



BULLETIN

AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS
*“THE VOICE OF PUBLIC HEALTH PHYSICIANS, GUARDIANS OF THE PUBLIC’S
HEALTH”*

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EXTRA! EXTRA!

This issue of the Bulletin, due out by February 1, 2004 was delayed. Consequently, later reports covering the Annual Meeting have been included.

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President’s Letter - February 2004

Dear Colleagues:

This is my last letter to you as President of AAPHP. I want to thank you all for the honor and privilege of serving you these past two years, concluding with the celebration of the 50th Anniversary of our founding in 1954.

It has been a momentous time with heightened challenges to the Public Health Community – bioterrorism, smallpox threat, SARS, uncertain resources and legal authority, dilution of qualified public health leadership, undermining of environmental safety regulations, continually increasing population of medically uninsured, epidemic obesity and diabetes in children and adolescents, health care disparities in minority populations, intimidation of scientists, to name but a few. AAPHP has taken stands on these issues through letters to the editor, AMA resolutions and making our opinions known in a variety of ways to CDC and other sectors of the Federal government and having representation on AMA, ACPM and SUNY Albany task forces dealing with adolescent health issues, health care disparities and the public health workforce. AAPHP has chaired the PMLF and participated in activities to enhance qualifications of professionals in public health leadership positions through position papers, resolutions and establishment and maintenance of the Job Market Initiative website.

Since our last Bulletin in November, 2003, we had our Fall General Membership Meeting in San Francisco and the AMA Interim Meeting in Honolulu, Hawaii - the reports of both are in this issue. At our AAPHP meeting on November 16th, we had an excellent presentation on Public Health Law, with Edward Richards, JD as our keynote presenter. As a follow-up, we discussed undertaking a Public Health Law Practice Project and have invited Mr. Richards to contribute an article to our Bulletin. We also had a presentation on Single Payer Health System, following which the membership voted to endorse the principles put forth in the JAMA article by Physicians for a National Health Plan (PNHP). Relative to this, a resolution to be presented to the AMA at I-03 on "The Promotion of Public Health Through System Change" was debated and supported. An initiative to hold an Open Forum on the Health Care System at the June or December 2004 AMA meeting is also being considered. AAPHP resolution objecting to intimidation of NIH researchers and requiring AMA action with Congress was successful. Our February 18th Annual Membership meeting in Orlando will have a panel on "Health Care Disparities and Public Health" with presentations by Dr. Arthur Elster, AMA, Dr. Alfio Rausa, AAPHP and state of Mississippi Department of Health and Dr. Jean Malecki, AAPHP and state of Florida Department of Health.

Our 50th Anniversary Celebration has been immeasurably enriched by the success of the History & Archives Committee. Through the efforts of Co-chairs, Dr. Joel Nitzkin who unearthed a treasure trove of Dr. Ben Freedman's papers bequeathed to Tulane University and Dr. Alfio Rausa who re-discovered multiple boxes of AAPHP records, we have been able to document the history of AAPHP these past 50 years, as well as the history of Public Health in the Americas. Dr. Nitzkin has researched and written papers on these historic findings with hope of publication in one of the relevant medical journals or independently. The crux of his discoveries will be shared in a keynote presentation at our Celebration event on the 18th. At that time we will honor the memory of Dr. Freedman by presenting three special Ben Freedman Awards for "long and dedicated service to AAPHP and the practice of Public Health" to Drs. Christopher (Kim) Buttery, Edward Press and Jonathan Weisbuch. The research will continue and my hope, given all this new material, is to complete an AAPHP Policy Compendium spanning our 50 years – a pet project - for review at our Fall meeting.

During these past few years, we have endeavored to find a "home" for our association, and were successful with NCCHC until they suffered a financial setback in the Fall and were no longer able to provide full services. They are keeping us afloat while we have been exploring other possibilities, i.e., PNHP, ACPM and PSR. I trust this situation will resolve itself before long, and we can again concentrate on increasing our membership and expanding our services.

Overall, this has been a busy and exciting two years. As I slip into the less demanding role of Immediate Past President, I extend my sincerest congratulations and best wishes for a most successful term to the in-coming President, Arvind K. Goyal, MD, MPH.

Sincerely,

Mary Ellen Bradshaw, MD
President AAPHP 2002-2004

Annual Membership Meeting
50th Anniversary Celebration
Orlando, Florida
February 18, 2004

PROGRAM

1:00PM-3:00PM **EDUCATION SESSION**

Health Care Disparities and Public Health

Chair: Arvind K. Goyal, MD, MPH

President-Elect, AAPHP

Panelists:

Arthur Elster, MD, MPH

Office of Science and Public Health, AMA

Jean Malecki, MD, MPH

Director, Florida State Department of Health
Alfia Rausa, MD, MPH
Director, Mississippi Department of Public Health

3:00PM-3:30PM **BREAK**

3:30PM-5:00PM **50th ANNIVERSARY CELEBRATION**

Chair: Alfio Rausa, MD, MPH
Vice President, AAPHP

Greetings

Robert G. Harmon, MD, MPH
President, ACPM

J. Edward Hill, MD
Past Chair AMA Board of Trustees

History of AAPHP Keynote Presentation

Joel L. Nitzkin, MD, MPH, DPA
Past President AAPHP

Co-Chair History & Archives Committee

Presentation of Ben Freedman, MD, MPH Awards

Alfia Rausa, MD, MPH
Vice President, AAPHP

Reflections by Award Recipients

Christopher (Kim) M. G. Buttery, MD, MPH
Edward Press, MD, MPH

Jonathan B. Weisbuch, MD, MPH

Refreshments

Hors d'oeuvres & Champagne Punch

5:30PM-8:30PM **BREAK FOR OPENING OF ACPM CONFERENCE**

8:30PM-10:30PM **BUSINESS MEETING**

History of AAPHP – The First Ten Years 1954-1964

AAPHP will celebrate its 50th Anniversary this February at the annual Preventive Medicine meeting in Orlando. As part of this celebration, AAPHP will be submitting one or more papers for publication on the history of AAPHP and the history of Public Health, and presenting some of this material at the Orlando meeting.

The early 1950's were a golden age for clinicians and a turbulent time for public health physicians. Physicians directed almost all hospitals and health departments. The process by which physicians were to be replaced by non-physicians was clearly evident. A chasm was growing between clinicians and public health physicians, and ever-stronger AMA opposition to "socialized medicine" was distancing the medical profession from what otherwise could and should have been strong community allies. Through all this, the public health physicians saw community organization, wellness, leadership skills, the need for an evidence base for public health policy, problems of aging, the need for lifelong physician education, the failure of medical schools to interest students in public health, and the limitations of conventional approaches to health education very much the same way that we see these issues today. The myth that "businessmen" can run healthcare facilities better than physicians is an issue worthy of reconsideration today.

In a note apparently written by Ben Freedman, MD, MPH, long-term Editor of the AAPHP Bulletin, Ben reflected on the origin of AAPHP in the following words:

When the AAPHP was organized, the problems were:

1. The growing estrangement of public health physicians from private practitioners
2. The pressure for admission of non-medical administrators to the Health Officers Section of APHA.

3. The changes in medical practice in the United States post World War II:
 - a. Rapid increase in the incomes of private practitioners in relation to public health physicians
 - b. Public health physicians who went to the army did not return to public health because of this income difference.
 - c. The DHEW pressure for Deprofessionalization
 - d. The tremendous increase in non-medical people in APH
 - e. The increasing fragmentation of public health programs (this note appears to reflect the trend to place public hospitals and clinics under the leadership of non-public-health agencies at state and local levels).

