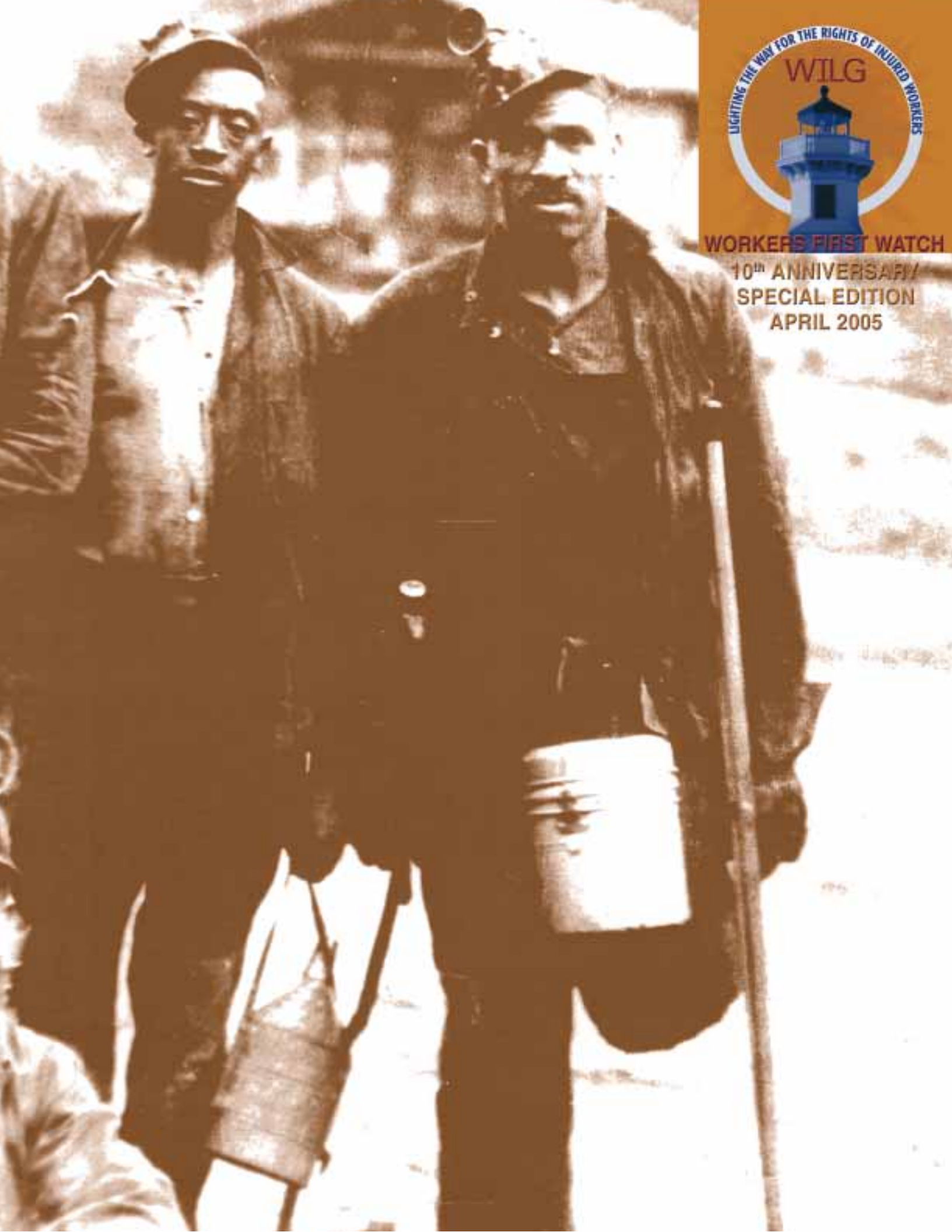

WILG

LIGHTING THE WAY FOR THE RIGHTS OF INJURED WORKERS

WORKERS FIRST WATCH

10th ANNIVERSARY SPECIAL EDITION

APRIL 2005

WILG President's Message

WILG is proud to celebrate its 10th Anniversary! We are an independent non-profit membership organization. WILG is dedicated to representing the interests of millions of workers and their families who, each year, suffer the consequences of workplace injuries and illnesses. We also maintain an affiliation with ATLA and work with labor and other worker justice groups in the interests of injured workers.

In April 2005, WILG held its 10th Anniversary Conference & CLE in Washington, DC. As part of the events leading up to this conference, WILG prepared this "Special Edition" of our quarterly magazine: "Workers First Watch". A sampling of the best articles over the past ten years appears on the following pages of this special issue of our magazine.

On behalf of the Officers and Board of Directors, I want to thank the Chair of the WFW Editorial Board, Tom Domer, and the WFW Executive Editor, Jay Causey, for their skill and dedication. The review and selection process from the decade's work was no small task. It was, of course, Jay Causey's efforts over the years in editing WFW and John Boyd's work with the "Litigator" that created the forums for articles to appear originally.

The first article in this WFW compendium issue is by John Boyd, immediate past president of WILG. John offers an insightful perspective on the politics of labor and how it impacts our issues. Other articles take us across a broad spectrum of subjects: from cross-examination techniques and practice pointers to policy issues affecting workers throughout the United States.

I am privileged to serve as WILG's President as we close this, our first decade. I want to thank all Directors and Sustaining Members. Your committee work and support are WILG's lifeblood. Special recognition must go to my predecessors. They made enormous contributions and brought us to where we are today: past presidents Jay Causey, Len Jernigan, Steve Embry, and John Boyd, as well as past chairs Ed Stewart, Lew Heller, and Mike Rucka.

In working together with the national executive officers –Deb Kohl, president-elect, Todd O'Malley, treasurer and Bob DeRose, secretary– I am confident under their leadership our mission will advance and our membership will grow in the decade to come. Without them, and you –as you are committed to the cause of worker justice– we would not be facing our next decade with such promise and bright prospects.

Todd McFarren, Esq.*
President of WILG

**Mr. McFarren took office as President of WILG on July 3, 2004. He is the editor of "Workplace Injury Litigation Book", published by Lawyers & Judges, Inc. and is a partner at Rucka, O'Boyle, Lombardo & McKenna. He may be reached in Watsonville, CA —a city he served for two terms as its Mayor— at 831-728-4200 or tmcfarren@rolmlaw.com.*

WORKERS INJURY
WILG
LAW&ADVOCACY GROUP
The national non-profit membership organization dedicated to representing the interests of millions of workers and their families who, each year, suffer the consequences of workplace injuries and illnesses.

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John B. Boyd is a founding member of WILG and is immediate past president. Since leaving the bench as a workers' compensation administrative law judge in 1983, his practice remains concentrated in workers' compensation, labor and personal injury litigation. He has chaired ATLA's Workers' Compensation and Workplace Injury Section, was Vice-President of the Missouri Association of Trial Attorneys, and has lecturered in workers' compensation programs and seminars over the past two decades. He is counsel to the Missouri AFL–CIO on workers' issues; and is a shareholder in Boyd & Kenter, PC, with offices in Kansas City and Sedalia, Missouri. John has a B.S. from Central Missouri State University and a J.D. from the University of Missouri—Kansas City School of Law.

Reflections on the History of WILG

By John B. Boyd, Kansas City, MO
Immediate Past President - WILG

Prologue

...No man is an island, entire of itself; every man is a piece of the continent, a part of the main...Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee. John Donne, 1624

It is commonly said that history is often the best guide for the future, for if we ignore the past, we will continue to make the same mistakes. Drawing from Donne's eloquence, WILG and its coalition partners have periodically acted in union to avoid the erosion and abrogation of justice for injured workers and their families. No one group can go it alone. Any loss is felt by all, no matter which partner is in the lead. If justice for working families is to be safeguarded, WILG and organized state and national labor organizations must act as one. There is no margin for error.

History

WILG and the National AFL-CIO ("NAFL") have participated in two 'summit' meetings held at the George Meany Center, in Silver Spring, Maryland. During the initial meeting, Jim Ellenberger, then Director of Safety and Health, NAFL, was instrumental in bringing together state AFL-CIO federation leaders, academicians, health care providers, and lawyers. His efforts were successful in getting each group to recognize our common interests and our need to work together to advance of justice for workers.

The second summit, a couple of years later, built upon those initial successes and resulted in common realizations:

- The state feds recognized that they could trust that WILG's members were committed to the common interests of advancing workers' rights and protections.
- The debate had to be turned from its focus on employer cost to whether the system is protecting injured workers and their families.
- The essential recommendations of the 1972 National Commission on State Workmen's Compensation Laws are worthy of updating to compel states' systems to be more responsive to the needs of employers and employees.
- Decades of legislative assault upon workers' compensation has been methodical and predictable, and the opposition to it has been poorly or untimely informed and organized. The cooperation between WILG, labor and its allies (such as Injured Worker Unions) needs to be further developed and strengthened.

- Legislation and regulation efforts, whether state or national, should be shared, bringing each group's talents to the process.
- The collaborative effort should be on-going, with regular summit meetings involving these and new participants.

Ellenberger retired before further jointly sponsored events could be scheduled. With the benefit of hindsight, it appears that if our coalition groups had continued to work as one, America's workforce might have been spared some of the following setbacks and losses.

Setbacks

- The Energy Employee Occupational Illness Compensation Program Act (EEOICPA) was developed and implemented without our involvement. This was a measure strongly pursued by NAFL, and had bipartisan congressional support. Designed to compensate Energy Department employees who were exposed to Beryllium and other hazards of atomic weapons production during the Cold War, the legislation was fraught with problems. By the time WILG was engaged, it was too late to effectuate meaningful changes that would protect workers who are denied benefits. (EEOICPA was improved to some extent by amendments in late 2004 that shifted responsibility for claims administration from the Department of Energy to the Department of Labor.)
- OSHA spent ten years creating a cumulative trauma standard designed to lower the incidences of injuries, which was killed shortly after George W. Bush was inaugurated in 2001. While WILG was not consulted in the development of this worthwhile effort, our members responded with calls of concern to Congress about the "death sentence" imposed by the Bush administration to these standards.
- California's 2004 recall of Governor Davis, and the election of a movie actor as Governor, involved considerable legislative battles over workers' compensation reform. The California state labor federation, without input from members of WILG and the California Applicant Attorneys Association (CAAA), orchestrated agreements which have widely been criticized as reducing benefit levels and access to basic workers' compensation coverages obtained through decades of struggle. Distrust and animosity permeated relationships between the groups, although several individual labor unions and regional councils were supportive of CAAA's efforts to stop the changes. The mending of those relationships must be quickly accomplished for the sake of those who traditionally have had the weakest voice – the injured workers.

Distrust and animosity permeated relationships between the groups…The mending must be quickly accomplished for the sake of those who traditionally have had the weakest voice – the injured workers.

Progress

The news is not all bad. Cooperative efforts by the coalition partners have resulted in some progress. In 1998, Ohio was faced with onerous one-sided 'reforms' muscled through the legislature by an anti-consumer majority and the governor. Labor and WILG joined forces with the Ohio Academy of Trial Lawyers to defeat the implementation of these changes in the now-legendary Proposition 1 battle, with business groups outspending labor and WILG by over a 10-1 margin.

In July 2003, President Steve Embry (CT) and Vice-President Todd O'Malley (PA) hosted a reception for the state federation leaders who were in San Francisco attending a national Workers' Voice Conference as we were simultaneously attending the ATLA summer convention. Initiated as WILG's president, I was a speaker at the Workers' Voice meeting to hundreds of attendees, many of whom were and are experiencing anti-worker legislation in their states. O'Malley, Mike O'Connor (PA) and I subsidized a dinner for over thirty of these same leaders, as well as for other worker-friendly political candidates and elected officials.

From April 29 to May 2, 2004, WILG hosted a "Labor Summit" in St. Louis. Many coalition partners were identified, including the National Interfaith Committee for Worker Justice. State federation leaders, as well as local, district and international unions, attended. Missouri Governor Bob Holden was a guest at the two-day summit. Several lessons were learned, including the fact there are a significant number of entities who share our goals (and that have funding for those projects). Yet, these groups are the least organized in terms of collaborative effort. The consensus was that all groups supportive of worker justice need to meet regularly.

On May 26-27,2004, President McFarren (CA) and I addressed a regional meeting of 18 state federation presidents. Invited as a result of the April 29th Labor Summit, we spoke about WILG, our interests in working with labor, the coalitions we have developed, and the need for us to develop a collaborative, long range strategy to elect worker-friendly legislators both locally and nationally. The president of a state fed examined an issue of *Workers' First Watch*, and wondered "who was our board member from his state." A few calls later, the two connected. Our member was quite happy about getting to know and work with his state's labor leadership, and WILG was the key to that connection. The state fed presidents unanimously agreed to meet with us in non-election years so as to maximize attendance.

In July, 2004, President McFarren and Boyd addressed a mid-west regional meeting of the International Association of Firefighters. Louie Wright, a regional vice-president of the international, is a WILG member. Firefighters learned of the commitment and expertise of WILG's members and the need for their various entities to become our coalition partner.

The Elections of 2004 & Beyond:

Labor voted in a significant numbers, yet reportedly - and incredibly - one-third of its members voted for Bush-Cheney and/or other Republicans in statewide races. A theory that has circulated about this phenomenon is the effect of 'moral values', such as abortion, stem-cell research, gay marriages, and of the issue of gun control.

Labor's house stands divided. Whether it will coalesce or evolve into multiple new entities is unknown. The Carpenters, UAW, Steelworkers, Teamsters, and Laborers have had their public differences with the NAFL. Recently, the Machinists have publicly disagreed with the direction of the NAFL concerning the centralization of power. John J. Sweeney, President of the AFL-CIO, worked diligently to get Kerry elected. His term is up in July, 2005. He had earlier announced plans for another term, but it is expected that he'll be challenged. Many believe his eventual successor may be Richard L. Trumka, current Secretary-Treasurer of the NAFL, but it is doubtful that he would run a contested race against President Sweeney.

As the struggle for survival unfolds...we could see a fundamental change of leadership.

The Building Trades are a group of unions that may seek the centralization of their power into 'super-unions', or the merging of some crafts into a larger entity. The Steelworkers are merging with PACE as this article is being written. As the struggle for survival unfolds, some suggest that we could see a return to the AFL separated from the CIO. We could see a fundamental change of leadership at the top of the NAFL, as well as in the power bases of these other named unions. Some of the names to follow in the next few months, beyond Sweeney and Trumka, are R. Thomas Buffenbarger (Machinists), Leo Gerard (Steelworkers), Ron Gettlefinger (UAW), James Hoffa (Teamsters) Douglas J. McCarron (Carpenters), Gerald W. McIntee (AFSCME), Terence M. O'Sullivan (Laborers), and Andrew L. Stern (SEIU).

At issue are efforts by the SEIU and others drastically remake the NAFL. Some of the proposals would have the NAFL order union mergers, assigned specific economic sectors to specific larger unions, invest $2 billion labor-wide in organizing, and earmarked $25 million for a national Wal-Mart campaign. Unless the federation revamps itself to meet changing workplace conditions and corporate power, the SEIU has threatened to pull its 1.6 million members out of the NAFL. (Mark Gruenberg, PAI staff writer, *Kansas City Labor Beacon*, January 15, 2005.)

Meetings are to be held of the NAFL's executive councils in March 2005, with the Central Labor Councils and state feds meeting in mid-February 2005, all to discuss reorganization. A "New Unity Partnership" has been formed of five unions' presidents who are promoting change. They are the Carpenters, Laborers, SEIU, and UNITE HERE.

In the 1960's, one-third of America's workforce was unionized. Today, that number is 13%. Over the last three years, labor has organized 2 million workers, but has lost 2.7 million covered jobs with livable wages and health care. Andy Stern, President of the SEIU, has proposed a realignment of the top 50 or so unions into 10 super-unions. He has proposed a maximum effort to spend labor's capital to organize. Much of that organizing effort will occur in white collar, technology, and healthcare fields.

Predicting a complex labor movement's ability to grow in the 21st century is difficult. Certainly, today's global economy, and the multiple favorable state and federal

tax breaks domestic companies retain with foreign outsourcing of jobs, is a dominant factor. Bush administration policies have thus far been significant obstacles, and little relief can be forecast. At the state level, 'right-to-work' movements, elimination of public sector employee collective bargaining, erosion of Project Labor Agreements and Prevailing Wage enforcement will collectively raise life and death issues for many unions.

> Imagine the impact if every injured worker who employed an attorney in order to obtain basic justice wrote to these elected officials between now and the next major election.

How Do We Act as One Again?

- Create or join "Election Victory Legal Teams." The lessons learned from the elections of 2000 about voter fraud, voter intimidation, and ballot irregularities led both major parties to mobilize their lawyers to be ready for legal challenges. WILG members should become active participants, and can work now to set up training and the network necessary to become adept in election issues. Start on a local level, reach out to the worker friendly elected officials and labor groups, and become a permanent asset.
- Hold meetings with key local labor and political leaders. Our members know the true 'movers-and-shakers' in their state's political climate. If not, we must identify those who are the policy makers versus those who rely upon others to set policy. Host a meeting with area union leaders, any logical coalition partners, and the state trial lawyers' association executive director. Agree that the premise for the meeting is to seek out areas of common agreement, to temporarily shelve any unresolved issues and conflicts that may exist between the parties. Pick area races where a difference can be achieved. Share polling, fund raising issues, and learn how to avoid duplication of effort.
- Elect worker-friendly legislators. Note that isn't necessarily the same as pro-Democrat or anti-Republican. Rather, in those districts that traditionally have elected anti-labor/consumer legislators, develop candidates to run for future office. Those candidates can be cultivated, for example, from the ranks of young associates in law firms, union retirees or disabled workers.
- Explore the repeal of the Hatch Act, so as to allow public employees to run for office. The public employee sector continues to grow in union membership, so this is a fertile ground of potential candidates.
- Pick the state races for 2006 within which to become engaged, and begin the process of developing the campaign now. If that means developing a theme for the candidates (such as insurance reform–i.e., "Cap Insurance Rates, not Injured Workers' Healthcare"), start the process of voter identification now.

> Injured workers and their families should not lose their chance to live the American Dream.

- WILG should meet with its coalition partners again. A Worker Justice Forum should involve participants from past labor summits. The agenda should embrace the lessons learned from the past three meetings and develop methods for implementing them so we'll be ready for the next assaults upon worker justice.
- So, how do we act as one again? It is not enough for local, statewide, and national Labor groups, together with the members of WILG to work singularly as we have done so often in the past. We must reach out and help groups that support worker justice to become organized in methods of communicating with one another, and to spread their worthwhile messages to similar audiences.
- Think of it this way: Be creative. If your budget allows, donate some of your television advertising time to public service announcements that can be jointly crafted with these groups. If they have a worker justice message that should be promoted, invite them to prepare something your firm can mail to current and former clients. You can write a compelling story of justice to be delivered from the pulpit in your church or synagogue.
- Continue to educate your clients on political issues affecting their rights. At critical times, such as during legislative sessions, when worker justice issues are at stake, help them write a letter to their state representative and senator. You can mail it. Have them explain how they are a registered voter in that official's district, that

they had to hire an attorney in order to get basic coverage for a work-related injury, and that they expect their legislator to remember to watch out for workers' interests over those of corporations.

