

American College of Preventive Medicine

Policy Committee Report February 2004

Chair: Mark Johnson
Vice Chair: Chris Armstrong

Staff: Mike Barry

Since reporting to the Board in November 2003, the ACPM Policy Committee and policy staff have focused on: (1) advocating to strengthen preventive medicine residency funding, (2) participating in the 2003 Interim Meeting of the AMA House of Delegates, (3) reviewing policy resolutions and preparing for the ACPM Town Hall Forum, (4) preparing a position on hospital privileges for preventive medicine physicians, and (5) other new business.

Advocacy for Preventive Medicine Residency Training

ACPM has continued targeted advocacy aimed at assuring funding for preventive medicine residency and other health professions training programs. After ending a contentious legislative session in 2003 without final passage of a Labor-HHS-Ed appropriations bill, Congress reconvened in 2004 and passed a consolidated omnibus spending package for FY 2004 that restores most of the funding for the HRSA Title VII health professions programs. These programs were zeroed out in both the President's budget and Senate appropriations bill. The final package, signed by the President on January 23, provides \$9.2 million in funding for Public Health, Preventive Medicine, and Dental Public Health training programs, an 11 percent cut from the FY 2003 level. Decisions about the final allocation for the PMR training programs have not yet been made and rest with HRSA's Bureau of Health Professions.

As expected, funding for most Title VII programs has been eliminated again in the President's FY 2005 budget request, which was released on February 2. ACPM is working closely with several coalitions—most notably the Coalition for Health Funding and the Health Professions and Nursing Education Coalition (HNPEC)—to advocate for an increase in the Budget Resolution allotment for all discretionary health programs, which would remove a significant barrier to a more favorable appropriation for health professions training programs. ACPM also has compiled examples of success stories from current Title VII grantees to include in ACPM and HPNEC advocacy materials.

Among other avenues for increasing funding for preventive medicine residency programs, ACPM is re-focusing attention on Medicare GME financing. ACPM, working under the umbrella of the Preventive Medicine Leadership Forum, has secured a meeting with key senior staff at the Center for Medicare and Medicaid Services (CMS) to discuss the Medicare GME payment rules vis-à-vis preventive medicine training. ACPM and its partners view the meeting, which will take place on February 12 at CMS headquarters in Baltimore, MD, as an opportunity to familiarize CMS officials with the importance of a well-trained preventive medicine workforce and enlighten them about the negative impact of current CMS regulatory barriers on preventive medicine training. This meeting is a result of several ACPM actions, including letters

and issue briefs sent to both the CMS Administrator and the Secretary of Health and Human Services as well as a meeting with the Secretary as part of a roundtable discussion on the health professions workforce. ACPM will report to the committee at its February meeting on the outcome of the meeting with CMS.

AMA House of Delegates

ACPM was active at the recent AMA House of Delegates Interim Meeting, held December 9-12 in Honolulu, HI. The House adopted two ACPM-sponsored policy resolutions at the meeting—one calling on the AMA to support the renewal and strengthening of the 1994 Assault Weapons Ban, which is set to expire in September 2004, and the second urging AMA to advocate for strengthening regional and national capacity to respond to acts of terrorism and other emergencies. The House deferred action on a third ACPM resolution—which called on AMA to advocate for environmental and policy interventions to promote physical activity—to the 2004 annual meeting. ACPM, in conjunction with the Section Council on Preventive Medicine, also held a reception at the Interim Meeting to honor ACPM Past President Doug Scutchfield, who received the prestigious AMA Distinguished Service Award during the Opening Session of the House. ACPM nominated Scutch for the award.

ACPM Resolutions / Town Hall Forum

ACPM issued a call to members for policy resolutions in its November issue of *ACPM Headlines*, in its Fall and Winter editions of *ACPM News*, and on the ACPM web site. The solicitation also was targeted to the ACPM Policy Committee.