In the mid-1950's, AAPHP dues were \$5 per year, and, when pleading for adequate pay for public health staff, Dr. L.L. Fatheree (Health Director, Joliet, IL) urged a salary in the amount of \$15,000 for physician directors of health departments and salaries of \$5,000 to \$6,000 per year for the chief public health nurse and public health engineer. Today, those dues and salaries seem quaint and anachronistic. When it comes to the major policy issues they were facing, however, many of their perceptions and policy recommendations would seem avant-garde, even today. Two examples follow:

In a 1956 article written by Dr. E.R. Krumbeigel (Commissioner of Health, Milwaukee, WI and 1955 President of AAPHP) entitled "A Philosophical Consideration of Leadership in Public Health." In this paper Dr. K explored the difficulty of a public health officer torn between the need to prioritize a limited number of programs vs the need to address a wide range of public health issues. The paper, however, is most notable for his words re the importance of citizen participation and partnership in setting public health priorities – a statement which was 40 years ahead of its time:

The major problem confronting the local public health physician is the difficult but interesting task of organizing a community environment (emphasis added by JLN) in which people may jointly engage in an inquiry of their own unique health problems and evaluation of potential solutions to them. To the uninitiated, this approach may loom like a long end run to the solution of any single problem but, from a long range community health program viewpoint, it is the shortest distance between two points. It is the most productive method for overcoming the common hostilities among our "local publics" which often serve to delay or prevent initiation of public health action programs.

The May 1956 AAPHP Bulletin featured a thoughtful and provocative essay by Dr. Herbert Ratner (Health Officer, Oak Park, IL, and then Editor of the Bulletin) entitled "Is Preventive Medicine the Ultimate Goal of Public Health." In this essay he excoriates public health physicians from focusing on the negative "preventive medicine," and not focusing on what he called "perfective medicine" – what we now call "wellness" --- pursuit of optimal physical and mental health.

After reviewing these historical materials, I (JLN) wonder – have we learned fundamentally new these past 50 years? By not knowing our history, are we condemned to repeat it?
-- see you in Orlando

Joel L. Nitzkin, MD, MPH, DPA
Past President AAPHP
Co-Chair, History & Archives Initiative Committee

General Membership Meeting
San Francisco, CA
November 16, 2003

MINUTES

President Mary Ellen Bradshaw, MD, called the meeting to order at 8:38 a.m. PST. Present were Vice President Alfio Rausa, MD, MPH; Secretary Camille Dillard, DO, MPH; Treasurer John Poundstone, MD, MPH; President-Elect Arvind Goyal, MD, MPH; Immediate Past President Dave Cundiff, MD, MPH; Tim Barth, MD; Dan Blumenthal, MD, MPH; Art Liang, MD, MPH; Perrienne Lurie, MD, MPH; Stan Reedy, MD, MPH; Jonathan Weisbuch, MD, MPH; and Ayanna Bradshaw-Sydnor, a first-year MPH student at Emory University. We were

joined during the business meeting by Annette Kussmaul, MD, MPH; Laura Travnicek; Robert Travnicek, MD, MPH; Peter Rumm, MD, MPH; Franklyn Judson, MD, MPH; Ashish Atseja, MD; and Robert England, MD, MPH.

Dr. Bradshaw gave the President's Report:

The AAPHP has expanded its influence with the AMA House of Delegates and with the AMA staff. Our participation in the Preventive Medicine Section Council has been very valuable in this regard. We plan to propose that this group be renamed the "Public Health and Preventive Medicine Section Council".

Dr. Goyal gave the President-Elect's Report:

As a past delegate to the AMA House of Delegates, Dr. Goyal attended the last AMA House of Delegates meeting on AAPHP's behalf. He notes that Public Health has dramatically increased its visibility in that body over the last several years. The AMA considered many public health issues, including obesity, tobacco control, and public health leadership. The AMA has generally taken strong stands in support of the public's health, and reaffirmed its commitment to public health as its highest priority. John Nelson, MD, MPH – a public health physician, running in large part on a public health platform – won an upset victory for the AMA presidency of 2004-2005.

Dr. Goyal represents AAPHP on the AMA's CPT Advisory Panel. The CPT panel is in process of approving payment for on-line consultations as a billable service. This may ultimately translate into insurance payment for all transactions other than face-to-face transactions. This may have implications for public service entities such as public health departments, poison control centers, and others whose work is delivered to individuals on a population basis.

Dr. Goyal attended an informative conference on "Healing Girls in the Juvenile Justice System" this year.

Dr. Goyal attended an AMA consultation on "Disparities in Health Care" in October 2003. Racial, ethnic, and language issues continue to have a pervasive effect on the quality of health care received by individuals and groups in the USA, and on the health status of these individuals and groups. Far-reaching proposals have been made in an attempt to reduce these system-wide disparities. Dr. Goyal requested feedback from the group. Discussion followed. Awareness, feedback, and consequences all help change behavior. Many variables other than health care systems have widespread impact on health disparities. Medical student training can capitalize on the opportunities and needs in this area.

It was proposed that AAPHP establish a task force on diversity and disparities, and establish this as a focus for future AAPHP educational activities. Dr. Bradshaw will arrange this.

Dr. Rausa gave the Vice President's Report:

Drs. Rausa and Nitzkin are organizing AAPHP archives, and preparing for the February 2004 meeting, in celebration of AAPHP's 50th anniversary in early 2004. Our celebrations will be held in Orlando, Florida. As part of this effort, we plan to prepare a compendium of AAPHP policy for all members' use. Dr. Weisbuch suggested that Dr. Bill Elsea may be willing and able to help with this. We discussed arrangements. An additional celebration may be appropriate at the AMA Annual Meeting in June 2004.

Dr. Poundstone gave the Treasurer's Report.

Once bills are paid, our balance will be about \$13,678. Income this year was almost \$9,000. We have at least \$1260 in the bank for the anniversary celebration.

Our business relationship with NCCHC will end with Judi Chavez' departure from that organization. We are entertaining several proposals and possibilities for staff support. Dr. Bradshaw added details. Dr. Poundstone will assist us in closing out our work with NCCHC. Discussion followed.

After a break, Dr. Weisbuch reported for the Education and Training Committee. We hope to find sponsorships for Category 1 Continuing Medical Education (CME) for public health physicians. Discussion followed.

Dr. Rumm reported for the Health Care Access Committee. Several national organizations have called for a national health care system as a means of assuring universal access to health care. Dr. Bradshaw asked whether AAPHP should add its organizational endorsement to the recently published (in JAMA) physicians' statement in support of universal national health insurance coverage. Discussion followed. Dr. Rumm moved that AAPHP support the physician's statement. After discussion, we decided to defer decision until after Dr. Johnston's presentation this afternoon.

Dr. Bradshaw informed members that she has signed AAPHP's endorsement of two AMA resolutions proposed by the American College of Preventive Medicine (ACPM). One of these resolutions is on strengthening the federal assault weapons ban. Another is on obesity and physical activity. Additional resolutions were discussed.

Dr. Bradshaw reported on our relationship with ACPM. There are several models for future cooperation. In discussion, most members suggested that there is an important role for AAPHP as a separate organization from ACPM.

