

# Part VII

## Legal Aspects of Public Health

### Chapter 72

## Occupational Health Law

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The Occupational Safety and Health Act  
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Occupational medicine is a branch of preventive medicine that “focuses on the relationship among” workers’ health, “the ability to perform work, the arrangements of work, and the physical, [biological], and chemical environments of the workplace.”<sup>1</sup>

From a medicolegal standpoint, occupational medicine is unique among the medical specialties. In no other specialty do regulatory and legislative mechanisms shape and drive the practice of medicine to the extent found in occupational health. Indeed an entire federal agency, the Occupational Safety and Health Administration (OSHA), has been established within the Department of Labor to safeguard the rights of this particular class of patients (the worker) and to specifically prevent or minimize the incidence of work-related disorders.

Providers of occupational health services also face unique challenges arising out of their dual loyalty to patients and employers. Can the occupational physician strive to uphold traditional notions of patient confidentiality, informed consent, and personal autonomy while simultaneously advancing the employer’s goals of increased productivity; public goodwill; decreased workers’ compensation costs; and promotion of worker, coworker, and customer health and safety? Although dual loyalties to employer and employee create the potential for conflict and impairment of medical judgment, in reality incidents of conflict occur far less frequently than might be anticipated.<sup>2</sup> Occupational health care providers (whether company employees, independent contractors, or private physicians) can most effectively limit their own liability, promote the health and safety of their patients, and preserve the legal and moral rights of workers through familiarization with occupational health laws and regulations and by adherence to good medical and risk management principles.

## THE OCCUPATIONAL SAFETY AND HEALTH ACT

In 1970 Congress passed the Occupational Safety and Health Act (OSH Act) “to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources.”<sup>3</sup> This legislation created OSHA, the primary functions of which are (1) to encourage employers and employees to reduce workplace hazards, (2) to promulgate and enforce standards that lessen or prevent job-related injuries and illnesses, (3) to establish separate but dependent responsibilities and rights for employers and employees with respect to achieving safe and healthful working conditions, (4) to maintain a reporting and record-keeping system of occupational injuries and illnesses, (5) to establish research and training programs in occupational safety and health, and (6) to encourage development of state occupational safety and health programs.

### Coverage

The OSH Act covers all employees and all employers (defined as any person engaged in a business affecting commerce who has employees) with the following exceptions:

1. Self-employed individuals.
2. Farms on which only immediate family members of the employer work.
3. Working conditions or workplaces regulated by other federal agencies under other federal statutes (e.g., Mine Safety and Health Act of 1969, Atomic Energy Act of 1954, Department of Transportation regulations).
4. Government employees.

Federal employees receive protection by an executive order that mandates federal compliance with OSHA regulations. State and municipal government employees may be

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protected if their states have OSHA-approved state plans that explicitly grant them coverage.

### Standard Setting

OSHA standards encompass four major categories: general industry, construction, maritime, and agriculture. In the absence of a specific OSHA standard for a particular working condition or workplace, employers must adhere to Section 5(a)(1) of the OSH Act, or the general duty clause. The general duty clause directs each employer to furnish "to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm."<sup>4</sup> Where OSHA has promulgated specific standards, the specific duty clause, Section 5(a)(2) of the OSH Act, mandates that employers "shall comply with occupational safety and health standards . . . promulgated under this chapter."<sup>5</sup>

Section 6(b) of the OSH Act authorizes the Secretary of Labor (hereinafter the Secretary) to promulgate, modify, or revoke any occupational safety and health standard. In adopting standards the Secretary must first publish a "Notice of Proposed Rulemaking" in the Federal Register and allow for a period of public response and written comments (at least 30 days, although usually 60 days or more). At the request of any interested party, OSHA will also schedule a public hearing. After the close of the comment period and public hearing, the Secretary must publish the final standard in the Federal Register.

### Enforcement

The OSH Act authorizes OSHA to conduct workplace inspections. As a result of a 1978 U.S. Supreme Court decision, however, OSHA compliance officers may no longer conduct warrantless inspections without the employer's consent.<sup>6</sup> Because OSHA has only about 2100 inspectors to police more than 6.5 million employers with a total of about 100 million

workers, the agency has established a priority system for inspections.<sup>7</sup> From highest to lowest, these priorities are (1) imminent danger situations, (2) catastrophes and fatal accidents, (3) employee complaints, (4) programmed high-hazard inspections, and (5) follow-up inspections.

