2017 Association of American Physicians Presidential Address

The public good of science for health

Linda P. Fried

April 22, 2017, was the date of the 132nd annual meeting of the Association of American Physicians (AAP). April 22nd was also the date of the March for Science, which was held in 600 cities globally. AAP was a formal sponsor of the march, with 84% of its members endorsing it. Apart from the march, the trisociety AAP-ASCI and American Physician Scientists Association (APSA) meeting offered its usual evidence of why the March for Science is relevant: that science both represents some of the best of the human condition — of curiosity, knowledge, and exploration of the meaning of being human — and is a basis for securing a better future.

The premise that science will serve better health futures goes back to the founding of the AAP in 1885. Established “for the advancement of scientific and practical medicine,” it was formed and led by the — then — young Turks, who were forceful leaders in bringing science to medicine in the US. Their expectation was that scientifically based medicine would transform the physician’s ability to improve the health of patients. We now can look back on the results: more than 130 years of advances in science have been critical to the US and to the world, creating dramatic improvements in health, well-being, life expectancy, and prosperity. One summary metric demonstrates an increase in life expectancy by over 30 years in the last 100 years (1), largely due to the scientific contributions of public health and medicine, improved education, and poverty alleviation. Further, Robert Solow’s Nobel Prize–winning attribution is that over half of all economic growth in the US since World War II is due to technological progress and our underlying investments in education, basic science, research and development, and infrastructure (2). At the same time, improved health status of the US, and of all nations, is fundamental to our productivity as well as our well-being and longevity.

I have had the opportunity to review the archives of the AAP and find that it offers a history of the roots and the trajectory of these achievements in terms of the US origins of medical and public health science and then the evolution of medical science in particular. I would like to reflect on this trajectory and accomplishments and suggest how I think this offers a lens to both our future and suggest a redefined status for science for health as a public good.

AAP was organized in 1885 to be a society of “American physicians and pathologists” — initially limited to 100 members — who would meet annually to discuss subjects of “general interest for the advancement of scientific and practical medicine” (Table 1).

The first council of AAP included seven physicians from the east coast, Chicago, and Montreal, including several who were at the forefront of the move to make science the basis for advancing medicine. The members are listed in Table 1. Two in the table, Doctors William Osler and William Henry Welch, are preeminent figures in medicine and science.

Figure 1 shows a photo of William Osler, who became AAP president in 1895, while he was writing The Principles and Practice of Medicine. Osler was the creator of the medical residency, bedside rounds, and clinical clerkships and was the author of “Aequanimitas.” He was one of the “fab four” who started the Johns Hopkins School of Medicine, the first US medical school committed to science as the foundation to medicine. Figure 2 shows a photo of the AAP president’s gavel. It is made from the wood from Dr. Osler’s birthplace in Bond Head, Canada.

The other member from the first AAP council meeting who I would like to particularly honor is William Henry Welch (Figure 3), the impresario of US scientific medicine who started the Johns Hopkins School of Medicine, recruited all of its initial faculty, and served as founding dean from 1893 to 1898 — with the goal of creating the first scientifically based school of medicine in the US. Welch was president of AAP in 1901. He subsequently served as founding dean of the first school of public health, at Johns Hopkins, from 1916 to 1926. In fact, Welch proposed that a school of public health be developed at the same time as the school of medicine, but that ultimately happened sequentially. Welch also served...
over his career as the founding editor of the *Journal of Experimental Medicine* and president or chairman of 19 major scientific organizations, including the American Medical Association (AMA), the American Association for the Advancement of Science (AAAS), the National Academy of Science (NAS), and the National Research Council as well as AAP.

The founders’ vision for AAP was to foster discourse and advances in understanding through an annual meeting that would span the full breadth of physician-led science and to generate exchange across disciplines and between science and practice. There were to be original communications and demonstrations of gross and microscopic preparations and of apparatus and instruments. After the first meetings, they immediately decided to “issue a volume of transactions each year” — since discontinued — and also decided that social events that would foster a community of medical scientists were important, and they created the annual dinner AAP still holds.

The first two AAP meetings give us insight into where medical science was at the onset of AAP. The first meeting had a debate: “Does the present state of knowledge justify a clinical and pathological correlation of rheumatism, gout, diabetes and chronic Bright’s disease?”

Other presentations included “Certain elements found in the blood of malarial fever” and “Demonstration of bacterial cultures from a case of mycotic endocarditis in man, and of specimens showing the experimental production of the disease in rabbits” — the first mention of animal models.

It is amazing that these scientific discoveries were occurring less than 40 years after Virchow first set out to create a cellular theory of human biology.