After a break, we began a panel on public health law with Mr. Edward Richards, JD, MPH, Harvey A. Peltier Professor of Law and Director of the Program in Law, Science, and Public Health at the Paul M. Hebert Law Center of Louisiana State University. Mr. Richards describes himself as an advocate for traditional public health law, rooted in the traditional origins of the "police power of the state". He stresses the importance of administrative law. Administrative law processes occupy the vast majority of public health legal activities. Administrative law principles are largely ignored, though, by many of the attorneys who have become involved in public health law since the beginning of the HIV/AIDS epidemic.

Mr. Richards criticized the "Model State Emergency Health Powers Act" (MSEHPA) as an overly detailed replacement for state laws that, in general, provide sweeping authority for state agencies to do whatever is needed to protect against diseases of public health importance. In the absence of detailed prescriptions for public health emergency situations, the courts have consistently upheld agencies' judgment when applied to changing circumstances.

Until recently, the bulk of legal scholarship has largely ignored public health law, while the courts deferred to public health agency judgments. Thus, public health statutes could remain relatively general and brief, while agency professionals remained free to apply their professional judgments in emergencies. The MSEHPA provides much more detailed prescriptions for various situations. By doing so, it removes a great deal of decision-making power from the public health agencies (which generally have the required expertise on disease control, and can act quickly). It grants this decision-making power to the judiciary (which generally lacks technical expertise, and acts more slowly).

Dr. Richards argued that this shift of power from agencies to judges, will represent a significant step backward in public health law for any states that choose to implement the MSEHPA. The real problem isn't the lack of legal basis for public health action; it's the lack of political will for public health action and the lack of budgetary resources to plan and carry out needed action!

Mr. Richards continued by discussing the current epidemic of bioterrorism planning and SARS planning requirements. Federal money primarily addresses the need for planning, not the capacity to carry the plans out! Hospital disaster plans, and those of almost every other institution, appear to assume excess capacity that doesn't usually exist. In fact, when legislators pass new laws, they often assume they have dealt with the problems and can safely cut public health budgets! Mr. Richards concluded by saying that we need to maintain and expand agencies' expertise, the agencies' staffing, and the public health officials' ability to protect health without fear of the political consequences.

As the first speaker on the reactor panel, Dr. Bob England cited Arizona's tuberculosis control law, which was rewritten some years ago because the old law provided few due-process protections for those subject to quarantine and other enforcement actions. In light of the widespread criticism of the "old laws", how can we be confident that future courts will also uphold us when needed? Dr. England suggested that public health powers should be insulated from day-to-day political pressure, in much the same way that the Federal Reserve Bank is insulated from political pressure. He cited examples of legislative bias enacted into statute. This is always a danger when the legislature considers even minor revisions to public health statutes.

As the second panel member, Dr. Weisbuch commented that public health agencies frequently consult legal counsel when they aren't sure what public health methods should be used in a particular situation. Public health physicians, and their staffs, should always strive to decide medically what measures are appropriate, then

consult attorneys if needed in order to carry out these measures. Dr. Weisbuch gave an example in which quarantine of an HIV-positive prostitute was made very difficult by Arizona's new quarantine laws, and other examples in which additional mandatory syphilis testing was impeded in the face of a congenital syphilis epidemic.

Speaking as an impromptu third panel member, Dr. James Haughton commented that political processes are how power is allocated. He said, "Early in my public health career, I learned that if you didn't participate, you would always be a victim." He noted that, early in his career in Houston, he found that an HIV-infected prostitute could not be quarantined due to an oversight in the drafting of HIV/AIDS law. He commented positively on California's systems that give a special role to the California Conference of Local Health Officers (CCLHO) as advisors to the Legislature, and that require the state Health Department to give the CCHLO an opportunity to comment on all proposed public health rules. He cited recent experience in Los Angeles, in which a new due-process requirement was attached to tuberculosis quarantine. He went to the County Counsel, asking the legal system to establish in advance how this requirement should be implemented. In many cases, Dr. Haughton has been able to persuade other entities to help out under unforeseen circumstances. Dr. Haughton also cautioned that when your friends want to help you change the law, you need to remember that others will also attempt to change the law at the same time.

Mr. Richards commented that traditional habeas corpus procedures have always provided an appeal mechanism for quarantine. There is no rational basis for the belief that existing public health laws will not stand up to scrutiny. However, with a growing number of legal scholars (and even some public health professionals) now stating that public health laws are outdated, there is a real threat that this may become a self-fulfilling prophesy at some time in the future.

Mr. Richards commented that many of those trying to "reform" public health law were also involved in the de-institutionalization of mental health. These measures weren't enacted because of legislators' concerns about improving the care of mental patients. "The advocates gave the legislators a flag to wrap themselves in, while cutting mental-health budgets." He fears that a similar process may occur with public health law and processes.

After another break, Bree Johnston, MD, MPH, spoke on "Single Payor National Health Insurance." The United States spends far more on health services per capita than any other country, but has worse outcomes. Much of this spending is administrative waste. Government spending alone would put the USA in a top rank of health care spending, if there were no private dollars entering the system at all. The World Health Association has ranked the U.S. health care system as 37th in the world, just between Slovenia and Costa Rica. Even middle-class people are afraid of the potential impact of health care expenses on their family's well-being. The USA has 44 million uninsured persons, with another 60 million people uninsured for part of the year. This results in delayed access to care and is associated with a 25% increase in overall mortality. Half of all bankruptcies involve a medical cause or debt. Many people with bankruptcy were insured at the time their illness began.

The crisis doesn't just affect people without insurance. Our health care system doesn't work well for people with insurance, for providers, or for employers. People with insurance face problems with underinsurance and hassles. The elderly and the sick poor do worse in HMO's, according to the Medical Outcomes Study (JAMA 1996; 276:1039). Providers often feel as if they're providing "hamster care", with paperwork and billing hassles, alienation, and pressure to provide care so quickly that patients' needs aren't met. Medical school deans report that managed care decreases time for research, time for teaching, and time for community service. Employers report skyrocketing health care costs, impacting competitiveness, and a sense of unfairness when some are covered and others aren't.

Administrative costs are estimated at \$150-300 billion per year, enough to buy health insurance for all of the United States' uninsured. The decline in caregiving has consequences. Kovner and Gergen (J Nurs Schol 1998; 30:315) found that both a lower level of RN staffing and the for-profit status of the hospital were associated with higher rates of post-operative pneumonia, pulmonary compromise, and urinary tract infections. Lower nursing staffing was also associated with post-operative thrombosis rates.

Some suggested solutions include:

1. The Market. Individuals get an allowance to purchase the care they want. This is a disaster for the sick, due to risk shifting. Studies of senior citizens suggest that neither the sick nor the healthy patients can comparison-shop effectively for health care. Poor choices are easy to make, and cannot be reliably revisited once one knows the outcome. Executives' financial conflicts of interest lead them to make unreasonable judgments.
2. Expand employment-based insurance.

3. Single Payer Health System: This would pay hospitals a set fee each year, with prohibitions on certain types of spending and investment. Practitioners could choose among three payment options. Enough money could be saved to cover Long Term Care.

Discussion followed. Attendees commented on the large private costs of Long Term Care insurance, and on the amount of rationing hidden in the present system. Attendees commented on the lack of mental health parity, and on the advantages of prompt, adequate mental health treatment. Advocacy is needed, but the message has to be simple enough for voters and others to understand. More information is available from www.pnhp.org, from www.healthcareoptions.ca.gov, or from JAMA August 13, 2003, pages 798-805.