ACPM received two resolutions for consideration at this year's forum:

- 01-04 – Specialization in Preventive Medicine & Public Health in the U.S.: A Resolution for 21st Century Reform
- 02-04 – Proposed Resolution Condemning Recent Attacks on Lesbian, Gay, Bisexual, and Transgender and HIV-Related Research

Both resolutions have been vetted through the Policy Committee via the listserv. ACPM has compiled the comments and shared them with the authors, providing them with an opportunity to make changes accordingly. See Attachment A for copies of the two resolutions. The Policy Committee will take action on these resolutions at its meeting in Orlando.

After consultation with the ACPM President and Policy Committee Chair, ACPM has decided to combine the standing Open Policy Forum with a more-inclusive ACPM Town Hall Forum. This decision was made for two reasons: (1) the continuing weak response to ACPM's call for resolutions and sagging attendance at the Open Policy Forum, and (2) the need for a forum to interact with ACPM members on internal College issues, such as the College's new strategic plan. The Town Hall Forum will become a standing feature of each annual meeting, combining both internal issues (e.g., strategic planning, performance measurement, and project development) with external policy issues (e.g., policy resolutions). The Town Hall Forum will be co-chaired by the ACPM President and the Policy Committee Chair. Because of scheduling, this year's Town Hall Forum will not feed into the discussions of the Policy Committee.

Hospital Privileges

At its previous meeting, the Policy Committee agreed on a recommendation, which was adopted by the Board, that ACPM develop guidance on a minimum set of hospital privileges that should be granted to physicians trained only in preventive medicine. The issue is limited mostly to GPM/PH physicians without clinical training in another specialty. Dr. Chris Armstrong, using existing guidelines used by the military and with input from several committee members, has developed a proposed set of privileges (see Attachment B). The document is currently under review by the full Policy Committee, and a revised draft will be presented to the committee and Board in Orlando for adoption.

Other Activities / New Business

- Visit http://www.acpm.org/pol_comp.htm to view ACPM's policy compendium for action taken since the November Board meeting.
- The Policy Committee is reviewing a position statement by the Collegium Ramazzini calling for an international ban on asbestos (see Attachment C) and considering whether ACPM should endorse the statement or take some other action in support of a ban (see <http://www.collegiumramazzini.org/>).
- ACPM is seeking guidance from the Policy Committee about whether and how to express its views about alleged attempts by the Bush Administration to undercut the World Health Organization's (WHO) initiative to reduce the worldwide incidence of obesity, diabetes, cancer and other chronic diseases. It has been suggested that ACPM might develop a resolution asking the AMA to weigh in on the WHO global plan (see <http://www.who.int/hpr/global.strategy.shtml>). Another option is for ACPM to send letters to the President and Secretary of HHS asking them to support the WHO plan.
- ACPM is consulting with the Chairs of the Policy Committee and Prevention Practice Committee about the College developing a position or policy statement on antibiotic resistance.

ACPM Policy Committee Report, February 2004
LIST OF ATTACHMENTS

- Attachment A** Policy resolutions submitted for consideration by the ACPM Policy Committee in conjunction with *Preventive Medicine 2004*
- Attachment B** Recommended hospital privileges for preventive medicine physicians (draft)
- Attachment C** Call for an international ban on asbestos (Collegium Ramazzini position statement)

ATTACHMENT A

**Policy resolutions submitted for consideration by the ACPM Policy
Committee in conjunction with *Preventive Medicine 2004***

1 **American College of Preventive Medicine – Policy Resolution # 01-04**
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4 Title: Specialization in Preventive Medicine & Public Health in the U.S.: A Resolution
5 for 21st Century Reform
6 Author: G. Ethan Feldman, MD, MBA, MHA, MPH, FACPM
7 Date: November 19, 2003
8

9 WHEREAS,

10 Many of key public health leadership roles at the federal, state, and local levels are being filled
11 by professionals who have neither completed residency training or board certification
12 requirements in Preventive Medicine & Public Health, nor become ACPM members; and
13

14 WHEREAS,

15 Residency specialization in Preventive Medicine & Public Health (PM/PH) in the U.S. has never
16 been documented to be either well respected, let alone well known among the U.S. citizenry or
17 medical community; and
18

19 WHEREAS,

20 Median salaries of Prevention Specialists in the U.S. remain substantially lower than virtually all
21 other medical specialties; and
22