- Repeat the letter writing at the conclusion of the case you are handling. Many legislators hear from organized businesses, but rarely from injured workers. Imagine the impact if every injured worker who employed an attorney in order to obtain basic justice wrote to these elected officials between now and the next major election. Expose them to organizations in their community, such as Interfaith Groups, citizen action committees, and injured worker unions. Take a client to your capitol to meet with his or her legislator when you are going there to lobby.
- Identify the themes common to all these groups, and then, based on one or more of those themes, host a meeting in your locale with as many of our friends as you can. Invite a worker-friendly legislator to attend. Develop a town meeting where you and these groups establish the agenda. Be sure to invite local legislators, some of whom may not be traditional supporters of injured workers, to the meeting. Let them hear the stories of multiple injustices. Get the media there.
- Injured workers and their families should not lose their chance to live the American Dream. They want to own a home and a car; have a savings account; and put a child through college. Occupational injuries too often have denied them that chance. While justice for them is what we seek in their individual cases, we have to look and act globally. It is up to us to use what talents and imagination that we can muster to gather our friends and act in unison. It is within our power. We cannot go it alone. We will not succeed separately. We must work together as Donne envisioned if we are to make the difference.

PRACTICE TIPS:

The bi-weekly "BEACON" contained relevant workers' compensation news from around the nation, conference and meeting announcements, and "Practice Tips" provided by members. Highlights of those tips are interspersed throughout this 10th Anniversary compendium issue of WFW.

Mild Brain Injury?

Any case involving a fall or car crash should trigger an inquiry by the comp lawyer into the possibility of a mild traumatic brain injury (TBI). Unfortunately, many treating physicians overlook this type of injury. The client should be examined by a qualified neuro-psychologist. If you need a brain injury questionnaire, contact Todd O'Malley (PA) 570-344-2117.

Intake: Licenses

Enlarge and photocopy the client's driver's license for the file (helps you recognize the client if there is a long gap between intake and formal hearing).

MapQuest Directions for Clients

Reduce the amount of phone calls and time spent on the telephone by giving your client directions via MapQuest (www.mapquest.com). Directions are given to the office, hearings, places for medical examinations, mediations and trials. These directions have been real time-savers and the clients appreciate written directions.

Fibromyalgia Criteria

The definitive criteria for diagnosing fibromyalgia can be obtained in a brief, conclusive 1990 report of the American College of Rheumatology. This report is available at www.wilg.org.

Intake: Ask About Other Lawyers

Your intake sheet for potential clients should ask questions about consultations with other lawyers. If there have been numerous consultations and/or another lawyer has been fired, red flags should go up. Proceed with caution.

Medication Addiction Myth

Do not fall into the trap of accepting the discredited medical notion that our clients may be "addicted" to pain medication or that they have to be weaned from pain medication for fear of addiction. Get "Pain Assessment and Management" for $45 from www.icaho.org the Joint Commission on Accreditation of Healthcare Organizations.

Hepatitis C (The Shadow Epidemic)

By Roy J. Baroff
Raleigh, NC

Hepatitis C (HCV) is a virus that causes inflammation of the liver and is currently the leading cause of liver transplants in the United States. Many in the medical community today call this virus a "shadow epidemic" because the disease itself has few, if any, symptoms and may not be diagnosed until years after initial exposure. Most people with the disease carry it without knowing they have it. Unfortunately, if the disease remains active over a number of years it can cause significant liver damage including cirrhosis (scarring of the liver as the virus destroys liver tissue) and hepatic cancer. Current information indicates that if a liver transplant is needed the cost is between $300,000 to $500,000.

Hepatitis C was not specifically identified until well into the 1970's and 80's when it was first called "Non A/ Non B" hepatitis. A test for the specific antibodies was not available until 1989 and was not in regular use for blood screening purposes until the early 1990's. HCV is a blood to blood pathogen, meaning that to be transmitted a person must have blood to blood contact with infected blood. Thus, the risk factors for HCV include:

- blood transfusions prior to 1990 (when testing precautions were put to into place)
- IV drug use with shared needles
- tattooing with dirty needles
- shared intra-nasal cocaine use with a straw
- multiple sex partners (although the incidence of sexual transmission is considered low)
- kidney dialysis patients
- any other blood to blood contact, including but not limited to sharing razors, needles, toothbrushes, or nail files. (Even a barber's scissors that have been in contact with infected blood, and then reused without cleaning, can be a risk factor.)

Obviously, health care workers and any other workers that come onto contact with another individual's blood are at a greater risk, as compared to the general public, of developing HCV.

Each year over 150,000 Americans develop Hepatitis C. An individual may develop an acute infection from 15 to 150 days after exposure, but the acute infection may or may not become symptomatic. Only about 25-35% develop symptoms, which are described as "flu-like" and may include some burning pain in the liver area. Many individuals with acute HCV describe feeling tired all the time.

Current testing includes the enzyme immunoassay test (EIA), which detects the antibody to HCV and has a testing sensitivity of

See HEPATITIS, page 38

IWJ Holds National Conference

The Interfaith Worker Justice organization holds its national conference in Chicago on May 22-24, 2005. Further information, visit: www.nicwj.*org (For a* related story, see page 41 of this special issue of WFW.)

The following WILG members each contributed $1000 as "IWJ Visionary Sponsors":

- Jay Causey
- Robert DeRose
- Tom Domer
- Philip Fulton
- Leonard Jernigan
- Doborah Kohl
- Paul McAndrew
- Michael O'Connor
- Todd O'Malley
- Rucka, O'Boyle, et al.
- William Vassar

Practice Pointers

Cross Examining the Psychiatric Expert

By Dorothy C. Sims
Ocala, FL

Dorothy C. Sims

Dorothy Sims is the senior partner in Sims, Amat, Stakenborg & Henry, P.A. with offices in Gainesville and Ocala, Florida. Ms. Sims studied international law at Oxford University and received her B.A. and J. D. from the University of Florida. She is Board Certified in workers' compensation law and sat on the Florida Bar Board Certification Committee. In l999, she was elected Chair of the Florida Bar Workers' Compensation Section, the first woman to hold that position in its 25-year history. She still serves on the Florida Bar Workers' Compensation Executive Committee. She was former president and co-founder of Florida Workers' Advocates, a statewide organization consisting of claimants' attorneys interested in lobbying and preserving rights for the injured workers and cofounder of the Marion County chapter of the Florida Association of Women Lawyers. She is currently the President of the Marion County Bar Association.

Ms. Sims has spoken on disability, impairment, psychiatric and cross-examination issues throughout the US and internationally, including Japan and India and Cuba. She also taught at the University of Florida College of Medicine in the Forensic Psychiatry Department and the Boston Mental Health Institute.

Fifteen years ago, a psychiatrist moved to town and began conducting evaluations on behalf of various insurance companies. The reports (over l00) were very similar. My clients fit the following categories:

l. They were blatant liars

2. There was nothing wrong with them, or

3. There was something seriously wrong with them that pre-existed, or, even caused the accident.

Well, I was confused.

Either I had this Bermuda Triangle over my office sucking all the bad clients of the universe into my waiting room; or, perhaps, the doctor might be a bit biased.

Deciding it was the latter, I spent the last ten years of my plaintiff's practice learning everything I could about the cross examination of a psychiatric witness. In so doing, my practice changed such that now I don't handle cases directly, but am retained by attorneys to take the depositions and trial examination of their psychiatric and neuropsychological witnesses. The education has been astounding. I have seen doctors do amazing things. They have alleged they did not need to report those scores that were favorable to the plaintiff, but only report those scores showing the plaintiff was not brain injured. They have claimed they could write a report concluding the plaintiff passed the mental status exam, when the transcript revealed the opposite. They have walked out of depositions, cursed at me in Yiddish, and advised me that I made them want to vomit. They have instructed me to remove my shirt during a deposition, claimed their powers of observation to be so great they could see under clothing

> Employers have effectively shifted the costs of work-related injuries and illnesses, making the rest of society subsidize unsafe work practices.

and even identify the color of my underwear. (The doctor was wrong, thank you very much!)

In many of the depositions, the doctor has either obfuscated the data or outright lied. A pattern has emerged. These "experts" can be exposed, and I suggest the following course of action:

A. BEFORE THE EXAMINATION

1. Do a Freedom Of Information Act Request to your state licensing board.
2. If the doctor works for a university, do an FOI request to the university too. Keep in mind, many universities will permit doctors to conduct outside consulting work. However, in order to do so, they must complete certain forms that list the income and by whom they were retained. This is very helpful in showing bias.

B. DURING THE EXAMINATION

1. Send a court reporter who never leaves your client alone, no matter how long the exam takes (remember, some can last as long as 8 hours and the reporter needs to know this in advance).
   - Provides the transcript in digital format. This makes it easier to share with other attorneys and is excellent for creating cross-examination questions because word searching capabilities in a digital document speed up the process.
   - Never releases a copy of the transcript to the defense attorney.
   - Remembers that *you* hired the reporter, and the reporter answers to you. Some physicians have tried to throw my reporters out of the evaluation. They stay. Period.
2. Can't afford a court reporter? Send a tape recorder with your client(s) and make sure your clients know when to turn the tape over by loaning them a watch with an alarm preset to go off at the end of the tape.

C. LOOK WHAT THE RAW DATA REVEALS (AND WHY THEY DON'T WANT TO PRODUCE IT)

1. **Look for erasure marks.** I had a doctor instruct a client to erase an answer that indicated the client was suicidal.
2. **Incorrect scoring**. Some doctors will score tests and testify that the patient scores out as not brain injured in concentration tests. However, I have seen the doctor input the wrong birth date, thus comparing the plaintiff with much older and more feeble individuals. When the correct birthday was put in, the results indicated impaired cognition.
3. **False scoring.** It's a great feeling in the middle of a deposition when the defense doctor admits to testifying that the plaintiff was a malingerer based on a test he or she scored incorrectly.
4. **Using the wrong tests.** Lately, many neuropsychologists have been testifying that certain malingering scales reflect lack of motivation. Be careful. Often these tests, in fact, reveal concentration problems.
5. **Playing with cut off scores.** Some doctors may testify that someone has flunked a "malingering test." The test booklet in the doctor's office reveals, in fact, the patient may have passed. Demand the test booklets and raw data.
6. **Giving too many tests.** Some tests suggest you administer several trials. Some doctors administer only one, or, if the test results are favorable to the plaintiff, they keep administering the same test until the plaintiff does poorly and only report the poor scores. The instructions are usually in the test booklet in the doctor's office.
7. **Giving clues.** Many doctors will provide significant clues such as, "Who was the President killed in the 60's in Dallas?" Then the doctor reports that the plaintiff could remember the Presidents back to Kennedy and has no memory problems. Interestingly, the clues were not in the report, nor was the fact that the plaintiff left out most of the Presidents between the current one and Kennedy.

8. **Doctor interference.** Some doctors administer tests and, in one case, took six cell phone calls during the concentration portion of the test. Other issues that affect concentration include the doctor frequently walking in and out of the room in which the test is being given or refusing the patient a cigarette break. Make sure the doctor documents the effects of medication on tests. Often the defense doctor will accuse the plaintiff of exaggerating his or her inability to concentrate when, in fact, the doctor is the main cause for the concentration problems. Mild TBI can cause concentration problems but your patient may score out as even moderately brain-injured depending on the doctor's behavior.

9. **Paper reviews.** If a psychologist did defense evaluation, was it a paper review or did the psychologist actually meet and evaluate the patient? If not, the report itself must contain a disclaimer.[1]

10. **Transport client.** Bring the client to the deposition of the doctor. Sometimes it helps keep the doctor a bit more honest.

11. **Observe the doctor's waiting room.** Recently, a doctor admitted the video camera I observed in the waiting room was for the doctor to spy on the evaluees. If the doctor treats patients, often pamphlets in the waiting room describe brain injury conditions that mirror your client's and are excellent for cross examination.

12. **Using old tests.** According to research done by James R. Flynn, he discovered that IQ scores increased from one generation to the next for **all** of the countries for which data existed. Now, this is what is known as the Flynn Effect. Let's say you are a defense doctor and you want to show a plaintiff does not have a brain injury. Administer an older version of a neuropsychological test and the plaintiff will score higher, maybe even not brain injured. Demand the doctor use the most recent test (as required by the APA Code of Ethics) and then you might find your client to test out as actually impaired.[2, 3]

13. **Ignoring the "retest" effect.** The doctor claims your client is not brain injured because he administered a test previously administered by your doctor and your client tested out much better. Therefore, defense doctor concludes either your client is malingering or cured. Try neither. Ask the doctor about the retest effect. Many tests, when administered twice, actually result in patients getting higher scores the second time because they remember stories read to them the first time the test was administered. This does not mean they are better. This is simply a factor of retest effect, and many studies exist to determine the exact increase in scores that might be expected based upon this phenomenon.

D. TEST(S) CONSIDERATIONS

1. **Lees-Haley Fake-Bad Scale**: This is a scale applied to the MMPI-2 and is commonly used by defense doctors to claim the plaintiff is malingering. This test is rejected by the authors of the MMPI-2 as being unscientific and over-reporting malingering.[4]

2. **Rey's 15 Item Memory Test:** This is a "malingering" test which defense doctors will claim show your client to be lying. However, if your client is elderly or has a low IQ, he may erroneously be classified as a malingerer.[5] Furthermore, clients with focal memory disturbances and diffuse cognitive impairment may perform poorly on this test.[6]

3. **Halstead-Reitan Neuropsychological Battery (H-R):** This commonly accepted neuropsychological battery comes with strict protocol requirements. The authors warn, "many altered and abbreviated versions of the tests in the HRB are being sold by numerous individuals and firms. Anyone using these versions should be aware that they have usually NOT been adequately validated, either through experimental studies or in clinical practice." Following strict protocol is crucial when administering this test. "The only authorized version of the HRB for adults is the one that duplicates the tests *exactly* as they were when the validation studies were done." [7]

4. **MMPI-2.** This test contains 567 true/false questions. However, frequently the defense doctors administer or interpret it incorrectly. Make sure to investigate the following:

   - The test should not be taken home (often psychologists, and even more often, psychiatrists permit it; it saves time). However, to do so violates test taking protocol.[8]
   - What software is used to grade the MMPI-2? The psychologists, especially if working in a government or university setting, have no

idea how the software was obtained or the differences between various software and simply approve the printout as gospel. "Research has shown that test interpretation services differ with respect to the amount of information and accuracy of the interpretations provided." [9]

- Did the patient leave 30 or more questions blank? If so, the test is invalid.[10]
- If the patient is not of this culture, was a culturally appropriate scoring key and proper norms used? In 18 years of deposing psychologists and psychiatrists I have *never* had this answered in the affirmative. Consider how someone from Cuba might answer questions (a bit high on the paranoia scale?) verses someone from the US.
- The defense doctor claims your client is lying because the F scale is elevated. (F= Frequency of items endorsed, *not* "Fake") "Extenuating stressful circumstances in an individual's life can also influence infrequent item responding. Stressful life factors tend to be associated with elevated F-Scale scores."[11] Different cultural background can cause an increase in the F scale. Therefore, culturally appropriate scoring keys and norms are vital.[12]

E. DURING THE DEPOSITION

1. Bring a laptop with an air card. When the doctor fails to bring the articles he relied upon, claiming they exist, turn the computer around and tell him he is more than welcome to look them up on the internet. This works great in a video deposition.
2. Bring a second laptop on which is loaded all prior depositions so prior testimony can be accessed with a word search function on your computer. This is much faster than tabbing hard copies.
3. The doctor claims to review the medical records. You are skeptical. Bring a plastic bag. At the conclusion of the deposition, seal the records in the plastic bag and advise the doctor you are giving them to the court reporter until your fingerprint expert can pick them up in the morning. Sit back and watch the fireworks.
4. The doctor claims he didn't recently alter the raw data and you know he/she did. Get out the plastic bag. Seal the document and advise opposing attorney you are having the ink dated at the lab of your choice. Some labs can tell you if ink is two years to six months old.
5. Point out the selective reporting that goes on in virtually every DME. High scales, such as scale 8 on the MMPI-2, can indicate the presence of a head injury. Never have I ever had a defense doctor admit to this in a report.
6. Ask the examiner if the patient did well on the mental status exam. Most doctors administer the Folstein Mental Status Exam which is actually a screening device for Alzheimer's patients. However, most defense examiners don't score the test, fail to ask all the questions, and, more importantly, lie about the results. Ask the doctor if the patient answered the questions correctly. When the doctor says yes, present the witness with the transcript that reflects many of the questions were answered incorrectly. Then file your Motion to Strike based on fraud.
7. The doctor testifies he does 1/3 plaintiff work (*yeah, right…*). Then he/she hands you a list of cases over the last several years in which he has testified but they do not identify the source of the referral, whether plaintiff or defense. Point out that he is hiding that information and it would only take a second or two to note on each case who referred it, but in leaving that information out you cannot address his possible bias. Then ask the doctor to identify each plaintiff referral on the list. In every case I've done this, the doctor was only able to identify one to two percent of his referrals as plaintiff. When faced with the task of deposing a defense-oriented psychiatric expert, assume you must verify everything and take nothing at face value. Many of these well-paid experts for the defense will stretch the limits of credibility to keep their customers happy. It's time to stop them.

Footnotes

[1]American Psychological Association Ethical Principles of Psychologists and Code of Conduct, *General standard and forensic activities* 7.2(b) & (c)(2002), at http://www.compassnet.com/dstrite/apa_ethicscode. html

[2]J.R Flynn, *The mean IQ of Americans: Massive gains 1932 to 1978*, in Psychological Bulletin 95 , 29-51 (1984).

[3]APA Code of Ethics 9.08 (2003), *at* http://www.apa.org/ethics, Obsolete Tests and Outdated Test Results.
(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.
(b) Psychologists do not base such decisions or recommendations on tests

FOOTNOTES cont. on page 30

Book Review

Fast Food Nation

The Dark Side of the All-American Meal

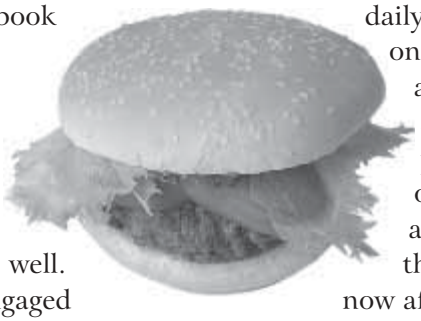
by Eric Schlosser

Houghton Mifflin, 2001

Reviewed by: Rod Rehm, Lincoln, NE

Rod Rehm

Rod Rehm has practiced workers' compensation in the Lincoln, NE area for over 20 years. He has been president of the Nebraska Association of Trial Attorneys, chairman of the state bar's Workers' Compensation Section, and has been a frequent speaker and author on trial practice and workers' comp issues in Nebraska for many years. He is a charter member of WILG, and a member of its Board since 1997. He has a B.S. from the University of Nebraska College of Business Administration, and a J.D. from the University of Nebraska College of Law.



Eric Schlosser's book should be read by every lawyer who represents working people, and defense attorneys would benefit from reading the book as well. Lawyers who are engaged in busy practices get drawn into the daily battles and often lose sight of the "big picture." This book helps us to step back and see the broader landscape of important societal issues; it's a great resource for looking at the forest rather than the trees.

Fast Food Nation is a systematic look at the fast food industry, with good insights into many facets of American life, business and justice. Along the way the author examines virtually all of the participants, from multi-billionaires to migrant packing plant workers. "Fast food", at least for me, becomes a metaphor for life in these new post-industrial times.

The introduction tells us just how large and pervasive the fast food industry has become. The statistics are startling and sobering. In 1970 Americans spent $6 billion on fast food; by 2000 the tab was $110 billion. Twenty five per cent of American adults eat fast food daily. McDonalds hires one million workers annually, more than any other public or private American organization. Schlosser asks us to consider how this behemoth grew and now affects all of us.

The book is organized in two parts. The first four chapters discuss the growth of fast food industry from humble origins in the 1940s to its present-day pre-eminence. As an example of the industry's power, in the mid-1990s the industry leveraged its influence to extract $385 million in job-training subsidies. However, Schlosser explains that the government largesse subsidized jobs that required little or no training and mainly employed part-time teenagers.

