



BULLETIN

AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

“The Voice of Public Health Physicians, Guardians of the Public’s Health”

Volume 51, Issue 1

JUNE 2005

President’s Letter



June 1, 2005

Dear Colleague,

A friend recently sent me this story:

In the beginning God covered the earth with broccoli and cauliflower and spinach, green and yellow and red vegetables of all kinds, so Man and Woman would live long and healthy lives.

Then using God’s Bountiful gifts, Satan created ice cream and donuts. And Satan said, “You want hot fudge with that?” and Man said, “Yes!” and Woman said, “I’ll have another with sprinkles.” And they gained 10 pounds.

Then God said, “Try my fresh fruits and green salad.”

And Satan responded with crumbled Bleu Cheese dressing and garlic toast on the side. And Man and Woman unfastened their waistbands and seat belts to fit following the repast.

God sent heart healthy veggies and olive oil in which to lightly saute the wholesome vegetables and a drink of water. And Satan then brought forth deep fried coconut shrimp, fried chicken and a big steak requiring its own platter, cocktails instead of water and chocolate cheesecake for dessert. And Man’s glucose and cholesterol levels spiked through the roof.

God then brought forth a pair of running shoes so that his children might lose those extra pounds. And Satan came forth with a cable TV with a remote control so Man would not have to toil changing channels. And

Man and Woman laughed and cried before the flickering lights eating potato chips and smoking tobacco.

Then God provided lean meat so Man would consume fewer calories and still satisfy his appetite. And Satan then produced the 99-cent cheeseburger, and said, “You want fries and Pepsi with that?” And Man said, “Yes! And super size them!” And Man went into cardiac arrest.

God sighed and created quadruple bypass surgery.

And Satan countered by creating HMO’s.

Such are the challenges faced by Public Health Physicians everyday! They preempt the “Satan” when they can and intervene with their voices, available resources and decisions when the health of their communities is put at risk. They are willing to learn, adopt and apply new strategies tested elsewhere. Their networking enhances the quality and quantity of populations they serve. Promotion of such practices in Public Health remains the mission of the American Association of Public Health Physicians (AAPHP), the Guardians of Public Health.

The AAPHP Officers and Board members spent considerable time last year looking and weighing various options for management of our office and membership functions. The American College of Preventive Medicine based in Washington, DC, will now provide our office management services for a fee. With this new arrangement, you will notice a significant enhancement of our communications in the coming months. Please call

or write anytime—your association, the AAPHP can help. Your comments and suggestions are always welcome.

Somebody said, none of us is as smart as all of us. Please send in your AAPHP dues for 2005, if you haven’t already done so, along with the renewal form on the back of this Bulletin. Please feel free to encourage others to join, especially if they can help make our collective voices even louder. The AAPHP membership remains open to all licensed physicians, residents and students, those who are willing to self-designate as Public Health Physicians. Remember a Silicon Valley proverb: If you are not a part of the tractor, you risk becoming a part of the road.

Sincerely,
Arvind K. Goyal, MD, MPH
President

2005 AAPHP Member Meeting

Join us for the Annual AAPHP member meeting in Chicago! Saturday, June 18, 2005 6:00pm—8:00pm, Room 4-D Chicago Hilton and Towers 720 S. Michigan

The program will include reports of AAPHP activities in the past year, Bylaws revisions as posted on the website and elsewhere in this Bulletin, elections for available Officer and Board positions and brief presentations by the AMA President, Dr. John Nelson and AMA President Elect, Dr. Edward Hill.

Details will be posted on the AAPHP website one week in advance of the meeting. Advance registration is not required and there is no charge to attend.

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AAPHP Treasurer's Report



Respectfully
submitted by:
**JOHN
POUNDSTONE,**
MD, MPH
*Account as of
May 2005*

Balance before
expenses: \$12,438.00

Web: Kim Buttery, MD 425.85

Other expenses not
yet billed or paid 1,400.00

Total 1,825.85

Balance after expected
expenses \$10,613.00

Includes memberships of \$2,460.00
that were paid by check. I've
heard nothing about payments by
credit card.

