WHO CARES IF IT

How Misapplied Practices Recordkeeping Infring

By Leslie Rex Stockel

A FEW YEARS AGO, while working as a safety manager for a mid-sized regional corporation, the author found herself in a conference room with three fellow safety managers and the director for corporate safety and health arguing over whether to report an injury on the OSHA 300 log. The case details were somewhat unusual: The employee had walked into a doorframe in the company lunchroom and suffered a laceration to the forehead that required sutures. This experienced group of safety professionals disagreed about the proper course. Some thought that because the employee was on a lunch break, the person was not in the course and scope of employment. Others felt that because the incident occurred on company property at the end of the break and the employee was headed back to their desk, the case should be recorded.

During this spirited conversation, what the author found odd was the extent to which resources were devoted to the question itself. Approximately half a million dollars of annual salaries were sitting in the room spending at least an hour trying to decide whether to fill out a government form. No one was concerned about paying the medical bills. There was little discussion about the root causes of the incident; the employee was looking at a mobile device reading an email when they walked into a doorframe. The foremost issue was whether the case should be counted as an OSHA recordable case, a category of workplace injury that must be reported and recorded according to federal OSHA recordkeeping rules. This decision would impact the organization's yearly safety goal and everyone's annual bonus. As a safety professional, the issue of OSHA recordability has always left the author feeling unsettled and wondering whether the significance is misplaced.

Most U.S.-based safety professionals should thoroughly understand the current law that requires certain employers to maintain documentation of work-related injuries and illnesses. The details of this requirement, prescribed in 29 CFR 1904 Recordkeeping and Reporting Occupational Injuries and Illnesses, inform employers about the decision parameters of injuries that must be recorded (OSHA, 1997). The essential tenet of the regulation is that a work-related injury requiring medical treatment beyond basic first aid must be documented. The regulation establishes detailed criteria for determining recordability based on the severity of the injury and the treatment prescribed. This point is where the ethical dilemma begins.

Many organizations use the OSHA recordable injury as a measure of safety success. The total recordable incident rate, the days away, restricted or transferred rate, and the lost workday case rate are all simple mathematical expressions of recordable cases over exposure time and are commonly used to establish annual performance goals for an organization, work groups and, in some cases, individual contributors. Performance measures are typically based on reducing these rates over a given period, typically annually. Additionally, some organizations use the incident rate metrics to benchmark and compare themselves to industry peers to determine the best in class. Others use the rates as selection criteria for bid awards to third-party contractors through external validation services. Recordkeeping practices, when properly administered, can assist an organization in selecting subcontractors with a conscientious commitment to worker safety. However, they also can put pressure on a bidder to micromanage incident reporting procedures. This can result in inappropriate pressure being applied to workers, making them feel intimidated or conflicted for reporting a work-related injury, which is itself a violation of the OSHA whistleblower provision.

While incredibly important, a clear problem lies in the situational detail and opportunity for variable application of the federal rules for OSHA recordability. The OSHA recordkeeping regulation is subject to interpretation, subjective opinion and manipulation. This condition creates tension between the need to comply with government regulations and the personal and organizational desire to achieve safety goals driven toward the prevention of injuries. Much discourse has been published on

KEY TAKEAWAYS

- **Overt emphasis on avoiding incident recordability creates a temptation to sacrifice or second-guess medical treatment to split the fine hairs of regulation, violating the ethics of care philosophy.**
- **Misapplied emphasis on OSHA recordability and a utilitarian mindset of zero accidents (zero recordables) can erode trust in the organization and ultimately damage the culture of safety.**
- **Injured employees must be cared for with their physical and mental health and well-being placed above any numerical evaluation of organizational safety metrics.**
- **Administrators tasked with OSHA recordkeeping decision-making should be insulated from the pressures to sacrifice employee care for the sake of safety performance metrics.**

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s in OSHA Injury & Illness
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the low efficacy of lagging indicators for safety performance, and many organizations adopt a "zero accidents" rhetorical mantra, which, in reality, can mean zero recordables (Clemens, 2005).

