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From the Editor

A Healthy Public: Whose Job Is It?

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From the Editor

A Healthy Public: Whose Job Is It?

The title of this editorial might strike some readers as somewhat whimsical, but it begs a larger and very serious question. In an era characterized by the post-September 11, 2001 national trauma, the emergence of new global health concerns such as SARS, and the continuing threat of worldwide bioterrorism, "it appears that at no time in the history of our country has the mission of promoting the public's health and safety resonated more clearly with the public and the government than now."[1] Yet, there are powerful cultural forces at work preventing a synergistic approach between medical education and education in public health. I would first like to describe this historical context, outline some of the barriers and facilitators to a synergistic approach, and describe Thomas Jefferson University's response to this important national challenge.

Astute observers like Stewart Bondurant, MD, at the University of North Carolina School of Medicine, have skillfully summarized the historical context regarding the lack of synergy between medical education and education for the public's health.[2] "Through the early years of the 20th century, practitioners of both medicine and public health…formed an effective team with a singular mission: to improve health. Together they coped with epidemics, inoculated children, and worked to achieve the safety of food and water supplies, but as medicine became more specialized and physicians acquired the tools to treat and even cure many health problems, that collaboration began to erode. By mid-century the schism was all but complete. Medicine, which had become increasingly expensive, operated from tertiary care hospitals and medical schools. The role of public health stopped at the hospital door and was confined to the community with disproportionate representation of medically underserved inner cities and rural areas. The result was predictable. People in public health no longer appreciated individual illness, and their counterparts in medicine lost sight of the overall concept of health."

Others described this schism in even more blatant terms. For example, Brandt and Gardner[3] contend that "public health professionals have characterized medicine as a field dominated by arrogance, self-interest, and economic aggrandizement. Medical professionals have typically viewed public health as a politically corrupted field populated with individuals who are intellectually incapable of medicine and science."

Given this admittedly bleak historical context, what then are some of the current barriers and facilitators toward creating a synergistic educational experience bringing together trainees in medicine and in the health of the public? Including those aforementioned cultural issues, the largest barrier appears to be financial. Physicians, after all, are rewarded for caring for the sick. Research dollars are funneled into efforts to find new treatments and cures for existing diseases. Medical schools including Jefferson Medical College depend not only on research money but also on funds from faculty practices and dollars for training new physicians and health professionals to care for the sick. Disproportionately far less money has been devoted to finding and testing ways to prevent these same diseases or deal with "the wider array of community health problems." This lack of appropriate economic incentives for prevention has also skewed the faculty reward system. This, in turn,

has created a dearth of appropriate role models of current medical school faculty devoted to issues solely concerned with prevention and the health of the public.

Oftentimes, medical schools and schools that train public health professionals are seen to be competing for the same shrinking pie of resources resulting in vast differences in power and prestige. The core difference in the approach to research in both environments serves as a barrier to creating synergies. Again, Bondurant notes,[2] "existing mechanisms are not adequate to fund the social, behavioral, and environmental science research that could provide greater understanding of the many contexts in which diseases thrive. Unlike biomedical research with its clinical trials and strict rules of proof, this kind of research is often viewed as soft because it rarely leads to specific interventions or provides the definitive results typical of biomedical research." Therefore, the cultural, financial, and research barriers to cooperation create a kind of organizational lethargy that is very difficult to overcome.

On the other hand, the facilitators for creating synergistic opportunities are many. As Lovinger has noted,[4] "some academic leaders see a silver lining in the recent spate of emerging infectious outbreaks and the public health response they engendered: the events put public health into the forefront of people's minds." Until SARS erupted, most people took public health for granted, believing that the public faced little, if any, risk from infectious diseases. In addition, a large number of prestigious organizations[5,6] have promoted blue ribbon panel reports calling for a major overhaul of our approach to the education of persons concerned with improving the health of the public.

Somewhat paradoxically, I believe that the growth and sustainability of managed care itself is a powerful force for synergy. Specifically, the focus that managed care brings to the health of the public enables these organizations to create teams of persons with training in epidemiology, quality of life measurement, disease management, health services research, and the like. It is the managed care focus on prevention that may serve as a unifying force between public health and medical education.

Finally, the Institute of Medicine (IOM) of the National Academy of Sciences recently called for an ecological approach to public health training with a commitment to eight new content areas including informatics, genomics, communication, cultural competence, community-based participatory research, global health policy and law, and public health ethics.[1]

Given these powerful cultural forces that have served to widen the schism between medical education and public health, and the current barriers and facilitators at work, how has Thomas Jefferson University responded to these challenges? Emeritus Dean of the College of Graduate Studies (CGS), Jussi Saukkonen, MD, PhD, had a vision to create a public health program on the campus of TJU. Ably assisted by Georgeanne Buescher, MSEd, and Jennifer Ravelli, MPH, along with a number of full-time and adjunct faculty, Dr. Saukkonen's efforts led to the creation of a Master of Science in Public Health (MSPH) program.

With Dr. Saukkonen's retirement at the end of calendar year 2003, a leadership transition occurred. Dr. James Keen, the new dean of the CGS at TJU, appointed Richard Wender, MD, the Alumni Professor and Chair of the Department of Family Medicine, and myself as co-directors of the MSPH program moving forward. In turn, Dr. Wender and I named a steering committee composed of members from each of

our two departments to lend day-to-day operational leadership to the program. The steering committee members include Jennifer Lofland, PharmD, from the Department of Health Policy, and James Plumb, MD, MPH, and James Diamond, PhD, from the Department of Family Medicine. Georgeanne Buescher, MSEd, Jennifer Ravelli, MPH, and Carol Beck, PhD, round out the steering committee membership.

While I am proud to be serving as a co-director of this innovative MSPH program, I am acutely aware of the issues outlined in this editorial. Along with my colleagues, I envision a series of operational and curricular changes and improvements that will strengthen the MSPH program for the future. For example, we have created an MSPH advisory board composed of leaders from the surrounding region with expertise and experience in public health affairs, including such persons as the president of the Philadelphia Health Management Corporation and the medical director for the Department of Public Health for the City of Philadelphia.

We will shortly coordinate our efforts with many of the training programs already on our campus in the hopes of offering house officers and fellows from many clinical programs the opportunity to obtain formal training in fields such as epidemiology, quality measurement, and the like. We are developing new courses that will address improving patient safety as a public health concern. We have signed a contract for two new textbooks with a prominent medical publisher that will serve as the core for other new courses under development. We have asked the MSPH students to elect a representative to serve on the steering committee who will articulate the views of the students. We are hoping to expand the research agenda of the MSPH program building on the experience and repertoire currently situated in both the Department of Family Medicine and the Department of Health Policy.

I believe we are beginning to answer some of the challenges laid out by the Association of American Medical Colleges, the IOM, the Blue Ridge Group, the Commonwealth Fund, and others, as we more closely articulate the mission of Jefferson Medical College and the developing MSPH program. It is gratifying for me to see faculty within two medical school departments busily involved in such activities as measuring and evaluating the quality of medical care in our faculty outpatient practices and then seamlessly moving to the classroom, often on the same day, to teach a course in the MSPH program on outcomes measurement! Yet, I know that many cultural and institutional barriers are in our path. The steering committee and advisory group recognize that it is *everyone's* job to help improve the health of the public. We hope to serve as facilitators, change agents, and even agitators in order to accomplish this important goal. As usual, I am interested in your views. You can reach me at my email address: david.nash@jefferson.edu.

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