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Submission to the Inquiry into Australia Post's treatment of injured and ill workers.

I, Dr. C. Costa, would like to put forward a submission to your Inquiry from the perspective of medical management of injured workers but also from an occupational health and public health perspective. My background and experience in this area of medicine is as follows:

- I am employed in private practice as a family physician and have higher qualifications in occupational health, having obtained my Masters in Public Health (Occupational Health) at Sydney University in 1987. I am also a Fellow of the Australian Faculty of Public Health Medicine of the Royal Australian College of Physicians.
- I have been working in private practice in the Inner West of Sydney for the last 30 years as a family medical practitioner and also as an Occupational Health Consultant; including management of work injuries as the nominated treating doctor. I am an authorised medical officer for WorkCover and trained in industrial injury and diseases. (My full CV is enclosed).

My reasons for submission into this inquiry stem from a concern for the welfare of workers whose health and safety can be compromised when their care is put into the hands of their employer.

I believe that family GPs are best placed to manage workplace injuries and illnesses. Where GPs are sidelined in favour of company doctors, patient care becomes fragmented and the risks of unethical treatment and even abuse are increased.

My own strong view is that finding and paying health professionals highly and instilling a corporate mentality is a slippery slope which encourages unethical behaviour by those same health professionals and a rush to the bottom in terms of standards and care.

The Hippocratic oath makes clear a doctor's obligation to put the care and wellbeing of the patient first and foremost. The losers in such a scenario are the injured workers – but also their employers, the wider public interest and the doctors themselves.

I declare no conflict of interest. My submission is provided as a private individual with a special interest and fairly unique experience in the matters under consideration by your Inquiry. I have not received funding from any individual or organisation in the preparation of my submission, neither direct nor in kind.

I offer the following points for consideration:

InjuryNet – A conflict of interest

Prior to writing my submission I did familiarise myself with the terms of reference of the inquiry. I have also familiarised myself with InjuryNet and the services they provide, and with the work of Dr Jennifer Christian in the US.

In particular, I note Dr Christian's rationalisation for facility nominated doctors (FNDs) – *"until now the distinct nature and importance of the stay at work and return to work process (SAW/RTW) has been overlooked. Finding better ways of handling key non medical aspects of that process will support optimal health and function for more individuals, encourage their contribution to society, help control the growth of disability program costs, and protect the competitive vitality of local and national economies"*.

I dispute the premise that the importance of early return to work has been overlooked in the general practice of occupational health in Australia.

It is accepted medical practice by family GPs in Australia that injured people are best returned to work as soon as is reasonably possible. This is not a particular attribute of Dr Christian or InjuryNet doctors. Most larger workplaces make suitable duties available and also inform treating doctors early of the availability of suitable duties following a workplace injury, particularly where a return to normal duties is not an immediate option. Australian family GPs are well aware of this and cooperate on a daily basis with industry.

What Dr Christian and InjuryNet appear to be promoting is not *"bridging a communication gap"* but a **preferred doctors' list for employers**. In this day and age of fax, email telephone and Case Conferencing (where the employer and the insurer and the injured worker meet directly with the treating doctor in a conference situation), there is no communication gap between the employer and a family GP.

Furthermore, workers' compensation legislation discourages **"doctor shopping"** by injured workers who are encouraged to stay with their nominated treating doctor. It could be inferred that a double standard would apply here – **in that Australia post is using InjuryNet to doctor shop on its own behalf.**

The InjuryNet model is the creation of a preferred doctor's list – where doctors are well-rewarded to perform in a certain way. They appear to be paid much higher fees than for other similar work, and their position on the list could be at the whim of the employer and subject to the doctor's results in early work return. It is a restricted doctor system not dissimilar to that operating in the Australian military – where servicemen and women are expected to see military doctors – and where the treatment or certificates of civilian doctors is not usually accepted.