AAPHP Association Facts

Current Officers and Trustees

President: Arvind K. Goyal, MD,
MPH, Rolling Meadows, IL

President Elect: Alfio Rausa, MD,
MPH, Greenwood, MS

Vice President: Kevin Sherin, MD,
MPH, Orlando, FL

Secretary: Dave Cundiff, MD, MPH,
Olympia, WA

Treasurer: John Poundstone, MD, MPH

Immediate Past President: Mary
Ellen Bradshaw, MD, Phoenix, AZ

Board of Trustees:
Kathleen H. Acree, MD, JD, MPH,
Sacramento, CA

Timothy Barth, MD, CCHP, Detroit, MI

Camille Dillard, DO, MPH,
Dolgeville, NY

Joshua Lipsman, MD, MPH, New
Rochelle, NY

Sindy Paul, MD, MPH, Yardley, PA

Stanley Reedy, MD, MPH, Ypsilanti, MI

Peter Rumm, MD, MPH, Wayne, PA

Elizabeth Safran, MD, MPH, Atlanta,
GA

AMA Delegate: Arvind K. Goyal,
MD, MPH, Rolling Meadows, IL

AMA Alternate Delegate: Douglas
Mack, MD, MPH, Bethesda, MD

Webmaster: C.M.G. Buttery, MD,
MPH, Urbanna, VA

Chair, Job Market Initiative: Joel L.
Nitzkin, MD, MPH, DPA, New
Orleans, LA

Manager, Member Services: Robert
S. Rader, Washington, DC

AAPHP Representation, Liaison Activities and Partnerships

- AMA House of Delegates
- AMA Section Council on Preventive Medicine
- AMA President's Forum
- Preventive Medicine Leadership Forum
- American Board of Preventive Medicine
- Preventive Medicine Residency Review Committee
- American Medical Women's Congress
- AMA CPT Advisory Committee
- The Commission to End Health Care Disparities
- CDC: Advisory Panel on Expedited Partner Therapy
- AMA Specialty Society Section
- National Commission for Correctional Health Care
- National Association of County and City Health Officials
- Association of State and Territorial Health Officials
- American College of Preventive Medicine
- Fireworks Coalition
- And many others!

AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

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Contact: Robert S. Rader, Manager, Member Services, rsr@acpm.org

Proposed AAPHP Bylaws Revisions

Respectfully submitted by:
KEVIN SHERIN, MD, MPH
May 24, 2005

Red (**bold**) are proposed, Green (*italic*) were approved in San Diego in February of 2003 but never input.

III. A. 2. A **special membership dues waiver shall occur for new members recruited and joining after June 30 in a calendar year. New members joining between Jan. 1 and June 30th of a calendar year shall receive a 50% discount for the annual dues only applicable to that first year of membership.**

III. B. Honorary

a. Physicians who are not **current** members of AAPHP, but who are **pre-eminent** in public health or preventive medicine or have achieved outstanding public health accomplishments may be considered for honorary membership.

c. Resident - Residents in accredited training programs in Preventive Medicine shall be eligible for membership rights under the non-dues membership category

d. Students - Medical students shall be eligible for membership rights under the non-dues membership category

C. General Membership Meetings

1. The Annual General *and Interim membership meetings* shall take place in conjunction with a **meeting of the AMA and another** public health meeting to be selected by the Board.

2. The interim general membership meeting shall also take place in conjunction with the annual meeting of the American Public Health Association (APHA) or another public health meeting selected by the board and approximately 5 months apart from C.1

3. *Additional Special meetings of the General Membership may be held at the discretion of the Board of Trustees with a specific purpose clearly specified in the meeting notice which will be sent to all members with at least 30 days notice.*

4. The general membership meeting shall be considered to have a quorum when not less than 5% of the membership is in attendance.

Article IV - Board of Trustees

The Board of trustees will be required to declare any and all conflicts of interest pursuant to the discharge of duties and before the commencement of any meetings of the board.

IV. D. **The Board of Trustees shall be considered to have a quorum when not less than 1/2 of total membership of the Board of trustees and officers are in attendance.**

Article V - Executive Committee

1. same
2. *The Executive Committee shall review the agendas for the Board and General Membership meetings prepared by the President.*
3. no change
4. *Actions of the Executive Committee shall be subject to review at the next Board Meeting.*

Article VI

C. Terms of President, President Elect and Immediate Past President

1. *The President shall take office at the end of the Annual General Membership Meeting in even numbered years to serve a term of two (2) years.*

F. Successor to other Officials

1. *If any of the other officer positions are vacated before the end of the specified term, the President shall appoint ~~a currently sitting trustee or Appointee~~ another member to fill that position until the next Annual Meeting.*

2. *Spelling of NEXT was corrected.*

Article VII - Duties of Officers

All officers will be expected to declare all conflicts of interest pursuant to the commencement of business meetings of the association and in the discharge of their duties