After an inspection, the area OSHA director may issue the employer a citation indicating the standards that have been violated and the length of time proposed for abatement of those violations. The area director also proposes penalties for these violations. The employer must post a copy of the citation in or near the cited work area for three days or until the violation is abated, whichever is longer. Table 72-1 summarizes the types of violations that OSHA may cite and the concomitant penalties that it may propose.

Employers may contest a citation, proposed penalty, or abatement period by filing a "Notice of Contest" within 15 working days of receipt of the citation and proposed penalty. The area OSHA director will forward the case to the Occupational Safety and Health Review Commission (OSHRC), an agency independent of the Department of Labor. An administrative law judge will rule on the case after a hearing. Any party may seek further review by the entire three-member OSHRC. Commission rulings in turn may be appealed to the U.S. Court of Appeals by any party.

## KEEPING THE WORKER INFORMED

More than 80,000 chemicals are in commercial use today.<sup>8</sup> Yet the health effects of many of these substances remain unknown. It is estimated that more than 32 million workers may be exposed to toxic agents in the workplace.<sup>9</sup> After passage of the OSH Act, OSHA promulgated a series of regulations to provide workers with more information about the agents present in their workplaces and to enhance the detection, treatment, and prevention of occupational

Violation	Penalty*
Other than serious violation (directly related to job safety and health but unlikely to cause death or serious harm)	Discretionary penalty of up to \$7000 per violation
Serious violation (substantial probability of death or serious harm, employer knew or should have known of hazard)	Mandatory penalty of up to \$7000 per violation
Willful violation (employer intentionally or knowingly committed a violation or was aware of a hazardous condition and failed to take steps to eliminate it)	Minimum penalty of \$5000 per violation, up to \$70,000 per violation (willful violations resulting in a worker's death may lead to criminal conviction with fines up to \$250,000 for an individual and \$500,000 for a corporation, imprisonment, or both)
Repeat violation (violation of a previously cited violation)	Fine of up to \$70,000 per violation
Failure to correct prior violation (failure to correct a violation before the abatement date)	Penalty of up to \$7000 for each day beyond the abatement date
Source: <a href="http://www.osha.gov/Firm_osh_data/100008.html">http://www.osha.gov/Firm_osh_data/100008.html</a> .	
* OSHA also may issue citations and proposed penalties after conviction for falsification of records, reports, or applications; for violations of posting requirements; or for interference with a compliance officer's performance of duties.	

**Table 72-1** OSHA violations and penalties

disorders. The following are three of these important provisions:

1. The Hazard Communication Standard.<sup>10</sup>
2. The Recording and Reporting Occupational Injuries and Illnesses Standard.<sup>11</sup>
3. The Access to Employee Exposure and Medical Records Standard.<sup>12</sup>

Although employers are ultimately responsible for safeguarding the health and safety of their workers, these regulations have given employees, unions, health care providers, and governmental and nongovernmental agencies a more decisive role in the management of workplace health and safety.

### **The Hazard Communication Standard**

OSHA promulgated the Hazard Communication Standard (HCS) to provide workers with the “right to know” the hazards of chemicals in their workplaces and to enable workers to take appropriate protective measures. Under the HCS, employers must (1) ensure the labeling of each container of hazardous chemicals in the workplace with appropriate identity and hazard warnings, (2) maintain and ensure employee access to Material Safety Data Sheets (MSDSs), and (3) provide employees with information and training on hazardous chemicals in their work areas. MSDSs list the chemical and physical properties of chemical substances, their health hazards, routes of exposure, emergency and first aid procedures, and protective measures for their handling and use. The HCS applies to only chemical agents. Furthermore, MSDSs are not subject to methodical review by regulatory agencies. Thus their quality and adequacy of information vary widely, and they may be of limited use to the clinician in the treatment of exposed workers.

The HCS also contains important provisions for health care provider access to the identities of trade secret chemicals. When a medical emergency exists, the chemical manufacturer, distributor, or employer must immediately divulge the identity of trade secret chemicals to the treating physician or nurse if this information is requested for purposes of emergency or first aid treatment. As soon as circumstances permit, the chemical manufacturer, importer, or employer may subsequently require the physician or nurse to sign a written statement of need and a confidentiality agreement.

