



American Association of Public Health Physicians

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The Voice of Public Health Physicians-Guardians of the Public's Health

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1. AAPHP Annual Meeting

MARK YOUR CALENDARS: The AAPHP annual meeting will be held in Chicago on June 12, 2010 (Saturday), once again in conjunction with the Annual AMA Meeting, June 12-15, 2010, Hyatt Regency Chicago. Outgoing AAPHP President Kevin Sherin, MD, MPH, will preside, and incoming president of AAPHP Tim Barth, MD, will take the helm!

Please join us for our annual celebrations and business meeting in Chicago with our AMA. Congratulations to our outgoing President, Dr. Sherin, who has recently been named the President of the Orange County FL Medical Society.

The incoming President of our AMA, Dr. Cecil B Wilson, of Winter Park FL, is not only a Past President of the FL Medical Association and the American College of Physicians, but in 1994 served as President of the Orange County Medical Society and retains his membership there today!

2. ACGME Threatens Training of Future Public Health Physicians and Threatens Downgrade of Preventive Medicine from Medical Specialty to Fellowship

Member Comment requested – deadline noon, Monday, February 22

ACGME is the Accreditation Council for Graduate Medical Education. It is a private non-profit organization originally formed in 1972 (as Liaison Committee for Graduate Medical Education) for the purpose of evaluating and accrediting medical residency programs in the United States.

Last month (January 2010) ACGME quietly posted on its web site a new set of proposed training requirements for residency programs in Preventive Medicine. They propose elimination of the requirement for an MPH degree and replacement of most of the public-health-related non-clinical training with one-on-one patient care time. The new guidelines encourage/require concurrent or prior clinical board certification in a clinical ACGME medical specialty (preferably but not necessarily a primary care specialty) as a prerequisite for the Preventive Medicine (PM) residency training. A written examination for PM Board Certification would still be required.

ANALYSIS and INTERPRETATION:

These proposed changes imply the following:

1. Non-clinical public health administration, policy work and medical epidemiology work no longer qualify as the definitive practice of PM as a medical specialty.
2. The medical specialty of PM is seen as purely clinical in nature (i.e. diagnosis and treatment of one patient at a time in a clinical setting).
3. Basic training in public health topics not included in usual clinical training are of such little importance that watering them down to weekly didactic sessions is a reasonable substitute for MPH training.

4. Those representing the specialty of PM to ACGME are so dominated by clinicians and academicians who have no understanding of the value of medical knowledge in addressing population health issues at a population level and no understanding of the value of using a physician's knowledge of the etiology, pathogenesis and natural history of health conditions and the efficacy of preventive and therapeutic interventions to guide community and medical center health policy.

a. Another way of stating this same concept is the idea that since policy and management decisions at a group or population level involve political and administrative skills – these decisions should be made by politicians and managers with no medical knowledge. The concept of a PM physician is a physician who has advanced training in the use of political and administrative methods to diagnose and “treat” health issues at a group or population level.

5. The practical impact of the recommendations as proposed is to downgrade specialty training in PM from that of a medical specialty in its own right to that of a fellowship within a clinical medical specialty.

Practical Implications of this Analysis:

1. The major determinants of risk of serious illness, injury and premature death reside in the community, not in the clinic. The major determinants of a patient's willingness or ability to adhere to prescribed regimens of care reside in the community, not the clinic or hospital. The major determinants of whether an individual seeks medical care for a preventive or therapeutic service also reside in the community, not in the clinic. These community factors are much stronger than the efforts of clinicians seeing patients one at a time in determining the incidence, prevalence and severity of preventable illness, injury and death. All of these statements are major reasons we need medical specialists in our community who are trained in the art and science of addressing health-related issues at a community level.

2. We live in the wealthiest society the world has ever known, yet our public health systems, on average and nationwide, are incapable of meeting community need for preventive and protective services. Our health care delivery system, despite being the most expensive the world has ever seen – gives us infant and adult mortality rates far worse than countries that spend less than half on healthcare, and denies access to more than 40 million of our citizens because of financial and other barriers. Almost half a century ago a decision seems to have been definitively but informally made to hand over control of both public health and healthcare systems to financial managers and administrators with no requirement for those individuals to have any advanced knowledge as to the causation and natural history of disease or the determinants of efficacy of medical treatment. Could this lack of medical knowledge and lack of physician involvement in the determination of healthcare and public health policy be part of the problem? Is it possible that infusion of such expertise might improve the health of our communities and the effectiveness and cost-efficiency of our healthcare and public health systems?