Article VIII - Executive Manager

A. The Board of Trustees may *select an Executive Manager who need not be a member of the AAPHP, with a defined position description or may execute another management contract as they see fit; said executive manager need not be a member of the Association; will to serve as chief Administrative Officer of the Association, assist the President, the Secretary and the Treasurer with all responsibilities of these offices, and maintain the Association's Headquarters Office. Once appointed, the Executive Manager shall serve until removed or replaced or said management contract shall be terminated as the board may see fit.*

B. *The Executive Manager or contracted management entity shall have charge of the headquarters office and shall employ such assistants and office staff as may be determined by the Board of Trustees as determined by the Board. In the case of an executive manager, he and his assistants and the office staff shall receive compensation and travel allowances, and be covered by such insurance as may be determined by the Board of Trustees by agreement with the agency serving as host to the headquarters office.*

C. The Executive manager **or contracted management entity** shall have authority to write checks and manage the financial affairs of the Association, under the direct supervision of the Treasurer.

D. *The Executive Manager or contracted management entity* shall serve as co-editor of the Bulletin, with the President ~~and whoever the President designates.~~ **or his/her designee.**

E. The Executive Manager **or contracted management entity designee** shall ~~may~~ serve as Parliamentarian at all Executive Committee, Board and General Membership meetings: *at all AAPHP meetings if qualified and if so designated by the President.*

F. In the event the executive manager position is vacant **or contracted management entity has been terminated and new contract management entity agreement is not yet in place**, the individual officers shall fulfill without the assistance of the executive manager, those duties assigned to them in Article VII Duties of Officers. (Remainder is unchanged)

Article IX - Appointments and Committees

A. 2. ~~All appointees shall be ex-officio members of the Board of Trustees. They shall participate in Board meetings, but not vote. Upon invitation by the President, all appointees can participate but not vote in Board meetings~~

4. Newsletter/*Bulletin* Co-Editors *The President or designee* and Executive Manager **or contracted management entity appointee** and others appointed by the president

F. Successor to Other Officials

1. If any of the other officer positions are vacated before the end of the specified term, the President shall appoint ~~a currently sitting trustee or~~

~~Appointee~~ **another member** to fill that position until the next Annual Meeting.

Article X - Financial Matters

B. Membership dues - ~~Dues shall be established by the Board of Trustees, then approved by the General Membership, at the annual General Membership meeting.~~ *The annual Membership Dues shall be reviewed by the Board and approved at the last General Membership meeting of a calendar year. The dues statement each year will be mailed before the end of the preceding year.*

D. An annual Budget shall be recommended to the Board of Trustees by the Treasurer, at the Board meeting immediately preceding the Annual General Membership Meeting, then approved by the General Membership ~~attending~~ **amending** the Annual General Membership Meeting.

Article XI - Relationship with American Medical Association (AMA)

B. AAPHP shall *encourage the AAPHP members to join the AMA.*

C. Young Physician Section

3. AAPHP Young Physicians meeting the qualifications noted in *Article XI C.1* ~~Article XI D.1~~, above, and present at the AAPHP Annual Meeting, shall elect, from within their membership, both a Delegate and Alternate Delegate to the AMA Young Physicians Section.

Article XII - Rules of Order

B. ~~The Executive Manager, when employed, shall serve as Parliamentarian at all meetings of the Association.~~ *A parliamentarian will be designated by the President for all AAPHP meetings.*

Article XIII - Amendments

A. These bylaws may be amended by a two-thirds vote of members present at any Annual *General* Meeting, provided that written notice has been

given by any means designed to reach all members. ~~sent in advance of the Meeting.~~ Publication of such notice in the *AAPHP Bulletin or on the AAPHP website* of the Association shall be construed ~~considered~~ as compliance with this requirement.

EPT for STI

Expedited Partner Treatment (EPT) for Sexually Transmitted Infections



Respectfully submitted by: DAVE CUNDIFF, MD, MPH, AAPHP Secretary

The “gold standard” for partner evaluation and treatment of

sexually transmitted infections (STIs) has long been thought to be a personal contact by a public health Disease Intervention Specialist (DIS). However, many jurisdictions are unable to fund DIS services for all of the dangerous sexually transmitted infections.

Recent studies from several institutions, including the University of Washington, show clinical and public health benefit from strategies in which antibiotics and instructions are given to the index patient for delivery to one or more sexual partners. This is known as “Patient-Delivered Partner Therapy” or PDPT. It is one of several strategies for “Expedited Partner Treatment” (EPT). Expedited Partner Treatment refers to any strategy that allows antibiotic treatment for partners without an individual clinician evaluation of each partner.

A variety of state laws, intended to maintain quality and prevent prescriber fraud, may discourage EPT in the various states. Only a few states, including Washington State, have assured that clinicians may prescribe EPT when they are not confident of

their ability to assure more conventional methods of partner evaluation and treatment.