This practice creates a dilemma for the professional tasked with the administrative upkeep of the required OSHA documentation (the OSHA 300 log) and is often the mediator between compliance with the regulatory rules and accomplishing the organizational goals. Additionally, extensive time and resources can be expended by practitioners in arbitrating questionable cases of whether to record or not to record. These resources are, therefore, not being directed toward actual field risk identification, assessment and mitigation.

While much discussion has taken place in publications and social media discourse relative to specific interpretations and application of the federal OSHA recordkeeping rules outlined in 29 CFR 1904, what has not been addressed in much detail is the relevance and propriety of using these data as ethical measures of safety success. Recent scholarship has questioned the statistical validity of the rate calculations as legitimate measurement devices (Hallowell et al., 2021). The following literature review conducted among prevailing industrial safety journals revealed little information on the ethical practice of injury and illness recordkeeping, revealing a gap in the scholarly field that this article seeks to fill.

Risk communication and workplace ethics is an established area of scholarly rhetorical inquiry. While ethics in workplace safety has been discussed by both practitioners and scholars, the topic has mostly been framed in a broader context of Aristotelian and utilitarian expediency and normative deontological virtue, which informs a fundamental tenet that protecting workers from harm is the right and ethical position. This critique seeks to evaluate the practice of applying the OSHA recordkeeping rules against a more modern ethical framework: the ethics of care. It will situate the misapplication of the OSHA recordkeeping outcomes and organizational performance metrics as an infringement of the care ethics philosophy. As a result of this work, safety scholars and practitioners can apply a different and more applicable ethical framework to their decision-making surrounding injury case management.

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OSHA Recordkeeping: A Necessary Evil?

In 1971, following the passage of the OSH Act of 1970, OSHA published the occupational injury and illness recording and reporting regulation, 29 CFR Part 1904. The injury and illness records were initially intended to have three purposes. First, they were intended to raise employer and employee awareness of the types of injuries and illnesses occurring to enable employers to correct hazardous workplace conditions. Second, they were intended to provide OSHA compliance staff with information to facilitate safety and health inspections. The third purpose was to produce aggregate statistical data on workplace injuries and illnesses for research, public information and targeted compliance interventions (OSHA, 1997).

In the early years, no specific guidance was provided on definitions of terms such as "work-related," "first aid" and "medical treatment," so the Bureau of Labor Statistics, tasked by OSHA with data collection and analysis, provided supplemental instructions. Over the years, the definitions have been revised and clarified many times, codifying specific definitions in regulations and compulsory guidance through official interpretation.

Besides the need for unambiguous definitions of terms, especially those relative to recordkeeping decision points, the chief criticism of the OSHA recordkeeping rule is that it results in underreporting of injuries and illnesses. In the mid-1980s and again in 2011, OSHA reviews discovered significant instances of underreporting. Several studies conducted during this same period, both from government-driven and independent, nonprofit organizations, found weaknesses in the structure of the recordkeeping system and made recommendations for improvement. In 1990, the U.S. Government Accounting Office found significant employer underreporting and cited reasons for this underreporting as 1. intentional underrecording in response to OSHA inspection policies or employer safety competitions; 2. unintentional underrecording because of a lack of understanding of the recording and reporting system; and 3. inaccurate recordkeeping because of the lack of priority placed on recordkeeping by employers caused by a lack of appropriate supervision of recordkeepers (OSHA, 1996).

In 1997 and again in 2001, OSHA revised the rule to incorporate changes recommended by these studies, amending and clarifying the definitions of those parameters used in recordability decision-making and reiterating that the intent of the system was for OSHA's purposes, which included macroanalysis of injury and illness data for specified industries and targeted enforcement efforts (OSHA, 1997; 2001a). Furthermore, in 2012 OSHA issued an enforcement memorandum stating that "workplace policies and practices that could discourage [injury] reporting . . . could constitute unlawful discrimination and a violation of [the OSH Act]" (OSHA, 2012). Furthermore, OSHA

has indicated that it intends to pursue even greater employer reporting obligations in the future, which could further exacerbate the problem.

