvine



**Neesha Mody, MD**  
University of California, Irvine



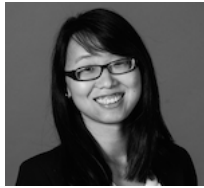
**Monya De, MD, MPH**  
University of Washington



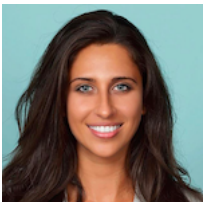
**Nnenna Okoye, MD, MPH**  
University of California, San Francisco



**Dane Dicaro,**  
**DO**  
University of California, Irvine



**Dallas Shi, MD, PhD, MBA**  
University of Utah



**Ashley Ennedy, DO**  
Loma Linda University

**Ashiq Zaman, MD, MHA**  
University of Texas



**Grant Hayes, MD, MPH**  
Loma Linda University

A special thanks to [Medlock Consulting](#) their generous contributions to support resident scholarships at WOHC.



## **WOHC 2019 AWARD RECIPIENTS**

### **JEAN SPENCER FELTON AWARD 2019**

Presented annually to a current or past member of the Western Occupational and Environmental Medical Association who has contributed significantly to the body of knowledge in the field of occupational and environmental medicine. [Learn more about Jean Spencer Felton.](#)

**Craig Conlon, MD, PhD**

Dr. Craig Conlon was born and raised in Southern California. He received his undergraduate degree from Pomona College in Claremont, California. He attended medical school at the Keck School of Medicine, University of Southern California. Dr. Conlon completed his Family Practice residency at a joint program through Western Medical Center and USC. He completed his Occupational Medicine residency through UCLA and UCSF. Dr. Conlon received his master's and PhD in Environmental Health Sciences through Cal State Northridge and UCLA, respectively. For the last 10 years Dr. Conlon has been working with The Permanente Medical Group in Occupational Medicine in Northern California. He is the Northern California medical director for Employee Health Services for Kaiser Permanente. His areas of interest in research revolve around musculo-skeletal disorders/injuries associated with computer-work station tasks and work-related carpal tunnel syndrome. Dr. Conlon has been married for 26 years, with one daughter in college in Southern California and one daughter in Veterinary School at UC Davis.

**RUTHERFORD T. JOHNSTONE AWARD LECTURE 2019**

Presented annually to a current or past member of the Western Occupational and Environmental Medical Association who has contributed significantly to the furthering of occupational and environmental medicine. [Learn more about Rutherford T. Johnstone.](#)

**Steven Pike, MD, MS, MBA, JD, FACOEM**

Dr. Steven Pike is Board certified in OEM, EM, Medical Toxicology, and CIH. He is an ACOEM Fellow; ACEP Fellow, ABMT Fellow, ACCT Fellow, Overseas Fellow RSM, and Master of Science, Toxicology (University of Arizona). Former Associate, Center for Toxicology (University of Arizona). M.B.A. and a J.D. (University of Arizona). He received his M.D. from UNM; Research Los Alamos National Laboratory. Dr. Pike was a National Science Foundation Undergraduate Research Participant on Research photo-fission products of thorium-232 (White Sands Missile Range, Nuclear Effects Laboratory Division). Dr. Pike completed his residency in Occupational

Medicine at ACOSH, NIOSH ERC. He chaired Arizona's Comparative Environmental Risk Assessment Project, and is Chair to the Occupational and Environmental Health Section Arizona-Mexico Commission Public Health Committee. He serves as an OEM consultant to Lesotho Highlands Development Authority, Kingdom of Lesotho and Republic of South Africa (Consortium for International Development's study for Lesotho Highlands Water Project). Dr. Pike has served as WOEMA's Newsletter Editor, & Treasurer, Vice-President, President, Chairman of the Board. He is currently a member on ACOEM's Board of Directors & Strategic Planning Committee, Past Chair & current member of the Committee of Fellowship Examiners, chair of the ACOEM Ethics Committee, member of the ACOEM Section Initiatives & Activities, Fellowship Special Task Force, Past Chair, Internal Affairs Workgroup, member of the Joint-House/Board Nominating Committee & Awards Committee, Co-Chairman of the Leadership Committee, and Delegate of the HOD. Dr. Pike is President of EnviroMD & Vice President of Tabershaw & Pike—multidisciplinary consulting practices in epidemiology, industrial hygiene, toxicology, and OEM. Dr. Pike holds medical licenses in Arizona, California, Hawaii, & New Mexico.

WOEMA is a regional component of the American College of Occupational and Environmental Medicine (ACOEM) and is dedicated to high-quality medical care and ethical principles governing the practice of occupational medicine.

***Administrative Office*** (Please use for all Accounting, Payments, and Invoices)

224 West State Street

Trenton, NJ 08608

***Local Office***

PHONE: (415) 764-4918

FAX: (415) 764-4915

Petaluma, CA

EMAIL: [woema@woema.org](mailto:woema@woema.org)