In response to this nationwide dilemma, the AAPHP (along with the Washington State Medical Association and the American Medical Women's Association) introduced a resolution at the December 2004 Interim Meeting of the AMA House of Delegates:

“RESOLVED, that our AMA recommends patient-delivered partner therapy (PDPT), where state laws permit, as an appropriate strategy for protection of the patient's and the public's health when treatment of all sex partners is not otherwise assured; and BE IT FURTHER

“RESOLVED, that our AMA encourages state licensing boards, medical societies, health and malpractice insurance carriers, and others to consider the demonstrated benefits of PDPT when evaluating the appropriateness of this practice; and BE IT FURTHER

“RESOLVED, that our AMA encourages continued research on expedited partner treatment (EPT) and other innovative strategies for sexually transmitted infection (STI) control; and BE IT FURTHER

“RESOLVED, that our AMA encourages federal, state, and local governments to fully fund STI control programs; and BE IT FURTHER

“RESOLVED, that our AMA supports and encourages efforts by the U.S. Centers for Disease Control and Prevention (CDC) to identify opportunities for increased use of PDPT; analyze existing and potential barriers to PDPT use; encourage use of PDPT in all appropriate settings; and establish model guidelines and recommendations for implementation of PDPT and other EPT strategies; and BE IT FURTHER

“RESOLVED, that our AMA notify appropriate medical societies, federal and state agencies, and malpractice carriers of its position on PDPT.”

Despite strong testimony from the distinguished public health physician H. Hunter Handsfield, MD, this resolution was ultimately referred to the AMA Board of Trustees rather than being immediately adopted. It appeared that many AMA Delegates wanted to wait for final publication of data and/or a definitive endorsement from CDC, before making AMA policy on this issue.

CDC organized a consultation on EPT in March 2005, in Atlanta. I was privileged to represent our AAPHP at this consultation. Former AAPHP Trustee Franklyn Judson, MD also attended as a representative of Denver's Public Health department. Our discussions were very open, respectful, and spirited!

EPT methods are not equally effective, and the best technique for one situation may not be best in another setting.

Randomized trials of public health interventions may be difficult to design because the “experimental” strategy may be complex and because the best “control” strategy may not be obvious.

EPT appears to vary in its benefits and risks, according to (1) differences in the gender of patients and of their partners; (2) use of EPT with different index diseases and in the context of different patterns of other STI's in the community; (3) differences in the packaging and educational materials used as part of an EPT plan; and (4) differences in community education, in the participation of community institutions, and in the resources used to follow up on each EPT prescription.

With leadership from Dr. Handsfield and many other STI experts, the CDC is working on developing a formal statement on EPT. Our AAPHP will remain involved in the development and implementation of national guidelines on these issues.

Webmaster's Report



Respectfully submitted by: C.M.G. (KIM) BUTTERY, MD, MPH

A website is only as valuable as its users make it; the “jobs” pages are the most visited. The annual meetings pages would be improved if the board provided more timely information so members could be alerted at least 8–10 weeks ahead, rather the one to two weeks for the last two meetings. Don MacCorquodale's column on interesting epidemiological studies ought to be a regular column, read at least once a month by our members, but it only gets a few hits. Members could improve the design with suggestions to me (the webmaster). The site could be used for topical discussions; although we have tried in the past, we rarely had more than two or three people use the discussion site. A new innovation on the web is provision of BLOGs or pages where anyone can sign in without a password and have their “two cents” say. Our site could be used to provide news or ideas for local health departments. There are lots of wonderful sites for public health information that my students find regularly, but I rarely hear about from busy health directors. One of our main services ought to be public information. There are about 6–10 health departments websites worth visiting, but even these suffer from lack of attention and timely information about the many ‘health’ topics bandied about by the media. I believe that a committee of health directors, interested in keeping their citizens informed, could help improve the information available on our website, and set standards for local health department websites. I am available to work with anyone if you are interested in enhancing our pages.

Job Market Initiatives

The AAPHP/ACPM Job Market Initiative – A 3.5 Year Review



Respectfully submitted by: JOEL L. NITZKIN, MD, MPH, DPA

The AAPHP/ACPM Job Market Initiative (JMI) web page first

went on line in October 2001. This web page, developed and managed by AAPHP, is accessible from both the AAPHP and ACPM websites (www.aaphp.org and www.acpm.org).

The goal of the JMI is, and has been, to strengthen the specialty of Preventive Medicine by increasing the number and quality of jobs expressing a preference for physicians trained in public health and preventive medicine.