At this point, Dr. Bradshaw closed the educational session and re-convened the business meeting. Support for a National Health Insurance policy was approved unanimously, with one abstention. Dr. Bradshaw was authorized to add AAPHP as a co-endorser of the National Health Insurance position statement. After further discussion, we adjourned at 6:51 pm.

Respectfully submitted,
Dave Cundiff, MD, MPH
Immediate Past President AAPHP

**GUEST ARTICLE:
PUBLIC HEALTH LAW**

The Legal Basis of Public Health Practice: A Project to Improve Legal Resources for Public Health Professionals
Edward P. Richards, Professor and Director of the Program in Law, Science, and Public Health, LSU Law Center,

Core public health functions - sanitation, disease control, environmental health - depend on legal authority. The sanitation movement brought together legal and scientific knowledge to nearly triple the life expectancy in the United States. Many fine public health law treatises and guides for health officers were published between 1850 and 1950. These helped public health officials and their lawyers deal with the problems of day to day practice and manage emergencies.

The success of public health led society to shift its concerns to chronic diseases and personal medical services. Few health departments have full time career public health lawyers on staff, and in many city, county, and state health departments public health law problems are handled by non-specialist attorneys. When lawyers have to address new legal issues, they turn to practice guides which are compilations of legal analysis and authority, forms, and model briefs that can be adapted for the specific cases. Unfortunately, these guides no longer exist for public health law. Once public health law was no longer seen as a well-defined practice area, these materials fell out of print. While there are some academic books on public health law, these provide little practical guidance to front line public health professionals and their attorneys.

The lack of modern practice materials has a profound impact on public health practice. When government public health attorneys are uncertain, they are reticent to act. This is reinforced by the pressure that advocacy groups put on health departments to prevent necessary public health actions. These groups and other private litigants often have greater legal resources than the health department, especially in smaller communities.

While the specific laws that govern public health practice differ state to state, they are fundamentally similar, and the underlying public issues are based on the same science. Public health departments would benefit if they could share legal resources and build up a central repository of public health practice materials. The Louisiana State University Law Center's Program in Law, Science, and Public Health is developing a public domain repository of public health practice materials. Some materials are already available on the project WWW site: <http://biotech.law.lsu.edu/>. More will be developed and published over the next 18 months. Public health directors and their attorneys are invited to submit briefs, forms, and other public health law documents to support this effort. If you are interested in contributing to this project, please contact Professor Edward P. Richard at richards@lsu.edu.

**Honolulu, Hawaii
December 5 - 9, 2003**

OVERVIEW

The AMA Interim HOD meeting is now focused entirely on issues of advocacy and legislation. All resolutions considered are to be so guided: others were deferred until the Annual meeting. A delightful performance of traditional Hawaiian chants and dance, the latter performed by a children's ensemble, preceded the formal business of the HOD. The address of AMA President, Donald J. Palmisano, MD, JD, emphasized the importance of "speaking with one voice to achieve legislative success". "United we triumph; divided we fail." As proof of this, he held up the recently passed Medicare Prescription Drug Bill as a victory for physicians and patients. He also referenced state and local medical societies that have had success with liability reform, notably, Texas which succeeded in changing the state constitution to specifically authorize caps on non-economic damages. He challenged each member of the HOD to recruit a fellow physician to join the AMA and to show mutual respect... doctor to doctor." There were a number of important reports and resolutions considered, including one submitted by AAPHP and two co-sponsored with ACPM. AAPHP was represented by Mary Ellen Bradshaw, MD, Alternate delegate, substituting as Delegate in the absence of Jonathan Weisbuch, MD, MPH who remained in Arizona managing the epidemic of flu and the related deaths of several children.

NOTEWORTHY ACTIVITIES

* At the Opening session, one of the two AMA Distinguished Service Awards, the Association's highest honor, was presented to F. Douglas Scutchfield, MD, MPH," a past president of ACPM and an active member of the HOD from 1976-2000 for his unwavering advocacy for public health issues such as tobacco and diabetes awareness." His acceptance speech, which called on the members of the HOD to reflect back on the day we took the Oath and what it meant to assume responsibility for the lives of other human beings, created a very pure and moving moment. ACPM hosted a reception in his honor at which AAPHP was represented.

* Nancy H. Nielsen, MD, PhD, assumed the role of Speaker of the HOD, and Jeremy A. Lazarus, MD as Vice Speaker. Both were elected in June.

* The Obesity Action Workshop on adult obesity featured Robert Kushner, MD, a national obesity expert and professor of Medicine at Northwestern University Feinberg School of Medicine who offered an overview of the obesity epidemic. He is the primary author of *Assessment and Management of Adult Obesity – A Primer for Physicians*. AAPHP's John Poundstone, MD, MPH and staff were cited as reviewers for this publication. Wayne N. Burton, MD, representing the Institute on Costs and Health Effects of Obesity spoke about the public health and economic impact of obesity and Gary L. Bryant, MD, Director of Gundersen Luthern Health System discussed the use of pedometers as a means of promoting physical activity.

* Forum on "Health Care Quality and Health Care Disparities – An Opportunity for Performance Improvement" featured a presentation by Carolyn Clancy, MD, Director of AHRQ. A panel, moderated by Clair Callen, MD, AMA Vice President for Public Health and Science, included among others, Rodney Hood, MD, Past President of NMA, and Kevin McKinney, MD, AMA Minority Affairs Governing Council Chair.

* AMA Foundation hosted a reception and presentation on its varied activities including grants for special projects focusing on particular health problems, i.e., obesity.

* Nancy H. Nielsen, MD, PhD, Speaker of the HOD hosted a luncheon for the women physician leaders in the HOD. Entertainment with a sing-a-long was provided by a musically talented trio of male HOD members and the Vice Speaker.

RESOLUTIONS

AAPHP Sponsored Resolutions

Resolution # 724 “Political Interference with NIH Grants Affecting Public Health”, originally on the Re-affirmation calendar, was extracted by the AAPHP Delegate who argued that the first Resolved was in fact NEW HOD policy. This was ADOPTED. The original resolves requested as follows::

- * That our American Medical Association assert as policy that objective science, not subjective ideology or politics, should be the basis for research, and the consequent practice of clinical medicine and public health (New HOD Policy); and
- * That our AMA communicate directly to the Department of Health and Human Services Secretary Tommy Thompson, the leaders of the Senate and Speaker of the House of Representatives its strong objection to political interference with the progress of scientific endeavor (Directive to Take Action); and
- * That our AMA stress that scientific researchers, recipients of peer-reviewed grants – funded by the taxes of the public for the benefit of the public- in the pursuit of answers to significant public health issues, should not be subject to intimidation or harassment at the behest of constituents acting on ideology, not science, (Directive to Take Action)

The Section on Medical Schools had submitted a similar resolution **#725 “Support of the National Institutes of Health Peer Review System”** requesting

That our AMA inform Congress of its strong support for the National Institutes of Health peer review system and its deep concern regarding apparent efforts to breach the integrity of the system. (Directive to Take Action) With AAPHP concurrence, this was ADOPTED in lieu of our last two resolves.

Resolution #836, “The Promotion of Public Health Through System Change” which requested:

- * That our American Medical Association, to improve the public’s health, recommit to a health system that assures access to all Americans regardless of age, employment status, medical condition or ability to pay (Directive to Take Action); and
- * That our AMA determine the most effective and efficient compensation system that will assure quality of care, protect non-profit and teaching hospitals, assure adequate compensation for all caregivers, allow for patient choice of providers, allow sufficient funds for public health, and reduce administrative costs below 10% of the health system budget (Directive to Take Action); and
- * That our AMA assure that the funding process not be dependent on the vagaries of multiple insurance payers, innumerable state and federal patches and bailouts to maintain one aspect of the system or another (Directive to Take Action) ;and
- * That our AMA report back to the House of Delegates at the 2004 Annual Meeting on the most efficient system to achieve these goals. (Directive to Take Action)

was on the RECOMMENDED AGAINST CONSIDERATION AT I-03 list.