Such a system may have inherent merits for the military – for the preservation of military-style discipline, particularly during war time. However, from an occupational perspective there can be severe limitations for both workers and employers – and this was amply demonstrated more recently by the BOI Inquiry into the deseal/ reseal programs for the F111 fighter jets in the RAAF (see Appendix 1). The cost in that instance is now being measured in terms of hundreds of servicemen and women with ruined lives and relationships and in very poor health – and a very large worker's compensation cost and social and economic loss to the broader community. I will refer in detail to this useful example later on.

The problem for the InjuryNet doctors, as it probably was for the RAAF doctors, is that the corporate culture and/or any high payment system would encourage inappropriate behaviour on the part of the health professionals. **When health professionals are part of a corporate culture, or are highly paid by a third party, and where there is not much scrutiny or code of conduct, it can create a serious distortions and conflict of interest.** The injuryNet model also contributes to fragmentation of patient care and the medical record – particularly with any serious or chronic injury for which symptoms are recurring and ongoing. The care the FND will provide may also be substandard/ limited due to a lack of the same social credit or cultural sensitivity or language that could be provided by the family GP.

Cultural Awareness & Sensitivity

Australia has a very diverse population, which is reflected in its population. I understand Australia Post has an ethnically diverse workforce with a large proportion of employees from non-English speaking backgrounds.

The ability to access public health services (much like education services, welfare services and so on) is dependent upon the individual's own understanding of the area which they wish to access, which in turn is effected by that individual's ability to confidently communicate in the dominant language and their knowledge of certain social and cultural norms.

Therefore, in a health situation, it is not only the doctor's medical knowledge that is necessary to deliver high standard of patient care but it is also the **treating doctor's knowledge of social and cultural factors which assists with their patient care**.

Most Australians should have the opportunity of seeing a treating doctor who is able to speak to them in their own language and is aware of any social and cultural belief system that could effect treatment.

This may be denied to the injured worker as the FND is much less likely to be able to provide similar characteristics, or be as suitably matched as the family doctor who has been sought out by the patient on such criteria. This could result in a **much-reduced ability to provide a proper service to the injured worker - and subsequent detrimental effect on the consultation and the outcomes**.

The family doctor is also familiar with the patient's family history, members of that family, the home environment and is easily able to navigate around these factors to provide useful suggestions and recommendations for the whole family. In my experience the symptoms and chronic injuries of the worker have a major impact on their families, as they must take on the burden that comes with being primary carers for the worker.

Chronic Injury and the Fragmentation of Patient Record

The InjuryNet model seems also to be based on a false premise – i.e. that all work injury is of a minor and short term nature and the use of an FND will be episodic and not interrupt or compete with the family doctors long term medical role**.**

In fact a significant minority of workplace-based injury can require long term follow up – such as "wear and tear" type injury or burn-out type musculo-skeletal injuries.

I believe the InjuryNet-style company doctor model poses a number of serious questions:

- What will happen if the condition becomes chronic and established or it is a more serious type injury requiring long-term medical management and follow up. Will the FND continue the management or pass it on the patient to the family doctor?
- Is the FND's medical record being made available to the family doctor as occurs when patients are seen at hospital or by the after hours doctor?
- What happens to the record if, as can often occur, when there is a permanent impairment and workers' compensation involved under an adversarial type workers' compensation system as occurs in Australia? **A patient may present to their treating doctor some years later in regard to a chronic back problem and would be at some disadvantage when they come to take early retirement or to access their superannuation through their family doctor – or to go on the disability support pension – if the records are unavailable.**
- How does a FND treat a patient without being aware of all of their family history and past health?
- Does the FND contact the family doctor?
- Do they take a full medical history when they see an injured worker?
- Is this cost effective when all of the medical history already available with the family doctor?

Particularly I would like to argue the case for the role of the treating family doctor in managing workplace injury – and that this benefits all sides of the work-injury equation – the injured worker, the employer and the insurer.

The treating family doctor is strongly positioned to manage workplace illness and injury within the community, has the trust of the patient, has strong ethics and principles of confidentiality and is responsible for the overall care of the patient and continuity of the medical record i.e. fragmentation of care is to be avoided wherever possible.

Further, under current workers' compensation legislation a nominated treating doctor is also obliged to stay in close communication with the workplace and the insurer and familiarise themselves with what suitable duties are available in the workplace. Family GPs are well-placed and highly capable of carrying out these tasks.

