FILE NAME: American Cyanamid (AMCY)

DATE: 1962

DOC#: AMCY002

DOCUMENT DESCRIPTION: Book Excerpt - Occupational Health in America

OCCUPATIONAL HEALTH IN AMERICA

by Henry B. Selleck

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THIS BOOK WAS PREPARED UNDER THE DIRECTION OF
THE HISTORY COMMITTEE OF THE INDUSTRIAL MEDICAL ASSOCIATION
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1962
Wayne State University Press Detroit

connection: "It is frequently said nowadays that after the war the industrial relations program will be adopted by practically all industries. The personnel and industrial relations leaders are claiming that accident prevention, and related problems, should come within the jurisdiction and control of the industrial relations or personnel staffs. You will hear much more about this a little later."

It is a matter of record that safety as a mainline activity is still in the hands of safety experts; medicine and surgery are still the responsibility of medical men; industrial relations and personnel problems remain under supervision of specialists in those fields. Nor is there reason to think that these vast and diverse enterprises could be successfully handled by a single administrative head except in small organizations.

These same considerations apply in the relationships of industrial medicine to the specialized fields of hygiene and public health, both of which have their own exclusive objectives but perforce rub shoulders on common ground in industries of every type and size. Hygiene, "the science of the preservation of health" or "the science of sanitation," is by dictionary definition an extremely broad term. Even in its limited application to industry it includes plant sanitation, the prevention of occupational diseases, and most of the basic procedures to assure the health of employees. In higher education it is a convenient classification covering instruction in widely varying phases of health maintenance.

"From the employer's viewpoint," wrote Doctor Mock in 1919, "industrial hygiene is now recognized as the cornerstone of maximum production. From the standpoint of the medical man it is the cornerstone of preventive medicine."[4] But what of its specific functions and responsibilities in industrial health?

As William R. Bradley, chief of the Industrial Hygiene Division of the American Cyanimid Company, explains it:

> The field of industrial hygiene is composed of those interested in the total environment of people while at work. The industrial hygienist may be a person more particularly interested in microchemical sampling and analysis, or his main interest or training may be in that distinct phase of engineering involving work-place environmental control from the standpoint of health maintenance.
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> Likewise, he may be interested particularly in the field of toxicology or in the field of health physics. Again he may be one who embraces more knowledge and experience in the field of atmospheric pollution prevention or in the field of industrial sanitation.
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> The industrial hygienist, then, is one who has a knowledge and appreciation of the general body of information regarding worker health preservation, although his specific interest or activity from time to time may be more closely directed towards one or more phases of the industrial hygiene field.
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> The American Industrial Hygiene Association now [in 1952] in its fourteenth year, provides a common ground upon which these closely related and associated disciplines may properly meet to exchange information.[5]

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employ general practitioners on part-time or call basis for the treatment of these conditions. Therefore, inasmuch as the general practitioners of medicine treat 100 percent of the nonoccupational disabilities and 85 percent of the occupational, the problem of removing the sources of ill health in industry is predominantly in the hands of the general medical profession. Any effort to obtain maximum results by way of health maintenance in industry must be through them.

At least as early as 1938, realizing the direct bearing of sickness on national productivity, the AAIP&S had a special (and extremely active) committee at work on studies of industrial absenteeism. In that year the group appointed by President Selby included Sayers (chairman), William A. Sawyer, D. L. Lynch, John J. Wittmer, J. B. McConnaughy (Aluminum Company of America), and R. D. Mudd (Chevrolet Grey Iron Foundry). This committee continued its work for several years with slight changes in personnel, A. W. Schoenleber (Standard Oil Company, New Jersey) replacing McConnaughy and Wittmer in 1939. Important among its reports was a recommendation submitted in June, 1940, outlining a simple record system which would provide industrial management with vitally needed information on absenteeism due to all forms of illness, whether or not of occupational origin.[4]

A few months before the Japanese attack on Pearl Harbor an all-important AAIP&S Committee on National Defense was appointed by the new president, T. Lyle Hazlett. Its chairman was Dan Lynch, perennially occupied with association activities, who had just retired from the presidency. Other members were Henry S. Brown (Michigan Bell Telephone Company), D. O. Hamblin (American Cyanamid Company), and Charles-Francis Long, an authority on the problems of tobacco workers.

In the summer of 1942 this committee released the results of an exhaustive study, known as the Lynch-Brown report, of wartime health problems and a detailed program for industrial management, designed to minimize the effects of possible enemy attack. It was a militant, and confident, presentation, but the over-all picture it painted of manpower losses through accident and illness was far from encouraging.

Citing National Safety Council accident statistics for 1941, the committee said: "Although it would appear from these data that occupational deaths and disabling injuries may not have increased in the same degree as employment, it still seems clear that the sacrifice of life and vital man-hours was not lessened appreciably. The reported 18,000 deaths and 1,600,000 disabling injuries represent a tremendous wastage of manpower, and a continued challenge to everyone concerned in saving lives and saving this nation."[5] Accident figures such as these were indeed shocking to contemplate, yet they were only an echo of much older industrial statistics. The rate of fatal and nonfatal injuries had followed a seesaw course for many years, showing no conclusive trend in either direction. The situation was one which led Sayers to comment: "In spite of the spectacular achievements which have been made in safety

Fe Railroad; and the New Jersey Association of Industrial Physicians & Surgeons, whose president, Donald O. Hamblin, was nationally prominent as medical director of the American Cyanamid Company, and an active worker in the AAIP&S.

In 1940 two more state societies became affiliated: a Michigan unit (R. H. Denham, of Grand Rapids, president) representing industrial volume and numerical strength sufficient to maintain an active component apart from the Central States Society; and the Georgia Association of Industrial Surgeons, under R. L. Rhodes, of Augusta, as president.

Notable advances were made in 1941. The Hawaiian society, accepted as a component in January, has remained the only such affiliate outside the continental territory of the United States. Originally designated as the Hawaiian Society of Industrial Physicians & Surgeons, it became in 1944 a unit of a new territorial organization which has since been listed among components as the Territorial Association of Plantation Physicians. Its overseas members, though numerically few, have enthusiastically supported the programs of the parent organization, insofar as they have been applicable.

Also in 1941, two large and important regions were given representation in the national structure, with acceptance of the Western Association of Industrial Physicians & Surgeons and the New England Conference of Industrial Physicians as component societies.[2] And Florida, Maryland and Milwaukee associations were added to the roster. The Georgia society, along with the Maryland and Milwaukee units, withdrew after brief periods, having found member support in wartime insufficient to justify participation in national activities.

It is of interest that personal representatives from seven of eleven components of record in 1941 were welcomed at the annual meeting of the Board of Directors in Pittsburgh on May 5. Of the other four the Hawaiian Society was deterred by distance, and the newly organized Western Association had held its first annual meeting on the preceding day. Its president, Robert T. Legge, sent a telegram of greeting and explanation to the Board in Pittsburgh.

There was no question, even at that early date, as to the value of active component societies in advancing the cause of industrial medicine, nationally as well as locally. They were in constant touch with both large and small industries and were thoroughly familiar with local medical programs. By monthly or quarterly meetings they kept interest alive and stimulated productive activities while, at the same time, furthering the aims and policies of the national organization.

On the other hand, development of the components presented several disturbing and difficult problems. There was a good deal of confusion and misunderstanding as to the status of a component society within the AAIP&S. The components, naturally, wanted no second-class membership. They did want a share of major responsibilities, and reasonable representation on the Board of Directors. They asked for clear-cut decisions as to dues, membership qualifications, rights and privileges.

These and other issues were aired at great length at the association's 1940 meet-