In nonemergency situations the chemical manufacturer, distributor, or employer must likewise disclose the identity of trade secret chemicals when requested by a health professional (defined by the regulation as a physician, occupational health nurse, industrial hygienist, toxicologist, or epidemiologist). Before disclosure, however, the health professional shall (1) submit a request in writing, (2) demonstrate an occupational health need for the information, (3) explain why disclosure of the chemical identity is essential (in lieu of other information, such as chemical properties, methods of exposure monitoring, methods of diagnosing and treating harmful exposures to the chemical, etc.), (4) enter into a written confidentiality agreement, and (5) describe procedures to maintain confidentiality of the disclosed information. The HCS is a valuable instrument

for providing health professionals with information about patient exposures.

### **Recording and Reporting Requirements**

Soon after passage of the OSH Act, OSHA promulgated standards to fulfill the Act’s mandate for the provision of record-keeping and reporting by employers and for the development of information and a system of analysis of occupational accidents and illnesses. Under 29 C.F.R. 1904, employers with more than 10 workers must maintain a log and summary of all recordable occupational injuries and illnesses. Recordable occupational injuries and illnesses include any fatality, injury, or illness that (1) is work-related, (2) is a new case, and (3) that either meets one or more general recording criteria or certain specific cases. General recording criteria include fatalities (regardless of the span between injury and death, or the duration of illness); restricted work or transfer to another job; medical treatment beyond first aid; loss of consciousness; or a diagnosis by a physician or other licensed health care professional of a significant injury or illness. Specific cases include needlestick injuries or cuts from sharp objects that are contaminated with another person’s blood or other potentially infectious material; medical removal of an employee under the medical surveillance requirements of an OSHA standard; occupational hearing loss; tuberculosis infection; or musculoskeletal disorders.

Employers must make entries in a log within 7 calendar days after notification of a recordable injury or illness. The form used to record this information is known as the OSHA 300 form or the Log of Work-Related Injuries and Illnesses (more commonly called the OSHA 300 Log). Employers must also complete an OSHA 301 Incident Report form or an equivalent form, such as an insurance form, to record supplementary information for each recordable injury or illness entered on the OSHA 300 Log. Additionally, at the end of each calendar year, employers must review the OSHA 300 Log and create an annual summary of recordable injuries and illnesses on the OSHA 300-A summary form or equivalent form. These three forms—the OSHA 300 Log, the OSHA 301 Incident Report, and the OSHA 300-A summary form—must be retained for 5 years following the end of the calendar year that these records cover.

In addition to these record-keeping requirements, the standard further imposes a reporting requirement on working establishments. Employers must report all incidents to the nearest area OSHA office within 8 hours when such work-related incidents result in a fatality or the inpatient hospitalization of three or more employees. This requirement applies to all employers, regardless of the size of their workforce.

This standard also grants OSHA, as well as other federal and state agencies, the authority to inspect and copy these logs of recordable injuries and illnesses (although some U.S. circuit courts have upheld the need to obtain a search warrant before such inspections). The regulations also

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ensure employee access to all such logs in their working establishment. These provisions have proved to be a useful source of epidemiological data to employees, unions, researchers, the Bureau of Labor Statistics, and other agencies.

### Access to Employee Exposure and Medical Records

Employers have no general duty to collect medical or exposure data on workers. Nonetheless, some specific OSHA standards, such as the lead standard, may require medical surveillance of workers exposed to specific agents. In other cases employers may voluntarily institute biological and environmental monitoring programs even when not mandated by OSHA. Regardless, to the extent that employers do compile medical and exposure records on workers exposed to toxic substances or harmful physical agents, they must ensure employee access to these data.

Employers shall make medical records available for examination and copying within 15 days of a request by an employee or his or her designated representative. The employer is obligated only to provide a worker with access to medical records relevant to that particular employee. Access to medical records of other employees requires the formal written consent of those other employees. Employers also must provide employees or their designated representatives with access to employee exposure records. When an employer lacks exposure records on a particular worker, the employer must provide that worker with exposure data of other employees who have similar job duties and working conditions. Under these circumstances, access to coworkers' exposure records does not require written consent. OSHA has the authority to examine and copy any medical or exposure record without formal written consent.

When medical records do exist on an employee, the employer is required to preserve and maintain these records for the duration of employment plus 30 years. Exposure records must be preserved and maintained for 30 years. Although these record retention requirements are the legal responsibility of the employer, it is recommended that independent contractor physicians who provide occupational health services to companies clarify the custodianship and disposition of medical records, specifying in advance the party to be charged with maintaining the medical records for the required duration.