3. Our proposed solution to these problems is to seek recognition by ACGME and the larger medical and lay communities that public health and healthcare policy and management and related epidemiologic work, when done by physicians trained to do this work, needs to be seen as the definitive practice of medicine – as definitive as one on one diagnosis and treatment. Stated in other terms – That the ACGME recognize that the specialty of General Preventive Medicine is a medical specialty whose patient, in general, is not an individual

human being, but a population of human beings, a cohort, the health of which is affected by factors in the physical environment, the socio-cultural-economic environment, and the biologic environment, both internal and external. Our patient, the COMMUNITY, like the patients of other specialists, (children and other age groups, women, certain organ systems, certain infectious agents, individuals with specific diseases, and those requiring special treatments) must be studied in depth and in detail for a period of time so that the Specialist in General Preventive Medicine is expert in the diagnosis and treatment of the many problems that may befall a community. These problems may be acute, such as an epidemic or natural disaster, or chronic relating to pollution events, changes in community behavior (smoking, other addictions or obesity), or the changing nature of biologic factors such as HIV, influenza, or the changing rates of disability and developmental phenomenon. Community based illness, disability and mortality is best evaluated and managed by medical professionals whose training has emphasized the role of environment in disease, the changing nature of culture and behavior in human pathology, and the economic, political, and administrative skills and technologies that are available for the amelioration of these problems in human populations. The practice of community medicine requires knowledge and skill in the identification and management of factors that cause disease, disability and death in populations of people.

PROPOSED AAPHP COMMENT TO ACGME (due March 4, 2010):

The American Association of Public Health Physicians (AAPHP) strongly objects to the proposed changes in Preventive Medicine (PM) medical specialty training on the following grounds:

1. A Masters Degree in Public Health (MPH) provides an introduction to the community factors that largely determine the incidence, and prevalence of disease and the ability of members of the community to adhere to prescribed regimens of care. This constitutes an introduction to the art and science of public health and preventive medicine that are essential for understanding how best to address health-related issues on a group or population basis. The MPH should be retained as a requirement – but with the understanding that the MPH training is only an introduction, and continuing education in the subsequent years of PM residency training must include substantial additional didactic training in public health topics more advanced than the basic MPH curriculum.
2. ACGME and other medical specialties should support the teaching of prevention and public health at three distinct stages of medical education:
 - a. Medical school curricula and all clinical post-graduate training programs should include PM training relative to basic epidemiology and what every physician should know about the importance and effectiveness of community preventive services and the detailed recommendations for clinical preventive services for the medical specialty in question.
 - b. Those clinicians desiring additional background in clinical preventive services should be offered PM fellowship training along the lines recommended in the proposed ACGME training modifications. This, without the requirement for a written examination, should be considered as a fellowship.
 - c. Those physicians desiring in-depth training in the art and science of addressing health issues at a group or population basis, should secure Public Health/General Preventive Medicine Residency training inclusive of the following:

- i. Retention of the requirement for an MPH degree, with the understanding that this training is necessary, but not sufficient for a physician to become a board certified specialist in PH/GPM.
 - ii. Requirement for of clinical training to assure that their training meets minimal requirement for medical licensure at the state level. **An issue needing additional comment and discussion is whether one or two years of such training be required, and how this training requirement should be defined. This definition, in turn, will need to relate to state level requirements for medical licensure. Comment needed on this point.** (While some may desire full residency training in a clinical specialty, such training should not be required as a prerequisite for PH/GPM residency training or board certification.)
 - iii. A minimum of two years of training in the policy, management and epidemiologic practice of public health, inclusive of didactic training in public health topics more advanced than that presented in the MPH curriculum. This shall be done with the clear understanding by all concerned that public health administration, policy and epidemiologic work constitutes the definitive practice of the medical specialty of PH/GPM. **Two years may be ideal, but may not be feasible – comment needed on this point.**
 - iv. **Completion of an epidemiologic study suitable for publication should be added as a requirement to sit for the PM specialty written and oral examinations. Some Residency programs might also require one or more planning, evaluation or feasibility studies.**
 - v. In addition to a written examination along the lines of the current ABPM examination, an oral examination will be required, to be administered by a panel of expert PH/GPM physicians to enable the applicant to demonstrate his or her understanding of the art and science of using medical knowledge on a group or population basis for health assessment, policy development and design and implementation of wellness and preventive services, and a clear understanding of the differences between use of this knowledge to guide the care of individual patients and implementing such initiatives on a community basis. This, in turn, will require demonstration of the ability to shift mental gears between a clinical approach to single patient issues to a social/political/administrative approach to addressing health issues on a group or population basis in both clinical and community settings.
- d. ACGME should formally recognize that jobs that address health issues on a group or population basis and are best filled by an individual with a physician’s knowledge of the causation and natural history of health-related conditions are best filled by PM physicians and that such roles shall be defined as the definitive practice of the medical specialty of Public Health/General Preventive Medicine, or just “Preventive Medicine.” The list of roles shall be as follows:

