Commentary

To Ask or Not to Ask: The Critical Role of the Primary Care Provider in Screening for Occupational Injuries and Exposures

Amy K. Liebman and Michael Rowland

Occupational injuries and illnesses are among the most prevalent patient care issues for clinicians working with migrant and seasonal farmworkers and other vulnerable patients migrating for work. Largely from Mexico and other Central American countries, migrant patients are a unique segment of the workforce in the United States. Factors such as lack of training, poor safety precautions, lack of health insurance, overrepresentation in dangerous industries, language barriers, piece-rate pay, undocumented worker status, and geographical and cultural isolation can put these workers at increased risk for occupationally related injuries and illnesses and long-term sequelae. Migrant workers are disproportionately represented in occupations with high injury and death rates, such as agriculture, forestry, and construction. Exposure to pesticides is a particular concern to migrant and seasonal farmworkers and their families.

Frontline providers caring for migrants, like the majority of primary healthcare providers, generally do not bring an occupational and environmental health perspective to their work with this population. The most basic tool to recognize such injuries and exposures is an environmental and occupational history. Pesticide poisonings and other occupational injuries may go unrecognized owing to the failure to take a proper exposure history.

In a study of North Carolina health department staff published in this journal in March 2008, Tutor and colleagues[1] found limited use of tools to screen for pesticide exposures in perinatal migrant patients and showed that staff is inadequately trained to effectively engage in pesticide exposure surveillance and prevention activities. In a commentary in the same journal volume, a health department director supported the study findings but suggested that screening for pesticide exposure is an inefficient use of time.[2]

Given the competing demands and severe time constraints in a primary care setting, we realize that healthcare providers struggle with ways to incorporate occupational medicine practices into their day-to-day efforts if they include them all. Taking an environmental and occupational history can seem daunting.

Migrant Clinicians Network (MCN), an international nonprofit organization with more than 5 000 healthcare-professional constituents caring for the mobile underserved, recognizes both the importance of identifying occupational injuries and exposures and the reality of the pressing demands and constraints facing the primary care providers. MCN believes, nonetheless, that being able to recognize occupational diseases and injuries is fundamental to providing quality primary care to migrants. With migrant workers, there is often no distinct line between basic occupational medicine and primary healthcare. Through a cooperative agreement with the Environmental Protection Agency, Office of Pesticides, MCN's program *Saving Lives by Changing Practices* offers training and resources to help migrant clinicians use a few key screening questions and integrate occupational medicine into the primary care setting.

Funding for the project *Saving Lives by Changing Practices* was provided by the Environmental Protection Agency, Office of Pesticide Programs (T-832731-01).

Corresponding Author: Amy K. Liebman, MPA, MA, Environmental and Occupational Health Initiatives, Migrant Clinicians Network, 5210 River Circle, Quantico, MD 21856 (aliebman@migrantclinician.org).

Amy K. Liebman, MPA, MA, is Director, Environmental and Occupational Health Initiatives, Migrant Clinicians Network, Quantico, Maryland.

Michael Rowland, MD, MPH, is Medical Director, Maine Migrant Health Program, Augusta, Maine.

J Public Health Management Practice, 2009, 15(2), 173–175

Migrant Clinicians Network recommends three brief screening questions for occupational and environmental exposures that could be incorporated into existing healthcare questionnaires that are used for routine patient-intake interviews:

1. Occupation: Describe what you do for work.
2. Activities and cause: Are there any physical activities that you do—at work or away from work—that you feel are harmful to you?
3. Substances/physical hazards and cause: Are you exposed to chemicals, fumes, dust, noise, and/or high heat at your work or away from work? Do you think these are harming you?