The three standards discussed in this section—the HCS, the Recording and Reporting Occupational Injuries and Illnesses Standard, and the Access to Employee Exposure and Medical Records Standard—collectively keep employees informed of the nature and risks of hazardous materials in their workplaces and of any resulting exposure or health effects. By communicating these risks to workers, OSHA seeks to (1) encourage employers to select safer materials and engineering controls; (2) enable workers to use better protective measures and handling procedures; (3) familiarize workers and health care providers with valuable emergency and first aid information; and (4) minimize

health hazards through earlier detection, treatment, and prevention of occupational disorders.

## DISCRIMINATION IN THE WORKPLACE

Americans “with disabilities are a discrete and insular minority who have been faced with restrictions and limitations... resulting from stereotypic assumptions not truly indicative of the individual ability... to participate in, and contribute to, society.”<sup>13</sup> The clinician functions as an important interface between disabled persons and the workplace in a variety of settings (e.g., primary care, preplacement physicals, WC and disability evaluations). It is incumbent on health care providers to make a fair and accurate assessment of workers' functional capabilities in relation to job tasks so as not to reinforce deep-rooted stereotypes about the disabled. Moreover, health care providers can play a key role in safeguarding the rights of workers and in educating employers through familiarization with recent legislative and judicial developments in the areas of employment and discrimination law.

### The Americans with Disabilities Act

Congress enacted the Americans with Disabilities Act (ADA) in 1990 to eliminate discrimination against the disabled. Although the ADA addresses five separate areas, this chapter focuses exclusively on Title I, employment discrimination.<sup>14</sup>

Title I of the ADA prohibits discrimination against qualified individuals with disabilities in virtually all employment contexts (i.e., job application, hiring, discharge, promotion, compensation, job training, and other terms, conditions, and privileges of employment). The act defines disability as (1) a physical or mental impairment that substantially limits one or more of the major life activities, (2) a record of such an impairment, or (3) being regarded as having such an impairment. “Physical or mental impairment” is further defined as “any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more... body systems.”<sup>15</sup> Persons associated with individuals (e.g., family members) with disabilities also receive protection under the ADA.

Under the ADA, qualification standards, tests, or selection criteria that employers administer to job applicants must be uniformly applied, job related, and consistent with business necessity. To be consistent with business necessity, a standard must concern an essential function of the job. An employer who denies an amputee a desk job on the basis of strength testing would be in violation of the ADA if, for example, lifting were not an essential job task. Moreover, even when the qualification standards are job related, the employer must first attempt to make reasonable accommodations before excluding disabled workers on the basis of those tests. Examples of reasonable accommodations may include modified work schedules, job restructuring, equipment modification, design of

wheelchair-accessible workstations, and provision of readers or interpreters.

The ADA provides the following three major defenses to employers charged with discrimination:

1. Selection criteria are job related and consistent with business necessity, and a disabled individual cannot perform essential job tasks even with reasonable accommodation.
2. Reasonable accommodation would impose an undue hardship on the employer.
3. A disabled individual poses a direct threat to himself or herself or to the health and safety of others in the workplace.

A regulation of the Equal Employment Opportunity Commission (EEOC) authorizes employers to exclude or refuse to hire an individual when job performance would endanger his or her own health or safety due to a disability. An important U.S. Supreme Court case, *Chevron U.S.A. Inc. v. Echazabal*, 122 S.Ct. 2045 (2002), upheld the EEOC regulation and affirmed an employer's right to exclude workers whose disabilities pose a direct threat to their own health and safety, as well as to the health and safety of other individuals in the workplace.

The ADA has several important implications for health professionals—whether company employees or independent contractors—who are often called on to perform employment physicals of job applicants or return-to-work assessments of injured workers.

First, clinicians and employers need to recognize that the ADA bars all preemployment (preoffer) physicals. Employers may continue to administer preoffer nonmedical tests (e.g., language proficiency or strength and agility testing) that are job related, but they may require a medical examination only after extending an offer of employment. This offer may be conditioned on the results of the postoffer, preplacement physical examination provided that all applicants for a particular position are subjected to such an examination regardless of disability.