23 WHEREAS,

24 Many counties in the U.S. are already projected to have insufficient numbers of mental health
25 &/or primary care clinicians to properly care for patients with acute complaints despite a
26 prolonged period of federal financial support for residency training nationwide; and
27

28 WHEREAS,

29 Current published & anecdotal evidence does not support a true market need, demand, added
30 value, or substantive return on investment for a Preventive Medicine specialist in either the
31 public or private sector; and
32

33 WHEREAS,

34 While the Institute of Medicine report and other evidence-based reports claim that the U.S. has a
35 relative shortage of Preventionists, there exist virtually no published data to support the
36 hypothesis that PM/PH residency trained & board-certified Preventive Medicine ACPM
37 physician members are more effective, save more lives, earn more money, or receive more
38 employment inquiries from head hunters, or more job offers, than those public health physicians
39 who are not PM/PH board-certified or eligible; and
40

41 WHEREAS,

42 Recent appointees for prominent public health positions such as the Surgeon General, secretary
43 of HHS, director of CDC, NIH, & NCI, & many other major disease prevention entities, have not
44 come from the ranks of physicians who have undergone formal residency training in Preventive
45 Medicine & Public Health; and
46

46 WHEREAS,

1 The specialty training in Preventive Medicine & Public Health was established to help train
2 doctors for leadership roles in U.S. public health practice & policy;

3
4 WE HEREBY RESOLVE THE FOLLOWING TO ENHANCE THE PRESTIGE, VALUE,
5 SPECIALIZATION, & STANDARDS OF TRAINING IN PREVENTIVE MEDICINE &
6 PUBLIC HEALTH :

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8
9 1. All physicians applying for residency in preventive medicine for training starting July 2005 or
10 later must have completed at least 3 years of accredited residency training in a clinical specialty
11 in the U.S. by the intended start date ;

12
13 2. All physicians who apply for board eligibility in preventive medicine must already be board
14 certified in a clinical specialty to sit for the preventive medicine board exam;

15
16 3. Preventive Medicine residency slots will be reduced by 33% by 2006, & by 50% by 2010;

17
18 4. The failure rate of the preventive medicine board exam will be increased from its current
19 baseline up to a rate between 55 & 67%;

20
21 5. ACPM will advocate for federal legislation mandating that all physicians appointed to
22 federal, state, & local public health leadership positions shall be board-eligible in Preventive
23 Medicine & Public Health by 2010.

24
25

1 **American College of Preventive Medicine – Policy Resolution # 02-04**
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4 Title: Condemning Recent Attacks on Lesbian, Gay, Bisexual, and Transgender and
5 HIV-Related Research
6

7 Author: Christopher R. Armstrong, MD, MPH, FACPM
8

9 Date: December 1, 2003 (Revised February 6, 2004)
10
11

12 Whereas, the leadership of the United States Department of Health and Human Services (DHHS)
13 and some members of Congress have taken actions that will limit the free exchange of scientific
14 information; intimidate researchers and staff at the DHHS; lessen support for Lesbian, Gay,
15 Bisexual, and Transgender (LGBT) and HIV research; and threaten the health of LGBT people.
16 Recent actions include:
17

- 18 • Withholding \$75,000 originally offered for a conference on Lesbian Health issues that
19 DHHS had supported the year before (1);
20
- 21 • Withdrawing support of and refusing to distribute the “*Healthy People 2010 Companion*
22 *Document for Lesbian, Gay, Bisexual, and Transgender Health*” recommendations
23 concerning LGBT health issues (2);
24
- 25 • Calling for investigations and the elimination of funding of LGBT and HIV research
26 projects by members of Congress (3);
27
- 28 • Deciding not to support a 2003 United Nations sponsored resolution condemning
29 discrimination based on sexual orientation (4); and
30
- 31 • Supporting statements by US Senator Rick Santorum (R-PA) equating homosexuality
32 with bestiality (5).
33

34 Whereas, sexual orientation and gender identity are intrinsic and immutable qualities—not merely
35 recreational options to conventional heterosexual sex.
36

37 Whereas, the attack on LGBT health research and programming comes at a time when the
38 previous Surgeon General, The American Public Health Association, and other medical and
39 health organizations are calling for increased LGBT research and lessening disparities based on
40 sexual orientation and gender identity (1).
41

42 Whereas, research and programs directed toward the health needs of LGBT people are now
43 facing the prospect of being unfairly scrutinized by federal agencies and losing their funding
44 because of special bills in Congress (6).
45

46 Whereas, these activities have created an environment detrimental to LGBT health research and

1 program development.