Chapters titled "The Founding Fathers", "Your Trusted Friends" and "Success" are interesting glimpses into the day-to-day business of the fast food world. The history of the industry is amazing. The combination of hard work, good luck and changes in society are well-documented. Ronald McDonald is recognized by 96% of American children, second only to Santa Claus. The book

explains why this has not been an accidental occurrence, and is chilling in detailing the effects of all the fast food advertising. The section on how school districts are being subsidized by the various brand names of fast food is disquieting. The hopes and dreams of franchisees are discussed in detail as well. It seems the "little guy" does not fare so well in this arena.

The second part –"Meat and Potatoes"– has the most direct bearing on lawyers. Schlosser describes how only a few producers and processors of food have grown and flourished in the "fast food nation" while most others have been harmed. "Cogs in the Great Machine" and "The Most Dangerous Job" deal with the meat packing industry and workplace injuries. The history of the modern meat industry is discussed in depth. The evolution and growth of these giant entities is closely tied to the needs of the fast food nation. The increase in the speed of work activity, the decrease in skill required, and consequent rise in the injury rate is discussed on an industry-wide basis. It's a grim picture.

Meat packing workers (overwhelmingly migrant) are being injured at a rate of 1 in 3 annually, and it is believed injuries are underreported due to the nature of the workforce. The individual stories seem all too familiar to those of us who represent workers. Reading how a journalist with a broader perspective sees the human side of these injuries should remind us of the importance of our work. I hope his words can invigorate and energize us to do more for our clients.

The chapter on ranching –"On the Range"– is touching and thought- provoking. The demise of family farms and ranches, and vast environmental damage, are attributed to the growth of our fast food nation. It is hard to accept the cowboy being replaced by Ronald McDonald as a societal icon or open space being replaced by endless strip malls filled with cookie cutter stores and restaurants.

See FOOD, page 44

PRACTICE TIPS:

Chemical Index

For an index of chemicals check out the NIOSH Pocket Guide to Hazardous Chemicals at: http://www.cdc.gov/niosh/npg/npgdname.html. This invaluable index lists symptoms and trade names, exposure limits, physical descriptions, symptoms, exposure routes, target organs, first aid procedures and much more.

Verification of Medical Credentials

Contact the American Board of Medical Specialties at 866-275-2267, visit their website (www.abms.org) or the AMA website (www.ama-assn.org) and select "Doctor Finder". Access is free, and user friendly. To check disciplinary records, contact the Federation of State Medical Boards (www.docinfo.org). It costs $9.75 to get a report. Public Citizens Health Research Group (202-588-1000) will provide you with a list of "questionable doctors" in your state. The cost is $20.00.

For Your Practice and Your Clients

When assuming the responsibility of representation of an injured worker, be sure to define exactly what legal responsibility is being undertaken. If representation is only for a workers' compensation claim, state this fact in the body of the retainer agreement or in an engagement letter, and then get the client to sign it.

Independent Contractor Denials

Ever had the situation where an employee's claim was denied because the employer fraudulently claimed independent contractor status? One client contacted the IRS and requested a tax determination. The IRS investigated and made a determination that he was an employee. Serious ramifications for the employer, but it was fun to watch.

Can You Admit Educational Videotapes?

Videotapes made for educational purposes can be admitted as learned treatises pursuant to Evidence Rule 803(18). *Constantino v. Herzog*, 203 F.3rd 164 (2nd Cir. 2000). "Videotapes are nothing more than a contemporary variant of a published treatise, periodical or pamphlet." *Loven v. State*, 831 S.W. 2nd 387, 397 (Tex. Ct. App. 1992).

AMA 5th Evaluation

The AMA has published a book entitled *Master the AMA Guides Fifth*: a helpful tool to understand the differences between the Fourth and the Fifth editions for evaluating permanent impairments. It is written by Linda Cocchiarella (editor of the 5th edition) and Stephen J. Lord. The cost is $139.00 and can be purchased from the AMA at 800-621-8335.

Give Workers the Benefit of the Bargain

By Randy Rabinowitz
Washington, DC

Randy Rabinowitz

Randy Rabinowitz served as Federal Counsel to WILG, and has a multifaceted professional profile including: Adjunct Professor at Washington College of Law, where she has taught regulation of workplace risks and labor and employment law; private law practice involving the representation of labor unions for OSHA standard setting issues and providing strategic and legislative advice on workers' compensation and civil litigation issues; Editor in Chief for BNA's forthcoming *Occupational Safety and Health Law, 2d Edition*. She has previously served as Counsel to the U.S. House of Representatives' Committee on Education and Labor for issues relating to workplace health and safety and labor relations. She has a B.A. from Johns Hopkins University, and a J.D. and L.L.M (Labor Law) from Georgetown University Law Center.

When states began adopting workers' compensation laws in the early 20th century, workers and employers were viewed as the mutual beneficiaries of a social bargain. Workers were to receive prompt payment for work-related injuries without regard to fault. Employers would bear responsibility for medical payments and partial wage replacement, but not for pain and suffering or punitive damages. By providing this limited compensation, employers would be shielded from the uncertainty of further liability and workers' compensation would be an employee's exclusive remedy for on-the-job injuries. Initially, no compensation was provided for occupational diseases. While compensation for occupational diseases was added later, such compensation has been more difficult to obtain that compensation for injuries.

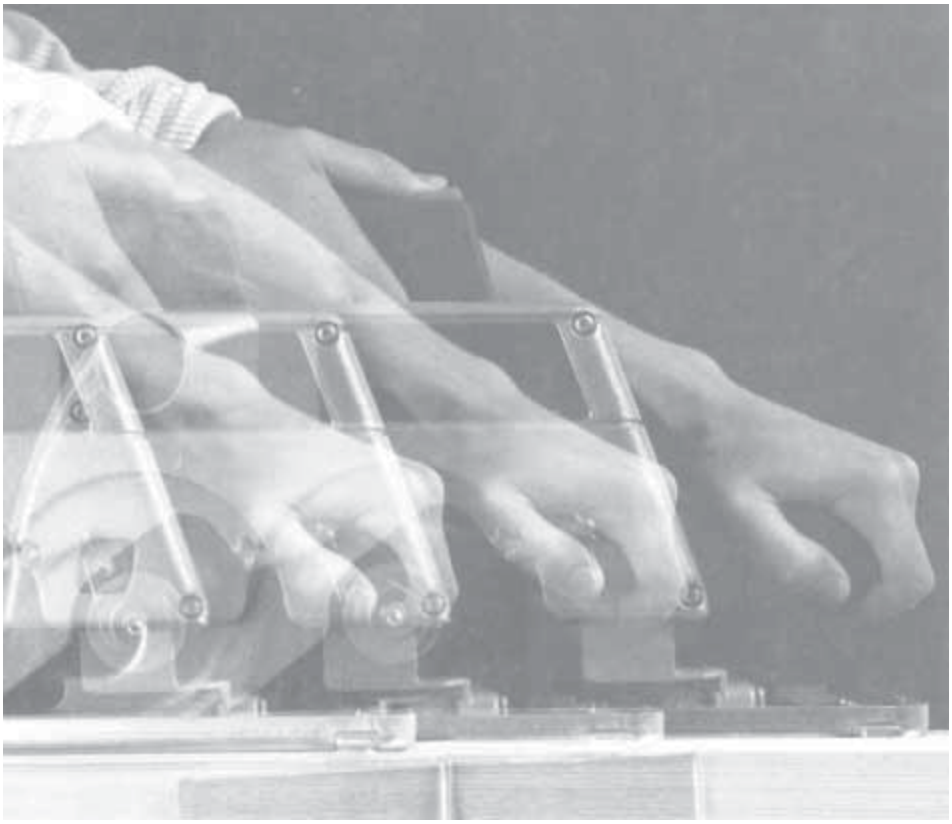
Initially, this bargain seemed like a good deal for both employers and workers. During the early 20th century, lawsuits by workers to recover for injuries were rarely successful. A triad of common law defenses — the fellow servant rule, assumption of risk, and contributory negligence – often combined to defeat worker claims. Some commentators have observed that workers increasingly could obtain jury verdicts for work-related injury claims, but the amount of these verdicts was low and judgments favorable to workers were often overturned on appeal.

Under these conditions, when few workers recovered in tort for injuries and those who did recovered minimal compensation, workers' compensation seemed like a blessing. It expanded coverage so all workers could obtain benefits, without having to prove fault. It eliminated antiquated common law defenses that blocked recovery. Few cared that the amount of benefits only partially replaced lost wages. Tort judgments and jury verdicts, even though they ostensibly included compensation for pain and suffering, were rarely much better. And, it was too risky to predict who would ultimately prevail and in court and who would get nothing. Few workers or their advocates fretted over whether it was worth giving up the right to sue their employer.

By 1972, when the Congressionally mandated National Commission on Workers' Compensation filed its report, workers' compensation was no longer financially adequate to protect injured workers. The National Commission found that benefits were too low, compensation too hard to obtain, and coverage too limited. Indeed, the National Commission

recommended that unless state workers' compensation laws were improved, Congress should adopt national minimum standards so workers received minimally acceptable compensation when injured or sick.

Following the National Commission's report, there was a flurry of activity in the state legislatures to improve benefits. But, efforts to improve the compensation provided to injured workers ended with the insurance "crisis" of the 1980s. Since then, pushed by the insurance industry and employers, state legislatures have aggressively attacked workers' compensation benefits. Fewer ailments qualify, the burden of proving an illness to be work-related is higher, benefits replace a smaller proportion of wages, medical benefits are paid only upon approval of a smaller group of physicians, usually selected by the employer, and injured workers are increasingly the subject of humiliating, intrusive and stigmatizing investigations for seeking benefits.



The Broken Bargain

These workers' compensation "deforms" have broken the bargain supporting workers' compensation. Workers' compensation is rarely an adequate remedy for workers. Too often it is a shield, protecting the employer from paying the true costs of injuries and illnesses caused by work. As these costs are shifted to other social insurance programs, taxpayers subsidize employers who fail to protect workers from harm.

Benefits under workers' compensation are inadequate. Indemnity payments have not kept up with inflation, so workers' compensation replaces an increasingly small proportion of wages lost from work-related injuries or illnesses. In California, indemnity benefits for over 60% of injured workers have not been increased since 1983. In the past two years, Governor Davis has twice vetoed legislation to increase benefits. A California worker permanently and totally disabled at work can receive maximum benefits of $230 per week. Death benefit awards are even lower. In some states, the death benefit due a unmarried worker with no dependent children is less than $10,000. The promise of meaningful wage replacement for work-related injuries –part of the workers' compensation bargain– is fiction.

Workers can no longer count on prompt payment of claims. Some insurers now routinely deny benefits claims, forcing workers into adversarial hearings to obtain benefits to which they are entitled. Delay in payment can take months, and if appeals are filed, years. While workers wait for benefits, medical and other bills go unpaid. Workers may be forced to abandon their claims or settle for less than they should receive to avoid bankruptcy. The promise of prompt payment of benefits –part of the workers' compensation bargain– is illusory.

Insurers routinely deny claims for certain occupational illnesses, even though they have no factual basis for doubting the claim. Insurers question causation for occupational diseases such as ergonomic injury, hearing loss, or latex allergy with no basis for doing so, forcing workers to hire expert witnesses to battle insurance company doctors. A recent case illustrates the point. A registered nurse who used latex gloves repeatedly every workday was denied compensation for severe latex allergy. The insurer argued that work was not the cause of her ailment, since she was exposed to latex condoms about once a week. Fortunately, the courts rejected the insurer's argument.

Benefits are no longer awarded without regard to fault. Many states have enacted laws denying benefits to workers who engage in behavior making injuries more likely. A positive drug or alcohol test may be grounds for denying benefits, even if it has nothing to do with an accident. The promise of benefits without regard to fault –part of the workers' compensation bargain– has disappeared.

Workers who file claims are often stigmatized for doing so. Safety bingo games in the workplace use peer pressure to discourage workers from reporting injuries. When workers do step forward, they are asked to waive medical privacy rights so their claim may be considered. No insurer should use a workers' injury as an excuse to peruse their medical file for embarrassing private information, but this routinely occurs. Finally, employers often initiate surveillance of workers who file claims, making them appear to be criminals just for seeking benefits, even though research consistently shows that employers and insurers defraud the workers' compensation system far more often than workers do.

> Rollbacks in workers' compensation mean that employees are no longer receiving the benefit of the bargain.

Rollbacks in workers' compensation mean that employees are no longer receiving the benefit of the bargain. Employers now pay only 38% of workers compensation costs. Workers pay 44%. Federal and state government programs, such as Medicaid, Social Security, and other poverty programs, subsidize the remaining costs. Employers have effectively shifted the costs of work-related injuries and illnesses, making the rest of society subsidize unsafe work practices.

Workers no longer receive the benefit of their workers' compensation bargain. If workers' compensation did not act as a bar, workers would be more likely to recover in tort for work related injuries than they were in the early 20th century. And, when they won in court, their tort judgments would be dramatically higher than 75 years ago. Workers' compensation payments represent an increasingly smaller percentage of what workers would otherwise expect to collect for their injuries. A tragic fire at the TOSCO refinery in California illustrates the point. Nine workers were burned extensively and many others killed. One worker, a long time employee of TOSCO, could not sue for damages. His exclusive remedy, workers' compensation, will pay him lifetime benefits not likely to exceed $150,000, hardly replacing this 50 year old worker's $50,000 per year salary before the accident. Eight other injured workers were contractors to TOSCO, so workers' compensation did not bar their suits for damages. Together, these workers settled their claims for $11 million. Injured workers are not getting the benefit of their bargain.

> Employers have effectively shifted the costs of work-related injuries and illnesses, making the rest of society subsidize unsafe work practices.

Cries about the inadequacy of workers' compensation often fall on deaf ears. Federal policy makers are unconcerned, believing the states have addressed the problem of compensating injured workers. Federal policy makers are generally ignorant of the deficiencies of workers' compensation. They are unaware of the vast sums of money the Federal government spends to subsidize inadequate indemnity payments under state law.

State lawmakers are equally ill-informed. Fearful of driving business away, and insulated from the every day concerns of injured workers, state officials have recently focused on lower workers compensation costs, mostly at the expense of the workers the program is designed to compensate.

Employers have been winning the debate –and depriving injured workers the benefit of their bargain– by conducting a coordinated, nationally orchestrated campaign to falsely depict workers as lazy and as cheats abusing the system. Injured workers and their allies have not had a coordinated, national message to respond.

WILG can fill this gap. By bringing together attorneys familiar with all state compensation systems, WILG provides a national forum for sharing information and developing a unified message. WILG can educate decision makers about the failings of workers' compensation. WILG can serve as an advocate for injured workers. And, WILG can expose employers and insurers who are shifting to workers, their families, and taxpayers generally the cost borne by workers injured or made ill on the job. Without such a coordinated effort, workers and their advocates will keep fighting annual battles in each state, winning some and losing others.

Daniel A. Fix

Daniel Fix is a sole practitioner in Lincoln, Nebraska, whose statewide practice is almost exclusively in the areas of workers' compensation and personal injury law. He graduated from the University of Nebraska in 1992 and the University of Nebraska College of Law in 1995. He has served as a special Assistant Attorney General for the State of Nebraska for Workers' Compensation Compliance and is a member of numerous national and local professional organizations and committees dedicated to improving the plight of injured individuals and advancement of the legal profession.

Representing the Undocumented Injured Worker

By Daniel A. Fix
Lincoln, NE

INTRODUCTION

Increasingly, workers' compensation practitioners must deal with the often thorny issues arising in the injury cases of undocumented workers. These workers are faced with much more than their injuries. There are intimidating uncertainties that their lack of legal status present, together with the usual handicaps of having few resources and little or no sophistication about the law or legal process, and the daunting prospect of facing the seemingly unlimited resources of their opponents. If they are willing to pursue these otherwise valid claims against such odds, they are likely to encounter defenses on a number of grounds based upon their undocumented status.

While my practice is limited to the state of Nebraska and the following analysis is primarily influenced by Nebraska law, I do believe that Nebraska's laws and my experiences are probably fairly representative of the laws and experiences faced by practitioners throughout the United States. The topics I have addressed in this article are far from settled and represent only my opinions and best understanding of these issues, so the usual caveats apply about relying upon any of the following as authoritative in a particular case.

THE ARGUMENTS AGAINST COVERAGE

Typically, employers make the following arguments to try to defeat the injury claims of undocumented workers:

1. **Immigration and Reform Control Act (IRCA) – preemption of state workers' compensation laws**

   The Immigration Reform and Control Act of 1986 (IRCA) makes it unlawful for employers to knowingly hire undocumented workers or for employees to use fraudulent documents to establish employment eligibility. The argument is that this federal law preempts the states' workers' compensation laws to the effect of precluding comp coverage.

2. **Not an Employee**

   Employers have argued that because the injured worker lied during and after the hiring process, or made a materially false misrepresentation, the "agreement for hire" is null and void. Thus, no valid contract of hire was formed, and the worker was not an "employee" to whom coverage of the state workers' comp act is extended.

In *Dowling v. Slotnik,* 712 A.3d 396 (Conn. 1998) the court considered the relevant statutory definition of "employee" for coverage under the Connecticut's act: "any person who ...entered into or works under any contract of service...with another..." Conn.Gen.Stat. §31-275(9). The employer argued that illegal aliens were not included in this definition. In upholding the right to benefits the court noted that the legislature's use of the phrase "any person" rather than "a person"..."strongly suggested an intent to include all workers rather than only those workers legally present" in the United States. The court further noted that the statute specifically excluded certain persons from coverage but that illegal aliens were not mentioned in this group of excluded persons.

3. **Void or Voidable Contract for Hire**

The defendants in *Dowling* also argued that a worker who is not working legally in the United States cannot form a contract for services and relied upon the general proposition of law that courts will not enforce illegal contracts. In rejecting the employer's argument the court noted that this general rule is applicable only to those contracts whose purpose is to violate the law. The court reasoned that refusal to enforce contracts such as those in violation of child labor laws would have the undesirable effect of precluding for such child workers the benefits conferred by the workers' compensation laws.

Similarly, in *Commercial Standard Fire & Marine Co. V. Galindo,* 484 S.W.2d 635 (Tex.Ct.Civ.App. El Paso, 1977) the employer argued that a contract to do something that cannot be done without violation of law is void. In rejecting the employer's argument, the court noted that illegal aliens are protected by the provisions of 42 U.S.C. §1981 in that "All persons within the jurisdiction of the United States shall have the same right in every State and territory to make and enforce contacts,...as enjoyed by white citizens."

> Denying benefits would actually "reward" the employer who knowingly hires the illegal alien.

4. **Fraudulent Misrepresentations**

Courts have also rejected employer arguments that false statements made by workers regarding their immigration status on employment contracts render such contracts voidable so as to exclude coverage under the Act. In *Dynasty Sample Co. v. Beltran*, 473 S.E.2d 773 (Ga.App. 1996) an illegal alien's right to recover benefits under the law was upheld based upon the court's finding that his false statements regarding immigration status at the time of hire had no causal relationship to his subsequent work-related injuries.

5. **Public Policy Argument Against Rewarding Illegal Aliens**

Employers have advanced the argument that it is against public policy to "reward" undocumented workers by awarding them workers' compensation benefits. At least one court has turned this argument on its head by pointing out that to deny benefits would actually "reward" the employer who knowingly hires the illegal alien. *Reinforced Earth Co. v. Astudillo*, 749 A.2d 1036 (Pa. Commwlth. Ct. 1999). The court specifically noted that employers would actually be encouraged to hire undocumented workers safe in the knowledge that obtaining workers' compensation insurance would be unnecessary. The court also noted undocumented immigrants have the right to sue in tort under our laws and pointed out that it would be illogical to deny them access to the statutory remedy of workers' compensation that was enacted as replacement for tort actions against employers.