Judgment by a review committee as “not being an advocacy and legislation issue” was the reason given when inquiry was made as to the rationale behind this action. Your delegate spoke with Dr. Nielsen, Speaker of the HOD regarding the matter and suggestion was made to re-submit in June at A-04 which we intend to do.

As a further consequence of this issue, your delegate and others developed the concept of having an **Open Forum on the Health Care System** at the June or perhaps, the December HOD. This Forum would feature a panel of speakers representing the broad spectrum of views in health systems. Prepared presentations responding to previously submitted questions would be followed by debate among the presenters and finally an open Q and A session from the audience - which we would hope would be composed of AMA and non-AMA members. In discussion with associations within the Section Council on Preventive Medicine and other national associations and state delegations as well as board members of the Forum on Medical Affairs, there is broad support for such an event. It was discussed with the Speaker of the HOD and future communication with all involved is anticipated.

Resolutions Co-sponsored with ACPM

Resolution #802, “Environmental and Policy Interventions to Promote Physical Activity” was RECOMMENDED AGAINST CONSIDERATION AT THE 2003 INTERIM MEETING,

Resolution # 911 “Authorization and Strengthening of the 1994 Assault Weapons Ban,” after some active debate over the rewording of a key resolve by the reference committee which was challenged by the AAPHP delegate, the original wording was restored and the resolution ADOPTED.

SECTION COUNCIL ON PREVENTIVE MEDICINE (SCPM)

The Section Council on Preventive Medicine met three times with the main business being review of the resolutions in the Handbook, visits from BOT members , discussion of future candidates from the Section and informational presentations from AMA staff.

WOMEN PHYSICIANS CONGRESS (WPC)

The **Governing Council** of the WPC conducted its Interim meeting, December 5th, reviewing the HOD Handbook, hosting visits from AMA staff and addressing futrre elections and meeting plans.

.The **2004 Women Physician Leaders Summit** will take place at the Renaissance Mayflower Hotel, Washington, DC on Saturday, March 27- Sunday, March 28, 2004. The topic for the Summit is “Leadership in a Complex World” and will feature, in addition to reports from the WPC Liaisons, presentations on “Racial and Ethnic Health Disparities: Your Patients are at Risk”. Willarda Edwards, MD, MBA, Chair, National Medical Association Board of Trustees; Helen Burstin, Md, MPH, Director, Center for Primary Care, Prevention and Clinical Partnerships, Agency for Healthcare Research and Quality and Alina Salganicoff, PhD, Vice President and Director of Women’s Health Policy, Kaiser Family Foundation will speak. Nawal M. Naur, MD, MPH, Founder/Director, African Women’s Health Practice, Brigham and Women’s Hospital, Boston and a Mac Arthur Fellow will address “Leadership with Results: Making a Difference for Women”. The Luncheon Presentation, “For Women Leaders: The Risks and Rewards of Difficult Decisions” will be delivered by Mary Schiavo, JD, author of *Flying Blind, Flying Safe*. Afternoon sessions include “The Path to Renewal: Prescription for Living a Life of Balance” by Mamta Gautam, MD, Founding Director, University of Ottawa Faculty Wellness Program and Assistant Professor, Department of Psychiatry, University of Ottawa. The concluding event will be a “Legislative Update” with Nancy Pelosi , Congresswoman, San Francisco, House Minority Leader (Invited) and Julius Hobson, Jr.on “What Physicians Need to Know”. For further information on registration, go to www.ama-assn.org/go/wpc.

Mary Ellen Bradshaw, MD, AAPHP’s representative to the WPC Governing Council is rotating off in June 2004, having completed her second two year term as an elected Representative At -Large. Those interested in presenting themselves as candidates for this elected position should contact the WPC as above.

The **Women’s Caucus**, open to all at the HOD, featured a panel presentation entitled “Incorporating Multiculturalism to Enhance Patient Care” which was well received by Caucus attendees and was made possible by collaborating with AMA Minority Affairs Council Governing Council which provided three of the four panelists.

REPRESENTATION

AAPHP was represented at the HOD by Mary Ellen Bradshaw, MD, Alternate Delegate substituting as Delegate

Respectfully submitted,

Mary Ellen Bradshaw, MD
“Delegate” AAPHP

Job Market Initiative – Future Uncertain - A Call to Action

AAPHP initiated what we now call our Job Market Initiative (JMI) six years ago at the Prevention 1998 meeting, with a series of speakers on job-related issues. As originally envisioned, the goal of the JMI was to increase the number and quality of jobs that required or specified a preference for physicians trained in Preventive Medicine. A survey done at the Prevention 99 meeting demonstrated that about 40% of the physicians attending the meeting were either looking for jobs, or considering changing jobs. In a paper published later that year, our JMI team noted that about 7% of the jobs advertised in selected major medical journals could best be filled with physicians with Preventive Medicine/Public Health/Population Medicine skills – but it was hard to find even single advertisements specifying a requirement or preference for such training. Most issues of these journals did not even have a “Preventive Medicine” or “Public Health” classification for ads – or, if they did, it had only one or two jobs listed in those classifications.

In October, 2001, AAPHP went on line with a JMI jobs page on our website. A few months later this was hotlinked to the ACPM web site so ACPM members could directly access it from there. In addition to the 30 to 50 ads free posted on our site, the JMI team abstracted ads from other journals and web sites – usually running a line listing with more than 100 abstracted ads. By April of 2002, the JMI team was receiving a continuous flow of thank-you notes and praise from both job applicants and employers who noted that people were connecting with jobs in ways that could never have happened without our web site.

When we started the JMI web page we anticipated that its value would be readily apparent, and that, to maintain this site we would be able to secure volunteer assistance from residency programs and others to assist with the abstracting of ads so that, with a reasonable minimum of continuing volunteer support from the core JMI team, we could build the abstracted ads to about 400 at any point in time, and secure revenue from paid ads from executive recruitment firms and others to indefinitely maintain the site on a financially self-supporting basis. Unfortunately, the volunteer assistance never materialized on a scale large enough to pursue the original plan. At several Prevention/Preventive Medicine programs we secured enthusiastic statements of support and commitment, which seemingly evaporated when the participants returned home. We projected the ability to secure paid advertising when we could demonstrate over 1,000 hits per month on a continuing basis, but, peaked at 742 in February of last year.

We have appealed to ACPM for financial and/or staff support, but, despite recognition of the value of this site, no such assistance has materialized to date.

To ease the burden carried by the JMI core team, we discontinued the abstraction of ads from other journals and web sites in February of last year, immediately following the Preventive Medicine 2003 meeting. This was then seen as a temporary measure, anticipating that volunteer or financial assistance might soon materialize. It did not. In addition, the continuing flow of thank-you communications and other positive feedback quickly evaporated – suggesting to us that the real value of this site was the abstraction of ads from other journals and web sites. This was something job applicants can not do without an enormous time commitment.

In October of this last year, we put both AAPHP and ACPM on notice that we did not see the JMI web page as a viable function with its current limitations. If we could not secure the assistance needed to at least reinstate the abstraction of ads from other journals and web sites, that the JMI web page would cease to exist after the end of March, 2004.