Second, clinicians should limit their role to advising employers about workers' functional abilities and limitations in performing the essential functions of the job with or without reasonable accommodation and to determining whether these workers meet the employers' health and safety requirements. To make such determinations of functional abilities and limitations, health professionals must insist that employers provide written job descriptions that accurately detail specific and essential job tasks. The employer has the responsibility to make all employment decisions and to determine the feasibility of reasonable accommodation. Nonetheless, health professionals may offer input on ways to achieve reasonable accommodation.

Third, the ADA imposes very strict limitations on the use of information from postoffer medical examinations and inquiries. Such information must be treated as confidential and must be maintained in separate medical files apart from personnel records. The employer must designate a specific person or persons to have access to the medical file. In some instances the release of confidential medical information may be allowable under the ADA, for

example, to inform supervisors or first aid personnel about necessary restrictions or emergency treatment; however, a release form from the examinee is always advisable. (Workers sometimes voluntarily disclose their diagnoses to supervisors or first aid responders on their shift to familiarize them with the signs and symptoms of their condition in the event of a medical emergency.)

Although the ADA discourages but does not explicitly prohibit clinicians from reporting actual diagnoses to employers, an action for breach of confidentiality may exist under certain state confidentiality laws if a release form is not signed by the examinee. In the absence of a release form, a clinician's best course of action is to inform the employer of functional abilities and necessary work restrictions (e.g., "no working at heights" and "no driving of company vehicles") rather than reporting actual diagnoses (e.g., "epilepsy").

Discrimination denies the disabled the many advantages of employment, including prestige, power, self-esteem, economic well-being, social outlets, and access to health insurance and other job benefits. The ADA will have far-reaching consequences in protecting the rights of the disabled and more fully integrating them into the workplace. Health professionals can play a critical role in fostering patient autonomy and educating employers while simultaneously promoting a safe and healthful workplace.

### **Gender Discrimination, Pregnancy, and Fetal Protection Policies**

As with the disabled, pregnant workers have often represented a disenfranchised group within the workplace. Although the ADA is broad sweeping, it does not shield these women from employment discrimination because "pregnancy" is not considered a physiological disorder under the Act's definition of disability. Nonetheless, pregnant workers receive ample protection under both legislative and judicial avenues.<sup>16</sup> The Civil Rights Act of 1964 (Title VII) prohibits discrimination on the basis of sex and, as amended through the Pregnancy Discrimination Act of 1978, further prohibits discrimination against "women affected by pregnancy, childbirth, or related medical conditions... for all employment related purposes."<sup>17</sup>

Despite the intent of these laws, a number of industries instituted fetal protection policies (FPPs) throughout the 1980s to exclude fertile or pregnant women from the workplace and to avert toxic exposures to the fetus. In some instances, companies went so far as to exclude all women, including postmenopausal women, from jobs or job tracks involving potential exposure to toxic substances unless these workers could provide documentation of surgical sterilization. These FPPs were unsound for several reasons:

1. They disregarded reproductive risks to male workers.
2. They assumed that all women in the workplace could or would become pregnant.
3. They essentially required female workers to proclaim their reproductive status to supervisors and coworkers

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(i.e., women remaining in the workplace were implicitly sterile).

4. They discouraged some women from applying for higher-paying jobs.
5. They encouraged other women to undergo unnecessary surgical sterilization solely to retain their jobs.
6. They overlooked the adverse health effects to the unemployed mother and child from forgone income and health benefits.

In 1991 the U.S. Supreme Court declared these FPPs to be unconstitutional in *International Union, UAW v. Johnson Controls, Inc.*<sup>18</sup> The court held these policies to be discriminatory because they did not apply equally to the reproductive capacity of male employees. Furthermore, the court held that “decisions about the welfare of future children must be left to the parents... rather than to the employers who hire those parents.”<sup>19</sup>

There are principally only two instances in which employers may discriminate on the basis of gender or pregnancy. Employers may deny employment when gender is a bona fide occupational qualification (BFOQ) reasonably necessary to the normal operation of that particular business or enterprise. Analogous to the ADA, the qualification standards must relate to the essence of the employer’s business. For example, a movie producer would be justified in claiming that male gender is a BFOQ when hiring actors for male roles. Under the safety exception, employers may discriminate on the basis of gender in those instances in which gender or pregnancy interferes with the employee’s ability to perform the job. For example, airlines are permitted to lay off pregnant flight attendants at various stages of pregnancy to ensure the safety of passengers. In all other instances women should be treated equally with men in the employment setting as long as they possess the necessary job-related skills and aptitudes.