1. **Academic** – primarily focused on teaching and research; mainly, but not entirely, in academic settings. Academic settings could be medical school/medical center, school of public health or other. Possible roles include deanships, department chairmanships and health services research.
2. **Aerospace** -- health and medical issues on individual and group bases relating to aviation and space travel.
3. **Bioterrorism/Homeland Security; Crisis and Disaster Management, surveillance, preparedness, emergency response, etc.**
4. **Clinical Preventive Medicine** – Preventive medicine in a clinical setting, with the PM physician doing preventive work on a full time basis, or spending part or most of his or her time in hands-on patient care, with role to advise others in department or agency on clinical and community preventive services.
5. **Correctional Health** – management of public health and medical issues in prisons and jails, including surveillance, epidemiology and liaison with non-correctional healthcare providers to assure continuity of care after release from prison or jail.
6. **Environmental Health**
7. **Epidemiology, Disease Control, and Community Health Assessment**— This includes public health and academic epidemiology, disease management, the technical aspects of community health assessment and September 20, 2005 JMI Web Site/Database Protocol page 4 of 11 pharmacoepidemiology. This differs from the policy/management roles in that it is primarily “technical” in nature.
8. **International Health**
9. **Policy/Management—Healthcare:** (primarily or entirely policy/administration) in healthcare, managed care and other health insurance settings (previously “Leadership/Management;” sometimes referred to as “Managerial Medicine”).
10. **Policy/Management – Public Health:** (primarily or entirely policy/administration) in federal, state and local public health agencies, community health centers, schools, and non-profit settings.
11. **Military Public Health and Medical Leadership**
12. **Occupational Medicine** – a preventive medicine specialty devoted to the health, safety and productivity of workers at their workplaces as well as in their community. It includes prevention and treatment of work-related and environmental injury and disease, wellness, health promotion, disability management, medical surveillance and productivity enhancement.
13. **Quality Improvement/Patient Safety/Quality Assurance**
14. **Product Development in pharmaceutical and other corporate settings.**
15. **Toxicology**, Medical on both clinical and population bases, including both acute and chronic effects.
16. **Wellness and Health Promotion:** a new area to be developed that crosses the line between “prevention of illness” and “enhancement of wellness” and deals with factors such as fitness, diet, and stress.
17. (**Other** roles of similar nature should also qualify) – ***School health administration and sports medicine immediately come to mind, but these are not included in the above listing because they were not listed in the document approved by ACPM at their 2003 meeting.***

PROPOSED AAPHP ADDITIONAL ACTION:

AAPHP should partner with existing public-health oriented PM residency training programs in pursuit of the policy guidelines noted above and actively pursue both development of and formal recognition of “Teaching Health Departments” to be considered the functional equivalent of “Teaching Hospitals” relative to PH/GPM training.

Note:

Stop by for your chance to discuss and comment on the ACGME proposal.

AAPHP Special Interest Table - The impact of proposed ACGME changes on public health physicians.

11:30 a.m. to 1:00 p.m. Thursday February 18 at Preventive Medicine 2010

Independence Center-Independence Level

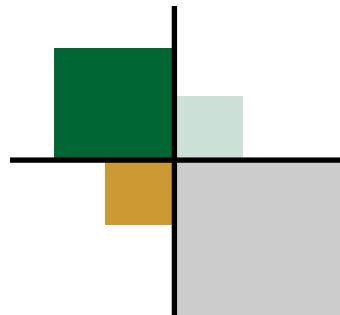
3. AMA Resolutions for 2010 Meeting

Arvind Goyal, MD, MPH, and Joe Murphy, MD, continue to develop excellent relationships within the AMA and its various committees of our respective delegates. Please make use of our AAPHP resolutions process to submit important resolutions to the AMA for considerations in the House of Delegates for the AMA-meeting in June. This is your opportunity as an AAPHP member to submit quality resolutions that represent public health interests, or interests for health policy or the health of all Americans.