UPDATE

At its Board Meeting in Orlando, on February 20, 2004, the American College of Preventive Medicine (ACPM) Board voted to instruct ACPM staff to develop a proposal for consideration by the American Association of Public Health Physicians (AAPHP) for ACPM to offer AAPHP affiliate status, provide office support to AAPHP, and to provide the staff time needed to resume the abstracting of ads from other journals and web sites for the Job Market Initiative (JMI).

This action by the ACPM Board follows the recent adoption of a new ACPM Strategic Plan in November of 2003. This Strategic Plan lists five "Strategic Priorities and Objectives" in what appears to be priority order. The first of the five is to "Market the value of Board certification in preventive medicine . . ." The first of the four sub-objectives includes the phrase ". . . increasing employer demand for preventive medicine physicians."

The amount of staff time offered for the JMI -- four hours per week -- is estimated to be the time required to do the limited abstracting previously done by AAPHP volunteers -- abstracting ads from selected other journals and web sites -- to bring the number of ads for preventive medicine and public health physicians to about 200 ads at any point in time. This was the minimum support specified by myself and Dr. Buttery to assure the viability of the JMI web page on a long-term basis, and to continue the posting of ads on this web page past the end of March, 2004.

Ultimately, we would hope to secure the volunteer or staff support adequate to abstract ads from a much wider range of journals and web sites -- to bring the number of ads posted at any point in time to about 400 -- and to support an organized outreach effort to individual potential employers of preventive medicine and public health physicians in order to dramatically increase the number and quality of jobs expressing a preference or requirement for board certification in Preventive Medicine.

We are indebted to Dr. Robert Harmon, the current President of ACPM for the leadership he has personally provided on behalf of the JMI -- both with regard to the anticipated offer of the staff support needed to continue the current web page, and for the high visibility given to the primary goal of the JMI in the new ACPM Strategic Plan.

We anticipate the generation of the proposal to AAPHP within the next several weeks, and a response by the AAPHP Board within a week or two of receipt of the ACPM proposal.

Joel L. Nitzkin, MD, MPH, DPA
Chair Job Market Initiative AAPHP

Annual Membership Meeting February 18, 2004 **Caribe Royale , Orlando, Florida**

MINUTES

Dr. Weisbuch convened our meeting at 1:08 p.m. EST. He brought greetings from AAPHP's President Mary Ellen Bradshaw, MD, who could not attend due to illness. Present for the educational session were Doctors Maria Agelli, Ellen Alkon, Alina Alonso, Tim Barth, Arthur Elster, Arvind Goyal, Edward Hill, Doug Mack, Jean Malecki, Joel Nitzkin, John Poundstone, Alfio Rausa, Robert Travnicek, Jonathan Weisbuch, and Dave Cundiff. Dr. Goyal introduced our three speakers on "Health Care Disparities and Public Health".

Dr. Elster spoke on the perspectives of the American Medical Association (AMA) on health disparities. This has been a big issue for the House of Delegates, and thus for the AMA staff, since the mid-1990's. Current AMA initiatives include the Federation Task Force on Disparities, which is scheduled for a second meeting on April 5-6, 2004; and a major staff emphasis on disparities within the AMA's Medicine and Public Health Program.

Dr. Malecki spoke on diversity within Palm Beach County, Florida, where there are major rural-urban disparities in age, income, race/ethnicity, healthcare access, and health status. Parents of Palm Beach County schoolchildren speak 126 different languages as primary languages at home! A malaria outbreak in July 2003 highlighted many patients' difficulties in accessing health care; the health care system's difficulties in recognizing malaria as a possibility; and the public health problems created when immigrants fear to access the healthcare and public health systems. Public information methods (including "Reverse 911" and school communication channels) were crucial to containing this outbreak promptly. To serve diverse peoples more effectively, the Palm Beach County Health Department has established a "Council on Cultural Communication", with subcommittees including Healthcare Access, Environmental Health, and other key areas.

Dr. Rausa spoke about his experience with disparities in rural Mississippi. In his early days, a program of wide, non-targeted publicity succeeded primarily in protecting non-minority populations at relatively low risk for the conditions of concern. Since then, many programs have succeeded in empowering rural populations and minorities specifically to address their own health problems. Other programs, such as Medicaid, provide healthcare resources in such a way that they tend to reduce disparities. Current state, local, and Federal budget pressures threaten to slow or reverse this progress.

In response to questions, Dr. Malecki said that, whether or not ethnicity-specific health data are available, it is vital to reach out to leaders of various ethnic communities. Dr. Elster clarified that, in the AMA's work, proposals to change the health care financing system are treated separately from other disparities-related issues. Dr. Elster said that those who are funding the AMA's disparities-related effort will look primarily at grant-related actions. It isn't clear whether direct measurement of grant-related impact would be feasible. Dr. Rausa and Dr. Malecki noted that it is difficult to achieve innovation in vaccine financing and delivery for the elderly, due to the incentives of the private market and the lack of mandatory vaccinations.

We adjourned at 3:00 p.m. Dr. Rausa called us back to order at 3:55 p.m., for a celebration of AAPHP's 50th anniversary. Additional attendees at the Celebration were Drs. David Blodgett, Robert Harmon, Annette Kussmaul, Charles Schade, and Hugh Tilson.

Dr. Harmon brought greetings from the American College of Preventive Medicine (ACPM). The ACPM is seeking closer ties with AAPHP, in order to advance the public's health more effectively.

Dr. Hill commended AAPHP for the quality of its representation in the AMA House of Delegates. AAPHP is the smallest of the specialty societies in the House of Delegates, but it is one of the most influential. AAPHP brings many worthwhile resolutions, and advocates skillfully for their passage. Dr. Nathan Davis, one of the AMA's founders, was also a skillful leader in the public health of Chicago in the 19th century. In the last 18 months, the AMA has committed itself to major public health initiatives and to a major role in public health. The AMA is committed to health care for everyone. More than 80 million Americans are uninsured at one time or another in any four-year period. The AMA is also committed to addressing the prevalence of unhealthy behaviors and conditions.

Dr. Nitzkin gave our keynote presentation on "The History of Public Health From an AAPHP Perspective", based on the writings of Dr. Ben Freedman and other documents from the AAPHP archives. When AAPHP was formed in 1954, it met twice a year in conjunction with the two AMA meetings. The major themes of AAPHP's first decade mirror the challenges of the centuries before, and of the decades since. We now have available a marvelous archive from AAPHP's early history. We hope to make much of this archive available on the web, in conjunction with the Tulane University libraries. From the beginning, AAPHP has advocated a model for sustainable community action, which requires (1) scientifically trained Health Officers, to analyze and implement control measures; (2) Boards of Health with some degree of political independence, to approve regulations; and (3) Departments of Health, with staff and funds to get the job done. Physicians have lost substantial control over community healthcare institutions and Health Departments. Physicians have also lost much of the control over their own work settings in the private sector. However, we need to examine the current potential for physician leadership. We must exert ourselves strategically to protect the public's health – both within the "House of Medicine" and within the larger community.

Dr. Rausa read the Awards Committee's presentations for this year's "Ben Freedman, MD, MPH Awards" for lifetime achievement and service to AAPHP. These awards are presented to Edward Press, MD, MPH; Kim Buttery, MD, MPH; and Jonathan B. Weisbuch, MD, MPH. In brief remarks, Dr. Weisbuch cited the need for political involvement, for active participation in the House of Medicine, and for Health Departments that prepare public health physicians and other professionals for the future.