Checks and balances

The bottom line is that there appears to be no mechanism of scrutiny of the activities of the FND (See example of airport doctor below). This cannot be a good situation for workers or employers – or for the health professionals themselves. The system seems devoid of any "checks and balances" and no guidelines or code of conduct seems to have been developed of which I am aware.

In such a situation there is a high risk for abuse and intimidation of the injured party – as these health professionals form a selected and powerful group, whose opinion is difficult to question and who have the imprimatur of the employer. At the very least, physicians are powerful figures in any society but in this case there also does not appear to be any written guidelines or code of conduct for FNDs.

I have observed a similar situation with specialists performing medicolegal assessments for workers' compensation claims – where there are no obvious guidelines and little recourse for patients. I have seen the patients following such assessments who complain of harassment or being physically examined in a fairly rough way, or of female patients being sexually assaulted or embarrassed or of reports claiming a full medical examination – when the patient is adamant that they were not even asked to remove any clothing. Whatever the merits of such complaints, it is very obvious that these complaints are **not** accepted or dealt with by the normal health complaints office that monitors our physicians, nor the ombudsman – and these patients told: "it is up to the workers' compensation system to sort it out".

Choice and an ethical system for the use of the FND system

Nevertheless, there can be a role for the FND or company physician.

Sometimes a workplace injury is acute and demands immediate assessment; and the family doctor is unavailable. Sometimes the injured worker does not have a family GP, or sometimes it is just simply more convenient for the patient to see the FND or the company doctor.

There is also the question of cost and affordability of care: i.e. sometimes the treating family doctor will demand payment up front pending acceptance of the workers' compensation claim by the insurer and this would put the injured worker at economic disadvantage.

There are a variety of reasons where the patient could elect to see the company doctor. **However "elect" is the operative word**. There should be no coercion. At all times patients should be free to choose their treating doctor. This is a right for all Australians.

Though treatment by the patient's personal physician is preferred, and serious concerns will always remain in regard to long-term treatment of work injuries by FND, referral to an FND or company doctor (or dedicated work injury treatment centre established by employer or insurer) should be a choice offered to the injured worker on certain conditions:

- the injured party is fully informed as to the pros and cons of such a service
- there is a strict code of conduct in regard to doctor's behaviour

- the medical record is kept confidential and not inappropriately shared with the employer
- the family doctor (or any future treating doctor) has access to the medical record and communication regarding diagnosis and treatment

There is little to be gained out of a medical consultation where there is hostility on one or both sides, and where there is no therapeutic relationship developed – especially for chronic injury. Such consultations would have little therapeutic merit and could be better classified as the health professional taking on policemen type role on behalf of the employer.

Nobody wins in such situations (as set out in the examples below) and there is inevitable hostility on the part of the injured worker, which could carry through to their work performance and in their general lives, sometimes with rather unpredictable and catastrophic results. It is not unusual for a worker with a chronic arm injury or suffering from chronic pain becoming depressed.

This is a well-known clinical entity classified as **Adjustment disorder**. In the normal course of events, an injured worker with a chronic work injury suffering from adjustment disorder would be counselled intermittently by his treating doctor and given supportive management.

If his or her psychological condition was to deteriorate i.e. chronic pain leading to chronic depression, alcoholism, family isolation etc., who would be responsible to assist and manage in this situation? Normally it is the family treating doctor. The vulnerable patient has someone to fall back on.

However in the situation where the work injury is ostensibly being managed by the FND – and where there is no relationship with a treating family doctor and/or the relationship has been interrupted and the patient has been sidelined from the family doctor – where does the patient go if they feel suicidal or if they are bashing their wife (or their husband) or if they are drinking way too much and effectively ‘out of control’?

This is not an unusual situation. In my experience as a family doctor over 30 years it is a common situation. Yet the FND, even were he/ she interested to provide support and holistic care, would be at a considerable disadvantage for all of the reasons set out above.