AAPHP resolutions must be submitted to Arvind Goyal at Arvindkgoyal@aol.com. I look forward to another great round of quality resolutions from our AAPHP. Currently, resolutions are in process for Prescription Drug abuse, Comments on the Preventive Medicine RRC proposal to drop the MPH requirements, and creation of a network of teaching health departments and community centers for health professions workforce development under health care reform. The election of Massachusetts US Senator Scott Brown has opened up a window of further dialog as final passage of health care reform goes forward this year. AAPHP hopes to leverage this opportunity for improving the training of physicians, public health physicians and health care professionals through a paradigm shift from “teaching hospitals”, to “teaching community health enterprises” that leverage prevention, cost savings and improved access and public health outcomes.

Remember to send in your 2010 AAPHP

Dues !!



4. AAPHP Information on Wikipedia

Since August, AAPHP has a new entry in Wikipedia. Some of you have helped edit this. Here is the very succinct write-up which is now presented with references.

American Association of Public Health Physicians

From Wikipedia, the free encyclopedia

The American Association of Public Health Physicians (AAPHP),^[1] is a professional association of [public health physicians](#). Its motto is "the voice of Public Health Physicians-Guardians of the Public's Health".

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Brief history

AAPHP was founded in 1954.^[2] Its initial purpose was to serve as the voice of physician directors of state and local health departments at the national level. Since its inception, AAPHP has been recognized by the American Medical Association as a medical specialty society, with formal representation in the AMA House of Delegates.^[3]

Initiatives and Health Policy Objectives

AAPHP's objectives now include advocacy on behalf of all public health physicians, whether employed in public or private settings, or academia. Current major issues include tobacco control,^{[4][5]} injury prevention, public health surveillance, disease control, correctional (prison/jail) health, policy and management training,^{[6][7]} workforce issues,^{[8][9][10]} and issues pertaining to access to health care, health equity, health disparities, cultural competence and preventive services.^{[11][12]}

Footnotes

1. [^] ["AAPHP The American Association of Public Health Physicians". www.AAPHP.org. http://www.aaphp.org](http://www.aaphp.org). Retrieved 2009-08-15.
2. [^] [""incorporation papers of AAPHP with State of Texas 1954""](http://www.aaphp.org). AAPHP. <http://www.aaphp.org>. Retrieved 2009-22-12.
3. [^] AMA House of Delegates November 2008 & June 2009
4. [^] Nitzkin JL, Rodu B, 2008. The case for harm reduction for control of tobacco-related illness and death. Resolution and White Paper, American Association of Public Health Physicians. Adopted October 26, 2008. [\[1\]](#)
5. [^] ["Norwegian citation for AAPHP role in Harm Reduction, page 12"](http://www.sirus.no/files/pub/484/sirusrap.2.09.eng.pdf). <http://www.sirus.no/files/pub/484/sirusrap.2.09.eng.pdf>. Retrieved 2009-08-21.
6. [^] ["Preventive Services Tool Kit"](http://www.aaphp.org). www.aaphp.org. <http://www.aaphp.org/pstk/2009/index.htm>. Retrieved 2009-09-25.
7. [^] ["Preventive Medicine Toolkit, example module"](http://www.commed.vcu.edu). www.commed.vcu.edu. http://www.commed.vcu.edu/PSTK_CME/20061009%20PSTK%20InstrManual%20Mod3%20Planning.pdf. Retrieved 2009-08-25.
8. [^] ***"letter to the editor, January 2006 AJPM. American Journal of Preventive Medicine. 2006;30;(1). p. 101.***
9. [^] *Response to "Public Health Physicians: An Endangered Species. American Journal of Preventive Medicine, Vol 22 No. 3. 2002. p. 214-216.*
10. [^] Nitzkin, J L.; Falcao, P; Janusz, N; Arraiano, J: Report of Two Preventive Medicine Job Market Surveys (Jan. 2001). American Journal of Preventive Medicine, Vol 20, No. 1.
11. [^] [""Center for Minority Health /UPitt"](http://www.cmh.pitt.edu/aahpc07.asp). cmp.pitt.edu. <http://www.cmh.pitt.edu/aahpc07.asp>. Retrieved 2008-08-21.
12. [^] **["AAPHP E news and bulletins"](http://www.aaphp.org/bulletincnt1.HTM). <http://www.aaphp.org/bulletincnt1.HTM>. Retrieved 2009-08-21**

