In Response to the 2002, Vol. 22, No. 4 Article Entitled

"The Rise and Fall of Occupational Medicine in the United States"

To the Editor:

Dr. LaDou[1] has offered a thought-provoking analysis of occupational medicine in the United States today. While we agree that there are significant challenges to occupational medicine, we differ with his conclusions on the value of residency training and believe that he has failed to address some of the central problems confronting occupational medicine today. Specifically, we believe that the future of occupational medicine can be bright, if it follows the lead of other medical specialties in requiring specialty training and board certification for its practitioners, and if it defines itself more broadly as occupational and environmental medicine.

As directors of occupational medicine residency programs, we have been involved for years in efforts to strengthen and expand the field of occupational medicine, broadening it to include environmental medicine, thereby enhancing our ability to attract physicians and medical students. We meet regularly, as LaDou states, but a central theme of our meetings is the recognition that the number and quality of applicants to our programs, and the number of graduates from our programs, remains a concern for all of us.[2] Furthermore, these sessions are always held with the involvement and participation of concerned stakeholders, including representatives from the National Institute for Occupational Safety and Health (NIOSH), which funds most of our training programs, as well as the Occupational Physicians Scholarship Fund, the American College of Occupational and Environmental Medicine, and the Association of Occupational and Environmental Clinics. NIOSH has been an essential partner in our discussions about the need to strengthen the field. Recent NIOSH initiatives, including an increase in research funding disbursements to education and research centers and a boost in training program grants, are evidence of a solid response to a pressing concern. We have also worked with the American College of Occupational and Environmental Medicine on projects to increase the visibility of occupational medicine in medical schools.

Although LaDou addresses the subject only indirectly, we believe that the central challenge confronting occupational medicine today is the absence of a clear consensus on the scope and emphases of occupational and environmental medicine. Occupational medicine is a specialty of the American Board of Preventive Medicine. The Accreditation Council for Graduate Medical Education (ACGME)[3] defines the specialty of preventive medicine as, "[The] specialty of medical practice that focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death." The ACGME[3] further states that, "Occupational medicine focuses on the health of workers including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures."

We believe strongly that residency-trained and board-certified specialists in occupational and environmental medicine are uniquely positioned to meet the needs of today's workplace, whether the goal is management of traditional chemical and physical hazards; maintenance of the overall health of the working population; assessment and prevention of new threats from chemical, biological, and radiological weapons; or assessment of environmental risks to workers and nonworkers alike. Most other medical specialties do not provide the knowledge, skills, and competencies to manage these problems in their training. By contrast, our graduates are well equipped to manage these new problems as well as the more traditional treatment of individuals with work-related injuries and illnesses.

Occupational medicine residencies will continue to train physicians with excellent clinical skills who can treat injured workers, and there is still a healthy demand in the workplace for graduates whose primary interest is injured-worker care. However, we agree with LaDou[1] that the traditional practice of occupational medicine, which emphasizes the care of injured workers, will continue to feel tremendous pressures from insurance carriers, employers, and other specialties. In our view, what distinguishes our graduates from other specialists are the skills that residency training offers in addition to good clinical training: a combination of occupational and environmental medicine, with a curriculum that includes epidemiology and biostatistics, toxicology, exposure assessment, environmental health, risk communication, and clinical preventive medicine. Together, these skills translate into competencies that give the residency-trained specialist unique qualifications in managing the health of individuals with injuries or illnesses due to occupational or environmental exposures, or in managing the health of working populations. Many corporations, healthcare organizations, universities, and government agencies look for physicians with the clinical, research, commu-

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nication, and policy-setting skills to direct their occupational and environmental medicine programs.

Unlike other medical specialties, occupational medicine historically has not required formal residency training for board certification or practice, which has undercut the value of the very training and certification that has proved essential to the success of other specialties.[4] In addition, other specialties, such as emergency medicine, have successfully convinced hospitals and insurers of the absolute necessity for certification, whereas occupational medicine has resisted the call for a similar requirement for its practitioners. Ultimately, the value of residency training and the need for the specialty is undermined if the majority of practitioners in the field do not require themselves to become certified specialists who can maintain the quality, integrity, and intellectual development of the specialty.

We agree with both Levy[5] and Lewis[6] that challenges to occupational medicine today go well beyond the specialty itself, and are a consequence of systemic changes in American health care, as well as representing a failure of occupational medicine leadership to redefine itself in a changing marketplace. Likewise, the nature of work and workplaces in America has changed dramatically, and offering our services to the service sector requires new strategies and perhaps new skills as well. We cannot alter all of these conditions by ourselves; however, we are not as gloomy as LaDou about the state of the specialty. The specialty of occupational and environmental medicine has significant potential for growth, if we clearly articulate who we are and what we do, and we nurture and support the training of certified specialists who can advance the intellectual foundations of our field.

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"The Rise and Fall of Occupational Medicine in the United States"

To the Editor:

As a board-certified occupational medicine specialist who has taught the subject since 1972 and who was co-director or director of an academic occupational and environmental medicine clinic in 1982–1997, let me strongly endorse Dr. Joseph LaDou's opinions.[1] He rightfully emphasized the importance of workers' compensation (WC) insurers in the structure and function of this field, but I wish he had specified a few more connections among phenomena.

For example, it is certainly true that only a fraction of workers with occupational illness receive WC benefits, and that most doctors who function as independent medical evaluators (IMEs) to determine WC eligibility fail to support work-relatedness, but the basic reason for such consistent bias is that the IME is selected by the WC claims manager, who is not going to refer to doctors who diagnose occupational illness because the claim denial rate is part of the claim manager's performance record. Many doctors quickly learn that if they want any more IME referrals, they should not diagnose occupational illness. Thus, the system design almost ensures such an outcome, which qualifies as institutional rather than individual corruption.[2] Disability insurance is closely related to WC insurance, utilizes the same IMEs, and is subject to the same diagnostic pressure.

Although some occupational physicians in this area function as IMEs, most of the IMEs do not regard themselves as occupational physicians and have no interest in board certification in this specialty. I have been told by certain corporate health and safety directors that they prefer to hire physician consultants with no training in occupational medicine because they are less encumbered with previous knowledge and more receptive to the corporate point of view. Dr. LaDou's description of academic circumstances was right on target.

The field of occupational medicine confers on its practitioners a major conflict of interest: skillful recognition of occupational illness may be incompatible with further employment or referral of patients.[3] A milder but similar conflict of interest has been affecting physicians whose concerns with patient care have been running counter to rules imposed by their health maintenance organization employers. The solution to these dilemmas will come, not by criticism of the individuals involved, but by restructuring the systems to correct the institutional bias.

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