In light of this legislative and judicial history, the following practices that screen out individual women or the entire class of women might be construed as discriminatory:

1. Implementing FPPs or other policies that exclude women from the workplace based on gender or reproductive status.
2. Applying coercion by providing female but not male workers or job applicants with information on reproductive risks or by requiring only female workers to sign waivers absolving the employer of liability in the event of an adverse reproductive outcome.
3. Administering special tests or medical examinations exclusively to women.
4. Using physiological parameters, such as muscle strength, as selection criteria when not a requirement for the job. (For this reason, as with the ADA, job descriptions that accurately reflect job tasks are vital.)
5. Using gender as a proxy for physiological parameters even when specific physiological traits (e.g., anthropometrics and muscle strength) are a requirement for the job and a high correlation exists between gender and ability to perform the job. (Employers must give each individual the opportunity to demonstrate that she meets the job parameters.)

## Workers’ Compensation

### Claims

Physicians who evaluate and treat workers with job-related injuries or illnesses must acquire a broad understanding of the workers’ compensation (WC) system and an appreciation of their role in the legal disposition of WC claims.

WC systems currently exist in all 50 states and in three federal jurisdictions.<sup>20</sup> WC is a no-fault system that evolved in the earlier part of the twentieth century to promote expeditious resolution of work-related claims. Injured workers relinquished their rights to bring an action in torts in exchange for a rapid, fixed, and automatic payment. The quid pro quo for the employer was a limited and predictable award. WC pays for medical and rehabilitation expenses and typically up to two thirds of wage replacement.

Unlike tort actions, WC claims do not require a showing of employer negligence. Therefore even injuries or illnesses resulting from the employee’s own negligence are compensable. Regardless of the cause of the injury, the worker carries the burden of proving by a preponderance of the evidence that a causal relationship exists between an occupational exposure and the resulting injury or illness; that is, the injury or illness must “arise out of or in the course of employment.” Employees also are generally entitled to compensation for work-related aggravation of preexisting disorders. To qualify for WC payments, the worker must prove damages, typically by demonstrating a disability or loss in earning capacity. Even when the occupational exposure results in an injury or illness that produces no disability, the employee may still be eligible for an award if the WC laws in that jurisdiction explicitly provide for such coverage, such as payment for scarring, disfigurement, or damage or loss of function of specific organs or body systems.

Physicians who evaluate and treat injured workers must strive to be objective when documenting physical findings and impairments. Although physicians are not discouraged from making assertions about causality, they must be prepared to support their conclusions in a deposition or courtroom should the claim lead to litigation. It is also incumbent on physicians to familiarize themselves with alternative work and transitional duty programs to minimize the length of disability.

### Confidentiality

Patients will often present treating physicians with authorization forms requesting release of medical records to the patient’s employer, the employer’s attorney, or the employer’s insurance company in support of a WC claim. By signing these release forms, patients do not waive all rights of confidentiality. It is critical that physicians disclose only information related to the disorder that forms the basis of the WC claim. Several physicians have been sued for releasing confidential information about HIV status that was unrelated to the WC claim, such as ear and sinus problems or head injury with back pain.<sup>21,22</sup> Patients sued these physicians under various theories, such as negligence, breach of confidentiality, breach of contract, and invasion of privacy.

## TORT LIABILITY

Many WC statutes contain “exclusive remedy provisions” that hold that WC shall provide the exclusive remedy for injuries and illnesses arising out of or in the course of employment. The goals of these provisions are to foreclose litigation and to limit the employer’s liability to WC. During the last few decades, however, workers have been attempting to circumvent the exclusive remedy provisions of WC laws and pursue tort suits. As in WC cases, plaintiffs in tort suits may recover for medical expenses and lost earnings, but because tort actions are more likely to take into account future promotions and job advancements, they may yield a higher award for wage replacement. Moreover, tort suits offer the additional advantage of recovery for certain types of damages unavailable under WC, such as pain and suffering, punitive damages, and loss of consortium.

Despite the greater financial incentive to bring a tort suit, the courts have been reluctant to carve out exceptions to the WC exclusive remedy provisions. The most common doctrines under which employees file tort suits are as follows:<sup>23</sup>

1. Third-party and product liability suits.
2. Intentional harm committed by an employer.
3. Injury by a coemployee (injuries by coemployee health care providers are discussed in the following section on medical malpractice).
4. Dual capacity doctrine (the employer assumes a second role or capacity sufficiently distinct from its role as employer such that workers injured by the employer while acting in this second capacity may recover outside of the WC system).

