THE PRIVATE PRACTITIONER AND OCCUPATIONAL MEDICINE

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It's no secret to anyone in this audience that the relationship between the private practitioner and occupational medicine has not been an especially close one. Rather, that relationship has been something on the order of first cousins who occasionally meet and then go their separate ways. This is not surprising because physicians in private practice—perhaps even more so than their patients—have been transfixed by the scientific and technological wonders of modern medicine. Thus, to some extent limited attention has been paid to external factors in disease causation, including occupational factors.

But strong and growing pressures for change are at work. To begin with, the costs of modern medicine have reached the point that private practice is not all that "private" anymore. Recent opinion polls, for example, demonstrate that public enchantment over the escalating quality of health care is now matched by public disenchantment over the escalating cost of that care. Hence, the socio-economic and political dimensions of health care have been given equal billing with its clinical dimensions. And there have arisen strong pressures for change, including changes in the relationship between the private practitioner and occupational medicine.

The need to moderate health-care costs has led to a re-emphasis of alternatives such as the prevention of disease or injury. This has led to renewed efforts to eliminate the environmental vectors of disease or injury, including those found in the workplace. Thus, occupational medicine has assumed growing importance not only as a specialty in itself, but also in terms of its import to physicians in private practice—or more specifically, to the health of their patients.

There are certain other pressures that are almost sure to make this relationship even closer as time goes by. Not the least among these is regulatory pressure. Certainly the activities of federal agencies such as the EPA and OSHA, not to mention the FDA and the FTC or the Food Safety and Quality Service of the USDA, serve to bring us closer together both as a profession and in our respective practices. I might add that American industry, and businesses large and small, also have been under intense public scrutiny. While those of us in the private sector may often feel like circling our wagons 'round for mutual protection, regulatory pressure does serve as a compelling reason to take mutual action in the resolution of problems common to us and of concern to society.

Less obvious, perhaps, but far more important in the long run, are at least three additional elements that should make consultation between private medicine and occupational medicine more common. First, ample historical precedent exists. Public health measures in general, especially prevention measures, have always played an important role in medicine, including American medicine.

If you'll recall, when the AMA was founded in 1847, it pledged itself to two primary

goals: to promote the art and the science of medicine, and the betterment of public health. Right from the beginning, the AMA devoted considerable time and attention to public health measures, including measures to cope with health hazards posed by the environment.

Among the first committees appointed by the AMA were the Committee on Practical Medicine—to assess the general state of health in the United States—and a Committee on Hygiene whose concerns included the environmental vectors of disease. Now as you can appreciate, very heavy initial emphasis was placed on the collection of statistics including vital statistics essential to the epidemiological approach to disease causation and treatment.

Eventually, these early efforts led to many of the beneficial public health improvements implemented later in the 1800's, including the development of sanitary sewer systems and pure water supplies in towns and cities across the country, and to the establishment of state boards of health.

At the turn of the century, Dr. Walter Reed and his US Army medical team discovered that the Aedes aegypti mosquito was the vector for yellow fever, a discovery that Dr. William Gorgas very shortly put to good use in the construction of the Panama Canal. Meanwhile, the United States was caught up in the Industrial Revolution and the population shift from farm to city. This revolution brought a welcome prosperity to the nation and allowed more Americans to secure the necessities of life, such as proper food and shelter, and an improved state of health.

But industrialization and urbanization also brought the beginnings of those environmental problems that trouble us today. As early as 1895, the Journal of the AMA editorially condemned the pollution of lakes and rivers. By 1900, problems arising from the occupational environment had become evident. Proposals for improvements in occupational health and safety and for the enactment of child labor laws gained added attention.

Problems stemming from urbanization also were evident. Thus, in 1903 an editorial in JAMA attributed a rising suicide rate primarily to "the great increase of urban population...and the increasing stress of modern life." During the early 1900's, automobiles also began to roll off the assembly lines in Detroit, which led the AMA, in 1923, to cite air pollution from automobile exhaust gases as a potential health hazard. The young and vigorous machine-age nation also produced considerable clank and clatter. As an article in our Journal in 1938 observed: "...the multiple and insidious ill effects of noise constitute an inadequately recognized, baneful influence on (the) lives of millions of persons throughout the country."

I could go on and cite numerous other examples of public health improvements that had their beginnings in the first half of this century and which were supported by our profession: the enactment of federal pure food and drug laws and the creation of the forerunner of the FDA, expansion of various disease immunization programs, the development of iodized salt, and the enrichment of food with vitamins and minerals. In any event, there is most definitely solid precedence for physicians in private practice to be concerned with the prevention, as well as the diagnosis and treatment, of health problems. Parenthetically, I wish to say that scientific and technological progress has enhanced our clinical and preventive capabilities. If clinical medicine has been literally revolutionized since the end of World War II, so has preventive medicine. Any number of new preventive capabilities could be cited, ranging from antibiotics, other drugs and

vaccines, to our burgeoning knowledge of genetic factors in disease. And, of course, occupational medicine has taken enormous strides in improving workers safety and injury control.