6. ***Hoffman Plastic Compounds, Inc. v. NLRB,* (No.00-1595 U.S. 3/27/02) – The Future?**

This case, whose reach remains unknown, is cause for much concern. The U.S. Supreme Court recently held federal immigration policy as expressed by the Immigration and Reform Control Act (IRCA) precluded an award of back pay to an undocumented worker who was laid off in retaliation for union organizing activities in violation of the National Labor Relations Act. In a 5 to 4 decision the Court found that "awarding back pay in a case like this not only trivializes the immigration laws, it also condones and encourages future violation..." of the IRCA. "We therefore conclude that allowing the ... award of back pay to illegal aliens would unduly infringe upon explicit statutory prohibitions critical to federal immigration policy, as expressed in IRCA. It would encourage

the successful evasion of apprehension by immigration authorities, condone prior violations of the immigration laws, and encourage future violations."

Hoffman sets a potentially dangerous precedent that I believe will be used as the basis for employer attempts to defeat undocumented worker claims for workers' compensation benefits. Although based upon interpretation and application of federal law, *Hoffman* would seem to support a strong argument for the preemption of state workers' compensation law by IRCA. The above-quoted language from the majority opinion will, no doubt, find its way into defense counsel arguments and briefs.

Predicting the long-term effect of *Hoffman* is difficult, however, it is my understanding that injured workers in Nebraska and California have already been asked to prove legal status following the *Hoffman* decision. It has been reported by the online publication, *Workcompcentral*, that the Department of Labor and the National Labor Relations Board will continue to enforce wage, hour and safety regulations regardless of immigration status, as will the California Labor Commissioner. We can only hope that the same will be true of the various state workers' compensation bodies.

BENEFITS

From my review of the case law it appears that the majority of jurisdictions have extended workers' compensation coverage to undocumented workers on the basis of statutory interpretation and public policy arguments. The question then becomes, to what benefits are undocumented injured workers entitled? The answer probably depends on the jurisdiction of injury and possibly the long-term effect of *Hoffman*.

Setting *Hoffman* aside, in those states that have vocational rehabilitation services available to injured workers, a very real and practical dilemma faces the injured worker and his or her attorney. If the worker has no legal status to work, how can he or she pursue vocational rehabilitation?

Obviously, the goal of vocational rehabilitation is to restore an injured worker to some type of gainful employment. This assumes that the individual has the physical, mental, and *legal* ability to work.

As officers of the court, we cannot ethically participate in the knowing misrepresentation of fact to the court or tribunal, and therefore, in my opinion, cannot participate in any scheme whereby an undocumented worker undertakes vocational services through the workers' compensation systems. This, of course, has the effect of limiting the types of benefits that these injured workers are afforded under these various workers' compensation laws.

Similarly, the entitlement to loss of earning power benefits becomes problematic. It would seem that if an injured worker has no legal status to work, he or she essentially has no earning power to begin with and no earning power to lose!

The undocumented worker's entitlement to temporary indemnity benefits is subject to similar analysis and may ultimately be impacted by *Hoffman*. If he or she cannot work *legally*, it can be argued that he or she cannot be entitled to temporary disability benefits designed for the replacement of lost wages that he or she "shouldn't/couldn't" have been earning in the first place. Would not the receipt of temporary total disability (wage replacement) benefits contravene the provisions and goals of IRCA under the *Hoffman* analysis?

From a public policy standpoint it seems clear that the undocumented worker is entitled to reasonable and necessary medical care in accordance with the governing workers' compensation law. It seems difficult to argue that these injured workers are any less entitled to medical care than any other injured worker. From public policy and common sense standpoints it makes no sense to deny any worker this fundamental right and to do so would quite likely result in the shift of responsibility from the employer, who received the benefit of the injured worker's labors, to governmental entities and charitable organizations.

In states such as Nebraska, where an injury to an extremity or "scheduled member" results in permanent impairment, the worker is entitled to some compensation

for the numerically assessed impairment according to the given state's statutory formula. Typically, these permanent partial disability (PPD) benefits are not intended to replace any loss in wages or earning power but are designed to compensate for the loss of function or permanent effects of an injury. It would seem difficult to justify denial of these types of benefits to an undocumented injured worker. The loss is real regardless of legal status and the compensation is for the injury, not for wage replacement.

What is certain is that representation of the undocumented worker presents complexities not present in other cases. One must always consider the ethical obligations to the client and to the court or other tribunal. In Nebraska for example, there is a requirement that the claimant's social security number be included on any petition filed with the Nebraska Workers' Compensation Court. Similarly, various administrative forms filed with the Court require inclusion of the claimant's social security number. Clearly, counsel can't be part of a knowing misrepresentation to a court or tribunal, and if the client insists on perpetrating a misrepresentation in this regard, counsel must withdraw.

SUGGESTIONS

Your first and principal obligation is to advise client of the complexities and risks of pursuing the claim, especially if litigation becomes necessary. It may be wise to consult with, or refer the client to, an immigration law specialist.

I have heard it suggested that lawyers might not want to know whether their clients have legal status to work. Failing to ask this question is, in my opinion, foolish. You cannot properly advise your client about the risks and ramifications of pursuing a claim, especially through litigation, if you ignore an important fact such as this. The damage and embarrassment is obvious in having this issue raised for the first time by defense counsel when your client is under oath in deposition or at trial/hearing.

Consider the issues you plead and the relief you ask for. By limiting the items you seek you may also limit the ability of the defendant's counsel to inquire of certain issues. For example, the client's legal status would seem to be irrelevant if all that is in dispute is an unpaid medical bill or future treatment.

Over the years I have found that speaking directly to the office of the Counsel for Discipline in Nebraska to be of great assistance. The office has been more than willing to discuss and think through ethical considerations with me. I encourage you to talk freely about these issues with your governing disciplinary body. Chances are they will have helpful information or that they can at least help you focus on your obligations.

CONCLUSION

Many lawyers refuse to consider representing the undocumented injured worker. I encourage you to take these cases and to work through the challenges they present. There is no single more vulnerable client who needs our help, and this is what makes us *lawyers* dedicated to representing injured workers!

PRACTICE TIPS:

MMI Definition: AMA 5th

The AMA Guides (5th Edition) defines "maximal medical improvement" (MMI) as follows: "A condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change; however, further recovery or deterioration is not anticipated." Page 601, page 19.

Having Trouble with the Treating Doctor?

If you are unable to communicate with your client's treating physician, see if the doctor is a member of the AMA. If so, go to www.ama-assn.org and enter "H-265.997" in the search box. You will find the "AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys". While there, also check out "Principles of Medical Ethics" (requirements for prompt responses to attorney requests).

For Your Practice and Your Clients

In many states employers are allowed to provide better WC benefits than state law requires. Many do provide those additional benefits via union contracts, individual employment agreements (written and oral), and by purchasing various riders and endorsements to their compensation insurance policies. One "endorsement" adds coverage for recreational and social activities which would ordinarily be outside the scope of many WC laws.

Book Review

Nickel & Dimed – On (Not) Getting By in America

by Barbara Ehrenreich

Henry Holt & Company
(2001) 221 pages
*Reviewed by Leonard T. Jernigan, Jr.**

Ever wondered how an individual can live on wages of $6 or $7 an hour? Barbara Ehrenreich, the author of 12 books and a frequent contributor to *Time, Harper's Magazine, The Nation*, and other major publications, asked herself this question, and then set out as an undercover reporter to learn the answer.

She had several rules: (1) she would not rely on any previous skills or her usual work to help out financially; (2) she had to take the highest-paying job that was offered and do the best she could to hold it; (3) she would always have a car, usually a Rent-A-Wreck; and (4) although she ruled out homelessness as an option, she would take the cheapest accommodations she could find that offered acceptable levels of safety and privacy. Her plan was simple: ". . . look for jobs, work those jobs, try to make ends meet." Millions of Americans do the same thing every day. In fact, about 30% of the workforce works for $8.00 an hour or less.

She worked as a waitress in Florida, a house cleaner in Maine, and a Wal-Mart stocker in Minnesota. Along the way she discovered some interesting facts:

Housing. In 1998, the year she started the project, an hourly wage of $8.89 was needed to afford a one-bedroom apartment, and the odds of a typical welfare recipient finding such a job was about 97 to 1. 59% of poor renters (4.4 million households) spend more than 50% of disposable income on shelter.

Housing is obviously a major problem for the working poor. They share rooms in flop-houses, live with a family member, live in trailers, boats, hotel rooms and cars. One lady lived in a van parked behind a shopping center at night. When asked why a fellow worker would pay a hotel $40 - $60 a day, the reply was "And where am I supposed to get a month's rent and a month's deposit for an apartment?"

Educational Differences. Throughout her experiment no one ever told her she seemed more intelligent or better educated than her co-workers. She quickly learned that low wage earners were just as bright and funny as the well educated and "anyone in the educated classes who thinks otherwise ought to broaden their circle of friends."

Drug Testing. 81% of large employers now require drug testing, up from 21% in 1987, and the rate of testing is highest in the South. A 1999 study by the ACLU revealed that such testing did not lower absenteeism, accidents, or turnover, and actually lowered productivity (presumably because of lower employee morale). In 1990 the federal government spent $11.7 million testing 29,000 employees, which revealed only 153 positive tests. The cost? $77,000 per drug user.

Tipped Employees. Although the Fair Labor Standards Act does not require employers to pay "tipped employees" more than $2.13 an hour, if the direct wages plus tips falls below the minimum wage, the employer is required to make up the difference. At the two restaurants where she worked, this legal requirement was never mentioned or posted.

Management Style. When a worker "crosses over" to management, attitudes seem to change. According to one worker, they become "corporate as opposed to human... They don't cut you no slack. You give and you give, and they take."

Stress in the Workplace. Between the mid-1980's and early 1990's, stress-related workplace injuries and illnesses increased. "Workers in a variety of industries are being squeezed to extract maximum productivity, to the detriment of their health."

Bathroom Breaks. Until April of 1998, there was no federally mandated right to bathroom breaks. One study on this topic in 1997 stated that workers were "amazed by outsiders' naive belief that their employers would permit them to perform this basic bodily function when necessary."

Multiple Jobs. In 1996 approximately 7.8 million workers, or 6.2% of the workforce, held two or more jobs. Two-thirds held one full-time job and another part-time job. Some worked two full-time jobs. She realized wherever she went that one job would never be enough.

Personality Testing. When applying for a Wal-Mart job, she was given an opinion survey and was told there were no right or wrong answers. She quickly realized the real function was to tell the potential employee: "You have no secrets from us." Personality testing in the marketplace is at an all-time high and supports a $400 million-a-year industry. Many workers see these tests as dehumanizing and intimidating.

Wal-Mart. In 1992 Wal-Mart became the largest retailer in the world. In 1998 it had 825,000 "associates" (employees), making up the largest private employer in the nation. During the interview process she was shown a videotape which discussed Wal-Mart's feeling of family and which warns potential workers against union activity. The videotape states that unions "no longer have much to offer workers" and people are leaving them "by the droves."

Overtime is a real problem. Employees in four states (West Virginia, New Mexico, Oregon and Colorado) have sued the company, alleging they were pressured into working overtime and that the company then erased the overtime hours from their time records. Two of the West Virginia plaintiffs, who had been promoted to management positions before leaving, admitted altering time records. The New Mexico suit, filed by 110 Wal-Mart employees, was settled when the company agreed to pay the overtime.

Personality Testing. When applying for a Wal-Mart job, she was given an opinion survey and was told there were no right or wrong answers. She quickly realized the real function was to tell the potential employee: "You have no secrets from us."

Physical Exertion. All of her jobs were physically demanding and some would have been physically damaging if performed month after month. She was in good shape, but learned something no one ever mentioned to her in the gym: "You feel it [weakness] coming on halfway through a shift or later, and you can interpret it the normal way as a symptom of a kind of low-level illness, curable with immediate rest."

Labor Shortage Means Higher Wages? Although most cities claim a labor shortage and employers have advertisements saying "now hiring," wages for people near the bottom of the labor market are fairly flat. Alan Greenspan, the Federal Reserve chief, has suggested that economic laws linking low employment to wage increases may no longer be operative. Although wages actually did go up between 1996 and 1999 (the poorest 10% of American workers saw wages rise from $5.49 an hour to $6.05 an hour), these wage increases did not bring low-wage workers up to the amounts they were earning in constant dollars in 1973 — 27 years ago. In 2000, the poorest 10% were only earning 91% of what they earned during the Watergate era.

How Much is Enough? According to the Economic Policy Institute, an average figure of $30,000 per year is needed to support a family of one adult and two children. The average hourly rate is $14.00 per hour. About 60% of the American workforce earns less than $14.00 an hour. Ehrenreich had always been told, "work hard and you'll get ahead." No one ever told her that you can work hard– "harder even than you ever thought possible– and still find yourself sinking ever deeper into poverty and debt."

Conclusion

This book is a sobering, realistic and well-written book about the difficulties facing hardworking Americans who are at the lower end of the economic scale. Barbara Ehrenreich cites statistics throughout, but she also writes about the people with whom she works, about their struggles and their ambitions. These are the people whose lives create the economic statistics, and this book allows all of us a rare opportunity to look behind the numbers and see real people, real jobs, and real problems.

The author's bio can be found on page 39 of this special edition of WFW.

From the Farm to Your Table: The Human Cost of Farm Labor

By Shelley Davis
Washington, DC

Shelley Davis is an attorney with over 20 years of experience, most of which have been in advocacy and health education for migrant and seasonal farm workers. Since 1996, she has been the Co-Executive Director of the Farmworker Justice Fund, Inc. (FJF), a national advocacy center based in Washington, D.C. FJF's mission is to improve the living and working conditions of farmworkers and their families. Shelley has represented farmworkers and their organizations in litigation, including a successful action to ban the use of the pesticide dinoseb, which causes birth defects. She has also authored a number of papers concerning working conditions of farmworkers and their families.

Shelley is a graduate of Bryn Mawr College (1973) and Catholic University, Columbus School of Law (1978). Prior to her work at FJF, she worked for the Migrant Legal Action Program, the Political Rights Defense Fund, and the Legal Assistance Foundation of Chicago.

On September 10, 2002, 14 farmworkers were killed when the van in which their employer was transporting them to work, toppled off a bridge. (Huang 2002). Because of accidents like this one, agriculture consistently ranks as one of the three most hazardous occupations in the United States.

In 2001, excluding those who perished in the World Trade Center, the fatality rate for workers employed in agriculture, forestry and fishing was 22.8 per 100,000 workers, which was more than five times higher than the death rate for all workers (4.3 per 100,000 employees). The only industry with a higher fatality rate was mining, with a rate of 30.0 per 100,000 workers. (Bureau of Labor Statistics 2002). Put another way, agricultural workers who account for only 2% of the total U.S. workforce suffered 12% of the fatal on-the-job injuries. The primary causes of agricultural workplace fatalities were motor vehicles (including tractors), farm equipment, falls, drowning, and exposure to harmful chemicals. State statistics show a similar trend: in 1990, 41% of the occupational fatalities suffered by Florida farmworkers were caused by transportation-related accidents. (Becker 1991).

Performing strenuous physical labor, for long hours, six or seven days per week, often under very hot or very cold conditions, leads to large numbers of non-fatal injuries among farmworkers. In 2000, the non-fatal injury rate for workers employed in crop-production agriculture was 6.7 per 100 workers, with 3.7 cases per 100 workers involving lost work time (Bureau of Labor Statistics 2001). These injuries included fractures due to falls, eye injuries from chemicals or debris ejected from machinery, lacerations from knives and machetes, strains, sprains and repetitive motion injuries from stooping, lifting and sorting, and a host of crush, contusion, and amputation injuries from working with farm equipment. (Bureau of Labor Statistics 2001; Wilk, 1986). A National Institute for Occupation Safety and Health (NIOSH) study of workers' compensation records from 1985 to 1987 reveals that sprain and strain injuries account for 37.2% of all claims filed by agricultural workers.

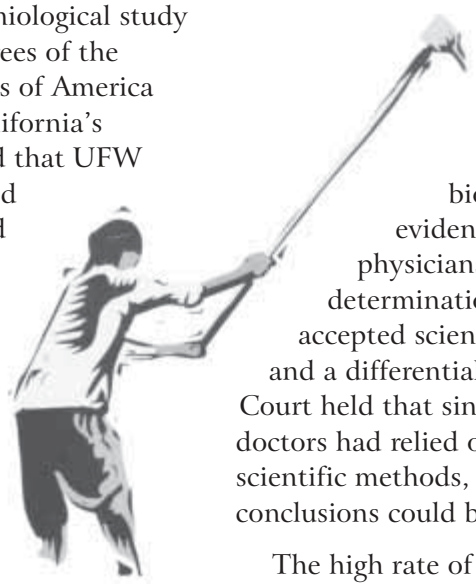
Many of these injuries could be prevented. The decline in the use of the short-handled hoe in California from 1965 to 1970 led to a 34% reduction in strain and sprain injuries in that state.

> **Performing strenuous physical labor, for long hours, six or seven days per week, often under very hot or very cold conditions, leads to large numbers of non-fatal injuries among farmworkers.**

Farmworkers suffer the highest rate of chemical-related illness of any occupational group (5.5 cases per 1,000 workers), according to the U.S. Bureau of Labor Statistics. (U.S. Department of Labor 1987). The U.S. Environmental Protection Agency (EPA) estimates that there are 10,000 to 20,000 physician-diagnosed cases of pesticide poisoning of farmworkers each year. (GAO 1992). In Washington State between 1987 and 1990, farmworkers had a rate of systemic poisoning that was 3.2 times higher than that of all workers and a rate of toxic disease that was 2.2 times the rate for all workers. (Demers1991). The actual number of work-related pesticide poisonings is unknown because farm workers do not always seek medical treatment for these conditions, many cases are improperly diagnosed, even recognized cases frequently go unreported and scientific knowledge is often insufficient to link chronic effects with specific pesticide exposures. (Moses 1989).

Acute effects of pesticide exposure range from nausea, dizziness, increased salivation, blurred vision, diarrhea, headaches, weakness, and skin rashes to respiratory failure, paralysis, convulsions, coma, and even death. (Moses 1998, Reigart 2000). Chronic exposure to pesticides may lead to birth defects, neurological disorders, infertility, and kidney or liver damage, Parkinson's disease, or cancer. (Moses 1998, Zahm 1993, CDC 1993, Congress 1990).

The EPA has identified more than 100 pesticides as possible or probable human carcinogens (e.g., chlorothalonil and captan); others have been identified as likely teratogens (e.g., benomyl, cyanazine, and methyl bromide) or endocrine disruptors (e.g., carbaryl and ziram), based on animal studies. (Moses 1998, Benbrook 1996). Farmworkers have an elevated rate of non-Hodgkin's lymphoma, multiple myeloma, and leukemia, and cancer of the stomach, prostate, testes, brain, and liver. (Zahm, 1993). Some of these cancer cases may be associated with excessive pesticide exposure. An epidemiological study of members and retirees of the United Farm Workers of America (UFW), utilizing California's cancer registry, found that UFW members had elevated rates of leukemia and brain cancer, compared to all Latinos in California. (Mills 2001). Many of these cancer cases were likely caused by occupational exposure to pesticides.



In a ground-breaking case, Florida attorney Nina Sachs secured a total permanent disability determination for a farmworker who is suffering from chronic health problems because of exposure to neurotoxic pesticides over many years. (*U.S. Sugar Corp.* 2001). For 27 years, the claimant, Henson, worked for U.S. Sugar as a mechanic. He spent most of his days in the fields repairing equipment, and was regularly exposed to pesticide spray or residues while performing his work. Many of the pesticides used were neurotoxic organophosphate insecticides. Over the years, he was treated by company doctors for shortness of breath, nausea, gastritis, and muscle weakness (all of which could be symptoms of pesticide exposure). In 1996, he went to his own doctor for similar symptoms. His physician diagnosed his condition as a paralyzed phrenic nerve, which had resulted in a partial collapse of one lung and left him confined to a wheelchair and ventilator dependent.