Other sources, references and notes

Resolutions of the AMA House of Delegates, 1989-2009 [search AMA website](#)

AAPHP Contact information at [AAPHP website](#)

External links

- * [AAPHP website](#)
- * [The case for harm reduction with tobacco, AAPHP white paper](#)

Retrieved from "http://en.wikipedia.org/wiki/American_Association_of_Public_Health_Physicians"

Haiti

Dr. Rony Francois
testified before
US Senate

5. Haiti Updates

Here are several web links to keep you up to date on the activities and needs in Haiti. Please share with AAPHP your experiences in responding to this tragedy.

The White House <http://www.whitehouse.gov/HaitiEarthquake>

U.S. Agency for International Development http://www.usaid.gov/locations/latin_america_caribbean/country/haiti/eq/

U.S. Department of Health and Human Services <http://www.hhs.gov/>

Centers for Disease Control and Prevention <http://emergency.cdc.gov/disasters/earthquakes/>

Doctors Without Borders <http://doctorswithoutborders.org/>

American Red Cross <http://www.redcross.org/>

United Nations Relief Information <http://www.unfoundation.org/donate/cerf.html>

AAPHP Member, Dr. Rony Francois' testified January 28, 2010 before the United States Senate, Committee on Foreign Relations on the Haiti Earthquake. If you want to see the hearings and testimony of several experts, go to the link below.

<http://www.c-span.org/Watch/Media/2010/01/28/HP/A/28965/Senate+Foreign+Relations+Cmte+Hearing+on+Haiti+Relief.aspx>

6. Tobacco Updates

Joel Nitzkin, MD, MPH, DPA

After three years of diligent policy-related work, the AAPHP Tobacco Control Task Force finds itself in the unexpected position of being a major advocate for the widespread use of electronic cigarettes, and in favor of adding a harm reduction component to current tobacco control programming based on informing actual and potential users of tobacco products of the relative risk profiles of each type of product, compared to conventional cigarettes.

It's important to note that neither I nor AAPHP have received or anticipate receipt of any financial support from any electronic cigarette enterprise, any other tobacco-related enterprise, or any pharmaceutical enterprise. The time, energy and costs we have incurred in pursuit of the E-cigarette issue are all based on our perception that the requested reclassification could pave the way to a harm reduction initiative that, in turn, with FDA oversight, could result in rapid and substantial reductions in tobacco-related illness and death without increasing the numbers of teens initiating nicotine use.

With all this in mind, and after being invited to do so by top level FDA leadership, I, on behalf of the AAPHP task force, submitted two Citizen Petitions to FDA relative to reclassification of E-cigarettes from "drug-device combinations" to "tobacco product."

The full reclassification petition is 21 pages in length, including an annotated index to the 296 pages of attached materials. The press conference petition is 10 pages in length, with the same index and attachments.

The Actions Requested and Summary of Justification statement for these two petitions are as follows:

Action Requested – Petition to Reclassify E-cigarettes from "Drug Device Combination" to "Tobacco Product"

AAPHP urges the Food and Drug Administration (FDA) to reclassify nicotine vaporizers (E-cigarettes) from "drug-device combination" to "tobacco product." This reclassification would be limited to E-cigarettes marketed as an alternative to conventional cigarettes for smokers wishing to avoid the toxic substances (other than nicotine) in cigarette smoke.

Since E-cigarettes meet the definition of "tobacco product" under the new FDA/Tobacco law, but do not meet the definition of either cigarette or smokeless tobacco product, it is our request that they be in a new category of "nicotine vaporizer" with strict FDA regulation of quality of manufacture and marketing, but with warning labels limited to the issue of nicotine addiction.