We adjourned at 5:13 p.m. Dr. Rausa re-convened us for a business session at 8:38 p.m. Additional attendees at the business session included Drs. Joshua Lipsman, Kevin Sherin, and Stephanie Smith. Dr. Rausa circulated a letter from Dr. Bradshaw, thanking AAPHP for the opportunity to serve as our President for 2002-2004.

On motion by Dr. Mack, the minutes of November 16, 2003 were approved unanimously.

Dr. Goyal reported for the Executive Committee. Meetings have been held regularly in accordance with our bylaws. On motion by Dr. Goyal, a motion of commendation for Dr. Bradshaw (with appropriate expenditure) was approved unanimously. In a subsequent clarification, members noted that this commendation refers to Dr. Bradshaw's service in multiple AAPHP positions.

Dr. Goyal presented the President-Elect's report. Dr. Rausa thanked all those who have helped to prepare our recent meetings. He particularly thanked Dr. Nitzkin for studying AAPHP's archives and speaking on AAPHP's history at today's Fiftieth Anniversary Celebration. This effort, which was begun partly due to Dr. Bradshaw's initiative, will provide a strong foundation for achieving proper recognition and compiling an AAPHP Policy Compendium.

Dr. Weisbuch reported for the AMA delegation. Dr. Bradshaw was the only AAPHP delegate who was able to attend the December 2003 Interim Meeting on Advocacy and Legislation of the AMA House of Delegates. At the December 2003 meeting, the substance of our resolution against political interference with the National Institutes of Health peer review process was ADOPTED. Our resolution in support of public health promotion through changes in the health care system was DEFERRED until the June 2004 meeting because, in the judgment of the review committee, it was not an "advocacy and legislation issue." We believe this ruling was mistaken. We plan to revisit this issue, with a strong focus on the evidence base, at the June 2004 meeting. The AAPHP/ACPM resolution on interventions to promote physical activity was also deferred until the June 2004 meeting. Another AAPHP/ACPM resolution on strengthening of the assault weapons ban was passed with the original AAPHP/ACPM wording, largely due to Dr. Bradshaw's vocal opposition to a weakening amendment.

Dr. Weisbuch pointed out that Dr. Bradshaw can no longer serve as the AAPHP representative to the Women Physicians' Congress. He suggested that AAPHP may wish to nominate a successor to run for this position.

Dr. Weisbuch moved that AAPHP re-introduce the resolution in support of public health promotion through changes in the health care system, retaining the original intent and essential features of the resolution.

At this point, Dr. Harmon entered, and the order of business was changed to allow Dr. Harmon's presentation to begin immediately. Speaking for ACPM as ACPM's president, Dr. Harmon presented two concept proposals from ACPM – one in which ACPM would provide office and staff support services for AAPHP, and another in which ACPM and AAPHP would formalize their mutual relationship as an "Affiliation" agreement.

Details of the proposed "Services" agreement would include: (1) ACPM service as the organizational address, telephone contact, and communication medium for AAPHP; (2) ACPM management of AAPHP's membership database and membership renewal process, including sending renewal notices and depositing dues payments; (3) ACPM to compile and distribute up to four AAPHP Bulletins per year; (4) ACPM maintenance of an AAPHP membership listserv; (5) ACPM to serve as a repository for corporate documents, such as minutes of meetings; and (6) ACPM to carry out the Job Market Initiative with appropriate training and support from AAPHP members. Much of this would be carried out electronically, with an annual fee to be negotiated by mutual agreement.

With respect to the staff services agreement, Dr. Harmon said he believed the ACPM proposal would probably cost AAPHP only a small amount more than our previous agreement with the National Commission on Correctional Health Care (NCCHC). ACPM would not recover all its costs under such an agreement, but would regard any losses as an "investment" in public health services and in membership recruitment.

Details of the proposed "Affiliation" agreement could include the following elements: (1) Regular communication between ACPM and AAPHP, including updates of organizational activities and issues in each other's governance meetings and publications; (2) ACPM Public Health Regent to be a member of AAPHP (which is already ACPM's policy); (3) Joint member recruitment and mutually discounted dues; (4) A special role for AAPHP in the new Center for Preventive Medicine; (5) A special role for AAPHP in the Preventive Medicine meeting series, including leadership of the public health track; (6) Coordination (although not approval) of each other's committee and policy activities, and Web site activities; and (7) Other activities as mutually agreed upon.

With respect to the "Affiliation" agreement, Dr. Harmon clarified that this would be an agreement between independent organizations, not the "component society" proposal that AAPHP has repeatedly declined.

Dr. Goyal clarified that NCCHC is providing most of the listed services to AAPHP on an interim basis. The services that NCCHC is not providing include staff support for meetings and minute-taking (not part of the ACPM proposal), and sending dues renewal notices. Dr. Goyal requested clarification about whether staff support for meetings would be included; Dr. Harmon replied that this is not part of the current proposal. However, a staff person may be available to track "action steps" from meetings, and follow up on these action steps. Dr. Goyal asked whether a "live person" would answer AAPHP's incoming telephone calls. Dr. Harmon clarified that most incoming calls would be answered by voicemail, with prompt return of calls.

Dr. Goyal requested clarification of the specific steps that ACPM would take to support the shared Job Market Initiative (JMI). Dr. Nitzkin clarified that the most important feature of the JMI seems to have been the abstraction of advertisements from other journals. To resume this feature would require approximately four hours of abstracting per week.

Dr. Goyal requested clarification of issues of autonomy, independence, and control. This has been an important issue for AAPHP in the past.

Dr. Goyal requested clarification of whether the "Support" and "Affiliation" proposals are inextricably linked, or whether the two proposals can be considered independently. Dr. Harmon replied that ACPM's hope is that the two proposals can be considered together, but that any agreement(s) would only be for a one-year period and would be re-evaluated regularly.

Dr. Nitzkin requested clarification of the time frame within which ACPM could provide services after the conclusion of an agreement. Dr. Harmon clarified that services could begin within a month or two after conclusion of an agreement.

Dr. Goyal thanked Dr. Harmon for his interest in, and pursuit of, stronger relationships between ACPM and AAPHP. Dr. Nitzkin suggested that closer relationships between ACPM and AAPHP could be very beneficial to both organizations, especially if AAPHP's grassroots orientation to public health practice can be reflected more fully in ACPM's policy-making process.

Dr. Poundstone moved approval of the ACPM proposals in concept, and authorization for the AAPHP's Executive Committee to work with ACPM to develop and refine these concepts.

During discussion, Dr. Goyal noted that we have recently received at least one other concept proposal to provide staff support for AAPHP. Staff support for meeting scheduling, agendas, and minutes have been a major issue for the last two years and are not directly addressed in the ACPM proposal. Dr. Goyal recommended that we address these needs if feasible. Dr. Nitzkin noted the practical and policy concerns that have been raised about these proposals, and recommended that these be addressed satisfactorily before any final approval of either agreement.

We noted ACPM's heavy reliance on E-mail as the preferred method of communication. AAPHP members attempting to reach ACPM staff by telephone have often been frustrated, while members contacting ACPM by E-mail have found ACPM staff to be very accessible. Dr. Mack is willing, if the ACPM proposals are approved, to serve as an in-person liaison if that service is needed.