2
3 Therefore, be it RESOLVED that The American College of Preventive Medicine:

- 4
5 1. Urges Congressional leaders to investigate recent attempts to undermine the scientific
6 peer-review process at the National Institutes of Health.
7
- 8 2. Urges the President of the United States of America, Congress, and DHHS to publicly
9 support the integrity of the National Institutes of Health's scientific peer-review process.
10
- 11 3. Urges the DHHS and Congress to cease all actions that unfairly jeopardize LGBT and
12 HIV research and programs.
13
- 14 4. Urges that DHHS recognize that LGBT people deserve the respect and consideration now
15 required for racial and ethnic minority groups, and recommit to end health disparities
16 based on sexual orientation and gender identity/expression.
17
- 18 5. Urge the President of the United States of America and Congress to maintain or increase
19 the appropriation for LGBT related research.
20

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ATTACHMENT B

**Recommended hospital privileges for preventive medicine
physicians (draft)**

PREVENTIVE MEDICINE - CORE PRIVILEGES

Comprehensive epidemiologic and clinical investigation and consultation for the prevention and control of disease, disability, and premature death, and evaluation, consultation, diagnosis, assessment of disease and injury risk, and treatment and intervention planning for individuals and population groups.

Preventable disease conditions including:

- Communicable diseases
- Tropical diseases
- Injuries
- Epidemics and unusual occurrences of diseases, disability and premature death
- Diseases of travelers
- Chronic diseases
- Chemical dependence
- Nosocomial infections
- Occupational and environmental diseases
- Diseases of lifestyle

Preliminary diagnosis, initial treatment, or stabilization of:

- Myocardial infarction
- Cardiac dysrhythmia
- Fluid and electrolyte disorders (all age groups)
- Heat-related illness
- Burns
- Shock
- Fractures
- Penetrating wounds
- Depressed level of consciousness and coma
- Abdominal surgical emergencies (all age groups)
- Appendicitis
- Gastrointestinal disorders
- Psychosis and potential suicide
- Poisoning
- Pyelonephritis
- Testicular torsion
- Hernia
- Urinary calculi
- Pulmonary insufficiency
- Decompression sickness
- Penetrating eye injuries
- Iritis

- 1 • Glaucoma
- 2 • Psoriasis and skin malignancy
- 3 • Pregnancy
- 4 • Pelvic pain
- 5 • Pelvic inflammatory disease
- 6 • Threatened, incomplete, and completed abortion
- 7 • Drug overdose
- 8 • Ruptured tubal ectopic pregnancy

9

10 Diagnostic or therapeutic procedures:

11

- 12 • Application of epidemiologic and biostatistical methods
- 13 • Interpretation of health care, injury, and infectious disease data
- 14 • Surveillance programs for diseases and injuries
- 15 • Investigation of epidemics and other health-related events
- 16 • Clinical and laboratory evaluations of individuals and groups
- 17 • Travel medicine clinical services and consultation
- 18 • Hospital infection control programs
- 19 • Prescription and administration of mass treatment, immunizations and medications to
- 20 control epidemics
- 21 • Disease contact tracking programs
- 22 • Individual and group education
- 23 • Immunization programs
- 24 • Disease and injury risk assessment of individuals and groups
- 25 • Disease screening and health risk assessment programs
- 26 • Interventions to modify or eliminate individual and group risk for disease and injury
- 27 • Application of biologic, behavioral, and environmental approaches to health promotion
- 28 and disease and injury prevention
- 29 • Disease and injury risk assessment associated with travel for individuals and groups
- 30 • Assessment of effectiveness of interventional programs
- 31 • Pulmonary function testing
- 32 • Cardio-pulmonary Resuscitation
- 33 • Endotracheal intubation (emergency)
- 34 • Audiometry
- 35 • Lumbar puncture
- 36 • Arterial blood gas sampling
- 37 • Initial interpretation of electrocardiogram before consultant confirmation
- 38 • Initial interpretation of chest, abdominal, skull, facial bone, and extremity x-rays before
- 39 consultant confirmation
- 40 • Incision and drainage of superficial abscesses
- 41 • Preparation and interpretation of potassium hydroxide and
- 42 Saline mounts for pathogens
- 43 • Incision and drainage of thrombosed external hemorrhoids
- 44 • Bladder catheterization