Health and Occupation

It is well established in the practice of Medicine that a person’s occupation will strongly influence their health and also strongly predict an individual’s future health. Historically, this was originally recorded in miners and noted with the scrotal cancers of the chimney sweeps in 18th century London – or the “Phossy” jaw in the match factories where workers were exposed to white phosphorus at the turn of the last century.

A famous work study in the 1950s noted that bus drivers were much likely to suffer heart attacks than bus conductors – of the same age and risk factors – and this was attributed to the fact that bus conductors are far more physically active – going up and down the stairs in the bus – than the drivers

A more recent example is asbestosis and Mesothelioma in asbestos workers, as has been well documented in the media with the ongoing lawsuits by former employees of the James Hardie Corporation. Reduced life expectancy in people working with asbestos was known and well-documented by 1920 – and these workers were unable to obtain life insurance cover even before then.

The knowledge was present but no moves where made to phase out asbestos until the 1970s – 50 years later – and no protection was given to these workers or the community over a prolonged period of time.

Yet the company physicians working in the asbestos industry would have had the information and the knowledge and the statistics to do something about the problem much earlier. (Or maybe they did inform management but the information was kept in-house.)

James Hardies workers did not benefit from having company doctors that were aware of their work conditions and the occupational hazards they faced. Clearly the problem here is not just an "information gap".

If the ideology behind InjuryNet were correct i.e. *"that their doctors are better placed to manage Australia Post's injured workers because they understand the Australia Post workplace better and would have a knowledge of the workplace and suitable duties available"* – why did the James Hardies asbestos company physicians not act earlier and more decisively as they were best placed to see what was happening in the workplace?

Example after example shows that despite their understanding of the workplace, company-paid doctors are vulnerable to compromising their medical treatment; acting on the best interests of the employer rather than the injured worker.

I also note in the description of InjuryNet that they are *"focussed on providing earliest possible primary care for injury and illness. We work with GPs to ensure prompt access"*. The problem here is that the family GP is not being involved in this process – and **there isn't enough reason given as to why InjuryNet can't work with the family GP?**

They go on to state that the InjuryNet practitioners have *"knowledge, communication, reassurance, commercial sense, objectivity, no fixed beliefs"*. Is the implication here that the family GP would not have such qualities?

Yet insurers, employers and rehabilitation organisations have open access to treating family doctors who can be quickly and comprehensively informed as to the history of the injury and who can quickly provide information as to the history of the injury, the patient's normal work duties, environmental factors at the workplace as well as the availability of suitable modified duties.

They then go on to state that InjuryNet performance is measured by lost time injury rates and lost hours, duration until return to pre-injury duties or permanent alternate duties. **I would comment that, when working with human beings, it is not a competition as to who can get the best score. Also important is the outcome of the injury, the patient's journey through the process and the holistic management by the treating family doctor.** (see below example of negative outcomes following harassment and abuse of injured worker at the airport).

It is incorrect for InjuryNet to imply that **their** GPs are better informed than any other treating doctor/GP. In this day and age family doctors are frequently contacted quite early following any significant work related injury and the employer and the rehabilitation provider and the insurer work very closely with the treating doctor. Communication is facilitated through e-mail and fax and by mail and by telephone and the treating doctor is constantly informed, the family treating doctor is constantly in the loop and informed as to what suitable duties are available at the workplace. This can go as far as to arrange regular Case Conferences at the Medical Centre including the patient, the doctor, rehabilitation provider and/or insurer and employer. Following such a Case Conference, a greater understanding of the injury and the progress is achieved on all sides and what is possible in regards to work return and suitable duties.

A further Case Conference or follow up phone call can even be scheduled by the employer and/ or the rehabilitation provider one or two weeks later to monitor outcomes and patient progress and the decisions taken at the previous conference.

When the family doctor certifies a patient in regards to work injury, there is also included a line at the bottom of the certificate which states "I agree to be this worker's Nominated Treating Doctor and to assist in his/her return to work" and there is a "yes" or a "no" box beside this statement which has to be ticked prior to the certificate being signed by the doctor and the injured worker. This guarantees that, at all times, the treating doctor will communicate and liaise and provide any reasonable information to the insurer, employer and/or rehabilitation provider.