During these past 3.5 years, the JMI web page has posted approximately 1,150 ads representing about 1,250 job opportunities. Of these ads, approximately 450 were from full page ads posted on the site, and approximately 700 were ads abstracted from other journals and websites, during the first 17 months of the JMI, when such abstracting was actively done. In its peak month (December 2002), 205 job opportunities were posted on the site. Since March of 2003, when the abstracting of ads from other sources was discontinued, the number of job and training ads has ranged from 30 to 57 per month, with the numbers staying reasonably consistent from year to year, with seasonal peaks each spring.

If we had adequate staff and/or volunteer support, I (Dr. Nitzkin) believe that we could be running between 300 and 500 job opportunities on a monthly basis. As was the case in 2001, less than one percent of the ads specify a requirement or preference for

physicians with residency training or Board Certification in Preventive Medicine. Jobs are listed on the site, and ads posted free of charge based on our best impression of jobs that could best be done by physicians with specialty training in public health and preventive medicine.

Over the 34 months for which data on hits per month are available, there have been 15,417 hits on the site—an average of 453 per month. The two peak months were January and February of 2003, with 667 and 742 hits per month respectively—just at the time we were discontinuing the abstraction of ads from other journals and web sites. There has been no apparent seasonal or secular trend to the number of hits per month. February and March of 2005 logged in at 401 and 510 hits respectively.

Our initial market studies and fiscal projections suggested that if and when we could log about 1,000 hits per month, we could then make the page financially self-sufficient by selling ads to executive recruitment firms—while continuing to post the ads free of charge. Unfortunately, we never reached that point.

At the Preventive Medicine 2005 meeting, this last February in Washington, DC, we received good faith commitments from both ACPM and the Young Physicians group to assist us with re-initiation of the abstraction of ads from other journals and web sites. Hopefully, within a reasonably short period of time, we should be able to reinstate the abstraction of ads and again begin tracking toward financial self-sufficiency for this web page.

Ads are posted under “Jobs” at www.aaphp.org and www.acpm.org. Check it out!!!

AAPHP RESOLUTIONS

AAPHP Resolution for AMA Meeting June 2005—Lessons from the Terry Schaivo Case



Respectfully submitted by: AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, ARVIND K. GOYAL, MD, DELEGATE

WHEREAS, Our AMA has consistently supported the Advanced Health Care Directives given by a patient to help in the End of Life decision making process; and

WHEREAS, Our AMA as well as several Specialty and State Medical Societies and Associations have participated actively in increasing awareness regarding Advanced Directives in several ways; and

WHEREAS, All 50 states now have laws pertaining to Advanced Directives which vary from one state to another, but do not force an individual to limit medical care if he or she is not so desirous; and

WHEREAS, Only 20 to 30 percent Americans are estimated to currently have written Advanced Directives and many of those may not be available to physicians caring for sick patients; and

WHEREAS, Lack of Advanced Directives has the potential to force delivery of unnecessary and expensive medical care sometimes to our sickest patients with little hope of recovery, who would not have desired that care; and

WHEREAS, Many highly publicized and politicized controversial cases in the last two decades in many different areas of the country have enhanced our appreciation of the issues involved including the dilemmas faced by family members of involved patients; and

WHEREAS, The recent case of terminally ill, Mrs. Terry Schaivo in Florida involved not just her family and physician/s as it should have been, but every facet of our legal and political system over an extended period of time before her tube feeding was withdrawn and she was allowed to die peacefully, causing significant unnecessary expense and pain for her family; and

WHEREAS, Many among us feel, the United States Congress had no role in the care, or treatment of the unfortunate Mrs. Schaivo; and

WHEREAS, The otherwise sound AMA Principles of Medical Ethics appear to be deficient in not explicitly recognizing any role for patients or legally responsible family members to influence the medical care provided to the patient, especially when patients are unable to speak for themselves; BE IT THEREFORE,

RESOLVED, That our AMA maintain its leadership role by further educating and encouraging Americans directly and via members and component societies on the necessity of writing and appropriately distributing Advanced Directives long before an illness strikes; and

RESOLVED, That our AMA Board discuss and report at the I-2005 HOD meeting on the feasibility of requiring by legislation or regulation, a written Advanced Directive at the time of enrollment in a health insurance plan including Medicare and Medicaid which will be available to physicians and hospitals upon request, or at the time of application for a Driver's Licence; and

RESOLVED, That our AMA Board explore and report back at the I-2005 HOD meeting the feasibility of collaborating with other interested organizations with the specific goals of increasing awareness, creation and easy accessibility of Advanced Directives by a majority of Americans; and

RESOLVED, That the AMA's Council on Ethical and Judicial Affairs consider adding to our Principles of Medical Ethics another item explicitly recognizing the rights of the patients in determining the care provided and legally responsible family members when patients are unable to speak for themselves; and further

RESOLVED, That the AMA's Principles of Medical Ethics be consistently adhered to by all physicians, not only when they are delivering patient care, but also when addressing health-related issues in a courtroom, a boardroom, a local community, the media or in the Congress of the United States.