To Record or Not to Record

A primary ethical decision point in the recordkeeping system is accepting an injury as a work-related event. In the regulatory text, the term "work-related" is defined as:

> An event or exposure in the work environment [that] either caused or contributed to the resulting condition or significantly aggravated a preexisting injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment. (OSHA, 2001b)

While this definition seems simple upon initial evaluation, it can be complex in application, with many nuances and potential inconsistencies based on specific scenarios. In the initial example of the employee who suffered a laceration after walking into a doorframe, the primary point of debate was whether the case was work-related at all. The regulation includes exemption language for incidents that occur on personal time including lunch, but also requires that the case be recorded if the employee was situated in the physical work environment or performing a work-related task, even if it occurs during personal time.

Adding to this confusion is the issue of compensability under the local workers' compensation system. What may be compensable may or may not be recordable depending on where the employee works. Blurred lines between telework and the home office environment have clouded this issue even further. The rules for OSHA recordkeeping and specific workers' compensation coverage are unique, and each case must be adjudicated individually and separately. The only issue held in common between these two systems is that a work-related injury allegedly occurred. A 2014 study of employer recordkeeping practices found that noncompliance with OSHA regulations was connected to workers' compensation administrative practices primarily due to confusion between the eligibility criteria defined in each system (Wuellner & Bonauto, 2014). Furthermore, this study also identified the practice of using injury and illness data in workplace safety awards programs and measuring job performance as likely motivators of underreporting.

A second problematic ethical decision point in the recording system is determining medical or first aid treatment. This difference in the severity threshold for recording injuries and illnesses is based on the particular phrasing of Section 8(c)(2) of the OSH Act, which states:

> The Secretary . . . shall prescribe regulations requiring employers to maintain accurate records of, and to make periodic reports on, work-related deaths, injuries and illnesses other than minor injuries requiring only first aid treatment and which do not involve medical treatment, loss of consciousness, restriction of work or motion, or transfer to another job. (OSH Act of 1970)

In the author's view, the definitions of first aid and medical treatment are key to the OSHA recordkeeping scheme and are the criteria most frequently evaluated by administrators when deciding whether a given work-related injury must be recorded. OSHA has attempted to simplify these definitions of the terms "medical treatment" and "first aid" by establishing a finite list of 14 specific treatments considered first aid, then determining that any treatment not listed is considered medical treatment. For example, nonprescription medications such as over-the-counter pain relievers are considered first aid treatment and are not recordable. However, if a physician prescribes a higher dosage of the same pain reliever, the treatment is considered medical and must be recorded (OSHA, 1997). This issue has been contentious and controversial. In the 2001 public comment on proposed revisions to the regulation, many commenters stated that the definitions and criteria for discernment between first aid and medical treatment were vague and did not reflect ongoing changes and innovations in medical treatment protocols adopted by the healthcare industry (OSHA, 2001a).

Employers typically use medical case management to control medical costs and monitor employee recuperation after an injury. These practices are valuable when assisting employees with ongoing treatments and rehabilitation after a severe injury. However, Fagan and Hodgson (2017) found that medical case management practices in the poultry industry, specifically those in on-site medical units such as an in-plant clinic, represented a significant cause of underreporting and underrecording of OSHA recordable cases. Additionally, in their study, Fagan and Hodgson found through employee interviews that employers' disciplinary and absentee programs had the most significant adverse effect on injury reporting. Furthermore, more unrecorded and underrecorded cases were identified in establishments with low injury rates than those with medium injury rates (Fagan & Hodgson, 2017), demonstrating that an overemphasis on numerical performance objectives impacts the process.

Ethics in Safety

A review of available literature showed that discussions of ethics in safety, whether scholarly or applied, have historically been broad-based and focused on the fundamental rhetorical argument that protecting workers is ethical and moral. Even the OSH Act establishes that employees have a fundamental and humanistic right to be protected from harm in their workplace (OSH Act of 1970). The foundation of ethics in the safety profession can be connected to professional practices of organizations such as the BCSP (2020). Code of Ethics and the ASSP (2012) Code of Professional Conduct. Both documents represent fundamental Kantian normative principles of honesty, fairness, truthfulness and integrity, informed by Aristotelean virtue ethics. For example, the BCSP Code of Ethics states that safety professionals must "be honest, fair and impartial; act with responsibility and integrity," and the ASSP Code of Professional Conduct states, "In all professional relationships, treat others with respect, civility and without discrimination."