In 1887, the second AAP meeting had 2 debates, one of clinical interest (“Antipyretic therapy and its use in the treatment of typhoid fever”) and one of pathological interest (“Embolic infarctions”) plus a presentation of “Cases of sewer gas poisoning.”

The meetings typically spanned pathophysiologic investigations, bacteriology, and evidence on the environmental causes of disease. After only two meetings, in October 1887, they had their first debate of the council about how narrow or broad the society should be. Council approved the following motion: “Dr. Miles should be informed of the large number of papers on cardiac subjects, and that it be suggested to him that it would be advisable to choose some other subject for discussion.”

The following year, 1888, in response to this request, the meeting ranged in topics from “Geographical distribution of typhoid in the US” to “Management of typhoid convalescence” to the “Demonstration by Dr. Welch of a series of microscopic specimens of the thyroid gland” to “Photographs of bacteria” to one cardiac topic: “Disturbances of heart rhythm with reference to their causation and their value in diagnosis.”

Table 2. 2017 trisociety meeting themes

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<tr>
<td>Healthy brain, healthy living</td>
<td>Promotion of cognitive resilience</td>
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<td>White House BRAIN initiative</td>
<td>Biology of memory and age-related memory loss</td>
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<tr>
<td>Drugs, neurotransmitters and the brain</td>
<td>Visualizing medicine</td>
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<td>Translational pathways to impact</td>
<td>Visualizing GPCR</td>
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<td>Areas requiring urgent responses</td>
<td>Microbial diagnostics</td>
</tr>
<tr>
<td>Vaccine development</td>
<td>Zika</td>
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<tr>
<td>Preparing for next pandemic</td>
<td>Global health security</td>
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This discussion continues to this day: how to learn from the most cutting edge of clinically relevant sciences in ways that honor key advances in science and also support cross-fertilization and synergies across fields. The 2017 meeting sought to tackle this 130-year-old discussion in a new way: the trisociety planning committee selected three themes (see Table 2) and invited speakers to represent the spectrum of physician-led science within each theme. Our goal here is to represent the phenomenal breadth of our members’ science, but also to do more of what the founders were intending: both the cross-fertilization across fields and linking the discrete parts of the full cycle of science to foster appreciation of the interconnectedness between sciences and propel translation to impact.

Figure 4 presents a conceptual expression of our goals to represent the full cycle of translation, which entails discovery at every level of the progression of science. Physician-led science for health (a) begins with the challenge of the clinical problem, (b) develops evidence as to its import and prevalence, and (c) establishes standardized characterization of the clinical problem and clinical and population-based evidence as to etiology and consequences. From this base, discovery involves hypothesis development, elucidation of question,
and evaluation (3, 4) of causes in populations and the laboratory (5). Ultimately, interventions can be developed from each stage to improve the clinical problem being addressed.

The archives of the scientific advances reported and discussed by AAP members since its inception show many of the same topics we considered at this 2017 meeting and illuminate the dramatic progression of science over more than 130 years. For instance, Table 3 displays some examples of original communications on brain science presented at AAP meetings in its initial years. Table 4 shows some of the initial presentations on approaches to measuring and displaying clinical characteristics circa 1900. Table 5 displays a range of examples of talks on infectious disease at AAP meetings from 1885 to 1914, while Table 6 displays examples of the early work on vaccines.

Susser and Stein, in 2009, offered a broad summary of the generational progression of science since Welch, conceived as eras and conceptually displayed in graphical form in Figure 5 and ref. 6. These eras very much align with AAP’s trajectory of science at its meetings. Further, the trajectory of health improvement in the US in the last 100 years resulted from these scientific advances along with improvements in living conditions, education, and poverty. The dramatic improvements in our population’s health is something that we sometimes take for granted, even while we constantly push forward to make the next advance that is needed. Just to tip our hat to those advances, we can compare measures of health status in 1900 to those in 2000: (a) In 1900, the top 3 causes of death were infectious diseases; by the mid-20th century it was chronic diseases (3). (b) From 1920 to 1940, the US saw dramatic declines in tuberculosis and typhoid fever, and in 1949, smallpox disappeared from the US; polio vaccines, implemented shortly after, led to eradication of polio in the US (4, 5). (c) Due to vaccines, it is estimated that 103 million cases of smallpox, polio, measles, rubella, mumps, hepatitis A, and diphtheria have been prevented in the US since 1924 — including 24 million in the last decade (7). (d) The advent of the antibiotic era in the mid-20th century was a component of the tremendous advances in pharmaceutical therapies. By 1950, more than half the drugs in common medical use had been unknown ten years before (4). (e) At the same time, population-based and laboratory evidence showed us that a substantial proportion of major chronic diseases are preventable. This includes 50% of cardiovascular disease (CVD) and 30% to 50% of cancers (8). Prevention is accomplished through environmental or lifestyle changes or early detection and treatment of risk factors. By 2000, interventions had resulted in a decline in age-adjusted CVD mortality rates to one-third of their 1960s baseline; half of this decline was due to effective prevention and half to treatment (9). (f) US life expectancy rose from 47 to 68 over 50 years and to 79 years over 100 years (1).