In the opinion of Henson's experts, the cumulative effect of his exposure to neurotoxic pesticides led to his phrenic nerve mononeuropathy. The non-treating physicians based their opinions on biological evidence; the treating physicians based their determinations on broadly accepted scientific literature and a differential diagnosis. The Court held that since Henson's doctors had relied on established scientific methods, their conclusions could be accepted.

The high rate of injuries among farmworkers is due in large measure to the inadequate workplace health and safety protections afforded them. Most federal labor standards partly or fully exempt agriculture. For example, the federal Field Sanitation Standard only requires farms with 11 or more employees to provide safe drinking water, hand-washing facilities, and toilets

in the field. (U.S. Department of Labor 1987). As such, it only applies to 36% of all farms. The lack of sanitary facilities in the fields causes high rates of heat stress or heat stroke, dermatitis, urinary tract infection, and third-world levels of parasitic infection. Under the Fair Labor Standards Act, farmworkers are not guaranteed overtime pay, so there is no economic incentive to limit the numbers of hours they work. As a consequence, accidents sometimes occur due to fatigue. In addition, the National Labor Relations Act excludes agricultural workers entirely, so only about 2% of agricultural workers are unionized. This prevents workers from having an organized voice to advocate for improved workplace safety.

Despite their high injury rate, not all agricultural workers are covered by workers' compensation. **Only 12 states provide farmworkers with the same level of workers' compensation coverage as other workers.** They are: Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Massachusetts, Montana, New Hampshire, New Jersey, Ohio, and Oregon. By contrast, **13 states do not require any coverage** of agricultural workers. These states are: Alabama, Arkansas, Indiana, Kansas, Kentucky, Mississippi, Nebraska, Nevada, New Mexico, North Dakota, Rhode Island, South Carolina, and Tennessee. **The remaining 25 states** impose greater limitations on coverage for farmworkers than for other employees. Partial-coverage states, like Florida and Maryland, exempt only small farms from the program while others, like Maine, exclude from benefits all farm workers who do not work all year round. (U.S. Department of Labor 1999). Finally, **federal law** requires that all employers of temporary foreign workers, estimated to number 40,000, who enter the United States legally with H-2A visas to perform agricultural work, must be covered by workers' compensation insurance.

Farmworkers play a crucial role in our economy and our daily lives, ensuring that American consumers can buy fresh fruits and vegetables at cheap prices. In return, farmworkers should be provided safe working conditions and workers' compensation benefits when they are injured or become ill on the job. With advocacy, these goals could be achieved.

References

Becker W.J., An Analysis of Agricultural Accidents in Florida -1990, Agricultural Engineering Department, Special Series, Report SS-AGE-25, Gainesville, FL, University of Florida (1991).

Bureau of Labor Statistics. National Census of Fatal Occupational Injuries in 2001. News Release. September 25, 2002. <http://www.bls.gov/iif/oshwc/cfoi/cfnr0008.pdf>http://www.bls.gov/iif/oshwc/cfoi/cfnr0008.pdf

Bureau of Labor Statistics. Workplace Injuries and Illnesses in 2000. News Release. December 18, 2001. <http://www.bls.gov/iif/oshwc/osh/os/osnr0013.pdf>http://www.bls.gov/iif/oshwc/osh/os/osnr0013.pdf

Cancer Incidence in the United Farmworkers of America 1987-1997, Am J. of Ind. Med. 40:596-603 (2001).

Carroll, Daniel, Gabbard, Susan, Myers, John, and Steege, Andrea. Findings From the National Agricultural Workers Survey/NIOSH Collaboration. Presented at the Midwest Migrant Stream Forum, November 2002.

Centers for Disease Control and Prevention, Occupational Pesticide Poisoning in Apple Orchards - Washington, 1993, MMWR 42(51-52); 993-995 (1994).

Charles M. Benbrook, Growing Doubt: A Primer on Pesticide Identified as Endocrine Disruptors (1996).

Demers P., Rosenstock L., "Occupational Injuries and Illnesses among Washington State Agricultural Workers," American Journal of Public Health 81(12):1656-1658 (1991).

Huang, Josie, "Pain & Desperation." Portland Press Herald. Portland, Maine. December 8, 2002.

Mills, Paul K., Kwong, Sandy, Cancer Incidence in the United Farm Workers of America (UFW), 1987-1997, American Journal of Industrial Medicine 40:596-603 (2001)

Moses, Marion. Pesticides. In Wallace RB (ed.): Public Health and Preventive Medicine. Appleton & Lange. 1998. pp. 593-605.

Moses, M., "Pesticide-related health problems and farmworkers," American Association of Occupational Health Nurses Journal, 37(3):115-130 (1989)

Neurotoxicity: Identifying and Controlling Poisons of the Nervous System (1990)

Reigart, Routt and Roberts, James. Recognition and Management of Pesticide Poisonings. 5th Ed. U.S. EPA. 1999.

U.S. Commission on Agricultural Workers. Report of the Commission on Agricultural Workers. 1992.

U.S. Congress, Office of Technology Assessment, Case Studies; Exposure to Lead, Pesticides in Agriculture, and Organic Solvents in the Workplace in State of California, Proposition 65 List of Chemicals Wilk (1986)

U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs, State Workers Compensation Laws, Table 3 (January 1999).

U.S. Department of Labor, Final Field Sanitation Standard, 52 Fed. Reg. 16050 (1987).

U.S. Department of Labor. Findings from the National Agricultural Workers Survey (NAWS) 1997-1998. March 2002.

U.S. General Accounting Office, Hired Farmworkers: Health and Well-being at Risk (HRD-20-46) (February 1992).

U.S. Sugar Corp. v. Henson, 823 So.2d 104 (2002)

Villarejo, Don, et al. Suffering in Silence: A Report on the Health of California's Agricultural Workers. California Institute for Rural Studies. November 2000.

Washington State Department of Labor and Industries, Farm Worker Health & Safety in Washington State: A Look at Workers' Compensation Data Olympia, WA, at 11 (1991).

Wilk Valerie. Health hazards to children in agriculture. Am J Ind Med 1993; 24:283-90.

Zahm, SH and Blair, A. Cancer Among Migrant and Seasonal Farmworkers: An Epidemiologic Review and Research Agenda. Am J Ind Med 24:753-766, 1993.

Zahm S.H., Blair B., "Cancer Among Migrant and Seasonal Farmworkers: An Epidemiologic Review and Research Agenda," American Journal of Industrial Medicine 24:753- 766 (1993).

The Labor Page

Rob McGarrah is an attorney who for several years has helped coordinate the AFL–CIO's national workers' compensation efforts. His position with the AFL–CIO involves advocating workers' rights in federal policy matters ranging from patients' rights to medical records privacy and health insurance reform. He was one of the original "Nader's Raiders", serving as staff attorney for Public Citizen's Health Research Group in the 1970s. From 1975 to 1997, he was staff attorney, and then director, of the first labor union public policy department with The American Federation of State, County and Municipal Employees (AFSCME). Among other accomplishments, during that period he launched AFSCME's successful drive to organize the clerical and technical workers at Harvard University. He joined President John Sweeney's public policy staff at AFL–CIO in 1997. Rob is a 1972 graduate of Villanova University Law School and received an MPH from Johns Hopkins University in 1999.

Death on the Job

By Robert McGarrah
Washington, DC

President Bush unwittingly touched off a furious debate over the adequacy of workers' compensation programs when he announced the Smallpox Vaccination Program to combat bioterrorism on December 13, 2002. Nearly four months after the President spoke, with America's fighting forces victorious in Baghdad, three workers were dead from heart attacks attributed to the smallpox vaccine, and Congress finally enacted a new national smallpox compensation program.

The President ordered all military personnel to be vaccinated against smallpox. For civilians, he said:

"We do recommend [smallpox] vaccinations for one other group of Americans that could be on the front lines of a biological attack. We will make the vaccine available on a voluntary basis to medical professionals and emergency personnel and response teams that would be the first on the scene in a smallpox emergency. These teams would immediately provide vaccine and treatment to Americans in a crisis and, to do this job effectively, members of these teams should be protected against the disease.

"I understand that many first responders will have questions before deciding whether to be vaccinated. We will make sure they have the medical advice they need to make an informed decision. Smallpox is a serious disease and we know that our enemies are trying to inflict serious harm. Yet there's no evidence that smallpox imminently threatens this country."[1]

The smallpox vaccine, made from a live virus, called vaccinia, is the most dangerous of all vaccines.

The smallpox vaccine, made from a live virus, called vaccinia, is the most dangerous of all vaccines. It was originally developed by Albert Jenner form cowpox in the Eighteenth Century. Smallpox was eradicated worldwide in 1980 and the last case in the United States was in 1949. According to the Center for Disease Control, for every one million people vaccinated, 1-2 will die, 14-52 will become seriously ill with potentially life-threatening reactions, including eczema

vaccinatum, progressive vaccinia (or vaccinia necrosum), or postvaccinal encephalitis.[2]

The Defense Department has taken extraordinary precautions to prevent deaths and adverse reactions among military and civilian personnel. The DoD smallpox vaccination program, of course, is run entirely by the federal government and is amply funded. If any vaccinee, or member of a vaccinee's household, has any reaction to the smallpox vaccine, the federal government provides complete medical care and full compensation through the military's health system (active duty servicemen and women) and the Veterans' Administration (once honorably discharged from the military). The Federal Employees Compensation Act (FECA) is available to all other civilian Defense Department personnel (as well as all other federal agencies and Members of Congress) and specifically covers all smallpox injuries.[3]

Unless state workers' compensation laws or job-based health insurance cover smallpox injuries, they have no coverage for the health care and lost income support they need in the event of an adverse reaction to the smallpox vaccine.

Most civilian First Responders, however, work for local police, fire and public health departments, or local hospitals. Unless state workers' compensation laws or job-based health insurance cover smallpox injuries, they have no coverage for the health care and lost income support they need in the even of an adverse reaction to the smallpox vaccine.

Speaking to reporters after the President's announcement in December, HHS Secretary Tommy Thompson said:

"They [civilian First Responders] will be able to get compensated of course under their own health insurance programs, and most of the individuals in the first category certainly will be people that are covered by health insurance, either by their employer or by their own personal plans."

"Secondly, they will also be covered by the state workers compensation laws of the particular state which would pay them compensation. And heaven forbid, if somebody dies, they would be able to receive the wrongful death portions of the workers' compensation law put out by the particular state."[4]

The Secretary's prediction proved wrong on both counts. First Responders who have health insurance at all have the same cost-sharing now required by all health insurance plans. Less fortunate First Responders, who figure among the 41 million uninsured Americans, have nothing at all to cover the medical care required to treat smallpox reactions. As for state workers' compensation, an AFL-CIO survey reveals that only 14 states clearly guarantee coverage of smallpox injuries as of April 2, 2003 (see next column).

State Workers' Compensation Coverage of Smallpox Vaccine Program Injuries

14 **States guarantee coverage:** AL, AZ, CO, ID, KY, MN, NH, NJ, ND, OH, TX, WA, WV, WI

5 **Yes** based on state case law, but no statement of guaranteed coverage available: CA, GA, IN, MA, MS

9 **No:** AR, CT, DE, FL, IL, ME, MI, MO, MT

8 **No** for some workers' compensation insurers in the states: IL, NY, NE, NM, OK, PA, TN, VA

12 **Still reviewing** smallpox coverage under workers' compensation: AK, IA, MD, ME, KS, LA, NC, OR, RI, VT, VA, WY

Health Event, by Severity	Cases Reported
Potentially Life Threatening Events	0
Moderate to Severe Events*	26
Other Severe Events**	24
Other Events of Concern	
Transfer of vaccinia virus to contacts***	0
Treatments with vaccinia immune globulin (VIG)	1

*Six cases resulted from vaccinia virus transmission from military personnel to civilian contacts.

****This category includes four myocardial infarctions, two cases of angina, and four cases of myopericarditis. Two of the three patients who had myocardial infarction died.**

***This category refers to the number of vaccinia virus transmission frmo civilian vaccinees. No cases of transmission from civilian vaccinees have been reported. Six cases of transmission from military personnel to civilian contacts have been reported.

Source: Center for Disease Control[5]

When the Bush administration first began planning for the President's Smallpox Vaccination Program in June 2002, key safety and health staffers from the American Nurses Association, the Service Employees International Union and the American Federation of State County and Municipal Employees warned that, without full federal funding for the program, cash-strapped state and local governments would be unable to match the DoD's comprehensive prevention and screening program. Moreover, they said, state workers' compensation laws would not cover vaccine injuries. Their predictions have, unfortunately, come true. The President asked that 450,00 First Responders take the vaccine by February 24, 2003. Yet, as of March 28 there were only 29,584 First Responders vaccinated, less than 7% of the administration's goal.

At the same time, the CDC reported two deaths among its official tally of 50 adverse events (see chart) and one death was reported in the DoD Smallpox Program. All three deaths were widely publicized.

Health Event, by Severity	Cases Reported
Potentially Life Threatening Events	0
Moderate to Severe Events[A]	26
Other Severe Events[B]	24
Other Events of Concern	
Transfer of vaccinia virus to contacts[C]	0
Treatments with vaccinia immune globulin (VIG)	1

[A]Six cases resulted from vaccinia virus transmission from military personnel to civilian contacts.

[B]This category includes four myocardial infarctions, two cases of angina, and four cases of myopericarditis. Two of the three patients who had myocardial infarction died.

[C]This category refers to the number of vaccinia virus transmissions from civilian vaccinees. No cases of transmission from civilian vaccinees have been reported. Six cases of transmission from military personnel to civilian contacts have been reported. *Source: Center for Disease Control*[5]

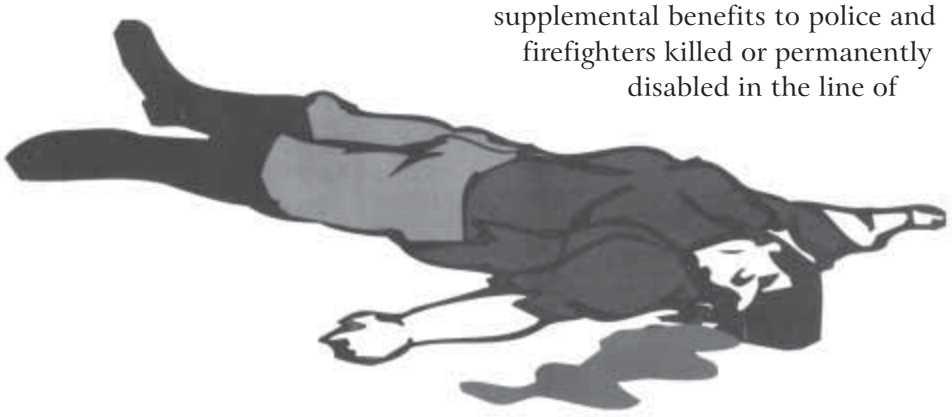
One of the deaths was a nurse from Salisbury, Maryland, a state that has yet to decide whether it will cover smallpox under its workers' compensation law.

Asked at the Senate Health Education Labor and Pensions Committee hearing on Smallpox why the administration had refused to follow its own Institute of Medicine recommendations calling for a compensation program for Smallpox First Responders, CDC Director Julie Gerberding said state workers' compensation laws were sufficient to do the job. In fact, as surveys by the Association of State and Territorial Health Officers and the AFL-CIO showed, only 14 states guarantee that their workers' compensation programs will cover smallpox injuries.[6] The American Insurance Association noted that the smallpox program was a voluntary program –no one required workers to get the smallpox vaccine as a part of their job– therefore, the AIA reasoned, smallpox would not be covered under workers compensation policies.[7]

Professor Leslie Boden, one of the Nation's leading experts on workers' compensation, noted that there were 50 different standards and laws, each with different waiting periods and benefit levels. Moreover, he noted the example of the federal Energy Employees Occupational Injury Compensation Act demonstrated that state workers compensation laws were simply not up to the job of compensating workers on a timely basis. Since EEOICPA was enacted in 2000 over 15,000 state workers' compensation claims have remained backlogged at the Department of Energy and the National Institute of Occupational Safety and Health (NIOSH). As if that weren't enough, Boden noted that state workers' compensation laws all contain waiting periods of 3-7 days, creating a significant barrier for smallpox First Responders.

Barely one month after the start of the Smallpox Vaccination Program—with fewer than 5, 000 First Responders vaccinated, the Bush administration bowed to circumstances and asked Congress to enact a federal compensation program. Yet the most remarkable feature in the administration's proposal was its reliance upon state workers' compensation as the primary source of coverage for smallpox injuries.

The Bush smallpox compensation plan is based upon a little-known law, the Public Safety Officers Benefit (PSOB) program, enacted in 1968 to provide supplemental benefits to police and firefighters killed or permanently disabled in the line of



duty. Police and firefighters, of course, have extensive benefits under state and local laws to compensate them and their families in the event death or injury. First Responders in the Smallpox Vaccination Program, however, have no other compensation program to rely upon. Consequently, as proposed by the administration, PSOB benefits for Smallpox First Responders would be their sole source of medical care and compensation.

After months of haggling, Senator Edward Kennedy announced an agreement with the White House that was enacted by the Congress the next day. The following are the key elements of the Smallpox Emergency Personnel Protection Act of 2003.

Eligible individuals include health care workers, law enforcement officers, firefighters, security personnel, emergency medical personnel and other public safety personnel who have volunteered for and received the smallpox vaccination as part of a state smallpox emergency response plan or any individual who is accidentally injured by a smallpox vaccination given to a First Responder.

Covered injuries are an injury, disability, illness, condition, or death (other than a minor injury such as minor scarring or minor local reaction) resulting from the smallpox vaccine, including cases of contact vaccinations during the period of January 24, 2003-February 24, 2004, as declared by the Secretary of Health and Human Services.

Benefits are secondary to any available workers' compensation, health insurance or other disability insurance benefits and may be received upon application to the Secretary of Health and Human Services, who will use a vaccine injury table to decide whether the injury is due to the smallpox vaccine. They include:

(a) all reasonable and necessary medical care to treat the injury and

(b) death benefits of either a lump sum payment of $262,100 or, if there are children under the age of 18, up to $50,000 per year;

(c) permanent and total disability benefits equal to 66 2/3% of wages (75% in the case of dependents) up to $50,000 per year for life;

(d) partial disability benefits of up to $262,100, payable at the same rate as permanent disability benefits and capped annually at $50,000 per year.

Appropriation: Congress appropriated $105 million for states to run the Smallpox Vaccination Program and $42 million for the smallpox compensation program.

Footnotes

[1] http://www.whitehouse.gov/news/releases/2002/12/20021213-7.html

[2] http://www.bt.cdc.gov/agent/smallpox/overview/faq.asp#safety

[3] http://www.dol.gov/esa/regs/compliance/owcp/dfec_smallpox_policy.htm

[4] http://www.cdc.gov/od/oc/media/transcripts/t021214.htm

[5] http://www.cdc.gov/od/oc/media/smpxrprt.htm

[6] ASTHO/AFL-CIO Surveys, March 2003.

[7] Business Insurance, January 13, 2003, p.1.

FOOTNOTES, continued from page 12

and measures that are obsolete and not useful for the current purpose.

[4] J.N. Butcher, et al. The Construct Validity of the Lees-Haley Fake-Bad Scale(FBS): Does this Scale Measure Somatic Malingering and Feigned Emotional Distress? 18, 473-485 *(*Archives of Clinical Neuropsychology June 2003). A.S. Bury & R.M. Bagby, The Detection of Feigned Uncoached and Coached Posttraumatic Stress Disorder with the MMPI-2 in a Sample of Workplace Accident Victims, 14(4), 472-484 (Psychological Assessment 2002).

[5] Otfried Spreen & Esther Strauss, A Compendium of Neuropsychological Tests, 674 (2d ed. Oxford University Press) (1988).