Theoretically, both WC and tort liability should provide employers with the incentive to promote a safe and healthful workplace. However, given the employer’s ability to insure and to pass on some of these costs to consumers, the extent to which these goals are accomplished remains unclear.

## LEGAL LIABILITY OF THE OCCUPATIONAL HEALTH CARE PROVIDER: MEDICAL MALPRACTICE

What is the legal liability of a health care provider who commits medical malpractice while under contract to provide occupational health services to a company’s employees? Management hires physicians, nurses, and other health care professionals—company salaried and independently contracted—for the benefit of the company (i.e., to ensure workers’ fitness for duty).

Historically, health care providers salaried by a company were considered coemployees of other workers. Consequently their negligent acts and the resulting injuries were regarded as arising out of and in the course of employment. The exclusive remedy provisions of WC laws therefore limited injured workers to recovery under the WC system. However, if the workers could establish that the health care

providers were not under the control of the company but rather were functioning as independent contractors, they could avail themselves of a remedy in torts.

The distinctions between coemployees and independent contractors have been problematic for the courts. Health care providers often have greater latitude than other employees in their exercise of judgment. At what point do their actions transcend the control of their employers and exceed the scope of employment? Some companies authorize and encourage occupational health care providers to furnish primary care services to employees and even to their families. At what point does the occupational health professional establish a health care provider–patient relationship, no longer acting solely for the benefit of the employer but also for the benefit of the employee?

The courts have developed two tests to determine whether an occupational health care provider is the coemployee of an injured worker (in which case the negligent act is covered by the employer’s WC policy) or an independent contractor (and therefore subject to tort liability). Under the control test, health care providers are more likely to be presumed company employees when management exerts greater control over their function, operation, and judgment. For example, clinicians act under the control of the company when they must follow predetermined guidelines and protocols in conducting physical examinations (e.g., which forms to use or which laboratory tests to conduct).

Under the indicia test, the court analyzes various indices of control that normally signify employee status. For example, health care providers are more likely to be categorized as company employees rather than independent contractors if they receive a salary, health insurance, and other company benefits; fall under the company’s WC and pension programs; work out of company offices; have regularly scheduled work hours; and report to the company’s chain of command.<sup>24</sup>

Despite these two tests, the immunity of occupational health care providers continues to erode. Although the control and indicia tests provide useful guidelines concerning the potential liability of the occupational health care provider, their application results in some uncertainty because many professionals only partially meet these criteria. For example, some clinicians who have a part-time private practice may request workers to follow-up after duty hours in their private offices. Other clinicians may work out of their own offices but see exclusively company employees. Furthermore, courts appreciate that workers often rely on the results of employment physicals to their detriment and that health professionals have a high degree of skill and training and are in a better position to warn patients of harm and to insure against losses. Thus, although courts were traditionally reluctant (even in the independent contractor setting) to hold that a physician–patient relationship existed between a prospective or actual employee and the physician conducting the examination at the employer’s request and for the employer’s benefit, more courts are willing to recognize that the “examination creates a relationship between the examining physician and the examinee, at least to the extent of the tests conducted.”<sup>25</sup>

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**Box 72-1. Risk Management Principles for Occupational Health Care Providers**

1. Request job descriptions that reflect essential job functions.
2. For company-employed physicians, provide medical services only:
  - To employees (to employees' dependents only if company authorizes in contract and provides malpractice coverage)
  - During normal business or duty hours
  - On company premises (if available)
  - To the extent delineated in employment contract
3. Adhere to company policies.
4. Evaluate necessity and purpose of components of physical examinations and medical surveillance programs.
5. Do not order unnecessary tests.
6. Ensure that all tests are interpreted by qualified individuals.
7. Inform patients of results of all tests.
8. Ensure adequate/reasonable follow-up (appropriate to circumstances).
9. Keep good records—document, document, document.

Therefore the wisest approach for occupational health care providers, whether company employees or independent contractors, is to conduct examinations and treatment with due care and to disclose the results from any tests or examinations performed to the patient. Health care providers must be cautious in following up with patients because attempts to offer advice or to treat may establish a health care provider-patient relationship and place their actions beyond the scope of employment. Health care providers who want to ensure that employees receive adequate follow-up without risking tort liability should consider sending certified letters to patients advising them of the results and of the need for follow-up with their own private family physicians or other specialists as appropriate. See Box 72-1 for more detailed risk management principles. Health care providers would be prudent to delineate these responsibilities in their contracts with employers. Furthermore, occupational health care providers employed by companies should not rely solely on employers' WC policies but also should be covered by malpractice insurance.