The Action Requested – Follow-up to July 22, 2009 Press Conference

AAPHP urges the Food and Drug Administration (FDA) to follow-up the July 22, 2009 press release and press conference with another press release and press conference to amend certain statements on the basis of new information provided as text and attachments to the two AAPHP petitions being submitted today. The tone and content of the initial press conference left the impression that FDA would not consider either reclassification of E-cigarettes from drug-device combination to tobacco product or consider a related harm-reduction initiative. FDA is urged to review the content of the two petitions with consideration of the possibility that the information herein provided will justify a change in the current FDA stance on these issues.

Justification

This request for reclassification of E-cigarettes from “drug-device combination” to “tobacco product” is based on the following:

Legal: In the mid-1990’s, the Supreme Court blocked FDA’s attempt to regulate tobacco products as drugs and ruled that separate legislative authority would be required for FDA to oversee tobacco products. This was reaffirmed by an opinion expressed by Judge Leon in January of this year, when he excoriated FDA for attempting to regulate E-cigarettes as drugs.

Ethical: FDA priorities are expected to be the protection of the public’s health. Agency decisions are expected to be based on the best available science. FDA should not mislead health-related organizations or the general public as to the health hazard posed by any product. FDA’s current stance relative to E-cigarettes, as presented at the July 22, 2009 FDA press conference, fails on all three of these considerations.

Medical Science and Epidemiology: Even FDA’s own analysis shows E-cigarettes to have the same nicotine with about the same levels of trace contamination found in pharmaceutical products already approved by FDA. Propylene glycol, the other major ingredient is generally recognized as safe. The risk of death attributable to tobacco use from smokeless tobacco products is less than 5%, and, for some products, less than 0.1% the risk of death from conventional cigarettes. The risk of death from E-cigarettes, as best we can estimate from available data, should be about the same as for long term use of pharmaceutical nicotine replacement therapy (NRT) products, at the lower end of this range.

Public Health Impact: Tobacco harm reduction is already well recognized as legitimate in the medical community in terms of long term use of NRT products. Tobacco harm reduction is endorsed by and the new FDA tobacco law in terms of reduced exposure conventional cigarettes. The new harm reduction component recommended in this petition would consist of honest communication to smokers as to the relative risk profiles presented by tobacco and tobacco-related products. On the basis of its review of the medical literature and the unpublished analyses of E-cigarettes presented in this petition, AAPHP has reached three conclusions: 1) reclassification of E-cigarettes as a tobacco product could open the door to a new harm-reduction component to current tobacco control policy; 2) this new harm reduction component presents the only feasible approach to rapidly and substantially reduce tobacco-related illness and death in the United States; and 3) with appropriate regulation of marketing now possible through the new FDA/Tobacco law, the public health benefits of this new harm reduction component could be secured without increasing the numbers of teens initiating nicotine use.

Objections to FDA approval of E-cigarettes as tobacco products are **speculative and largely based on misinformation.**

To learn more about how we developed this policy stance, and the action we are now taking, please check out the two-page “Lessons Learned” summary of all this, and the full text of both the petitions and attachments posted today on the Tobacco Issues Page of our www.aaphp.org web site.

7. AAPHP Strategic Plan

Your AAPHP is engaging in further development of its strategic plan for the next 10 years. A well thought out strategic plan should help our organization to become even more sustainable in the decade of 2010-2020. Please take time to reflect on AAPHP membership, its strengths, its weaknesses, its opportunities, and its challenges for the next decade. Email your thoughts to magyarsf@bellsouth.net and we will collate these for further development. In an effort to make our organization more sustainable we will take advantage of every opportunity to grow our organization and increase our influence within organized medicine, and public health advocacy. Part of that effort will include our opportunities for employment as public health physicians.

Working within the context of our current strategic plan, AAPHP is vigorously addressing a number of issues of critical importance to public health physicians. These include, but are not limited to 1) Identifying and expanding job opportunities for public health physicians through our Job Market Initiative; 2) Defending against attempts to weaken public health and preventive medicine training by eliminating the requirement for MPH and other public health training, and diluting training programs by excessive insistence on clinical service time; 3) Developing the concept of the "Teaching Health Department" to a level of respect and authority equal to that of the teaching hospital; 4) Continuing efforts on the tobacco front to secure rapid and substantial reductions in tobacco-related illness and death among current smokers, and doing so in a way that will not increase the numbers of teens initiating tobacco use. In support of all of the above, we have established pages on our web site, blogs and notices in our monthly e-news messages to encourage any and all AAPHP members to participate in policy development related to these issues -- and do so without the need to take time off work to attend national meetings.