Safety professionals often face a tension between their own ethical and moral codes and the organizational constraints placed upon them (Wachter, 2011). Parboteeah and Kapp (2008) found that principled local ethical climates represent an ideal environment to foster sustained organizational safety performance and that promulgating societal safety laws and regulations may not be directly relevant to safety performance. Safety ethics heretofore has focused more on utilitarianism (a means to an end), Kantian obligation (the right thing to do) and egalitarian justice (compliance with rules).

What Is the Ethics of Care?

The fundamental philosophy of the ethics of care differs from traditional deontological ethical principles in that it places moral significance on the interdependencies of relationships and provides the ethical motive of the act and not the utilitarian means or ends that justify it. While still considered a normative theory,

care ethics was developed initially as a power contrast to the moral theories of Kantian deontology and utilitarian consequentialism. However, it bears some resemblance with moral theories such as Aristotelian virtue ethics and Confucianism (Colton & Holmes, 2018; Duffy, 2014). One early seminal use of the term "care ethics" was that the care perspective was a different but equally legitimate form of moral reasoning and established that two parties in a caring relationship (the one caring and the cared for) is an ethical ground (Gilligan, 1993). Gilligan affirmed that both parties have some form of obligation to care reciprocally and meet the other morally, although not necessarily in the same manner (Engster & Hamington, 2015). Care ethics requires a foundation of trust, an essential relation between particular persons, as the fundamental concept of morality (Baier, 1986). Contemporary philosophers view care ethics as the most basic moral value in that a caring person, motivated to care for others, can participate in practical, ethical caring practices (Held, 2006). In comparison, traditional egalitarian theories of justice, which depend on fundamental principles and practices of care through autonomy without supplementation, undermine themselves (Kittay, 2011). Ruddick (2009) describes ethics of care as an ethos defined in opposition to justice, a kind of labor, and a special relationship, most often defined as a practice, value, disposition or virtue. Furthermore, Ruddick held that care ethics is frequently portrayed as an overlapping set of concepts: a species of activity that includes performances to maintain, contain and repair the world so that beings can live in it as well as possible. Care can also be understood as virtuous motives or communicative skills. Sander-Staudt (2021) cites Rachels (1999), McLaren (2001) and Halwani (2003) and describes the ethics of care as performative actions that involve maintaining and meeting the needs of oneself and others. Affirming the importance of caring motivation, emotion and the body in moral deliberation and reasoning ascribes an element of dignity and interdependence between persons (Sander-Staudt, 2021). Finally, the ethics of care encourages people to evaluate their caring for others as an essential dignity of life (Tronto, 1998).

How Do These Worlds Collide?

Incident reporting and investigation are essential components of a robust and effective safety management system in industrial environments. Documenting and analyzing events where system failures occur is necessary to determine root causes that, if modified, would prevent incident recurrence. The practice of evaluating incident data trends is also a critical function that must be conducted to focus attention and resources appropriately. However, the post-incident fact-gathering process can be misguided due to a disproportionate emphasis on recordability prevention via medical case management instead of root-cause analysis and risk mitigation. Safety professionals and medical case managers tasked with administrative upkeep of the mandatory injury documentation are mediators between the egalitarian compliance requirements, the utilitarian goal of determining the incident's root cause, and the ethics of care principle's emotional and physical concern for workers affected by the incident. In poorly managed safety cultures, the incident investigation system can be viewed adversely by employees as an interrogation and blaming process rather than a fact-based, evaluative process. This condition, compounded with an undue emphasis on recordable avoidance, can explicitly and implicitly communicate to workers that the organizational leadership cares more about the statistical outcomes than the worker's physical and mental well-being. This situation is in violation of the fundamental ethics of care philosophy.

> Injured employees must be cared for with their physical and mental health well-being placed above any numerical evaluation of organizational safety metrics.

Zero Accidents or Zero Recordables?

