Medicine and Public Health: Recovering our Shared History – and Jumpstarting Our Future

CDC/AMA First National Congress on Public Health Readiness

Opening Plenary Session

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Good afternoon – and welcome to this first national Congress on Public Health Readiness – held by the CDC in partnership with the AMA.

Today is indeed an historic moment in American medicine and American public health. Because today we recommit ourselves to bridging the divide that too often seems to separate our two disciplines.

This divide is a relatively new one, historically speaking. In ancient times, for example, physicians taking the first Hippocratic oath swore by the Greek gods Aesculapius and Hygeia.

The son of Apollo, Aesculapius was a physician who eventually became the Greek god of medicine. Hygeia, his daughter, was goddess of good health, ward against plague and – under her Roman name, Salus – protector of the public health.

Although today's physicians swear by neither god, Aesculapius lives on in the symbol that has come to define our profession. The staff and the snake of medicine was originally Aesculapius standard – and is now ours. But Hygeia's memory has faded from medicine's consciousness – much as public health itself has faded from physician training and practice.

Today, we physicians are here because we know it is long past time to rediscover – and embrace – our long lost relative, public health. And we hope our colleagues in public health – are here for much the same reason.

In this day and age – we can no longer afford to be a family divided.

Those who know me know I am as passionate about public health as I am about clinical medicine. I proudly bear the letters MD – and MPH – after my name. And I am committed to bringing organized medicine back to its public health roots – and public health physicians – back to their clinical roots.

Because we don't have to go back as far as the Greeks to know that medicine and public health belong together.

Dr. Nathan Davis, founder and two-time President of the American Medical Association – was an outstanding physician – and outspoken defender of public health, particularly the health of his adopted city, Chicago.

For Dr. Davis, who practiced medicine in the mid-nineteenth century, patient health and population health were inextricably connected. The major infectious diseases of his time – cholera, smallpox, typhoid, malaria, diphtheria, dysentery, scarlet fever and tuberculosis – all demanded a coordinated medical and public health response. Dr. Davis understood that his patients would never be safe from infectious disease – unless the overall population was safe first.

For this reason, he worked tirelessly to improve Chicago's public health infrastructure. In addition to caring for patients, he helped establish effective sewer, water and garbage removal systems for Chicago. He encouraged vaccination against smallpox, the registration of deaths and births, and the creation of a city board of health.

Today, it is abundantly clear that health and sanitation endeavors like these – were part of one of the most amazing health stories ever told: the creation of America's public health system.

This system is credited with adding at least 25 years to American life in the last century. It has done so, in part, by promoting vaccination, motor-vehicle safety, family planning, food safety, tobacco cessation – and, close to my own heart as an obstetrician – maternal and fetal health.

In fact, our nation's many public health endeavors of the past one hundred years have been so successful – that our public health system has in many ways become the victim of its own success, its triumphs so pervasive – that they became invisible. Until recently, public health funding was grossly underfunded in much of our country. Now it is merely underfunded.

Yet a quick overview of the facts – shows that public health still has much to accomplish – especially in partnership with clinical medicine.

In developed nations, we have controlled and even eradicated many infectious diseases. Yet emerging and reemerging infectious diseases – such as HIV-AIDS, tuberculosis and SARS – continue to pose a threat. Physicians on the frontlines of patient care must be prepared to respond appropriately – and we need help and coordination from our public health colleagues to do so.

We also need your input – and you need ours – as we address common public health problems, such as the epidemics of obesity, tobacco use, drug addiction and violence. These problems affect individual patients and populations alike – and we need to talk to each other about how we can curb these epidemics – for physicians, that means one patient at a time.

Finally, and perhaps most relevant to our work today – is that our nation faces a very real threat – from terrorist events involving conventional, nuclear, chemical or even biological weapons. Such events will send patients swarming to physicians – and place huge demands on the public health infrastructure. We need to figure out – how we can do more, together, should the unthinkable occur.

In short, it is clear to the AMA and other physician organizations that we must build on existing partnerships with the CDC and other public health organizations – so we can prepare for everyday and extraordinary threats to the public health – to our patients' health.

Experience has already shown us how critical these partnerships can be – in a changed world.

For many physicians, the wakeup call came on September 11, 2001 – and in the days and weeks that followed.

Following the attacks on the World Trade Center and Pentagon, more than 35,000 physicians and other health professionals contacted the AMA – to volunteer. There was a resounding sense in the physician community that doctors wanted to help – in any way possible. But there was an equally strong sense – that they were not quite sure how or where to proceed in the midst of a national disaster.

Then, just a few weeks later, the anthrax attacks began. Again, physicians were deeply concerned about this threat – but most of them had not thought or heard about anthrax since medical school. How would they recognize inhalation anthrax victims? What would they tell already panicked – but in all likelihood healthy – patients?

Clearly, the anthrax attacks presented a major medicine and public health problem – and demanded a coordinated response. Thus the AMA – and the American Hospital Association – partnered with the CDC to create and broadcast the video, "Anthrax: What Every Physician Should Know."

The AMA made this tape available to physicians through our Web site, along with a site – devoted solely to disaster preparedness and response. The Journal of the American Medical Association dedicated an entire issue to potential bioterrorist agents – and made it available online.

Finally, we coordinated our major messages to the public – our patients – with the CDC and other public health entities: Don't stockpile CIPRO – don't buy gas masks – and most of all, don't panic.

Our experience with anthrax reminded the physician community – how crucial our coordination with public health entities could be – in terms of education, outreach, and response – not only to acts of bioterrorism – but also to naturally occurring outbreaks of disease.

This point came home again less than two years after September 11, when SARS emerged in China and other parts of Asia and Canada. Once again, the AMA and the CDC coordinated their efforts – to good effect.