Given the nation’s health care reform, the role of public health, public health officers, and physicians interested in public health should become even more important. Our Job Market Initiative, JMI should continue to build. Our organization has committed \$3500 of special monies to begin development of the JMI. http://aaphp.org/JobMarket/PHP_positions.asp is the link for our job market initiative which can be found on the www.aaphp.org. Spread the word, and the link to colleagues, employers, and websites or newsletters which physicians and employers may use.

The goal of the AAPHP Job Market Initiative is now, and always has been to increase the number and quality of jobs that specify a requirement or preference for public health physicians. We have consistently posted more public health jobs on our web site than either ACPM or APHA, and have been the only organization representing public health physicians to work with employers and recruiters along this line. This last week, the AAPHP Board allocated an expanded budget for JMI development over the next six months for the

purpose of further expanding our listings and reach, and to do the marketing needed to secure recruitment firm and large employer financial support for the JMI. Members interested in this issue are urged to consider upgrading their AAPHP membership to the sustaining level to further enhance our ability to expand such job opportunities.

8. NACCHO Data Set Information

Joel Nitzkin, MD, MPH, DPA

The recent NACCHO data from the 49 states and District of Columbia showed 676 local health departments with MD directors in 1993, 370 in 2005 and only 300 in 2008. The overall trend is alarming, with an average loss of 3.8% per year from 1993 to 2005, and an accelerated loss from a much smaller base of 6.3% between 2005 and 2008.

In 2008, there were only 11 states with more than 10 MD local health officers. There were only 6 in which more than half of the local health officers were physicians. There is only one state (Virginia) that held its' own with 100% MD local health directors.

It seems to me (Joel Nitzkin) that, if we are to work together to rebuild a public health physician community based largely on local health directors—we should focus on those states that already have the strongest showing, and related training programs—to strengthen them, perhaps to focus on securing membership from them—then reaching out, possibly through NACo and the Conference of Mayors to yet other communities.

These data, as I see them, present a discouraging but not hopeless picture, and do show where the strongest PH physician communities are to be found.

9. Job Market Initiative AAPHP NEEDS ACTIVE LEADS FOR INCLUSION ON AAPHP.ORG SITE

Joel Nitzkin, MD, MPH, DPA

Our work to re-invigorate our JMI job listings is going well. Our total job postings are now up to 139. This is up from 24 only six months ago. Compared to last month, the number of ads are about the same, but the number of hits is up from 155 to 201. At this point, the JMI has been authorized to expand the listings and initiate activities to secure paid ads from recruitment firms and others to both cover the ongoing costs of the JMI and to enable us to further expand our activities. If all goes very well, it may be possible for the JMI to begin to serve as a source of revenue for the AAPHP General Fund.

Anyone wishing additional information, such as the listing of jobs currently posted, or the background to the JMI -- please see the Jobs page at www.aaphp.org. For additional information, please feel free to contact the JMI coordinator, Dr. Joel Nitzkin, at (504) 899 7893.



10. Please Let Us Help You

AAPH is the voice of public health physicians and welcomes all physicians who are committed to the public's health. **AAPH** accomplishes its work with a maximum of volunteer labor and a minimum of cash expense. We are proud to make the E Bulletin and other **AAPH** materials available without charge to physicians and medical students interested in public health.

If you haven't done so already, please download **AAPH's 2010 Membership Form** right away at <http://www.aaphp.org/Membership/2010MembForm.pdf> and send it to us by fax or postal mail. Please make your 2010 membership as generous as you can. Consider "Supporting" or "Sustaining" membership for 2010 if you are able to do so.

Remember, renewal of your dues, membership, and updated information for AAPH is vital as we try to increase our membership ranks. I AGAIN CHALLENGE ALL AAPH MEMBERS TO RECRUIT AT LEAST ONE OF YOUR COLLEAGUES OVER THE NEXT YEAR. HAVE YOU TALKED TO YOUR FRIENDS AND COLLEAGUES ABOUT AAPH?

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Please also tell your friends and colleagues about **AAPH's** representation of Public Health Physicians. E-Bulletin subscriptions are still free, on request, to any interested physician or medical student. We welcome new subscribers and members Thank you for your support!

Kevin Sherin, MD, MPH (ksherin@yahoo.com) AAPH President and E—Bulletin Editor

11. To Contact E-Bulletin

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