It is difficult to accept InjuryNet or Dr. Jennifer Christian claiming that the InjuryNet doctors would have some fundamental knowledge which would not be available to the treating family doctor – or that they could claim that the treating family doctor would be ignorant in regards to the workplace.

And as in the case of asbestos – and also the RAAF deseal/reseal program in the 70's, 80's and 90's, the factory/ military doctors having all of the information at hand, did not make them better doctors in that situation, or lead to a better management of the health problems. It did 'get the job done' and it did manage the time loss problem – but these were limited goals in the scheme of things and now a much bigger problem for the men and women involved and a much bigger cost to the workers involved and our society.

I note the submission provided by Dr. Jennifer Christian in support of InjuryNet she states that:

"Averting needless time off work related to medical conditions improves overall outcomes of health related episodes, and it helps people stay employed and businesses remain vital, all of which is usually good for all the parties and for society". Her **emphasis here seems to be on productivity** (which is of course important) and early work return. (Which were probably the same over riding priorities in the reseal/ reseal program – see Appendix 1).

Whilst the above principles are not in question, she does not give any cogent reasons why InjuryNet doctors would be any better placed than treating family doctors.

Her submission is very patronising of family physicians and I am unsure whether she has much experience of the Australian situation. It must be noted here that the US Health System is entirely different to that of Australia and/or Canada.

In the US there are not very many family doctors and few American citizens can afford to visit a family treating doctor – as the cost is usually around $300. Family medical practitioners in the US are thus in the same category as any other "specialists" such as neurologists or orthopaedic surgeons. Many American citizens cannot afford to see a doctor or alternatively will see a doctor in a Managed Care System, which is often run by insurance companies including worker's compensation insurance companies.

Further, her sentiments that *"If you pay doctors more you will get the right results"* are regrettable.

I incidentally did enquire as to the fee being paid by InjuryNET for a consultation with an Australian Post injured worker. I understand that the average fee per patient contact is around a $177 per episode. This is a very high fee and would contrast to the standard medical fee in Australia of around $35 bulk billed and the standard consultation under Worker's Compensation payments under New South Wales WorkCover which is around $65.

Needless to say, **if doctors are being paid triple the usual rate for a service consultation, they will try and keep the payee happy**. This would result in a conflict of interest on the part of the treating doctor and, as Mark Twain aptly pointed out at the turn of the 20th century: "If you want to know a man's opinion, look to see where he gets his oats".

Both Dr Christian and InjuryNet believe that the doctor should be paid well for their service in reducing time loss secondary to work injury. They do not seem to have any qualms that this would **compromise the doctor's role and independence in the therapeutic relationship.**

Quoting directly from Dr Jennifer Christian on her Internet blog:

"The purpose statement in our revised Partner Attraction Plan for The 60 Summits Project says that we are 'creating a community of like-minded people' across North America. And, that within our community, we intend to 'enable buyers and sellers of products and services that effectively prevent needless work disability to find each other so that they thrive and prosper'.

We all gotta stop acting 'too pure to be paid'. If the people who adopt this new model can't do well by doing the right thing, how the heck will this paradigm ever get propagated and take hold?

The reality is that we all choose things to do because they benefit us in some way – either they are fun or they make us feel like we are good people, or they help us advance our knowledge, mastery, reputations or careers, or they further our sales goals or they reduce our overhead. My personal intention is that all the people associated with The 60 Summits Project -- including me -- profit in some way from our participation in or support for it -- personally, professionally, financially -- and ideally in all three ways!"

Naturally there would be some distrust on the part of the injured patient particularly in regard to the doctor's opinion and confidentiality issues where it is known that the doctor:

A. Is being paid by a third party connected with the employer and,

B. That the payment was significantly higher than the normal payment for such a service.

It would be of particular concern when referral to InjuryNet doctors is occurring subsequent to the injured worker having already seen and received treatment from their nominated treating doctor. This would normally be for purpose of "second opinion" – which is a common thing in medicine, especially prior to surgery or in case of serious illness. However I would note that "second opinion" is normally referred to someone with no vested interest - because the "second opinion" should be independent. And "second opinion" would be tainted where the InjuryNET doctor is being paid an unusually high fee for such opinion.