Reviewing data like these, and many more, it is clear that science has transformed the health of our nation — the dream of 130-plus years ago has borne fruit. This evidence that science can really improve health provides a basis for changing the conversation in the public sphere to one of understanding both health and the science that enables it as “public goods.”

To explore this, let’s start with the arguments used by economists through the concept of “public bads,” which is applied to global health challenges. “Public bads” is a formal economic term for circumstances that are seriously negative for people and society and that are “nonexcludable,” meaning that everyone is at risk (10). Generally, pandemics, HIV, and other contagious diseases or drug-resistant microbial strains are readily recognized as “public bads,” along with poor food quality, and food and water insecurity.

We also now know that societies that are ill are less productive. If we look at diseases endemic outside the US, such as malaria, the “public bad” impact is clear:

Table 3. AAP Brain science, circa 1900

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>1897</td>
<td>On an epidemic of cerebrospinal meningitis caused by diplococcus intracellularis meningitides (3,000 Cases of melancholia)</td>
</tr>
<tr>
<td>1888</td>
<td>Cerebral localization: practical aspects</td>
</tr>
<tr>
<td>1899</td>
<td>The application of thyroid extract in treatment of a cerebral neoplasm</td>
</tr>
<tr>
<td>1914</td>
<td>The microscopic evidence as to the organic nature of dementia praecox</td>
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Table 4. Visualizing medicine

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<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>1890</td>
<td>Sphygmomograms for measurement of slow pulse</td>
</tr>
<tr>
<td>1892</td>
<td>Roentgen rays in thoracic disease</td>
</tr>
<tr>
<td>1900</td>
<td>A new modified sphygmograph</td>
</tr>
<tr>
<td>1903</td>
<td>The influence of the X-ray on metabolism in leukemia</td>
</tr>
<tr>
<td>1908</td>
<td>Fatigue in schoolchildren as tested by ergograph</td>
</tr>
</tbody>
</table>
and its causes. Among many in the news own “public bads” in terms of ill health al context. And yet the US has many of its discussions have occurred in a global public goods for the health economy (11). Our recognition of ill health as a “public bad” has not led to renewed commitment to strengthen environmental science and modifiability of health or the highly cost-effective benefits of prevention. Or perhaps they do not see a public responsibility to resolve these “public bads.”

The modifiability to resolve these “public bads.”

A statistical and experimental study of terminal infections
A toxigenic germ found in ice cream and its chemical products
Some toxicogenic germs found in poisonous foods
Diminished prevalence of syphilis
Some toxigenic germs found in ice cream and its chemical products
A statistical and experimental study of terminal infections

1892: Bacteriological study of drinking water
Treatment of experimental TB by Koch’s tuberculin

1887: Geographic distribution of typhoid fever
Management of the stage of convalescence in typhoid fever
Some forms of paralysis of the typhoid fever
Micro and macro specimens of “bovine TB”
Specimens of the microbe of syphilis
Dr. Welch demonstrated a series of microscopical specimens of the thyroid gland after partial extirpation; Dr. Prudden did the same from a case of myxedema.

1890: Relation of micro-organisms to inflammation and suppuration
Influence of soils in causation of disease

1891: What can and should be done to limit the prevalence of TB in man? An expert in sanitary administration for cholera in Glasgow 1866
1891: Relation of drinking water to disease
1892: Bacteriological study of drinking water

from 1965 to 1990, more than one-third of the countries with intensive malaria had negative economic growth, compared to an average rate of economic growth of 2.3% in countries without malaria (11). Our recognition of ill health as a “public bad” has recently extended — as our evidence as to modifiability has grown — to other global exposures that affect health and that require collective action to protect people, including curtailing tobacco smoking and the serious impact on health of both air pollution and global warming. Thus far, these discussions have occurred in a global context. And yet the US has many of its own “public bads” in terms of ill health and its causes. Among many in the news in the last year is the recognition of serious causes of ill health from water pollution from industrial run-off or corroded pipes. (Notably, the relation of drinking water to disease was first introduced in AAP in 1892 in a presentation on the “Bacteriological study of drinking water.”)