The AMA participated in regular conference calls with the CDC on issues pertinent to physicians. We created a SARS-specific Web site to ensure that the latest and most relevant information was made available to physicians as soon as possible.

The information the CDC shared with the AMA proved crucial to our outreach efforts – both to physicians and to patients. Indeed, during the SARS outbreak, the AMA's SARS Web site averaged 3000 unique hits per day.

Today, we continue to participate in CDC and IOM meetings – on what we have learned from the SARS outbreak. Indeed, we believe that working together to critique our response to unusual public health threats, such as SARS – is a vital way to make both disciplines better prepared – for whatever comes next.

In the cases of anthrax and SARS, the AMA and the CDC were able to get vital information to physicians in the field – and quickly. In both cases, we kept America's patients safe – both from disease and from panic.

However, we also know that – we were also plain lucky. Our nation was attacked with anthrax – not a highly infectious agent, like small pox. And by the time SARS reached

our shores – we had already been forewarned and no SARS "super spreaders" found their way to the United States.

Next time we might not be so lucky. We need to prepare for worst-case scenarios – together, now – and not in the middle of an outbreak or attack.

Because even today, almost three years post 9-11, a gap still exists between what physicians and hospitals want to be able to do, should an act of bioterrrism or other disaster take place – and what we actually could do.

A survey that originated with the AMA Ethics group has shown that a majority of physicians want to help in time of national disaster. However, only 20 percent said they felt prepared to do so.

Today, the AMA is attempting to address this knowledge gap through the AMA Center for Disaster Preparedness and Emergency Response, under the direction of Dr James James. This center offers training courses focused on mass casualty events, including nuclear events, infectious disease outbreaks and natural disasters.

We hope the courses will help standardize physician disaster response in our nation. As H.G. Wells once said, "human history . . . [is] a race between education and catastrophe" – and the AMA wants education to rule the day.

As proud as we are of the work of the Center, however, we know we can't address this knowledge gap alone – nor can we address the many other challenges to effective disaster preparedness without help. Issues such as the need for increased laboratory capacity and hospital surge capacity – for improved information technology and communication systems – and, perhaps above all, the need for standard benchmarks for preparedness across the health care and emergency responder community.

Then there is the issue of how to finance these necessities – in an era when our entire health care system, including our hospitals, is under duress.

Escalating medical liability costs, decreasing reimbursements, state budget cuts, workforce shortages, and growing numbers of uninsured – are all putting pressure on our health care system. As such, we in clinical medicine are having an increasingly difficult time simply meeting our day-to-day obligations to human health – never mind extraordinary demands, such as those presented by natural or manmade disaster.

These aren't easy problems to address. Nor do we expect to fix them in the short time we have together. However, by better understanding the challenges we face – and by building on existing partnerships – we can and will identify next steps – to prepare our nation for whatever public health threats may come our way.

Because the gap between what is possible – and what we are prepared for – is still way too wide for comfort.

As we make every effort to address that gap, it is also crucial that we don't lose sight of everyday public health dangers – and everyday public health preparedness. We must also partner to address more common – but no less deadly – threats.

The AMA's efforts to work with the CDC on influenza vaccine – offers a good example of how we each become more effective when we work together.

As most health professionals know, far more Americans die from influenza every year – than die in terrorist attacks. In 2001, approximately 3000 people were killed in the attacks on the Pentagon and World Trade Center. That same year – approximately 36,000 Americans died from influenza.

Vaccinating more Americans could save thousands of lives – safely and inexpensively. However, physicians can't vaccinate without vaccines – and that's where an AMA / CDC partnership has proven crucial.

In 2001, to ensure that adequate amounts of vaccine were manufactured, the AMA collaborated with the CDC to establish the National Influenza Vaccine Summit. This partnership of over 50 stakeholders analyzed the production process of the influenza vaccine – and put into effect many stopgaps to prevent distribution delays, such as those that characterized the 2000-2001 flu season.

As you know, 2003 turned out to be a bad flu year due to the appearance of a new influenza virus. This fact – combined with lots of media coverage – increased demand for the vaccine beyond expectations. However, the shortage of vaccine would have been much worse – had the National Influenza Vaccine Summit not been convened.

This collaboration is just one potent example of how the AMA and CDC can work together – for the good of individual patients and patient populations.

The AMA is also paying attention to a number of other public health issues – such as eliminating racial and ethnic disparities in care, curbing the epidemics of tobacco and obesity, promoting older driver safety and – to name two issues close to my heart – preventing underage and binge drinking – and ending family violence.

Public health problems like these – bear directly on the work physicians do in their offices and clinics – because these problems touch the lives of our patients – and undermine their health.

Yet neither physicians in private practice – nor public health officials removed from the day-to-day realities of direct patient care – can take on these problems alone. Any more than either group alone can prepare for a major infectious disease outbreak – natural disaster – or bioterrrorist event – without input and help from the other.

For this reason it is imperative that the CDC and AMA continue our close working relationship, in support of both health security – and the health of the public.

We also need to formalize this relationship – so that we work even more efficiently and effectively, as leading advocates for human health.

We have an incredible opportunity before us – to begin anew and to forge an unshakeable alliance between our two disciplines.

Let us use the next two days to remind ourselves – that we can do so much more for patients and patient populations – if we work together.

Let us think about new ways to connect, collaborate and coordinate – about extraordinary threats to America's patients – and about the more mundane, but no less deadly, everyday threats.

Let us cross the divide that separates medicine and public health – build bridges between our work – and remember that we are all part of the same family of health.

I welcome you to this first National Congress on Public Health Readiness – and I look forward to seeing what new possibilities for collaboration and action we can envision – together.