In these situations there is a high risk here that the patient will be mistreated even by the most idealistic of doctors.

Summary

In summary the compromised quality of care, the possibility for abuse, the fragmentation of care and the significant ethical considerations as set out above should all be considered in assessing Australia Post's treatment of injured and ill workers.

The InjuryNet system of FND employed by Australia Post would appear to be overly coercive and create unnecessary hostility and antagonism within the work force. Australia Post has not made out a reasonable argument as to why the current system as it exists in Australian General Practice – and/or an opt-in InjuryNET type system would not be sufficient and/or satisfactory.

Australia Post already has a valuable resource, a network of truly independent and high-quality treating doctors to treat its workforce: family GPs, who are willing to holistically treat their patient and work with employers to get the best outcomes for all involved. Australian family GPs are a great asset to industry and our community.

In the final analysis everyone wins if the patient can be screened and treated quickly by their family doctor. The majority of Australian doctors are fully aware of the benefits of early return to work whenever possible and agree to cooperate with the workers' compensation system.

For injured workers, particularly those with chronic conditions, the implications of using an InjuryNet doctor to treat the work injury are that the patient may be under-managed, as they don't have a therapeutic relationship with their doctor and they may be marginalised from the wider medical system.

The question has to be asked of Australia Post whether they are using a sledgehammer to smash a nut. There probably is a limited role for an FND program as set out above - but this should be an opt-in for those patients who do NOT have a treating family doctor, or who cannot get in to see their family treating doctor in reasonable amount of time following injury. The family treating doctor should be the first person contacted following an injury and timely appointments arranged and follow up in due

course to arrange for work return and suitable duties if required.

Particularly it should be an opt-in scheme and without any coercion – to facilitate and assist those workers who would have difficulty accessing reasonable medical care. At all times it needs to be explained to the injured worker that the FND is paid by Australia Post and the payment to the FND should at all times be in accordance with the average payment to non-FND doctors.

The current socially accepted position is that any vested interest by a treating doctor needs to be volunteered to the patient beforehand i.e. where the doctor has a relationship with the drug company, local private hospital or x-ray facility or where the doctor has a separate contract with the employer or the insurer. This does not always appear to be the case (see example below of multiple roles of treating doctor at airport) and where work injury is involved.

I cannot opine as to the social and economic responsibility of Australia Post to the wider community in regard to long term morbidity and social consequences of mistreatment of their injured workers by FND doctors.

However, to prevent a worker from seeing his treating family doctor in regards to his employment-related injuries would place a lot of responsibility on the company doctors – and results in shielding of information from the family doctor and the community – with dire consequences for the worker but also the employer and the community in the long term.

Appendix 1

Why information (or lack thereof) is not the problem impeding good medical management of workers – the example of the RAAF and the Deseal/ Reseal program at the Amberley Air Force Base in south east Queensland from 1978 to 1999.

The maintenance activity, known as the Deseal/Reseal program, involved the removal of sealants from internal tanks of the aircraft and replacement of that cement with a new mixture. The fuel tanks in the F111 aircraft were inside the fuselage itself and in the wings of the aircraft. They were flying fuel tanks! "The sealant initially applied to the aircraft during manufacture gradually broke down over time allowing the fuel to leak from the aircraft. The deseal/reseal program was developed on a somewhat ad hoc basis, with some initial input from the United States Air force. The Australian program commenced in 1978 and ended in 1999. Over this time there were four different programs which involved various approaches to the activity."

Those programs were: the first deseal/ reseal 1977 - 1982; the second deseal/ reseal program, 1991 - 1993; the spray seal program, 1996 -1999; and the wings deseal/ reseal program, 1985 - 1992.