Stronger AMA Health Care Advocacy Agenda



Respectfully submitted by: AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, ARVIND K. GOYAL, MD, DELEGATE

WHEREAS, The AMA Board deserves an A for its effort in developing a focused agenda for Health care Advocacy in 2005; and

WHEREAS, This document has been widely publicized to physicians and others and catalogues the various activities of the AMA on behalf of the member physicians and the patients they serve; and

WHEREAS, Opportunities exist to improve the AMA's articulation of its activities and agenda for the future—in 2006 and beyond; BE IT THEREFORE,

RESOLVED, That our AMA include in its priorities and published agenda:

- Preservation of Physician-Patient Relationship
- Resolve to contain cost of quality healthcare and prescribed medications

- Empower Communities across America with evidence based health information
- Provide qualified Public Health Leadership in times of peace as well as disaster

AMA Reports for AAPHP



Respectfully submitted by: RON DAVIS, MD, AMA TRUSTEE
April 2005

1. AMA 2005 Healthcare Advocacy Agenda

Toward the end of 2004, the AMA Board of Trustees approved a Healthcare Advocacy Agenda for 2005. "Improving Public Health" is one of seven items on the agenda:

- Medical Liability Reform
- Medicare Physician Payment Reform
- Expanding Coverage for the Uninsured and Increasing Access to Care
- Improving Public Health through:
 - Promoting healthy lifestyles
 - Eliminating health disparities
- Regulatory Relief
- Managed Care Reform
- Clinical Quality Improvement and Patient Safety

This agenda will affect allocation of AMA resources for advocacy.

2. Disaster Preparedness

The AMA has a strong program in disaster preparedness. It has developed a National Disaster Life Support (NDLS) Program to better prepare healthcare professionals and emergency response personnel for mass casualty events.

3. Tobacco

The AMA has signed onto amicus briefs in a) the appeals for two important class action lawsuits on tobacco (the *Engle* and *Price* cases), and b) legal challenges to local smoke-free ordinances in Montana, Kentucky, and Washington State. Based on the AMA's organization of a sign-on letter to the CMS in support of Partnership for Prevention's petition for Medicare coverage of tobacco cessation counseling, the CMS recently issued a memo announcing coverage for such counseling for "a patient with a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or who is taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information."

4. Alcohol

The AMA has a strong program in prevention of alcohol abuse, through its Office of Alcohol and Other Drug Abuse. The Office oversees two important programs funded by the Robert Wood Johnson Foundation: a) Reducing Underage Drinking through Coalitions: Youth and Adults United for a Change; and b) A Matter of Degree: The National Effort to Reduce High-Risk Drinking Among College Students.

5. Obesity

The AMA convened a well-attended National Summit on Obesity on October 20, 2004 in Chicago. The Association has developed a comprehensive "Primer: Assessment and

Management of Adult Obesity," which is available online, in CD-ROM, and as a series of printed booklets.

6. Health Disparities

In partnership with the National Medical Association and the National Hispanic Medical Association, the AMA has convened the Commission to End Health Care Disparities. Comprised of leaders from the nation's largest physician organizations and more than 30 health-related groups, the Commission will work to educate physicians and health professionals about healthcare disparities while identifying and developing strategies to eliminate gaps in care based on race and culture. The Robert Wood Johnson Foundation is supporting the effort.

7. Influenza Vaccine

The AMA, in partnership with the CDC, has co-sponsored the annual National Influenza Summit meetings, including one held in April 2004. The AMA House of Delegates approved a comprehensive report on this subject at its December 2004 meeting. The report proposed strategies for strengthening the infrastructure for adult immunization.

8. TV Violence

I had the opportunity to testify on behalf of the AMA at a Congressional field hearing on TV violence in Chicago, held on September 13, 2004.

9. Safety Belt Legislation

Senator John Warner's legislation would withhold federal highway funds from states unless they raise their safety belt use to 90 percent or adopt a "primary enforcement" law. Research indicates that adoption of primary enforcement legislation leads to an increase in seatbelt use of 10 percentage points. Senator Warner introduced the legislation as an amendment to another bill, and the amendment was tabled by a vote of 56-42.