- 1 • Removal of corneal foreign body
- 2 • Preparation and interpretation of Gram stains for pathogens
- 3 • Performance of PAP smears
- 4 • Performance of pelvic examination
- 5 • Splinting or stabilizing spine and extremity fractures
- 6 • Performance of fluorescein stain for conjunctival lesions
- 7 • Suture closure of 1° layer wounds
- 8 • Eye irrigation
- 9 • Local infiltration anesthesia
- 10 • Intravenous infusion

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12 Comprehensive examination, diagnosis, and management of:

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- 14 • Uncomplicated gynecologic problems, including vaginitis and sexually transmitted
15 disease, contraception advice, prescription of oral contraceptives, and screening pelvic
16 examination
- 17 • Uncomplicated internal medicine problems, including cardiac disease, arthritis,
18 gastrointestinal disease, hepatic disease, infectious disease, hypertension, anemia,
19 pulmonary disease, renal disease, diabetes, neurologic disease and thyroid disease
- 20 • Uncomplicated dermatologic problems, not to include psoriasis or malignancy, but
21 including acne, verrucae, herpes simplex, seborrhea, dyshidrosis, scabies, pediculosis,
22 cold injury, immersion dermatitis, plantar warts, corns, calluses, and excisional punch
23 biopsy
- 24 • Uncomplicated orthopedic problems including muscle strain, sprains, low back pain,
25 bursitis, tendonitis, and minor musculoskeletal trauma
- 26 • Uncomplicated otolaryngologic problems, including otitis media and externa, cerumen
27 occlusion of canal, pharyngitis, laryngitis, removal of nasal or auditory canal foreign
28 body, nosebleed, and rhinitis
- 29 • Uncomplicated urologic problems, including cystitis, prostatitis, epididymitis, and
30 sexually-transmitted disease
- 31 • Uncomplicated behavioral problems, including crisis intervention, short-term individual
32 counseling for difficulty with interpersonal relationships or adapting to authority, and
33 problems related to substance use and abuse
- 34 • Uncomplicated environmental or occupationally-related problems, including asbestos,
35 heat, and noise exposure screening and monitoring
- 36 • Uncomplicated ophthalmologic problems, including conjunctivitis, visual acuity testing,
37 corneal abrasion, and conjunctival foreign body
- 38 • Routine, uncomplicated prenatal care, up to 20 weeks gestation
- 39 • Uncomplicated pediatric problems, including well child care, pediatric preventive care
40 counseling, otitis, bronchitis, pneumonia, asthma, gastroenteritis and viral exanthemas

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PREVENTIVE MEDICINE - SUPPLEMENTAL PRIVILEGES

- Disaster preparedness design and management
- Implementation of disaster relief efforts
- Application of group behavior modification techniques
- Advanced epidemiologic biostatistical methods
- Interventional drug or vaccine studies

ATTACHMENT C

**Call for an international ban on asbestos (Collegium Ramazzini
position statement)**

1 Collegium Ramazzini

2 *"...a bridge between the world of scientific discovery and the social and political centres which*
3 *must act on these discoveries..."*

5 **CALL FOR AN INTERNATIONAL BAN ON ASBESTOS**

6 **To eliminate the burden of disease and death that is caused worldwide by exposure to**
7 **asbestos, the Collegium Ramazzini calls for an immediate ban on all mining and use of**
8 **asbestos. To be effective, this ban must be international in scope and must be enforced in**
9 **every country in the world.**

10 Asbestos is an occupational and environmental hazard of catastrophic proportion. Asbestos has
11 been responsible for over 200,000 deaths in the United States, and it will cause millions more
12 deaths worldwide. The profound tragedy of the asbestos epidemic is that all illnesses and deaths
13 related to asbestos are entirely preventable.