Workers/ RAAF servicemen whilst working on the deseal/ reseal at Amberley Air Force Base were heavily exposed to a multiplicity of toxic chemicals. The work process involved both men and women and was described thus: *"It was necessary to enter an aircraft and dismantle plumbing which meant that you got doused with aviation fuel, then the operator would put in their own plumbing to spray chemical inside the fuel tank to seal it. There were 44 gallon drums of a chemical called SR51, the contents of which had to be pumped with manual hand pumps into vats where the chemical was heated before being pumped into the aircraft with constant heavy exposures of the skin and respiratory system.*

It was impossible not to splash one self when manhandling the pumps etc. It then followed a stage where the tanks were flushed with detergents then the operator would have to enter the fuel tanks to remove the sprinkler system. The actual tanks were large enough to accommodate a man, although it was not possible to stand up in a tank. Then much work had to be performed to seal the plumbing, having first removed the old sealant. Finally, white overalls and face mask with two filters were provided and these were worn when cleaning the tanks with a jet of water. The water would penetrate between the gloves and overalls and through the gaps in the overalls and through the filters so that the operator was soaking wet and also could taste the chemicals. Working on the tanks would take 15 to 20 minutes at a time and using the water current would take several days. There would be heavy exposure to the chemicals either as such or in solution. It was impossible to wash the chemical off your skin and one would "go home smelling" with chemicals from head to toe - so that it was necessary to sleep apart from one's wife in a separate bed. It took days, if not weeks for the evil smell to leave the skin".

The servicemen and civilian contractors were treated and monitored by doctors within the RAAF. This would closely mimic an InjuryNet type scenario, although military doctors had even more control of the workforce injury and morbidity – (servicemen and women are not allowed to seek medical opinion outside of the military.)

There was also probably a culture within the military (again not dissimilar to the InjuryNet model) where complaints of servicemen of lower rank would be trivialised and a command structure that emphasised getting the job done over safety and health of the servicemen and women. Similarly, I think it was one of the ancient philosophers, Plato who observed, "when people become ill, send them back to work. They will either die or get better" - i.e. **servicemen and women on the deseal/reseal program were inevitably sent back to same toxic work exposures** and all of the participants in the program that I have talked to confirmed that their symptoms were not taken seriously, or told that their abnormal tests were probably due to *"too much alcohol"* – or given only very basic symptomatic care, such as *"take 2 Panadol tablets for headache"*.

According to the InjuryNet rationale, the RAAF doctors should have been uniquely placed to detect and assist in preventing health problems in these workers i.e. resulting from the deseal/ reseal program, and could have taken a proactive approach in regard to the health of the servicemen working in that program. Yet nothing of the sort happened.

From the RAAF Inquiry's own findings:

"Ultimately it was realised there may have been a connection between the ongoing medical complaints and the deseal/ reseal work involved and an inquiry was ordered. Under the Defence Regulations a Board of Inquiry (BOI) was held. The BOI concluded, Volume Two, Chapter Seven that many of the chemicals used during the deseal/reseal program were classed as hazardous substances.

The chemical products can be broadly grouped into desealants, solvents/ cleaners, adhesion promoters/ primers, and sealants. Of these, the ones most likely to have represented the greatest hazards were those with higher toxicity, but also those used in the greatest volume and within confined spaces or poorly ventilated areas. The most notable of these chemicals were:

a. the chemical desealants SR51 and SR51A used on the first program;

b. the solvents, particularly MIL-C-38736 ('MILSPEC') and MEK;

c. the adhesion promoter PR148;

d. the epoxy barriers, being materials normally used as structural adhesives; and

e. the MMS 425 primer for the spray seal which contained strontium chromate and isocyanates;

f. the sealants, which contain proportions of solvents to assist working the sealant before cure, including;

g. the toluene based sprayable polythioether sealant PR2911,

h. PR1750 polysulphide sealant, and

i. fluorosilicone sealant;

j. finally, aviation turbine fuel (AVTUR).

During the program a number of workers experienced a variety of illnesses including depression and increased alcoholism, headaches, nausea and skin rashes. Yet the RAAF doctors appeared to take little action on behalf of those exposed to the toxic chemicals. The emphasis appeared on "getting the job done" and productivity was placed ahead of the health of the individual.