The motion was amended, with Dr. Poundstone's consent, to read "support of the ACPM proposals in concept, and give direction to the AAPHP's Executive Committee or Board of Trustees to work with ACPM to develop and refine these concepts within the next four weeks." The amended motion was approved without dissent.

Dr. Alkon will attend the ACPM Board meeting this Friday, February 20, 2004. She agreed to present AAPHP's positive response in concept, and to report back to AAPHP's officers and board on any discussion at that meeting.

At this point, we resumed discussion of the AMA Delegation Report. Dr. Alkon requested that the Institute of Medicine report on the public health impacts of our health care system be incorporated into our presentation at the AMA's June 2004 meeting. Dr. Weisbuch accepted this as a friendly amendment. The amended motion (to re-introduce the resolution in support of public health promotion through changes in the health care system, incorporating relevant IOM reports and other evidence in support of the resolution) passed unanimously. After this, the AMA Delegation's report was accepted unanimously.

Dr. Goyal moved that AAPHP dues for regular members be set at \$85.00 for calendar year 2005. He further proposed that we plan for dues of \$90.00 for calendar year 2006. Depending on the specifics of any ACPM affiliation agreement, we may offer a mutually agreed joint-membership discount from the full dues; this motion would not preclude such a discount. Our bylaws require the 2005 dues to be set at this meeting. Already discounted dues, such as those for retired and student members, would not be raised under this proposal. After discussion, the motion carried by a vote of eight in favor, with three opposed.

Dr. Rausa and Dr. Nitzkin reported for the History and Archives Committee. We are pursuing publication of our historical summaries in external journals.

Dr. Goyal reported for the Nominating Committee. The Committee has worked hard to define the vacancies and find candidates for each position. Dr. Goyal nominated Dr. Rausa for President-Elect, the term in that office to run from 2004 to 2006. Dr. Goyal nominated Dr. Sherin as Vice President for 2004-2006. Dr. Camille Dillard has requested to resign early as Secretary, but has expressed interest in remaining as a Board member. Dr. Goyal nominated Dr. Cundiff as Secretary for the remainder of Dr. Dillard's term (2004-2005). Dr. Goyal nominated Dr. Poundstone to remain as Treasurer for another three-year term (2004-2007). Dr. Goyal nominated Dr. Perriane Lurie for a full three-year term on the Board of Trustees (2004-2007). This will be Dr. Lurie's first full term on the Board, and she will be eligible for reappointment in 2007. Dr. Goyal nominated Dr. Dillard for a full three-year term on the Board of Trustees (2004-2007). Dr. Dillard will also be eligible for reappointment in 2007. All of the nominees listed above were elected by acclamation.

Dr. Goyal noted that an additional AAPHP Trustee seat is reserved for a Public Health physician who meets the AMA definition of a “Young Physician” (age 40 or younger, or less than five years after completion of the most recent residency). Dr. Goyal has identified some potential candidates, but asked for the members’ permissions to finalize this appointment later.

Dr. Goyal noted that Drs. Weisbuch and Bradshaw are willing to serve as our AMA Delegate and Alternate Delegate only through the AMA’s June 2004 meeting. He requested a commendation for these delegates’ efforts on our behalf. For a two-year term from July 2004 to July 2006, Dr. Goyal nominated himself as Delegate and Dr. Mack as Alternate Delegate. These nominations, and the commendation for Drs. Weisbuch and Bradshaw, were approved without dissent.

Dr. Weisbuch distributed a matrix of upcoming meetings of related organizations, with a suggestion that we consider options other than the current practice of meeting only in conjunction with ACPM and APHA. The question was deferred, with the suggestion that a broader group of members might be polled for input.

Dr. Weisbuch noted that Dr. Bradshaw is pursuing the opportunity to coordinate an Open Forum on the Health CareSystem, on behalf of AAPHP and possibly with other organizations, in conjunction with one of the AMA’s 2004 meetings. Past expenses for similar events have not been excessive, because the AMA was cooperative. We hope that such an event can be organized.

Dr. Mack requested consideration of a proposed resolution :

TITLE: Resolution advocating fee-waived medical licensure for volunteer physicians:

WHEREAS the large number of medically uninsured persons in the United States poses a potentially serious public health problem; and

WHEREAS health services access in communities would benefit from the availability of volunteer physicians’ services; and

WHEREAS increasing numbers of retired physicians could be available to provide these medical services free of charge; therefore be it

RESOLVED that AAPHP seek state legislative action to create a licensure category for Volunteer Service Physicians; and be it further

RESOLVED that a model Volunteer Service Physician program would stipulate the following conditions:

- ◆ Volunteer Service Physicians may not accept payment for their services;
- ◆ Volunteer Service Physicians must complete CME requirements;
- ◆ Volunteer Service Physicians are exempt from payment of renewal fees; and
- ◆ Volunteer Service Physicians may resume active status upon payment of fees.

In discussion on this resolution, Dr. Goyal suggested that the resolution should also be forwarded to the AMA and to the Federation of State Medical Boards (FSNB). The proposed resolution was approved unanimously.

Dr. Weisbuch suggested that members might have an interest in helping with the Job Market Initiative.

We adjourned at 11:48 p.m. EST, with thanks to all. Dr. Goyal assumed office as AAPHP’s President at the end of the meeting.

Respectfully submitted,
Dave Cundiff, MD, MPH

NOTES FROM THE WEBMASTER

<http://www.nlm.nih.gov/medlineplus/> gives health departments an excellent link for those using their websites to take viewers to information, by topic., from the NLM.

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Arvind K. Goyal, MD, MPH
Rolling Meadows, IL
E-mail:ArvindkGoyal@aol.com

VICE PRESIDENT

Kevin Sherin, MD
Orlando, FL
E-mailKevin_Sherin@doh.state.fl.us

PRESIDENT ELECT

Alfio Rausa MD, MPH
Greenwood, MS
E-mail:arausa@mshd.state.ms.us

SECRETARY

Dave Cundiff, MD, MPH
Olympia, WA
E-mail: cundiff@reachone.com

TREASURER

John Poundstone, MD, MPH
Lexington, KY
Email: jpound@infionline.net

IMMEDIATE PAST PRESIDENT

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Phoenix, AZ
E-mail: MEBMD@aol.com

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AMA Delegate –6/2004

Jonathan B. Weisbuch, MD, MPH
Phoenix, AZ
E-mail: jbweisbuch@earthlink.net

AMA Alternate Delegate-6/2004

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Phoenix, AZ

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NB

There will be a change of AAPHP address. For the immediate future, continue to send correspondence to:

AAPHP

1300 W. Belmont Ave.
Chicago, Illinois 60657-3200
Phone (773) 832-4400
Fax (773) 880-2424

Email: aaphp@iname.com

Web: <http://www.aaphp.org>

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American Association of Public Health Physicians
“The Voice of Public Health Physicians, Guardians of the Public's Health”

Membership/Renewal Application

Name: _____

Title: _____
(first) (middle) (last) (degrees)

Address: _____

Telephone: _____ Fax: _____ E-

Mail: _____

I am a graduate of _____

(School of Medicine or Osteopathy) (date)

I am currently (circle all that apply) : 1. a student 2. a resident 3. in active practice (3a. academic 3b.administrative 3c.consultative)

4. retired 5. other

I am a current member of: AMA _____ Yes _____ No; ACPM _____ Yes _____ No
ATPM _____ Yes _____ No; APHA _____ Yes _____ No

Membership Category for 2004	Dues
Residents/students/retired/reduced income	\$30.00
Active Physicians	\$75.00
Life Membership	\$750.00

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