10. Dietary Supplements

The AMA supported FDA action to ban ephedra-containing dietary supplements (which the FDA finally accomplished in April 2004) and amending the Dietary Supplement Health and Education Act of 1994 so as to require that manufacturers prove that dietary supplements are safe and effective before being able to market them (as is the case for prescription and over-the-counter medications).

11. Clinical Trials Registry

The AMA House of Delegates adopted a Council on Scientific Affairs report in June 2004, calling for the formation of a single, comprehensive registry for all Phase 2, 3, and 4 clinical trials, to be operated by the federal government and to be accessible for free to all. The registry would mitigate the problem of publication bias which has received substantial publicity in the last few years (especially in regards to the use of anti-depressants by children and the use of COX-2 inhibitors such as Vioxx).

12. AMA Preventive Medicine Section Council

Leaders of the Preventive Medicine Section Council (which consists of the prevention organizations represented in the AMA House of Delegates, including ACPM, AAPHP, ACOEM, and AsMA) will be meeting with the AMA Board chair and Executive Vice President at the AMA House of Delegates annual meeting in June 2005. A key item on the agenda will be the need to secure adequate federal funding for preventive medicine residency programs. (Editor's Note: The Section Council on Preventive Medicine is chaired by the AAPHP President, Dr. Arvind K. Goyal this year.)

13. AMA Membership

All public health and preventive medicine physicians need to support the AMA through membership. The AMA is a strong advocate for public health, and public health and preventive medicine physicians need to reciprocate through our own membership in the Association. Physicians can join or re-join the AMA at its website (www.ama-assn.org).

14. Healing the System: The AMA Plan to Rescue U.S. Medicine

The AMA must be responsive to its rank-and-file members on core issues of concern to all physicians. The AMA has packaged its activities on these core issues into a program called "Healing the System: The AMA Plan to Rescue U.S. Medicine." Components of the program

address: financing care for low-income patients, lack of health insurance and choice, evolving managed care, patient safety, America's liability crisis and strengthening Medicare.

15. My Campaign for Re-election to AMA Board of Trustees

I am running for re-election to the AMA Board of Trustees at the AMA's annual meeting in June 2005. I was pleased to receive an endorsement and financial contribution for the campaign from the AAPHP Board of Directors. I would also be grateful for any personal contacts that AAPHP members can make on behalf of my candidacy with AMA delegates and alternate delegates whom they may know. Please contact me (ron.davis@ama-assn.org) if you would like a list of AMA delegates and alternate delegates.

Tobacco Commentaries

AAPHP 2004 Annual Meeting Report of AAPHP Session on Tobacco



Respectfully submitted by: KEVIN SHERIN, MD, MPH, Vice President, AAPHP

The American Association of Public Health Physicians

(AAPHP) held its joint annual meeting with APHA at the Washington Convention Center in Washington, DC on November 7, 2004.

Arvind Goyal, MD, MPH, President of the AAPHP, convened the business portion of the meeting. Kevin Sherin, MD, MPH, the director of the Orange County Health Department and current AAPHP Vice President, helped coordinate AAPHP's forum on tobacco policy.

The tobacco policy forum included a number of key leaders and decision makers representing local and State public health agencies, public health academia, correctional health physicians, social marketing experts and tobacco policy experts.

The keynote speaker, Mike Siegel, MD, MPH, who completed a CDC EIS fellowship in smoking and health, is currently associate professor at Boston University School of Public Health. Dr. Siegel gave detailed background on the proposed FDA tobacco legislation which died in committee in the last Congress.

Attendees learned that the impetus for FDA involvement in tobacco control grew in the early 1980's at a time when the AMA actually held tobacco stocks! Mike reinforced our awareness that the most effective tobacco control programs are those that are comprehensive in nature, involve marketing strategies and public campaigns such as Florida's own "Truth" program, are aimed at both smoking cessation and reduced

AMA's National Disaster Life Support (NDLS)

Core Disaster Life Support (CDLS) CDLS is an introduction to all-hazards preparedness for basic EMTs, allied health workers and technicians, law enforcement officials, administrators and planners, entry-level Medical Reserve Corps, dentists, pharmacists, office-based physicians and nurses and anyone needing an introductory program. The course is presented in a four-hour didactic format, and provides an overview of disasters including events such as natural and man-made, traumatic and explosive, nuclear and radiological, biological and chemical. The overall goal is to introduce participants to basic concepts and terms reinforced in greater detail in the BDLS and ADLS courses.