[6] *Id.* at 673.

[7] R.M.Reitan & D. Wolfson,. *The Halstead-Reitan Neuropsychological Battery* 121, *in* Theory and Clinical Interpretation (Tuscon, AZ Neuropsychology Press 2d ed.) (l993).

[8] Kenneth S. Pope, James N. Butcher, & Joyce Seelen, The MMPI MMPI-2 & MMPI- A in Court 161 (American Psychological Association 1999).

[9]Yossef S. Ben-Porath, John R. Graham. Gordon C. N. Hall, Richard D. Hirschman, & Maria S. Zaragoza, *Forensic Application of the MMPI-2* 194, Applied Psychology, Individual and Social Community Issues (Sage Publishing Corporation 1995).

[10]James Butcher, MMPI-2, User's Guide 8 (Regents University of Minnesota 1998).

[11] Kenneth S. Pope, James N. Butcher, & Joyce Seelen,The MMPI, MMPI-2 and MMPI-A. In Court 104 (American Psychological Association 1999).

[12]*Id.* at 104.

Who's Paying The Bills? The Federal Dilemma of Cost Shifting in Workers' Comp Claims

By Jon L. Gelman
Wayne, NJ

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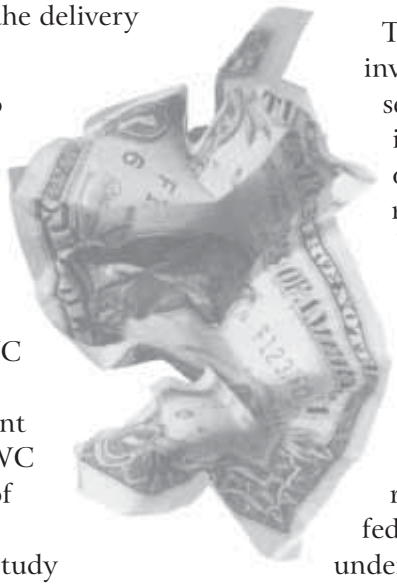
The federal government continues to struggle with the need to share data from workers' compensation (WC) programs an effort to reduce payment errors. While both systems provide benefits to injured workers, the United States General Accounting Office (GAO) reported, in a May 2001 study, that the lack of a uniform and consistent method to collect data on a national level has led to irregularities in the delivery of federal benefits.

In a recent report to Congress, the GAO observed that between 1991 and 1998, $43 billion was paid in cash by the federal government for medical benefits for WC related claims. GAO revealed that "significant errors" existed in the WC offset process by way of overpayments and underpayments. The study discloses that the federal government is unintentionally subsidizing WC insurance companies throughout the United States on a massive scale.



The study reviewed the programs of various states including the records from the State of Virginia. Virginia was utilized as a sentinel guide since it has maintained a central database for the collection of WC data. GAO examined the records from the Health Care Financing Administration (HCFA), which administers not only the Medicare Program, but also the Department of Agricultural (USDA) Stamp Program, the Department of Housing and Urban Development (HUD) Section 8 Rental Vouchers and Certificates Programs, and child support enforcement activities.

The federal investigation found several shortcomings in the present system of reporting the receipt of WC benefits, including the Social Security Administration's (SSA) regulation of the WC offset provision. The GAO report recognized that the federal program was undermined by the lack of reliable information identifying the recipients of state WC benefits. No national reporting system presently identifies WC beneficiaries. As a result, some beneficiaries are overpaid while others are underpaid.

The present federal system relies upon the applicants and their beneficiaries to report receipt of WC benefits to the SSA. This approach lacks a valid system of

verification and mandatory compliance. It is difficult for the SSA to obtain an accurate report of benefit payments. The GAO reported that 50% of the beneficiaries of disability benefits who have been subject to offset have been paid inaccurately. Over $1.5 billion in payment errors relating to the WC offset have been identified. Eighty-five percent of the errors occur when disability insurance beneficiaries do not report reduction in the WC benefits.

In reviewing the VA system, the study revealed that SSA was unaware that 20% of the disability insurance beneficiaries were receiving concurrent benefits. It was observed that lump-sum compensation payments do not always produce close approximation of the benefit value of the lump-sum payments, as called for by the Social Security Act. The GAO suggested that there were unrealistic approximations made by the WC system.

The report concluded that solutions exist to correct the present failure to integrate data between the federal and state systems. However, these are prohibited by the fragmented structure of the WC programs throughout the U.S. and by the lack of federal involvement in the state delivery systems. One of the methods recommended for solving this problem was better sharing of data with the federal government and/or data from WC carriers. The report suggested that WC insurers should voluntarily report payments made to WC beneficiaries. The difficulty recognized with that proposal is the reluctance of insurance carriers to incur additional reporting costs.

The report recognizes that an incentive to voluntary compliance may be needed to obtain reliable and timely data. The GAO suggests that SSA and HCFA initially conduct a sampling of data to determine whether the sharing of WC beneficiary information will be helpful at all and whether it will improve the accuracy of federal benefit payments.

Furthermore, the GAO report to Congress revisits the issue of lump-sum WC benefits and the interpretation of data that they represent ((62 FR 51923-51926 (1997). It highlights the need to revise the policies governing how monthly benefit values of a lump-sum payment should be determined by SSA offset provisions. Previous attempts to implement these changes through administrative regulations have been met with significant opposition by all parties in the WC arena. The federal report suggests that the Congress consider legislative action to resolve this long-standing operational problem of identifying WC beneficiaries in a multiple state jurisdictional landscape that is constantly in a state of flux from changing legislative provisions and administrative regulations.

Similar findings concerning cost shifting from WC carriers to federal programs have been previously reported in a 1992 study by J. Leigh, S. Markowitz, M. Fahs, and P. Landrigan, *Costs of Occupational Injuries and Illnesses*, University of Michigan Press (2000). That report concluded that $28.5 billion (18.3% of total cost) is erroneously paid by the federal government. Consequently, the federal government is compelled to raise revenue by taxes, and the injured worker incurs an increased tax burden. Ironically, injured workers are already paying $68.6 billion (44.2% of all medical costs) directly through out-of-pocket expenditures.

As the new economy falters, and an additional financial burden is placed upon the SSA, additional revenue sources will be required. Since it is the Bush administration's intention to utilize the Social Security Trust Fund to fund the federal budget, it is more than obvious that the US Congress will review this issue in greater depth in the near future.

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Practice Pointers

Cross-Examining the Vocational Expert in Workers' Comp Cases

By John B. Boyd
Kansas City, MO

John B. Boyd

John B. Boyd is a founding member of WILG and is immediate past president. Since leaving the bench as a Workers' Compensation administrative law judge in 1983, his practice remains concentrated in workers' compensation, labor and personal injury litigation. He has chaired ATLA's Workers' Compensation and Workplace Injury Section, was Vice-President of the Missouri Association of Trial Attorneys, and has lecturered in workers' compensation programs and seminars over the past two decades. He is counsel to the Missouri AFL-CIO on workers' issues; and is a shareholder in Boyd & Kenter, PC, with offices in Kansas City and Sedalia, Missouri. John has a B.S. from Central Missouri State University and a J.D. from the University of Missouri—Kansas City School of Law.

This article is abstracted from a longer article by John Boyd, with lengthy examples of cross-examination techniques available in the *Workplace Injury Litigation Book,* Lawyers & Judges (2004).

While there are no magical formulas or techniques for successful cross-examination of any witness, including the vocational expert, the more the advocate knows about the witness, the better are the chances of finding inconsistencies, weaknesses, and predictable opinions to exploit. Start with keeping a series of files, arranged by the V.E.'s resume, reports, and past depositions. If available, order ASCII disks of depositions of all experts you attend. Store those electronic depositions in your clients' individual word processing file, and keep a separate copy in an expert witness data bank. Before our firm started this, we kept the "mini" paper versions in file cabinets dedicated for all experts, including V.E.s.

If you haven't started such a library, employ ATLA's Exchange, Depoconnect, or similar vendors to obtain depositions on file by your colleagues. Consider using the workers' compensation list serve features of your state trial lawyers' association, ATLA, and WILG, to solicit information about the V.E. as well as the experiences of your list mates.

Contact the professional organizations listed on the V.E.'s resume to verify membership or licenses in good standing. Many V.E.s also testify at Social Security hearings. Find out if administrative law judges are using them. If not, there may be a reason worth investigating.

Sometimes, a V.E.'s resume or curriculum vitae reveals fertile grounds for cross-examination: an unusually long time period between when their practice began until board certification; or, a lack of formal education in the field of their practice.

Everyone is taught never to ask a question to which you don't know the answer. If I had followed the safe path, I would never have known the following:

Q I note from your C.V. that you practiced in the field for eight years before you were certified; did I read that correctly?

A Yes.

Q Why don't you tell me how many times you failed the testing to obtain board certification status?

A Twice.

Q When you failed to pass the test each time, did they tell you what areas of the discipline you flunked?

A No.

Q And they did test you on subjects such as you are offering opinions about here today, didn't they?

A Yes.

Q And you can't tell us if you failed those subjects both times, can you?

A Well, I did pass it on my third try."

A V.E.'s lack of formal education and "hands-on" job experience can also be revealing. Many have degrees in social work, not vocational rehabilitation. Exploit these weaknesses if present.

Q And you can't tell us if you failed those subjects both times, can you?

A Well, I did pass it on my third try."

Past reports and prior sworn testimony of a V.E. are fertile grounds for impeachment, when the V.E. offers opinions in your case that cannot be reconciled with what you have in your library. Some V.E.s actually will market their services to insurance companies and defense law firms, and this possible bias can be exploited as well.

Sometimes you cannot find much information about an expert witness. It is therefore mandatory to have some technical resources available in your library, which you must understand how to use. One such resource is the *Dictionary of Occupational Titles* (4th Edition, Revised 1991). It can be purchased in paperback version, and is available via the Internet at www.oalj.dol.gov.libdot.htm. Many V.E.s still utilize this as a resource, although they increasingly rely upon updated information available via the Internet. This newer resource is from the U.S. Department of Labor, O*Net, and is located at www.onetcenter.org.

During your preparation, you will have developed topics or strings of proof, and a theme of what you hope to extract from the expert. Consider taking the opportunity during your cross to pull these thoughts together. Be flexible, and take what the expert has given you to build upon your themes.

Background information may reveal that the V.E. has worked in areas other than where your client worked and lived. The expert's experience with the job market, and with placement of workers into specific jobs, may be mostly from an irrelevant locale. Also, terminologies used by V.E.s have special connotations. An occupational classification is that which is catalogued in the D.O.T., for example, and may not correspond directly with available jobs in the areas where your client lives and worked.

The art of cross-examination is a life-long learning process. In this arena, knowledge is power.

At first blush, a proposition uttered by an expert can seem plausible, such as the answer to the last question. However, consider going from a specific to the general application, or from the general statement to a specific, of the V.E.'s proposition. Difficulty in or lack of experience in applying this proposition may as well render the opinion suspect.

V.E.s use several computerized models. Problems inherent with such usage can be illustrated through your cross-examination. Typically, these programs do not allow for your client's perception of pain and how it interferes with activities of daily living. Instead, they rely upon the information that the V.E. chooses to enter concerning education, past work, and physical or emotional restrictions identified by treating and evaluating physicians.

V.E.s employ these programs to come up with occupational classifications that the expert will rely upon in concluding your client is not totally disabled. The advocate can consider challenges under *Daubert* or *Kuhmo Tire* if the state courts have adopted these federal tests to the scientific reliability of the programs. Several states, however, have not as yet adopted these tests, so you may wish to consider the standards of reliability in your jurisdiction.

The art of cross-examination is a life-long learning process. In this arena, knowledge is power: knowledge of the facts of your client's medical and work histories; knowledge of the V.E.'s past recorded testimony or reports; and knowledge of the resources employed by V.E.s all contribute to the successful cross-examination. The phrase –"the devil is always in the details"– is particularly relevant to this area of advocacy for your clients.

Medical Corner

Dr. Manish Fozdar is a forensic psychiatrist in private practice who lives in Wake Forest. He has chaired the Forensic Neuropsychiatry Committee of the American Academy of Psychiatry and Law. From 1998–2002, Dr. Fozdar directed the Brain Injury clinic at Duke University Medical Center. Prior to that, he served as director of the Behavioral Epilepsy Program at Allegheny General Hospital in Pittsburgh, PA. Dr. Fozdar concluded his psychiatry residency training at Harvard Medical School in 1994, then completed a fellowship in Consultation-Liaison Psychiatry and another in Neuropsychiatry at Harvard affiliated hospitals.

Psychiatric Disability Due to Occupational Stress and Injury

By Manish A. Fozdar, M.D.
Wake Forest, NC

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The International Labor Office of the United Nations announced in its 1993 monograph that job stress was The 20th Century Disease.[1] The report stated that job stress had reached epidemic proportions. Today, we are at the beginning of the twenty-first century. Job stress has only gotten worse. More and more people are forced to work more hours due to dramatic changes in the work environment and culture. Acquisitions and mergers, globalization of economic forces, and the increasing cost of living are some of the factors contributing to it, while many more women are in the work force than ever before.

Disability claims due to stress and psychiatric disorders have increased dramatically in last decade or so. Stress-related workers' compensation claims in California rose 700 percent between 1979 and 1988. Psychiatric or stress disability claims now outnumber those due to low back pain.

Recent court decisions have recognized depression and other psychological conditions as occupational diseases that are compensable under workers' compensation laws.[2] Courts were initially reluctant to compensate mental injury claims because of inherent distrust towards these claims, fear of malingering, and lack of objective methods to determine causality. Even now, getting a disability claim approved by the Social Security Administration is an uphill, arduous, and often costly task for people who already cannot work because of physical and/or mental disorders. This battle was recently highlighted in a series of articles published in the Raleigh newspaper *The News & Observer*.

Occupational Psychiatric Disorders

Scarce epidemiological data are available on the prevalence of psychiatric disorders associated with the workplace. In *Psychiatric Aspects of Occupational Medicine*, Holland suggests that among hourly workers, mood and anxiety disorders, psychotic disorders, and personality disorders are common.[3] In addition, substance abuse is often present.

Neuropsychiatric disorders such as traumatic brain injuries and organic brain damage due to environmental toxins are routinely treated in my practice. Chronic

back pain and other pain syndromes are widely prevalent and exact an enormous toll on the economy and one's own quality of life. Chronic pain is often present with comorbid psychiatric conditions such as depression.[4]

Workplace violence has been getting increasing attention due to several high profile cases. A worker may be exposed to a life-threatening situation personally, as in hostage situations, or may be a witness to a gruesome killing. These individuals may suffer from post-traumatic stress disorder or other anxiety disorders as a result.

Most of these conditions often become chronic with a relapsing and remitting course. Significant residual symptoms persist even when the acute phase of the illness is over. It is not possible to discuss the phenomenology of these various disorders here, but the interested reader is referred to DSM-IV.[5]

Psychiatric Evaluation of a Workers' Compensation or Disability Claim

A thorough neuropsychiatric and medical history is the single most important step in the evaluation process. Unlike for purely medical illnesses, such as orthopedic injuries, objectively validated measures of impairment are unavailable in psychiatry. An outline of psychiatric evaluation is illustrated below.

Psychiatric Evaluation Guideline

- Demographic information and basic data
- Reason for evaluation
- Chief complaint(s) and current symptoms
- Past psychiatric history including detailed substance abuse history
- Medical/surgical history
- Family history
- Personal history including socio-economic, occupational, childhood, marital, educational, physical/sexual abuse, etc.
- Collateral information from any and all available sources
- Current medications
- Thorough mental status evaluation, including cognitive screening
- Diagnostic formulation
- Prognosis
- Treatment recommendations

The psychiatric interview can then be supplemented with other tests as necessary, such as personality testing, neuro-psychological testing, brain imaging studies, and other laboratory tests. It is important to keep in mind that each individual is unique and therefore the evaluation process must take into consideration individual variables. The psychiatric examiner must be familiar with the work requirements and other work-related conditions of the examinee. For example, it is important to know whether a person has to work in a noisy environment, such as near machinery, when he may be suffering from Post-Traumatic Stress Disorder. Those who suffer from PTSD may find it almost impossible to tolerate loud noises.

Mental illness leads to maladaptive behaviors and various coping mechanisms that may severely limit an individual's ability to meet the demands of work environments. For a psychiatric examiner, it may become quite difficult to ascertain how a person with mental illness may or may not be able to adapt to the demands of his work environment. Knowledge of various functional and cognitive impairments caused by mental disorders and application of that knowledge to each individual case is the cornerstone of this kind of examination.

Psychiatric Illness and Functional Impairments

The *American Medical Association Guides to the Evaluation of Permananet Impairment* provides principles on which to make psychiatric impairment ratings. It puts emphasis on the effect of mental illness on four critical areas of functioning: 1) activities of daily living; 2) social functioning; 3) concentration, persistence and pace; and 4) adaptation. An exhaustive review, of course, is not possible here, but a few salient points will be discussed to illustrate how various symptoms lead to work limitations.

Mood Disorders

Depression can produce myriad symptomatology ranging from diminished initiation and motivation to significant cognitive problems. Psychomotor slowing can significantly affect work speed, meeting deadlines for job projects, etc. Persistent ruminative thoughts can make it impossible to concentrate for any length of time. Sleep disturbances and cognitive

problems can cause diminished attention and concentration, reduced mental flexibility, memory deficits, and inefficiency in performing serial and sequential tasks. It may become quite difficult to perform any work in close proximity to others without being distracted. A person with significant depression may not be able to carry out even simple instructions.

Bipolar disorder can produce extremes in mood states. This can vary from severe depression to a full-fledged manic episode. A person in a manic phase may become quite hyperactive and unable to complete a single task. Significant irritability, grandiose and inflated self-esteem, and a sense of entitlement can lead to serious interpersonal difficulties and therefore inability to get along with co-workers or heed a supervisor's instructions. Some people with bipolar disorder have serious psychotic symptoms, including hallucinations and delusions leading to a distorted perception of reality. Pressure of speech, flight of ideas, and tangential thinking make communication impossible.

Mood disorders are usually chronic. There may be periods of complete to partial remission in between acute episodes. Research has established that the more the number of relapses, the higher the chance of each relapse becoming more severe, and in some cases, treatment-resistant. Comprehensive treatment, including medications, psychotherapy, and social interventions can produce long-lasting remissions. However, even in these cases, some residual symptoms may persist leading to functional impairment in one area or another.

Anxiety Disorders

ANXIETY DISORDERS	POTENTIAL FUNCTIONAL IMPAIRMENTS
Panic Disorder	Episodic cognitive dysfunction; fear of closed spaces; fear of crowds
Generalized Anxiety Disorder	Diminished concentration, attention, and memory; communication difficulties
Phobic Disorder	Avoidance – specific phobias can lead to specific impairments (e.g., fear of flying limits travel, or social phobia leads to avoidance of co-workers and clients)
Obsessive-Compulsive Disorder	Attention/concentration problems; difficulty making decisions; significant time spent in performing physical and/or mental rituals
Post-Traumatic Stress Disorder	Difficulty with concentration; irritability and anger outbursts; avoidance of activities, places, and people that may arouse recollections of trauma; emotional blunting

Psychotic Disorders

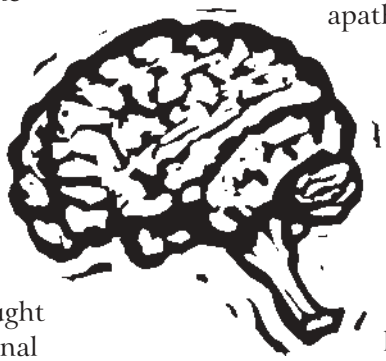
Various psychotic disorders, including schizophrenia and delusional disorders, can lead to varying degrees of impairment. A person with delusions of persecution may be able to work in a highly structured environment. On the other hand, chronic schizophrenia can lead to prolonged periods of institutionalization. Impaired social skills, cognitive dysfunction, and distorted perceptions are the most common impairments in schizophrenia that can interfere with work capacity. Negative symptoms of schizophrenia such as avolition, apathy, and poverty of speech and thought can cause severe interpersonal limitations. Positive symptoms, such as hallucinations and delusions, can lead to agitation, bizarre behavior, and even a frank danger to self or others. Schizophrenia, in general, causes much more severe and persistent dysfunction in an individual than depression or anxiety.