14 Safer substitutes for asbestos exist, and they have been introduced successfully in many nations.
15 The grave hazards of exposure to asbestos and the availability of safer substitute materials have
16 led a growing number of countries to eliminate all import and use of asbestos. In the United
17 States, there has occurred drastic reduction of asbestos usage. Asbestos has been banned by
18 Sweden, Norway, Denmark, The Netherlands, Finland, Germany, Italy, Belgium, France,
19 Austria, Poland, and Saudi Arabia.

20 **The Collegium Ramazzini**

21 The Collegium Ramazzini is an international academic society that examines critical issues in
22 occupational and environmental medicine. The Collegium is dedicated to the prevention of
23 disease and the promotion of health. The Collegium derives its name from Bernardino
24 Ramazzini, the father of occupational medicine, a professor of medicine of the Universities of
25 Modena and Padua in the late 1600s and the early 1700s. The Collegium is comprised of 180
26 physicians and scientists from 35 countries, each of whom is elected to membership. The
27 Collegium is independent of commercial interests.

28 **Background**

29 The health consequences of asbestos in contemporary industrial society have been documented
30 extensively in the world scientific literature. The toll of illnesses and deaths among asbestos
31 workers in mining, construction, and heavy industry is well known. The pioneering work of
32 British, South African, and Italian investigators (Doll, 1955; Wagner, Speggs, Marchan, 1960;
33 Vigliani, Mottura, Maranzana, 1964) laid the foundation for definitive investigations by Irvin J.
34 Selikoff and his colleagues of insulation workers in the United States. Selikoff's monumental
35 studies showed, first, the greatly increased mortality experience of insulation workers (Selikoff,
36 Hammond, Churg, 1964) and, later, the synergistic relationship between tobacco smoking and
37 asbestos work (Selikoff, Hammond, Churg, 1969). Men who were followed more than 20 years
38 from first onset of exposure sustained excessive risks of lung cancer and mesothelioma, as well
39 as risk of other neoplasias (Selikoff, Seidman, 1991). These risks affect not only asbestos

1 workers, but their families and neighbors (from material on clothing or plant emissions), users of
2 products that contain asbestos, and the public at large.

3 Asbestos is a commercial term applied to certain fibrous minerals with the properties of thermal
4 resistance, tensile strength, and acoustic insulation. Asbestos minerals are divided into two
5 groups: serpentine and amphibole. There is only one type of asbestos derived from serpentine
6 minerals, chrysotile, also known as white asbestos. Amphibole minerals include five asbestos
7 species: amosite, crocidolite, tremolite, anthophyllite, and actinolite. Two of these are
8 commercially valuable: amosite, or brown asbestos, and crocidolite, or blue asbestos. The other
9 amphibole minerals are of little commercial importance.

10 All forms of asbestos cause asbestosis, a progressive fibrotic disease of the lungs. All can cause
11 lung cancer and malignant mesothelioma (IPCS, 1988; Dement, Brown, Okun, 1994). Asbestos
12 has been declared a proven human carcinogen by the U. S. Environmental Protection Agency
13 (EPA) and by the International Agency for Research on Cancer of the World Health
14 Organization (EPA, 1986; IARC, 1987). Early indications that chrysotile might be much safer
15 than other forms of asbestos have not been confirmed (UNEP, ILO, WHO, 1998). The
16 preponderance of scientific evidence to date demonstrates that chrysotile, too, causes cancers,
17 including lung cancer and mesothelioma (Smith, Wright, 1996; Stayner, Dankovic, Lemen,
18 1996). Canadian chrysotile that is amphibole-free still is associated with mesotheliomas (Frank,
19 Dodson, Williams, 1998).