There are, in fact, strong bonds between occupational medicine and the private practitioner in terms of a dedication to clinical advancement; take, for instance, Drs. Creech and Johnson and their linkage of polyvinyl chloride with angiosarcoma of the liver. All such advances obviously have important implications for medicine in general, for private practitioners and for the health and well-being of the public at large. Which explains why the AMA has been sponsoring these annual Congress on Occupational Health since 1939. Our Department of Environmental, Public and Occupational Health also has helped focus public attention on many other diverse issues, such as the population problem, energy supplies and solid waste management.

I should add that we have supported the major pieces of legislation to protect our environment from air, water and noise pollution. We have, in fact, emphasized that since our environment is a national resource, the federal government has an important role to play in protecting it.

At the same time, however, the AMA has publicly objected to irrational government initiatives. For example, in a statement to the Interagency Regulatory Liaison Group in Washington, we urged that the IRLG be more scientific in its "Scientific Bases for Identification of Potential Carcinogens and Estimation of Risks", and recommended that they appoint a "blue ribbon" panel of leading physicians and other scientists to design and oversee this country's scientific inquiries into the myriad unknowns of the human carcinogenesis problem. We further urged the Group to require more wide-ranging professional peer review and opportunity for comment on the scientific integrity and appropriateness of studies having major regulatory significance.

In any event, I think you'll agree that my remarks demonstrate that there are economic, regulatory, historical and clinical reasons for private practitioners to stress prevention, as well as treatment, of disease. To do so requires the compilation of a complete medical history of the patient, including consultation with occupational medical professionals when appropriate.

There is one additional factor that serves to bring us together. I'm referring to the new and stronger ties between the health care system and business, industry and corporate management. These new ties have come about primarily through two major private sector initiatives to cope with the health-care cost problem—the Voluntary Effort and the deliberations, and subsequent recommendations, of the National Commission on the Cost of Medical Care. As you may recall, the Voluntary Effort was established in 1977 by a coalition of groups, including the AMA and the two largest hospital associations, as well as health insurers, consumers, government, and business and industry. The VE was instrumental in reducing the growth rate of total hospital expenses from 15.6% in 1977 to 12.8% in 1978 and effecting an estimated savings of $1.5 billion. This year, we hope to hold the growth rate to 11.6%, for an estimated savings of $3 billion.

The lion's share of credit for reducing health care costs should go to state and local VE coalitions all across the country. As one indicator of state and local commitment, consider the results of a questionnaire sent to state and local medical societies by the AMA. The questionnaire revealed that: 97% of our state societies are active in the VE; 70% have an organized physician committee for participation in the VE; while a majority of county medical societies also responded affirmatively to both questions.

Local physicians have also responded positively to an AMA plea of June 1978 by Dr. Tom Nesbitt, to bring the annual rate of increase in their own professional fees down to the level of the "all items" component of the Consumer Price Index. For the 12-month period ending in August 1979, the rate of increase in physicians' fees was just 9.6% or 2.2% below the 11.8% increase for "all items." Thus, practicing physicians are fulfilling their cost-containment responsibilities, in their own offices as well as in the hospital.

Furthermore, the AMA is committed to the proposition that the VE must be just one part of an integrated, long-range program of cost containment. This full-scale, long term approach to the cost problem is keyed to the recommendations of the AMA's National Commission on the Cost of Medical Care, which, though sponsored by the AMA, was an independent entity.

Like VE, the Commission also was widely representative of the major institutions in our society and included insurers, consumers, organized labor, government, business and industry. The Commission's 48 major recommendations, most of which have been approved by the AMA's House of Delegates, would instill permanent changes in the health-care economy; such as: greater marketplace choice in the costs and benefits of health-care coverage offered employees and other consumers; consumer sharing in the cost of insured care, with appropriate assistance for the needs of low-income families; fair-market competition between prepaid group practices and other providers and insurance systems; and adjustment of private and government insurance benefit packages "...to provide balanced coverage of alternative services and settings in the provision of health care."

The AMA, then, believes that a concerted, continuing campaign to voluntarily contain health care costs is an absolute imperative, as is the coalition of private sector institutions to shape and sustain this campaign—a coalition that includes business and industry. And let me tell you here and now that this is not just window dressing.

Over the past two years, an AMA-instigated program has taken our officers into the executive suites of more than 75 of the major US corporations to get management views on health care problems—including costs—and to familiarize business leaders with the recommendations of the National Cost Commission. And just three weeks ago, AMA and business leaders met at AMA headquarters to discuss specific plans for an action program through which the business community and local medical societies can mutually resolve some of the problems that exist. I should add that these problems are not related to cost alone, but involve issues such as access to care, employee time loss and employee rehabilitation.

In any case, it should be abundantly clear that these new avenues of communication and cooperation can be used to reach other mutual goals, including those of occupational medicine. As a matter of fact, the Commission's recommendations also stress the crucial value of preventive measures, including the early detection and resolution of developing health programs ,and the necessity to motivate the public to adopt more healthful lifestyles.

In closing, I think you must agree that the relationship between the private practitioners and occupational medicine will become closer and more constructive as time goes by. Not only will the new relationship be in our own best interests, but it will also be in the best interests of our patients and our society as well.

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