The BOI findings were released on 2 July 2001 and concluded there were systemic safety failings and exposure of maintenance personnel to toxic chemicals. The BOI findings can be summarised as follows:

1. Notwithstanding the onset of symptoms by workers shortly after their exposure to toxic chemical, the seriousness of the problems was not recognised until 2000. This failure was attributed to organisational failures within the Royal Australian Air Force
2. **The relative powerlessness of the maintenance workers with regard to ignored complaints of symptoms and of inadequate personal protective equipment.** (my emphasis)
3. The total reliance on personal protective equipment to protect workers from the hazards involved in working with toxic substances in confined areas, rather than finding engineering solutions to the problem of fuel tank leaks, or greater effort to find non toxic substances with which to do the job.
4. The problems with personal protective equipment leading to either a failure by

   workers to wear the protective equipment or when it was worn, its inadequate protection against the chemicals.

As a consequence of the BOI's findings, the government commissioned a health study known as the Study of Health Outcomes in Aircraft Maintenance Personnel (SHOAMP) to compare a series of general health, medical and neuropsychological outcomes between F-111 deseal/ reseal personnel and appropriate comparison groups.

The study found a strong association with regard to quality of life, sexual function mood and memory. Physical and mental components were significantly decreased, placing deseal/ reseal personnel in the 20th to 30th percentile of the Australian population. Depression and anxiety were increased almost 2 fold and sexual dysfunction increased 2.5 fold and memory impairment was increased four-fold.

The study found a moderate association with regard to dermatitis, moles/ naevi, chronic obstructive lung disease and tests within the neuropsychological domain. Dermatitis was increased 1.5 to 2.5 fold, at 2 fold increase in moles/ naevi and obstructive lung disease.

"In conclusion, the SHOAMP study, while noting there are unavoidable uncertainties in the interpretation of the study results, found that the results pointed to an association between F-111 deseal/ reseal involvement and poor physical and mental quality of life, erectile dysfunction, depression, anxiety and subjective memory impairment".

Phase II of the SHOAMP was in respect to the mortality and cancer incidence study, this study concluded that there is a 40 to 50% higher incidence of cancer in deseal/reseal personnel.

So here we had a workplace situation where men and women were working with highly toxic chemicals in very confined spaces without breathing equipment – and where the work process was all fairly experimental and being *"made up as they went along"* and no attempt to substitute with safer chemicals or re engineer the process – and when the workers complained of symptoms to the workplace doctors (who according to InjuryNet theory, would have well briefed on workplace and hazards involved), **their complaints and symptoms were either ignored or trivialised by the doctors.**

It is fairly stated in the Encyclopaedia of the Occupational Health and Safety, International Labour Office, Geneva (which is the gold standard on such matters and in the area of occupation medicine)-"responsible societies are realising more and more that potentially hazardous chemicals must be laboratory tested so that suspected harmful products can be identified, and either controlled or eliminated, before being introduced into commerce. Only in this manner can the risk of exposing unsuspecting populations be minimised. It is one thing to introduce chemical of a known hazardous entity e.g. to workers who are trained and equipped to handle them, but another to expose whole populations (small or large) who are unwary and uneducated with regard to the risks involved and without means to counter them."

The reseal/ reseal workers are currently accessing workers' compensation benefits through the courts and according to the findings of the RAAF Inquiry's own findings - although unlikely to make up for the hundreds of ruined lives including health family and relationships, but the question still would remain – and particularly relevant given the InjuryNet model – **why the RAAF doctors did not speak up on behalf of the servicemen and women involved in the program** – particularly given that the work process was a) not in accord with basic occupational hygiene principles, b) the protective equipment was inadequate and c) the maintenance workers and RAAF members were not provided with sufficient information and particularly not provided with the MSDS of the toxic chemicals with which they were intimately involved over a long period.

There are obvious parallels for people working in the Armed Forces and workers in enterprises such as Australia Post where medical access is restricted to virtual in-house FND - and where workers are expected to follow orders and where it is difficult, and even discouraged, to obtain alternative or second medical opinion.

Dr C. Costa

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