20 A leading asbestos researcher, Julian Peto, and his colleagues predict that deaths from
21 mesothelioma among men in Western Europe will increase from just over 5,000 in 1998 to about
22 9,000 by the year 2018. In Western Europe alone, past asbestos exposure will cause a quarter of
23 a million deaths from mesothelioma over the next 35 years. The number of lung cancer deaths
24 caused by asbestos is at least equal to the number of mesotheliomas, suggesting that there will be
25 more than half a million asbestos cancer deaths in Western Europe over the next 35 years (Peto
26 et al, 1999). In Sweden, Jarvholm has reported that the number of deaths caused each year by
27 malignant mesothelioma is greater than the number of deaths caused in that country by all
28 workplace injuries (Jarvholm, Englund, Albin, 1999).

29 **The need for a ban**

30 An immediate international ban on the mining and use of asbestos is necessary because the risks
31 cannot be controlled by technology or by regulation of work practices. The strictest occupational
32 exposure limits in the world for chrysotile asbestos (0.1 f/cc) are estimated to be associated with
33 lifetime risks of 4/1,000 for lung cancer and 2/1,000n for asbestosis (Stayner et al, 1997). These
34 exposure limits can be technically achieved in the United States and in a few other highly
35 industrialized countries, but the residual risks still are too high to be acceptable. In newly
36 industrializing countries engaged in mining, manufacturing, and construction, asbestos exposures
37 are often much higher, and the potential for epidemics of asbestos disease is greatly increased
38 (Giannasi, Thebaud-Mony, 1997; Izmerov, Flovskaya, Kovalevskiy, 1998).

39 Scientists and responsible authorities in countries still allowing the use of asbestos should have
40 no illusions that "A controlled use" of asbestos is a realistic alternative to a ban. Moreover, even
41 the best workplace controls cannot prevent occupational and environmental exposures to
42 products in use or to waste. Environmental exposure from the continued use of asbestos still is a

1 serious problem. A recent study of women residing in communities in Canadian asbestos mining
2 areas found a seven fold increase in the mortality rate from pleural cancer (Camus, Siemiatycki,
3 Meek, 1998). Large quantities of asbestos remain as a legacy of past construction practices in
4 many thousands of schools, homes, and commercial buildings in developed countries, and are
5 now accumulating in thousands of communities in developing countries.

6 An international ban on mining and use of asbestos is necessary because country-by-country
7 actions have shifted rather than eliminated the health risks of asbestos. The asbestos industry has
8 a powerful influence over public policy in many countries. In the United States, the asbestos
9 industry succeeded in 1991 in overturning the EPA=s recommended ban and phase-out of
10 asbestos by a technical ruling in the courts, Canada, Russia, and other asbestos-exporting
11 countries have developed major markets in the newly industrializing nations. Conditions of
12 current asbestos use in developing countries now resemble those that existed in the industrialized
13 countries before the dangers of asbestos were widely recognized.

14 The commercial tactics of the asbestos industry are very similar to those of the tobacco industry.
15 In the absence of international sanctions, losses resulting from reduced cigarette consumption in
16 the developed countries are offset by heavy selling to the Third World. In similar fashion, the
17 industrially developed world has responded to the asbestos health catastrophe with a progressive
18 ban on the use of asbestos. In response, the asbestos industry is progressively transferring its
19 commercial activities and the health hazards to the Third World.

20 Multinational asbestos corporations present a deplorable history of international exploitation.
21 These firms have opened large and profitable internal and export markets in Brazil elsewhere in
22 Latin America, and in India, Thailand, Nigeria, Angola, Mexico, Uruguay, and Argentina. Brazil
23 is now the fifth largest producer and consumer of asbestos in the world, after Russia, Canada,
24 Kazakstan, and China. While asbestos use in the United States amounts to less than 100 g per
25 citizen per year, asbestos use in Brazil averages more than 1,000 g per citizen per year. In third-
26 world countries, use of asbestos has been increasing at an annual rate of about 7 percent.

27 **Conclusion**

28 The grave health hazards of asbestos are entirely preventable. The health risks of asbestos
29 exposure are not acceptable in either industrially developed or newly industrializing nations.
30 Moreover, suitable, safe substitutes for asbestos are available. An immediate worldwide ban on
31 the production and use of asbestos is long overdue, fully justified and absolutely necessary.

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2
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