**CONCLUSION**

Occupational health care providers are in a unique position to ensure worker health and safety. Because they interact with injured workers at every phase of employment—preplacement, preinjury, and postinjury—they have a profound impact on the disposition of job applicants and employees in the workplace. Occupational health professionals place a strong emphasis on prevention. Familiarization with judicial, legislative, and regulatory mandates will enable them to preserve the health and uphold the rights of workers, to educate employers, and to minimize their own liability.

**Endnotes**

1. From the ACGME Special Requirements for Residency Education in Occupational Medicine, effective Jan. 1, 1993.

2. J.A. Gold, *The Physician and the Corporation*, 3 *Bioethics Bull.* 1 (Fall 1989).
3. 29 U.S.C. §651(b) (1988).
4. 29 U.S.C. §654(a)(1) (1988).
5. 29 U.S.C. §654(a)(2).
6. *Marshall v. Barlow's, Inc.*, 436 U.S. 307 (1978).
7. <http://www.osha.gov/oshinfo/mission.html>.
8. <http://www.cdc.gov/od/ohs/symposium/symp71.htm>.
9. OSHA 3110, Access to Medical and Exposure Records 1 (1989).
10. 29 C.F.R. 1910.1200.
11. 29 C.F.R. 1904.
12. 29 C.F.R. 1910.1020.
13. 42 U.S.C. §12101(a)(7) (Supp. IV 1992).
14. Americans with Disabilities Act of 1990: Title I, Employment; Title II, Public Service/Public Transportation; Title III, Public Accommodation & Services Operated by Private Entities; Title IV, Telecommunications; Title V, Miscellaneous Provisions.
15. Note that current drug abusers receive no protection under the ADA because illegal drug use is not considered a disability under the act. However, alcoholics and fully rehabilitated drug abusers may be protected under the ADA (unless they fail to meet productivity and other performance standards that cannot be corrected by reasonable accommodation).
16. 42 U.S.C. §2000e-2(a) (1988).
17. 42 U.S.C. §2000e(k) (1988).
18. *International Union, UAW v. Johnson Controls, Inc.*, 111 S.Ct. 1196 (1991).
19. *Id.* at 1207.
20. L.I. Boden, *Workers' Compensation*, in *Occupational Health: Recognizing and Preventing Work-Related Disease* 202 (B.S. Levy & D.H. Wegeman eds., Little, Brown & Company, Boston 1995).
21. *Doe v. Roe*, 190 A.D. 2d 463 (1993).
22. *Urbaniak v. Newton*, 277 Cal. Rptr. 354 (Cal. App. 1 Dist. 1991).
23. Modified from S.L. Birnbaum & B. Wrubel, *Workers' Compensation and the Employer's Immunity Shield: Recent Exceptions to Exclusivity*, 50 *J. Products Liability* 119 (1982).
24. See, e.g., *Garcia v. Iserson*, 33 N.Y. 2d 421, 309 N.E. 2d 420 (1970), holding that worker's exclusive remedy fell under WC law. The plaintiff could not maintain a malpractice action against a company physician because the injuries arose out of and in the course of employment since the company employed the physician at a weekly salary and took the usual payroll deductions, required the physician to work on company premises during certain scheduled hours, and included the physician in the company's medical plan and WC policy. See also *Golini v. Nachtfall*, 38 N.Y. 2d 745, 343 N.E. 2d 762 (1975), holding that WC provided the exclusive remedy to the plaintiff injured by a physician who received company salary and benefits and worked in company facilities.
25. *Green v. Walker*, 910 F. 2d 291 (5th Cir. 1990), holding that physician who was under contract to perform annual employment physicals was liable for malpractice in failing to diagnose and report cancer to examinee.

**General References**

- N.A. Ashford & C.C. Caldart, *Technology, Law, and the Working Environment* (Van Nostrand Reinhold, New York 1991).
- B.P. Billauer, *The Legal Liability of the Occupational Health Professional*, 27 *J. Occup. Med.* 185-188 (1985).
- J. Ladou, ed., *Occupational Medicine* (Appleton & Lange, Norwalk, Conn. 1990).