Chronic Pain

Pain is a subjective experience for which objective measures are unavailable. Pain experience is the result of dynamic interaction between various factors: anatomic abnormality, psychological factors, and environmental influences. A person with chronic low back pain may be unable to perform various mechanical tasks including lifting, bending, and sitting or standing for long periods of time. Chronic pain is often associated with depression, and that can further limit functioning. A thorough Functional Capacity Evaluation (FCE) is helpful to objectively document functional impairments.

Organic Brain Disorders

Examples of chronic organic brain disorders are traumatic brain injury and dementia. Both can cause significant and permanent cognitive impairments that can be objectively documented by psychometric testing. Traumatic brain injury can result in a new onset of mood disorder, most notably depression. Personality changes characterized by irritability, anger outbursts, apathy, and poor insight are not uncommon. These changes can lead to significant interpersonal problems and poor job performance.



It is important to understand that various psychiatric disorders can coexist. For example, a person

suffering from depression may also have significant panic disorder, while depression is far too often present with post-traumatic stress disorder. A comprehensive psychiatric evaluation should include screening for these different disorders.

Some Parting Thoughts

Some have called the 1990s "The Decade of the Brain". Groundbreaking research has led to substantial advances in understanding and treating mental disorders. For example, the availability of various brain imaging techniques has shed more light on how various psychiatric disorders may be the result of anatomic and functional changes in different areas of the brain. This has given validity to mental illnesses as "physiological" disorders.

Finally, the evolving field of psychoneuroimmunology has helped us understand how stress leads to alterations in brain chemistry and physiology, which in turn may affect our immune function, exacerbate or precipitate mental illness, or cause physical ailments.

Footnotes

[1] International Labor Office, World Labor Report 1993, Geneva, United Nations International Labor Office, 1993.

[2] Jordan v. Central Piedmont Community College, 476 S.E. 2d 410, N.C. App., 1996; Toler v. Black and Decker, 518 S.E. 2d 547, N.C. App., 1999; Calloway v. Memorial Mission Hospital, 528 S.E. 2d 397, N.C. App., 2000.

[3] P. Holland, Psychiatric Aspects of Occupational Medicine, Handbook of Occupational Medicine, McKunney, R. (ed),. Boston, Little, Brown, 1988.

[4] Goli V., Fozdar M. Chronic Pain and Depression, TEN (Trends in Evidence-Based Neuropsychiatry), 2002;4(2):40-47.

[5] Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, American Psychiatric Association.

HEPATITIS, continued from page 8

about 90%. If the EIA test is positive, then further testing is necessary to confirm the diagnosis, and usually the PCR test or specific genetic testing is used for this purpose. The gold standard for diagnosing and evaluating the progression of Hepatitis C is a liver biopsy.

Individuals who carry HCV may also be identified by increased levels of certain liver enzymes. These include alanine aminotransferase (ALT), as well as gamma glutamy transpeptidase (GGT) enzymes, among others. However, there are reported cases where a liver biopsy has confirmed the presence of the Hepatitis C virus but there are no elevated liver enzymes as well as no symptoms.

About 85% of HCV infected individuals fail to clear the virus by 6 months and usually develop chronic hepatitis which, again, may or may not have symptoms. Individuals with chronic HCV generally experience a gradual progression of the disease over periods of 10 to 40 years. Individuals with chronic HCV also generally show high ALT and AST levels which reveal ongoing liver damage. However one cannot reliably predict the severity of liver damage based on elevated blood chemistry. Epidemiology of HCV indicates that about 20% of patients with chronic Hepatitis C develop cirrhosis and of those patients about 25% develop liver failure and die.

Current treatment for Hepatitis C is somewhat limited but includes the drug Interferon Alpha 2 B and a new Interferon cocktail that is currently on trial. The Interferon treatment is given by injection and has many significant side effects including flu-like symptoms, headaches, fever, fatigue, loss of appetite, nausea and vomiting. The side effects of Interferon can be disabling while the chronic nature of Hepatitis C may or may not be disabling. In terms of response to this treatment, approximately 50% initially respond positively; however, the long term positive response rate to interferon treatment is approximately 20%. While this treatment can reduce the presence of HCV, there is no current cure for the virus. Hepatitis C as an occupational disease in a potential workers' compensation claim requires careful analysis and scrutiny of the specific facts of the case. Since diagnosis can occur many years after the exposure it is important to review pertinent statutes of limitation. Frequently, individuals learn they have Hepatitis C while doing routine blood work to change their life insurance policy or when giving blood at the American Red Cross, which started a screening process in 1991. Because they have no disability they usually do no consider filing a claim.

The Center for Disease Control has an excellent web site with a specific Hepatitis C page which can be found at *www.cdc.gov/ncidod/diseases/hepatitis/c/index.htm.* The Hepatitis Foundation International has a website at *www.hepfi.org* and provides advocacy for individuals with Hepatitis C. There are also numerous support groups and other information sources on the web.

Medical Corner

Dealing with the Difficult Doctor

By Leonard T. Jernigan, Jr.
Raleigh, NC

Leonard T. Jernigan, Jr.

Leonard T. Jernigan, Jr. practices workers' compensation and personal injury law in Raleigh, NC. He is a charter member of WILG and has served as WILG President during 2001-02. He has been Chair of ATLA's Workers' Compensation and Workplace Injury Section, and has served on the Board of Governors for the North Carolina Academy of Trial Lawyers. Len is author of *North Carolina Workers' Compensation Practice*, has been an Adjunct Professor of Law at North Carolina Central University Law School, and has been a frequent lecturer and author on issues of North Carolina personal injury and workers' comp law. He has a B.A. from the University of North Carolina, and a J.D. from North Carolina Central University.

I. Introduction

A doctor's opinion is crucial to every worker's compensation claim. Most doctors give honest and rational opinions as to disability, permanency and causation. As we all know, however, there are some physicians who have a different agenda and either do not take the time to properly evaluate a patient or they intentionally downplay the potential seriousness of the injury. The following steps may help in your search for the truth.

II. Some Potential Solutions

1. **Check credentials.** It is a strange but true fact that some experts have falsified their curriculum vitae. If a physician has lied about his qualifications, his expert opinion just went out the window. One way to verify credentials is to check the American Medical Association's web page (http://www.amaassn.org). Select "Doctor Finder" and then follow the instructions until you get to "Find a Physician" and type in the name, address and zip code. If you are seeking a specialist, a doctor certification can be checked by phone with the AMA. For medical doctors call (800) 776-2378. For osteopathic doctors call (800) 621-1773, ext. 7445.

2. **Check disciplinary records.** According to the Federation of State Medical Boards 4,432 disciplinary actions were taken against 3,880 physicians in 1996. There are approximately 650,000 licensed physicians in the United States. The Federation is responsible for promoting high standards for licensure and practice, and serves as the primary center for collecting, monitoring and reviewing actions taken against physicians. (A full report can be obtained by calling (817) 868-4000. The report is also available on their web site (http://www.fsmd.org/b_action.htm). Sidney Wolfe, a physician who is director of the Public Citizens Health Research Group (a consumer watchdog organization) has analyzed this document and his report can be obtained by calling (202) 588-1000. You can also obtain a list of "Questionable Doctors" from Public Citizen for each state.

3. **Communicate, communicate, communicate.** It is important to find out as much as you can about the

physician involved in your case. See if he is listed on the internet. If he has written any articles, see what the focus is. Ask other physicians, nurses, hospital employees and others in the community about this person.

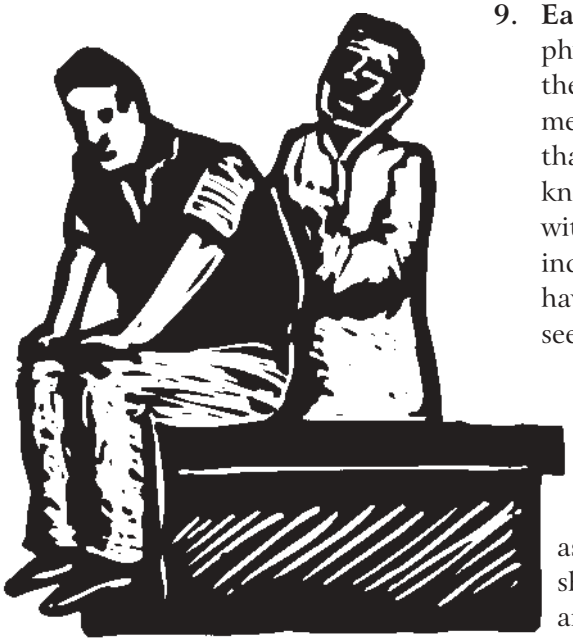
Now, with this information in hand, schedule an appointment to talk with the doctor. Try not to schedule it during his lunch break, or while he is seeing patients. You want his undivided attention and you will not get it if he is thinking about some medical crisis sitting in the next room.

4. **Build a relationship.** In workers' compensation cases you are likely to see the same physician over and over again, particularly if you practice in a small town. If you have a private conference with your doctor and you receive a bill, pay it promptly. I have been absolutely amazed at how many doctors have been stung financially by some lawyer in the past; unfortunately, that physician now holds it against me personally, as though all lawyers are to blame.

5. **Take your client to the deposition.** Whenever I have a situation where I am convinced the physician is about to denigrate my client or try to personally attack the client's credibility, I take the client to the deposition. It is extremely difficult for the doctor to look his patient in the eye and assert malingering.

6. **Be honest with the physician.** There are often serious problems related to the case. The better policy is to bring these to the attention of the doctor and discuss them up front. If you won't, the defense lawyer will. You will then get a strange look from the physician as you see him wondering why he was never given this information. It may change his mind about how he views the case in its entirety. Often you are unable to repair the damage.

7. **Explain the burden of proof, causation, and the system.** Although most doctors don't watch a lot of television, it is hard not to watch any without some type of litigation, and it is usually criminal law. "Beyond a reasonable doubt" is not the



standard used in workers' compensation cases and you want to make sure the doctor has a clear understanding about the burden of proof. Physicians are also trained to believe that something is not true unless blind studies can prove it to an absolute certainty. We often tell them that the greater weight of the evidence is all that is needed, and that simply means 51% in the medical-legal context. In some instances, this information has been a revelation to the doctors on causation issues.

8. **Explain case procedure and why you are there.** Unfortunately, I had the experience of walking into a deposition where the first question from the physician was "What's going on and what's this got to do with me?" Just prior to a deposition is not the time to be answering this question. Some physicians never have had their depositions before and are unnerved at the prospect. Explain the process and explain the necessity for the medical testimony.

9. **Ease tension.** Behind every physician-patient relationship there is the potential for a medical negligence claim. Ease that fear by letting the doctor know that the client is pleased with the care the doctor (if indeed that is true). She may have reviewed the chart and seen something that concerns her, so reassurance of this nature is vital. If you are aware of a potential medical negligence claim, choose your words carefully. I can assure you she will. You should not misrepresent anything concerning this issue.

10. **Know the medicine.** Some of us think doctors keep up with all the latest articles and studies concerning relevant medical areas. HMOs, PPOs, and other managed care organizations barely pay them for seeing patients. "Reading medical journals" is not under the pay provision of most insurance contracts. Therefore, understand and become familiar with the medicals terms involved in this case, have a theory on causation, and search for the latest articles on

the subject. Tell the doctor that she is the expert and you are just trying to understand the medicine, and you are well aware that a non-expert with a little bit of knowledge can be dangerous.

11. ***Ex Parte* Communications.** Each state differs as to whether a defense lawyer or adjuster can communicate with a treating physician without the express consent of the patient/client. Fortunately, a North Carolina case prohibited such contact. The remedy was to strike the deposition of the doctor involved. This was a hard remedy for the defense, but it has cured this particular problem, especially as to defense lawyers poisoning the well. It is a case worth reading, and I recommend it to you. *Salaam v. Department of Transportation*, 122 N.C. App. 83, 468 S.E.2d 536 (1996). In those states that do not prohibit *ex parte* communications, I would not hesitate to urge you to continue to challenge these rulings.

12. **Follow-up.** Basketball fans know that most free-throws don't go in unless the shooter has a good follow-through on the shot. Simply jerking the ball toward the basket reduces its changes of success. Similarly, if you are building a relationship with a doctor or his staff, you should follow through after the case is over. If the doctor has been particularly helpful, be sure to thank the doctor in writing and/or send a gift.

13. **Be prepared to destroy credibility.** Some doctors are paid to destroy your case. Some doctors will even step across the line and give false testimony about medical care. They will be more likely to do this if they can do it successfully without any penalty. Under these circumstances, an attorney should be prepared to take appropriate action. Don't hesitate to attack their credibility, and if properly documented, report these individuals to the appropriate licensing boards and peer review groups at hospitals, etc.

III. Conclusion

Just as you investigate doctors and "ask around" about physicians in your community, I suspect the doctors do the same about you. If you are an honest, fair, and competent attorney it will be reported back. If you are not, that will also be reported back. Keep in mind that it takes years to build a reputation but it can be destroyed overnight. The best advice to any attorney is to maintain high standards of integrity and competency and to treat all persons, physicians or otherwise, as you would like to be treated. I can assure you it will pay rich dividends over you long career.

Cooperative Agreement Reached

By Todd McFarren, WILG President

A meeting held in Chicago in early March 2005 between the leaders of WILG and IWJ* produced an agreement to cosponsor a Workers Justice Summit in the Fall of 2005. Building on WILG's prior labor summits, this one will reach out to injured workers' organizations and other groups struggling for worker justice, in addition to our friends in unionized labor.

Thanks to Deb Kohl (WILG President-Elect), Paul McAndrew (Vice-President for Education) and Tom Domer (Chair of the WFW Editorial Board) for their excellent articulation of WILG's goals and accomplishments.

Special thanks to the indefatigable Bob DeRose (WILG Secretary) for bringing the two groups together and facilitating a successful meeting. Finally, it was John Boyd (WILG Immediate Past President) who engineered the foundation upon which this agreement stands. His presentation of the history of WILG was the clincher; it should be taped and distributed to all our members. The Worker Justice Summit is planned for September 29-October 1. Mark your calendar now.

* IWJ (the national organization of Interfaith Worker Justice) was founded in 1996 and is committed to strengthening workplace justice. Its mission includes educating, organizing, and mobilizing the U.S. religious community —as well as working with other organizations— on issues and campaigns to improve the wages, benefits, and working conditions for workers, especially low-wage workers.

WILG Hosts Worker Justice Summit

WILG is sponsoring –in conjunction with IJW and the Missouri AFL-CIO– a "Worker Justice Summit" in Kansas City, Missouri on September 29 through October 1, 2005.

Leaders from across the United States, whose stewardship is essential for protecting and restoring justice for workers and their families, will discuss strategies for accomplishing this mission. Formerly known as a Labor Summit, this year's Summit is renamed to reflect the expanded role of many coalition partners who share these interests.

Currently, the schedule calls for:

Thursday, Sept. 29	Registration & welcoming cocktail reception (WILG Board meets 4:00 – 6:00 pm)
Friday, Sept. 30	Worker Justice Discussions and Educational Sessions: 8:00 am – 4:00 pm
Friday, Sept. 30	Catered Dinner for attendees, held at the Truman Library, with tours of the facilities and special entertainment
Saturday, Oct. 1	Worker Justice Discussions and Educational Sessions: 8:00 am – 4:00 pm

A Simple Guide to the MMPI-2 for the Unversed and Uninitiated Attorney

By Hugh Cox
Greenville, NC

Hugh Cox

A single practitioner in rural eastern North Carolina, Hugh practices workers' compensation, Social Security, and veterans' VA service-connected benefits. He is licensed as an attorney in North Carolina and the District of Columbia (inactive). His practice includes cases in the North Carolina Courts and Industrial Commission, Federal District Courts, U.S. Court of Appeals for Veterans' Claims, U.S. Court of Appeals for the Fourth Circuit, and the U.S. Court of Appeals for the Federal Circuit. His legal memberships include WILG, National Organization of Social Security Claimants' Representatives (NOSSCR), National Organization of Veterans' Advocates (NOVA), NC Academy of Trial Lawyers, American Trial Lawyers Association, and local and state bar associations. His law school degree is from North Carolina Central University in the Class of 1974. To contact: hughcox@hughcox.com or www.hughcox.com.

Some Basics:

- The Minnesota Multiphasic Personality Inventory 2 (MMPI-2) is one of the most validated clinical tests employed by psychologists to identify psychological adjustment factors. The copyright for the MMPI, MMPI-2 and MMPI-A is held by the University of Minnesota.
- The test is used throughout the world in many languages. The original MMPI was developed in the 1940s for psychiatric and medical screening. In the early 1980s, the MMPI-2 was developed to update the MMPI with minor "fine tuning". The MMPI-A was later developed for use with adolescents.
- The original MMPI contained 566 true - false questions. The MMPI-2 contains 567 true – false questions. There is no time limit for taking the test. The usual time required for taking the test is one to two hours.
- The MMPI-2 is relatively easy to score and the scoring can be easily computerized. The MMPI-2 is an objective test rather than a subjective one. The test measures specific "scales". These scales present clear and valid descriptions of personality, psychological symptoms and other acceptable clinical factors.

The Scales:

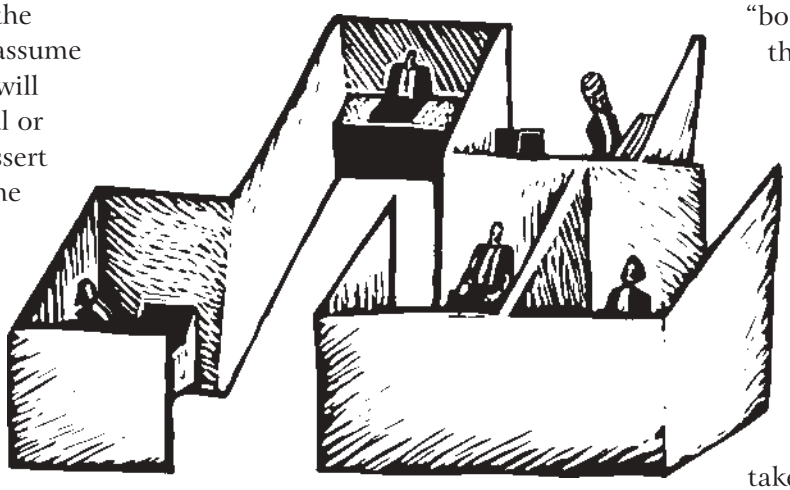
- Generally the test taker who fails to answer 30 items or more of the first 370 items is presumed to have a invalid test. Thirty or more omissions beyond item 370 affect *supplemental* content scales.
- The "L" scale measures an individual's ability to volunteer negative self-information. An L score of greater than 65 generally identifies an individual who is not willing to volunteer negative information. Such a score renders the test invalid.
- The "K" scale measures defensiveness and denial. Many other MPI-2 scales are derived from the K scale.
- The "F" scale measures the tendency to exaggerate psychological problems.
- There are two consistency scales identified as "VRIN" and "TRIN". With 567 questions, a psychologist can compare combinations of similar questions to test consistency. Inconsistency renders the test invalid. All of the above scales measure validity.
- The *clinical* scales measure psychological factors. Generally, a score in excess of 65 would suggest a possible psychological concern or issue. "D" is for

depression. "Mf" is for sexual identity. "Pa" is for Paranoia. "Hs" is for hysteria. "Hs" is for hypochondriasis. "Pd" is for psychopathology. "O" is for introversion. "Ma" is for Hypomania. "Pt" is for anxiety. "Sc" is for schizophrenia.