It is the latter that takes me from the concept of “public bads” to its companion concept, “public goods.” Most goods are private — in the sense that consumption can be withheld until a payment is made for them and once consumed, they cannot be consumed again. In contrast, we implicitly understand that health is a public good and that health meets the economists’ definition of “public goods” as goods that are useful for the public generally, exist in the public domain, and where the benefit is shared at the societal level. Further, consumption by one individual does not reduce the amount available to be consumed by another individual, and individuals cannot be effectively excluded from use (Table 7). Examples generally cited as public goods are national parks, public transport, and clean air. The public good nature of health can now be advanced because of the evidence that health is modifiable. That science gives us the knowledge of how to improve health forms the argument for societal investment in science for health. This has rarely, if at all, been articulated in this context. We can do this now because of a century of compelling evidence that health and longevity can be improved, that improvements are based on scientific knowledge, and, together, they propel the well-being of society.

Based on this rationale, I think that we would do well to now apply the concept of global public goods for global health to our own US-focused articulation of why science for health matters as well as to health itself.

There are two parts to health as a public good. First, scientific knowledge itself is a public good. The cost of sharing knowledge with everyone is zero or relatively modest, and your knowing something does not limit your ability to know it. Plus, knowledge has important public properties of decreasing disparities and strengthening society. Of course, knowledge also has significant private properties, since it is produced by individual researchers and teams and can be withheld and thus made “excludable”; further, researchers want to be adequately rewarded for their efforts and to have adequate investment for innovations in R&D products. For these reasons, it is thought that policies should foster both private and public goods for the health economy (11).

Second, the health that results from scientific knowledge is a public good. As
I cited before, public goods undermine a society’s productivity and well-being. Because communicable diseases are not exclusive to one person or group versus another and if you get it that doesn’t mean it won’t, communicable disease control is most readily recognized as a public good: once achieved, it benefits all people, both poor and rich and future as well as present generations. Additionally, one person’s “consumption” — let’s say preventive measures or treatment — is often necessary for another to benefit in the case of infectious diseases. We now know this is also true in the case of social contagion, such as for obesity (12) or even for our collective health care costs (13). To achieve prevention or treatment requires collective investment in the knowledge and then investment in the provision of the solutions. An outstanding example of this presented at this 2017 trisociety meeting is the new approaches to pandemic preparedness (14).

One other critical aspect of public goods is that the production and provision of these goods are often not remunerated sufficiently for the market to find it worthwhile to invest. Often, there are no natural commercial incentives to produce these goods in a market economy. Therefore, underprovision is likely for public goods without any strong special interest support (15). This is the basis for what Adam Smith argued in 1802: he recognized the existence of certain goods which he thought “may be in the highest degree advantageous to a great society, but are, however, of such a nature that the profits could never repay the expense to an individual or small number of individuals, and which it therefore cannot be expected that any individual or small number of individuals should erect” (16).

But, as was articulated at the 2017 trisociety meeting, public and private sectors need to enact this together. We now know that investing in health for all — as a public good — has a high return on investment (ROI) for society. The prevention and containment of infectious or communicable diseases are classic cases of public goods and high returns. For example, it is estimated that devoting an additional $100 million to HIV vaccine research and development is valued to generate returns 6-fold as high (14). The ROI is at least as high from decreasing air pollution (17).

Another recent example is the Human Genome Project, conducted from 1988 to 2003 and costing 0.005% of the US GDP spread out over 15 years, or $3.6 billion. Even before we see the health effects realized to the extent we anticipate (18, 19), it is estimated that the Genome Project had an ROI over 14,000% in terms of economic output per federal dollar invested since 1988 and 310,000 jobs (20). Beyond this, US health science investment is a global public good for our interdependent world, helping people everywhere benefit from, as Speth said, “the accumulated stock of global knowledge” (21).

Collective action for the creation of public goods — by both the public and private sectors together — underpins each of these.

The health of our population would greatly benefit from our societal investment in both improving health itself and in the science for health, recognizing that both are public goods: for the knowledge production by science is a value and translates into value for individuals and the productivity of society and high ROI for health. Further, the nonexcludability and nonripariousness of health for all of us (if you get healthy, it doesn’t deprive me of the oppor-
decades, commitment to public goods

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today, April 22, 2017, advocates that the

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expectation.

we need to include health investments in

that public good expectation.