It is important to further examine the critical reasons to screen for occupational and environmental injuries and exposures. The rationale includes the following:

1. Pesticide-related diseases can present similarly to common medical conditions and often display nonspecific signs and symptoms. Without knowledge of patients' exposure history and occupation, such pesticide exposures can go unrecognized, potentially causing further illness or exacerbating an existing condition.
2. Screening for pesticide and other occupationally related exposures and injuries may give the provider an indication of a sentinel event. Migrant workers are largely employed in occupations that are inherently risky, and they are more likely than other workers to be either exposed to hazardous substances or injured on the job. Agriculture and construction are two of the most dangerous occupations. While the Environmental Protection Agency-administered Worker Protection Standard offers a set of guidelines to protect farmworkers, there is simply not enough enforcement, and not all growers follow the rules accordingly. Other occupations such as construction are regulated by Occupational Safety and Health Administration, which also has a poor track record of enforcement. By default, safety monitoring may fall to the primary medical provider.
3. Screening in any population should focus on those exposures and conditions that have the greatest impact on health. For a migrant population, occupational injury and illness, transportation injuries, and tuberculosis infection are far more significant than for the general population.
4. If the condition is accurately identified as work related, the worker may be eligible for workers' compensation, and the clinician or clinic or both may be reimbursed accordingly.
5. Often, patients feel that if a provider does not ask about a certain topic, it is not important, not a risk, or perhaps the provider just does not care. Thus, simply asking about risks may help patients understand that there are potential hazards. This is analogous to discussing the health risks of tobacco. Furthermore, hearing a healthcare provider ask about risks and hazards may reinforce workplace safety messages that the worker may have heard during training, or even change the patient's perception of workplace risk.

The solution to diminishing occupational injuries and exposures must be multifaceted and must take place on a number of levels, often far from the clinic setting. Workplace, regulatory, policy, and enforcement changes are all needed. Preventive education and safety training for workers and their families are also essential to lessen injuries and exposures. But, there is a critical role for the clinician in this effort.

Migrant Clinicians Network has conducted a successful initiative to integrate occupational medicine into the primary care setting in four pilot partnerships with Migrant and Community Health Centers. These partnerships involved provider training and simple, but relevant, clinical system changes. In addition, the program linked primary care providers with occupational and environmental medicine specialists. In one

BOX 1

The Migrant Clinicians Network's project *Saving Lives by Changing Practices* is guided by the expertise of a committee of occupational and environmental specialists, primary care providers, and farmworker advocates. The names and affiliations of each member are listed below. All of the committee members endorse MCN's efforts to promote screening in the primary care setting.

- Shelley Davis, JD, Deputy Director, Farmworker Justice (Recently Deceased)
- Joe Fortuna, MD, American College of Occupational and Environmental Medicine, Board of Directors and Section for Occupationally Underserved Populations
- Matthew C. Keifer, MD, MPH, Professor, Occupational and Environmental Medicine, University of Washington
- Wilton Kennedy, PA-C, MMSC, Program Director, Physician Assistant Program, Jefferson College of Health Science, Past President of MCN
- Katherine H. Kirkland, MPH, Executive Director, Association of Occupational and Environmental Clinics
- Dennis H. Penzell, DO, MS, FACP, Clinical Associate Professor, University of South Florida College of Medicine/Nova Southeastern College of Osteopathic Medicine
- Michael Rowland, MD, MPH, Medical Director, Maine Migrant Health Program
- Daniel L. Sudakin, MD, MPH, Director, National Pesticide Medical Monitoring Program, Oregon State University
- Edward Zuroweste, MD, MCN Chief Medical Officer, Migrant Clinicians Network

program, the clinic asked one additional question and found 40 percent of its encounters were work related (Box 1).

Clinical resources and patient educational materials as well as information about MCN's project *Saving Lives by Changing Practices* are available on MCN's Web site at www.migrantclinician.org.

REFERENCES

1. Tutor R, Zarate M, Loury S. Pesticide exposure surveillance and prevention skills of staff in eastern North Carolina Health Departments. *J Public Health Manag Pract.* 2008;14(3):299–310.
2. Morrow J. The role of local public health agencies in pesticide exposure. *J Public Health Manag Pract.* 2008;14(3):311–312.