- There are approximately 20 other *supplemental* clinical scales measuring such specific problems as addiction proneness, obsessiveness, work attitudes, and post-traumatic stress disorder. For instance, the "*Pk*" and "*Ps*" supplemental scales measure and identify post traumatic stress disorder (PTSD) with considerable accuracy.

Some Legal Assumptions:

- When the plaintiff is notified that the defense wishes to give an MMPI-2 evaluation, the plaintiff's counsel must assume that the defense experts will selectively use the clinical or supplemental scales to assert information adverse to the plaintiff's case.
- The MMPI-2 does not measure pain. It only measures psychological effects of pain.
- Most physicians are not "licensed" to give the MMPI-2. Most test givers are clinical psychologists who are permitted and "licensed" to give the test. It is critical that the actual test giver be cross-examined before the physician who relies on the results of the MMPI-2. The usual sequence of events arranged by the defense is that the plaintiff's attorney must cross-examine a physician who did not administer the MMPI-2 test to the plaintiff.
- Many psychologists refuse to give the "raw" test data to any attorney. Numerous articles are published in psychology literature "guiding" psychologists in avoiding "discovery" of the basic test answers. These tactics include: (1) citing that the test is copyrighted; (2) that the test cannot be shared with anyone but a trained psychologist; and, (3) requiring the attorney to subpoena the test results and answers. Sometimes a complaint by the test taker to the appropriate state regulation board will produce the desired results. The two most important documents for the plaintiff's case are the test answer sheet and the basic profile scores (it resembles a graph sheet).



- Increasingly, psychologists do not give the full 567 questions to the test taker. The U.S. Department of Veterans Affairs (formally the Veterans Administration) routinely allows their retained psychologists to give only the first 300 questions of the MMPI-2. The plaintiff attorney must question the client test taker carefully to determine how many questions were actually answered (the injured worker should testify that he was instructed to "stop" taking the test before completion). Many psychologists believe (and will testify) that the MMPI-2 test cannot be valid when only 300 questions are answered. Almost every psychologist will admit that answering 300 questions cannot render or produce valid supplemental clinical scales. As one treatise states, "Some MMPI-2 users consider any protocol invalid and uninterpretable that has more than 30 omitted items or a T scale greater than 65 on one or more of the standard validity scales."
- Many MMPI-2 reports are computer-generated. Most of these computer-generated reports have standard "boilerplate" language that the test taker's results may be affected by "secondary gain", "legal outcome", or "exaggerated" responses (somatoform). In fact, the only way to eliminate such inappropriate language is for the clinical psychologist to take extra time to edit the computer-generated test results.
- Most triers of fact will consider the word, "somatoform" as the equivalent of the "malingering".
- Without the complete tests results, the plaintiff's attorney may never know that the defense medical expert selectively chose only factors to harm the plaintiff's case. Indeed, the defense attorney or psychiatrist may not know the test scales were invalid.

Some Advice for Attorneys:

- The best expert for the plaintiff attorney is a clinical psychologist who is actually licensed to give the MMPI-2.
- The plaintiff's attorney should never submit to a deposition of the defendant's physician or psychologist until the "raw" test results and basic profile scores are obtained beforehand. The test giver should be deposed first.
- A lower cost alternative is an authoritative treatise about the MMPI-2. Such a text is *The MMPI, MMPI-2 & MMPI-A in Court – A Practical Guide for Expert Witnesses and Attorneys* by Pope, Butcher and Seelen as published by the American Psychological Association in 1993 (ISDN 1-55798-182-5). Another treatise is *MMPI-2, Assessing Personality and Psychopathology* (Third Edition) by John R. Graham published by Oxford University Press in 2000 (ISBN 0-19-511481-7).
- The plaintiff's attorney must be prepared earlier rather than later. The deposition is not the time to learn about the MMPI-2.
- Fortunately, most psychiatrists or physicians know very little about the MMPI-2 and are not licensed to give the test. They are vulnerable to cross examination questions like, "Doctor, do you know what the "*Pd*" scale measures?" And "Do you know the MMPI–2 clinical or supplemental scale score to validate your diagnosis?" Once a physician admits that he is not familiar with the MMPI-2 scales, the physician may open the door to deposition of the MMPI-2 test giver.
- The plaintiff's attorney should be prepared to force the defense psychiatrist or clinical psychologist to admit that the MMPI-2 test results may show other favorable conclusions to help the plaintiff's case. For instance, the "WRK" supplemental scale score measures attitudes toward work. A plaintiff within the normal range could generally be considered a "satisfied and good worker".

Conclusion:

- Medical opinions are generally for sale to the highest bidder. This "market" and the current political dynamics give significant advantage to the defendant's attorney. Such advantage may be overcome by the plaintiff attorney's preparation and experience.
- The plaintiff's choice of psychologist or psychiatrist is critical. Any plaintiff medical provider who can show exemplary care, but disinterest in the legal outcome, can enhance the plaintiff's chances for justice.
- The plaintiff's attorney must reveal the "biased" conclusions of the defendant's psychological or medical experts – and the lack of experience using the validity, clinical and supplemental scales.
- The complexity of the MMPI-2 –even for psychologists– can assist the plaintiff's attorney in reaching the truth about psychiatric disability.

FOOD, continued from page 14

"What's in the Meat?" has received the most media attention because it frightens the consumer of fast food. This chapter explains how unsafe, unclean and unregulated the meat we eat actually is. Talk shows had a feast with this topic (pun intended). We all need to know about how E-coli threatens so many of us. Public shock over how little the fast food nation cares about what we eat put this well written and well-documented book on the New York Times bestseller list for three months or so.

Every congressman, senator, governor and state legislator in America should read this book. Trial lawyers and trial lawyer organizations should know this book because it tells what happens if an industry is allowed to run itself without regard for the public.

If enough people of good conscience had known of the abuses, perhaps we would not be subsidizing huge entities to create low paying dangerous jobs that exploit the most vulnerable workers and their families in our society.

Hopefully, if more of us learn the whole story of this segment of our society, we can begin to make some changes that will benefit our clients, their families and our fellow citizens. Please read the book.

Malingering – Are the So-Called "Objective Tests" Reliable?

By Jay Causey
Seattle, WA

Jay Causey

Jay Causey has practiced in Seattle for over 27 years in workers' compensation and other forms of disability law. He served as WILG president for a two-year term, from 1999 to 2001, and has been a Board member since the group's inception in 1995. He is past chair of the workers' compensation sections of both Washington State Trial Lawyers' Association and ATLA, and is a Charter member of the National Organization of Social Security Claimants' Representatives. From 2001 to 2004, he was the editor and publisher of WILG's periodic magazine, *Workers First Watch*, and continues to serve as Executive Editor of WFW. In 2003 he received a WILG Service Award his various roles in the organization.

He is a graduate of Yale University and the University of Washington School of Law.

You're faced with the standard situation: the client has undergone what is styled as "successful" low back disc surgery. Post-surgery tests look "good", other than "typical" degenerative changes. The attending physician can't understand why your client continues to complain bitterly of intractable pain and inability to function.

When queried by the comp insurer, the AP demurs, suggesting referral for a functional capacity assessment (FCE) by a physical therapist. The carrier also schedules an IME. The FCE reports "nonorganic signs" and a suboptimal effort by your client, inferring malingering. The IME notes "positive Waddell's signs" and "essentially" negative post-surgery imaging, concluding your client should be able to work. Compensation is terminated.

This typical scenario invokes potentially five major indices for the carrier to assert your client is malingering, or is at least consciously magnifying symptoms:

(1) Diagnostic tests, such as CT scan, MRI or EMG

(2) Waddell's signs

(3) Functional capacity assessments (FCEs)

(4) Variability of performance on physical exam

(5) MMPI-2 testing.

An excellent article in the November 1999 issue of the North Carolina Academy of Trial Lawyers TRIAL, written by a currently sitting ALJ for the Social Security Administration, highlights the inherent weaknesses of these tests when used to "prove", or support, the allegation of malingering. A reading of the complete article and footnotes is recommended, but the author's following points may serve as helpful reminders:

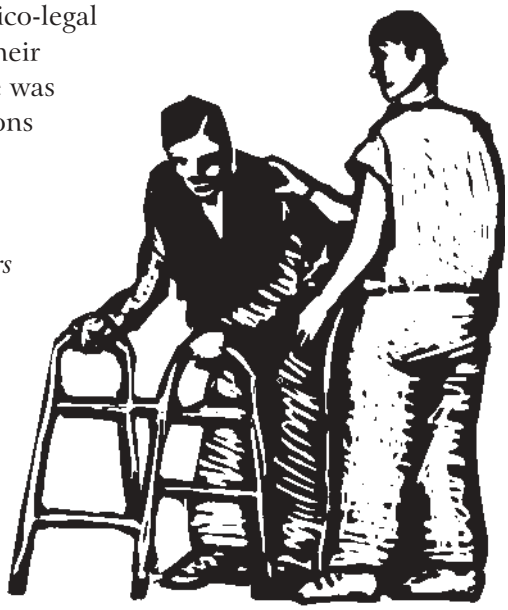
Diagnostic Tests

- CT scans do not generally reveal soft tissue pathology, and even MRIs will not show early histopathologic changes in tissue.
- There is weak correlation between MRI findings and back pain: 30% of *asymptomatic* patients have abnormal MRI findings, and 42% of subjects *with no low back pain* have radiographic criteria for lumbar segmental instability.
- An EMG will not be positive until *3 weeks* after onset of symptoms, and may be a "false negative" if a back case does not involve *radicular* pain.

- Assuming there is a basis for finding valid pain complaints, no diagnostic test can reliably be used to assess the *severity* of the pain.

Waddell's Signs

- Although "positive" signs are frequently used as an indication of faking or simulated incapacity, Dr. Waddell recently co-authored an article asserting that the test was never intended for this purpose, and that the signs have been misinterpreted and misused in medico-legal assessments. Their original purpose was to identify persons *whose physical recovery might be affected by psychosocial factors and who might need this type assessment or treatment.*



- Waddell's signs may not accurately rule out an *organic* basis for pain: tenderness tests are deemed "positive" if they don't follow a pattern associated with nerve root irritation, but structures other than the nerve root can lead to pain over a broad area.
- The "overreaction" test is highly subjective, and can be greatly affected by past experience, cultural background and socioeconomic status.

Functional Capacity Evaluations

- There are as many as ten formats for FCEs, much variability in measurements obtained, measuring instruments used, etc, and a variety of professionals from different disciplines, all contending for certification, criticize their competitors' principles and approaches as invalid.
- Only one of ten FCE formats has been the subject of a validity study published in a peer-reviewed journal.
- Typical 2-4 hour FCE testing is not followed by a "next day" assessment, so it does not reliably measure the capacity for consecutive 8-hour day work activity.
- Range of motion testing does not correlate well with levels of functioning, according to recent studies.
- "Sincerity of effort" tests, such as grip strength, have been shown in recent studies to have questionable validity.
- Results of isometric or isokinetic tests used in some FCEs have been shown in recent studies to correlate poorly with performance of functional activities.

Variability of Performance

- Recent studies indicate that variability in performance during a repeated movement test, often characterized as "giveway weakness", is a characteristic of the task itself and not an indication of questionable motivation.
- A recent article says that reduction of effort on successive testing can be due to a number of factors, such as pain, fear of injury, physiologic perception of excess load, neuromuscular inhibition, or other psychological factors.

MMPI-2 Testing

- A recent article espousing the predictive validity of parts of the MMPI-2 in back pain patients cautions consideration of the self-report nature of the data, and to view the results as "hypotheses" needing empirical testing.
- Another recent article states that attempts to categorize a typical pain profile with the MMPI-2 have been unsuccessful, and the results have been inconsistent.
- Yet another recent article indicates that none of the MMPI-2 indices appear sufficiently reliable for predicting malingering.

Vibration Disease in the Workplace

By Stephen Embry
Groton, CT

Stephen Embry is a founding member of WILG, and served as its president from 2002-2003. He graduated from the American University in 1971 and the University of Connecticut Schoolof Law in 1975. He is a past Chairman of ATLA Workers' Compensation Section. He is editor of the *Longshore Textbook*, and is national speaker on issues of workplace safety and workers' compensation. He practices in Groton, Connecticut with the firm of Embry and Neusner.

In the early part of the twentieth century, stonecutters in Bedford, Indiana made the transition from hand held hammer to pneumatic tools. The new air powered hammers were a technological marvel promising increased productivity with a reduction of effort. However, within a few years many of the workers began complaining of a strange new malady. The workers' hands would grow numb and their fingers would turn white. The workers suffered from lack of grip strength, and had difficulty performing routine tasks such as picking up small articles, or fastening buttons.

Local physicians suspected that the condition was work related and requested help from the United States Bureau of Labor, which sent Dr. Alice Hamilton to investigate. After examining a number of the workers, she found that 89% had "dead hand", caused by the vibration produced by the machines drilling through the limestone rock.

Dr Hamilton gave a classic description of the effect of the affliction in on of the workers:

> "He had been out of doors for over an hour and in order to be able to show me his hands in a typical condition he had refrained from rubbing them violently and swinging arms about, as he would ordinarily do to restore his circulation. The discomfort, however, had grown so intense in his fingers that he could not bear it any longer and almost at once after I had arrived he began rubbing and kneading and shaking his hands. The four fingers of his left had were a dead greenish white and were shrunken, quite like the hands of a corpse"[1]

Since Dr. Hamilton's study, thousands of similar injuries have been reported in a wide variety of industries. In the early 1960's, an epidemic of vibration white finger in Scandinavia lead Sweden to begin regulating the amount of vibration exposure allowed of forestry workers. Chain saw manufacturers responded by developing anti-vibration saws that placed rubber shock absorbers between the saw handles and the machine body. This simple engineering change, coupled with modest employment rule modifications, resulted in a dramatic drop in the incidence of disease in sawyers.

However, when the scientific community moved to improve other products and work processes they were met with intense resistance. In the early 1970's, the International Standards

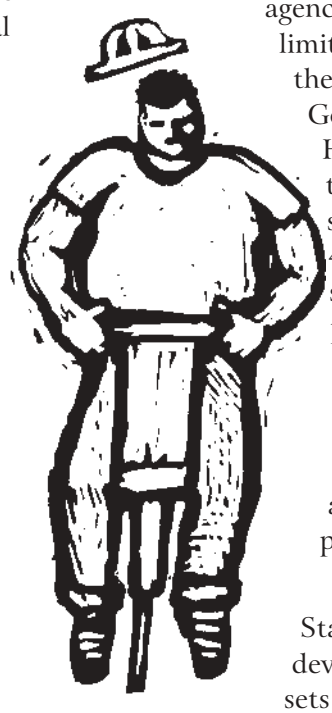
Organization proposed a simple standard for the measurement of vibration, which was opposed by American trade groups who expressed fear that regulation would follow measurement.

The American manufacturers of pneumatic tools also acted in conjunction with European manufacturers to delay and discourage the use of warning labels to advise workers about the dangers of vibration. In fact, in the mid 1980's the British Health and Safety Executive advised tool manufacturers that the risk of vibration injuries was so great that warnings were required to be placed on their tools, and that mere instruction in operator's manuals was not adequate. The manufacturers responded by urging that the vibration-warning symbol be removed from a proposed standard of industrial warnings, and by discouraging the use of warning on their tools.

In the late 1970's, after tests in Europe had established that standard methods of vibration measurement were reliable, the Europeans proposed that this information be shared with NIOSH, which had begun a study of vibration disease in the Untied States. The Compressed Air and Gas Institute, the American trade organization for the pneumatic tool manufacturers, requested that this information not be shared with American public health authorities, and the Europeans agreed to withhold this information from the public.

Consequently, thousands of operators of pneumatic and electric powered grinders, chipping hammer, needle guns and impact wrenches continue to develop the disease. In 1985 large numbers of grinders at the General Dynamics shipyard in Groton, Connecticut were found to have vibration disease. Studies performed by the Yale University Occupational Health Clinic found that nearly 80% of the grinders in the shipyard had hand arm vibration disease, and carpal tunnel syndrome.

The disease has a number of names: dead hand, vibration white finger, hand arm vibration syndrome, or Reynauds disease of occupational origin. Regardless of the name used, the symptoms are consistent and debilitating.



The first symptoms are usually tingling of the fingers, which gradually spreads down the finger to the hands. Continued exposure to vibration results in blanching or whitening of the fingers caused by vasospasm of the circulation of blood in the fingers.

If exposure continues, the blanching will come more frequently and increase in severity. Since cold weather and not vibration provoke the attacks, many workers and their physicians fail to make the connection and misdiagnose the disease as carpal tunnel syndrome, or thoracic outlet syndrome.

As the condition progresses, it causes damage to the nerves and blood vessels of the hands, which often is permanent. Vibration also contributes to the development of disease of the median nerve as it passes through the carpal tunnel. In rare cases the disease may progress to gangrene, and may trigger reflex sympathetic dystrophy.

Development of the condition is largely a function of the dose of vibration to which the worker is exposed. The dose is usually expressed in terms of acceleration measured in meters per second squared.

A number of standard setting agencies have suggested daily limits for exposure. In 1984 the American Conference of Government and Industrial Hygienists adopted a threshold limit value that set permissible exposure at 4 meters per second squared for 4 to 8 hours per day, 6 meters per second squared for 2 to 4 hours per day, while vibration levels of 8 meters per second squared are limited to 1 to 2 hours per day.

The International Standards Organization has developed a guideline that sets standard for measuring vibration and which predicts the effects of vibration exposure on workers.[2] The American National Standards Institute has adopted similar standards. [3]

In general, as the level of vibration increases, the incidence of the disease also increases:

- At 2 meters per second squared, 10% of workers are likely to get the disease in 15 years.
- At 5 meters per second squared, 10% of the population will develop the condition in 6 years.

The condition has been specifically noted by the American Medical Association, which provides in the *Guides to the Evaluation of Permanent Impairments*[4] an impairment rating as high as

90% to 100% of the whole person in severe cases.

Recently, nearly 400 cases arising from General Dynamics were settled with the manufacturers of pneumatic tools after a remand from the Connecticut Supreme Court, which specifically noted: "we conclude that the jury properly concluded that the defendants tools had been defectively designed."[5]

The hazardous effects of vibration have been discussed in hundreds of studies dating back to the early part of the century. NIOSH recently reviewed the medical literature and concluded there is substantial evidence that as intensity and duration of exposure to vibrating tools increase, the risk of developing HAVS increases. Most of the studies showed a positive association between high level of exposure to HAV and the vascular symptoms of HAVS. Many of the studies reflect there is a strong association between HAVS and exposure to vibrating tools in the work place.

The temporal relationships and consistency between exposure and symptoms of HAVS are well established in these studies. The mechanisms by which HAV produces neurological, vascular, and musculoskeletal damage are supported by some experimental evidence. Many of the studies have shown an exposure-response relationship between dose exposure of HAV and the prevalence and symptom severity of HAVS.[6]

[1] Bureau of Labor Statistics, U.S. Dept. of Labor, Bull. No. 18 (Industrial Accident & Hygiene Series No. 19)

[2] International Standards Organization, Standard for the Measurement of the Effects of Vibration on the Human Hand, ISO 5349.

[3] ANSI

[4] American Medical Assoc., Guides to the evaluation of Permanent Impairment, 4th Edition, 1993

[5] Potter v. Chicago Pneumatic Tool Co. 694 A 2nd 1397 (Conn. 1997)

[6] Musculoskeletal Disorders and Workplace Factors, NIOSH July 1997

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- occasional referrals from other WILG members; and,
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