An overt emphasis on avoiding incident recordability, whether implicit or explicit, creates a temptation and pressure by administrators to sacrifice or second-guess medical treatment to split the fine hairs of regulatory requirements and exploit loopholes in those rules established by OSHA. Furthermore, safety performance measures focused on the zero-recordable objective represent a utilitarian de jure approach that only superficially boosts the organization's public appearance. This misguided emphasis does little to engage workers in a mutually beneficial culture where they perceive themselves as cared for by leadership and subsequently care about organizational success. This utilitarian mindset can erode trust in the organization and ultimately damage the culture of safety. Organizational leaders have an ethical responsibility to care for their employees. How this protection manifests into action in the workplace requires both emotional concerns for the well-being of others with intentionality of actions and inactions (Ciulla, 2009).

Is There a Better Way?

OSHA never intended for this reporting and recording system to be used as an internal performance measurement device. As stated in 1971, its original intention was to bring employers' attention to the hazards present in their workplaces and gather statistical data for internal macro trend analysis, resource prioritization and public communications. Furthermore, the practice of using injury statistics as an effective predictor of future incidents has been called into question as having little to an even negative correlation between minor injuries and more significant incidents and fatalities (Busch et al., 2021). A particular flaw in using the recordkeeping system for performance tracking is that recordability criteria do not always equivocate with the actual severity of the incident. It is dependent on the judgment of the medical treatment provider and is easily manipulated by all parties in the process—the injured employee (patient), the medical provider, the medical case manager and the recordkeeping administrator.

We Have to Measure Something

One of the most common arguments in favor of using the OSHA recordkeeping system as a performance metric is the absence of a more effective and valid measurement tool. Proponents argue that since a federal regulation grounds the process, it provides a level playing field by which all workplaces apply the same set of rules. Furthermore, advocates have positioned that if a company has a robust culture of safety and caring for workers, the negative connotations of injury reporting are moot, and the controversy surrounding OSHA recordkeeping decisions is irrelevant. While this condition is aspirational and provides a legitimate rebuttal, the reality of practice would suggest otherwise. Social media and anecdotal stories reflect that the ethical conflict between recordkeeping and safety metrics persists throughout the safety profession.

Much discourse in the safety community is centered around lagging and leading indicators for measuring safety performance. Injury statistics are considered lagging indicators because they view what already happened and cannot be changed. Leading indicators are those elements that are predictors of the operational condition of the system. Leading indicators for safety performance include implementing a safety management system framework based on external criteria such as a consensus standard (e.g., ANSI Z10; ISO 45001). Close-call incidents, often called "near-miss" events, have been classified as a leading indicator because, while an event occurred in the past, no harm resulted, and, therefore, an opportunity exists for root-cause analysis, organizational learning and recurrence prevention. Leading indicators focus on embodied actions of participants with emphasis on hazard identification, evaluation and mitigations before an actual incident with loss occurs.

Recommendations for Practical Improvement

At a minimum, organizations should consider dividing the administrative decision-making function from the investigation process: separating those who determine the root causes of the incident from those who coordinate injury treatment and medical case management from OSHA recordkeeping. Those administrators placed to ensure compliance with federal recordkeeping rules should be insulated and protected from the pressures of safety goal achievement. Injured employees must be cared for with their physical and mental health well-being placed above any numerical evaluation of organizational safety metrics. Reviews of safety goal establishment should question any lagging indicators used and strive for the adoption of more leading-based indicators to ensure that performance measurement systems are encouraging the desired proactive safety behaviors and action and not discouraging incident reporting for the sake of a goal.

Conclusion

This evaluation of the ethics of care theory applied to the OSHA injury and illness recordkeeping system seeks to describe and explain how the egalitarian system creates conflict and potential ethical dilemmas. The universally accepted normative ethic that worker safety is a just and ethical concept is challenged by the practice of using an arbitrary, inconsistent process for measuring safety success. If the ethics of care informs that caring is a multifaceted, performative action grounded in the individual well-being of both parties, then any action that places an injured employee in the crosshairs of administrative scrutiny challenges that principle and is counterintuitive to the larger ethical framework that protecting workers from harm is right and just. Organizational leaders should prioritize their resources on actions that support the ethics of care concepts, focusing on what matters: protecting (and caring for) people and mitigating risk. **PSJ**

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