The High-Risk Disease Notification and Prevention Program

Role of Personal Physicians

ALAN L. ENGELBERG[a]

Department of Public Health
American Medical Association
Chicago, Illinois 60610

This presentation focuses on the implications of the High-Risk Disease Notification and Prevention bills (S.79 and H.R.162) for personal physicians and how these implications may affect the preventive focus of the bills. Three topics will be discussed: (1) the personal physicians' role in the notification program; (2) payment for medical services; and (3) training for nonoccupational physicians. Most activists who labor for or against the passage of these bills work full-time in the occupational health arena, and see these bills as they would affect employees, businesses, and academic institutions. Some sections of the bills mention specifically the "employee's personal physician," yet most "personal physicians" are not occupational medicine physicians. As we are all painfully aware, with the lack of time in medical school curricula (an average of 4 hours in 4 years), most medical students and physicians barely realize that the specialty of occupational medicine exists, that people can become diseased because of exposures at work, and that physicians and other health and safety professionals can prevent disease and injury at work and even enhance the health of workers. Despite this general lack of knowledge, the American Medical Association (AMA), which represents the broad base of "personal physicians" in the United States, has long supported occupational safety and health legislation, especially since the late 1960s, when the great concerns about worker safety culminated in the passage of the Occupational Safety and Health Act of 1970. The AMA's position on the high-risk disease notification and prevention bills follows this trend: early on, the AMA's Council on Legislation supported the concept of notifying employees at high risk for developing occupational disease; however, the Council was troubled by many specific provisions of the bills, partly because it was not sure how these bills would affect "personal physicians" and their relations with their employee-patients.

Now that the two bills are nearly identical, their objectives and implications are clearer. Section 9 of S.79 describes the medical monitoring procedures, and paragraphs (c)(1) and (c)(2) of this section mention specifically the roles of the employee's personal physician. Paragraph (c)(1) states that the employee's physician may "medically determine that an employee who is a member of a population at risk shows evidence of the development of the disease described in the notice or other symptoms or conditions increasing the likelihood of incidence of such disease." This language is far superior to the language in previous versions of the bill by relating directly to what physicians normally do: physicians determine whether or not diseases are present or if in a particular individual a heightened

[a] Present address: Monsanto, 800 N. Lindbergh Blvd., St. Louis, Missouri 63167.

likelihood of disease is present (even though in the case of occupational diseases most employees' personal physicians may be a little out of their territory). Previous versions of the bill gave the employee's physician the power to authorize removal of the patient from the job. This power to effect a job action should never rest with a personal physician; rather, it is vested in an employer, a regulatory administrator, or a court, and perhaps the employee. I refer to this past language to state what I believe are the proper and improper roles of personal physicians in the high-risk notification process, so that the proper role is not altered when regulations are drawn up to implement the bills.

Alternative bills have been introduced, whose sponsors argued (speciously) that S.79 and H.R.162 are not designed with prevention in mind. Medical monitoring is a form of secondary prevention rather than primary prevention; nonetheless, the medical monitoring provisions constitute prevention. But this does raise a dilemma when it comes to payment for medical monitoring services. There are three groups of employees who are covered by these bills. First are the employees whose high risk resulted from exposures while employed by their present employer. For them, the employers must pay for medical monitoring. Second are the employees whose high risk resulted from exposures while employed by past employers. H.R.162 mentions this group and provides for a cost-sharing mechanism between the present employer and the notified employee. Third are the retirees; neither bill mentions them, which implies that the retirees would have to pay for their own medical monitoring services. Thus, two of the three groups of employees would have to pay for all or part of the medical monitoring services. As we all know, many persons in the United States are medically underinsured or uninsured. It is not hard to imagine that a large number of present and past employees who would be notified under the program would also be counted among the legions of uninsured or underinsured and therefore would have to pay out-of-pocket. Even those who have "adequate" medical insurance may face a problem, and herein lies the dilemma. Those of us in prevention know that medical monitoring constitutes prevention. So do third-party payers, who generally do not cover clinical preventive services. By calling the disease notification program "preventive," we may be limiting its effectiveness.

Finally, there is the issue of training. The bills would establish centers of excellence in occupational health whose functions would be to perform medical monitoring and train others to do the same. The notification letter itself will mention the name of the nearest center of excellence, and perhaps those who live nearby would benefit from the center's expertise. However, the number of notified workers who use these centers would be vanishingly small, indeed. Most notified employees would not live close to these centers, and they and those who live close more than likely would favor visits to their personal physicians rather than to faceless academic institutions. An example of this was recently highlighted in *Medical Benefits*,[1] which reported that employers were facing difficulty in getting their retirees to use either health maintenance organizations (HMOs) or preferred provider organizations (PPOs) as a way of cutting down health care coverage costs; the retirees wanted to remain under the care of the personal physicians with whom they had built up trusting relationships. The entire medical monitoring process, and hence the preventive nature of the notification program, may fall apart unless the many physicians who are untrained in occupational medicine learn enough about occupational medicine to function appropriately under the notification program. These physicians will no doubt follow suggested monitoring protocols, but they will certainly fall short of providing adequate counseling that must accompany physical examinations and laboratory proce-

dures. Unless physicians understand the need for lifetime, periodic follow-up on a 6-month or yearly basis, they may not instruct their patients to return.

As with most bills, Congress will appropriate insufficient funds to implement the program the bills envision. Most of the funding should go to strengthen the program where it is to have the greatest effect—at the level of the individual employee. Those who allocate the resources should understand that the training of personal physicians in all aspects of high-risk notification and medical monitoring should be given high priority. The effectiveness of the program should not end at the physician's office door.

REFERENCE

1. GIESEL, J. Doctor loyalty deters retirees from use of HMOs. Business Insurance December 21, 1987. Reported *In* Med. Benefits, January 15, 1988 :3–4.