Implicit in this is the social compact

involved. One dimension of that social

compact is with us, the scientists them-
selves: that scientific results that were cre-
ated as public goods are made fully avail-
able to the public — nonexcludable and

alrous.

The March for Science that was held
today, April 22, 2017, advocates that the

value and need for ongoing investment in

ience — and its basis for sound pol-
icy — needs to be valued by our political
leadership and by the public itself. In past
decades, commitment to public goods

is thought to have receded, in part from

higher valuation of market forces and pa-
ent rights; this has contributed to our lack of

paredness or effective response to

any of the health crises we have seen
domestically and globally (11). Overall, as

has been said by Sean Pool as of 2011, “The

US has not kept up. Our national invest-

ments in research and development as a

percentage of discretionary public spend-

have fallen from a 17% high (1962) to

9% today, with the biggest decline in civil-

research and development” (23).

Actually, all the evidence indicates

that we need more science for health at
this critical time. We are on the cusp of

many breakthroughs in long-standing as
well as emerging areas. At the same time,

many new health needs and opportunities

are emerging — starting with the evidence

that the health status of the US has fallen

substantially relative to peer nations in

the last two decades and now stands at
the bottom of our peer nations according to a

report of the National Academy of Med-
icine (NAM)/National Research Council
(NRC) (24, 25).

The themes of today’s trisociety meet-
ing include some of the urgent and emerg-
ing issues for our health. These needs

extend much further, from the health

impact of poisoned water in the US to the

health and disease challenges of older age

in an aging society to antimicrobial resis-
tance and many more. Further, new issues

stand on longstanding problems: the US

stroke belt was originally in the northeast,
then moved to the southeast as the north-
east became healthier. Since 1940, the

highest stroke mortality rates have been,
and remain, in the southeast US (26). This

same area is also a hot spot in the US op-

oid addiction belt, for obesity, and a region

of high cancer mortality hot spots.

One could argue that leadership by

members of the AAP and by the organi-

zation itself may be more important than
ever and that the investment in science

for solutions is critical. This takes us back
to the March for Science today across the

US and the AAP membership’s stance — by

84% of members — that the organization

should formally endorse the march. Some

say that AAP is a “pure science” organiza-
tion and should not offer opinions on any-
thing outside the conduct of the science
itself, and others say that this is not some-
thing AAP has done. Interestingly, at least
to me, I reviewed the history of the AAP to
ask myself this question. I found that, since

its inception, the AAP has spoken out,

albeit intermittently, as an organization on

issues of science, policy, and practice for

the public good in areas of its mission: that

objective science and evidence are essen-
tial foundations for improving health and

health care.

In his 1978 AAP presidential address,

Kurt Isselbacher said that “I look forward
to the time when the Association includes

in its responsibilities a new role — involve-

ment in the shaping of science and health

policy, for there can be little doubt that

what happens in the powerful corridors of

Congress is as important to our future as

what happens in our lecture halls and our

laboratories.” The AAP’s endorsement of

the March for Science is in line with his

wish and with the evidence.

In a fitting conclusion to this year’s

AAP meeting, I am pleased to announce

that the 2016–2017 council has just com-

pleted substantial work leading to a 21st

Century Statement of the mission of the

AAP (Table 8). Perhaps the evidence of

a public goods framework of science for

health, united with the modern under-

standing of public and private collec-
tive commitments required to meet our
responsible for health, could now be

Table 7. Principles of public goods

Once provided, no one can be excluded from consuming them (nonexcludable)

One person’s consumption of them does not prevent anyone else’s (they are nonrival in consumption)

Example: reduction in risk of infectious disease incidence

No commercial incentive to produce these goods, since enjoyment cannot be made conditional on payment

ReFs. 21 and 27

Table 8. AAP mission statement

The Association of American Physicians, established October 10, 1885, is an honorific, elected society of America’s leading

physician-scientists who exemplify the pinnacle of pioneering and enduring, impactful contributions to improve health.

The AAP seeks to inspire the full breadth of physician-led research across all fields of science related to medicine and

health, and to build a community of physician-scientists in support of the principle that objective science and evidence are

essential foundations for improving patient care and the health of Americans.

Among other activities, AAP fulfills its mission by holding an annual meeting of physician-scientists to showcase and

share science, and communicating on issues of science and practice for the public good. In partnership with other societies

including the American Society for Clinical Investigation, AAP offers mentorship and role models for physician-scientists

who are early in their careers.
translated into a 21st century social compact — addressing the essential and sustained basis for societal investment in science and in health. The AAP’s sponsorship of the March for Science is consistent with this vision.