Basic Disaster Life Support (BDLS) BDLS is a review of the all-hazards topics covered in CDLS and adds critical information on the health care professional's role in the public health and incident management systems, community mental health and special needs of vulnerable populations. The target audience for the course is physicians, physician assistants, nurses, dentists, pharmacists, allied health professionals, public health professionals and veterinarians. The course is primarily didactic with a flexible format that can be delivered in one day or in multiple sessions. BDLS can be presented to large audiences (more than 100 participants), limited only by classroom size.

Advanced Disaster Life Support (ADLS) ADLS is a more advanced practicum course for trained BDLS providers. It is an intensive course that trains students in mass casualty decontamination, use of personal protective equipment, essential skills and mass casualty incident information systems and technology applications. The course uses simulated all-hazards scenarios, interactive sessions and drills with high-fidelity mannequins and volunteer patients to gain a true-to-life, practical experience in treatment and response. The course is presented over two days—day one is primarily didactic and day two consists of hands-on training distributed over four ADLS training stations.

youth initiation of tobacco, increase taxes on tobacco products and ban smoking in public venues and workplaces. Dr. Siegel listed possible adverse effects of the proposed FDA tobacco rule which focused on youth tobacco. For example, industry could gain leverage with the public and limit future gains of any proposed regulation once passed by citing their “proactive stance in supporting FDA regulation,” or by selectively using positive public relations efforts, e.g. Philip Morris USA, or moving on to developing “safer cigarettes” once “some harmful additives” are removed, (but others are added).

The proposed regulation was weakened by language inserted to make it very easy for industry to meet standards by making “reasonable efforts” or “intending to reduce harm.”

Dave Cundiff, MD, MPH, current AAPHP secretary, presented the view from the AAPHP and recent key history in which he was involved in 1998 by helping all parties not to buy into the “Master tobacco settlement” which would have absolved industry of possible future claims.

A Piece of Tobacco History



Respectfully submitted by: DAVE CUNDIFF, MD, MPH, AAPHP Secretary (and Past President)

Dr. Cundiff discussed AAPHP’s response to a somewhat similar situation in 1997–1998. During the decade from 1987 to 1997, the American Medical Association (AMA) House of Delegates had put in place a framework of tobacco control policies to guide AMA’s work in tobacco control. One part of that framework—AMA’s opposition to legal immunity for the tobacco industry was to be tested during 1997–1998.

In the spring of 1998, the AMA invited more than 100 tobacco control stakeholders—including AAPHP representatives—to a “summit” meeting outside Chicago. At this meeting, an agreement among representatives of state Attorneys General, major tobacco companies, and a few health-related organizations was presented for stakeholder feedback.

This agreement—dubbed the “Global Settlement” by its advocates and eventually derided as an “immunity deal” by its critics—was proposed as a settlement for the states’ Medicaid-related damage suits. It provided for regulation of future tobacco industry marketing behavior; tobacco industry cash payments to health groups for tobacco control activities; settlement of the state lawsuits themselves; and prohibition of any other lawsuits against the tobacco industry in United States courts. Under this proposed grant of immunity, no public or private entity could ever again sue a tobacco company for its pre-1997 conduct.

Stakeholders’ reactions at the spring 1997 summit were mixed. Larger organizations (other than those that had been involved in the secret negotiations) were generally guarded. Smaller grassroots groups strongly criticized the immunity aspects of the proposed settlement right away. They pointed out that litigation is one of the best ways of educating the public; that the fear of litigation can motivate the industry; and that tobacco control activities would be hampered if tobacco control funding depended on future tobacco sales.

Over the summer of 1997, most of the larger, staffed national organizations coalesced in support of the “Global Settlement” proposal. Notable exceptions included the American Lung Association and American Medical Women’s Association, which opposed the immunity deal; and the American Public Health Association, which remained neutral until its Governing Council overwhelmingly opposed immunity in the fall.

Also that summer, grass roots groups (including AAPHP) networked around their opposition to immunity for the tobacco industry. Dr. C. Everett Koop, former U.S. Surgeon General, publicly opposed immunity. His opposition provided critical support through this crucial time. AAPHP representatives and others networked through e-mail and live electronic chat. AAPHP Board and Executive Committee members spent a great deal of time discussing tobacco control issues. AAPHP’s President Joel Nitzkin and Secretary Ginny Dato wrote and distributed issue summaries for our members. AAPHP’s degree of member involvement on this issue was much greater than the member involvement of the organizations that favored the immunity deal.

Board members’ support for an anti-immunity stand was strong, but not unanimous. Some Board members were uncomfortable taking a stand when the public health community was divided and most “establishment” organizations were taking the opposite stand. One valued AAPHP Board member eventually resigned from the Board over this issue.

In early fall of 1997, the “Global Settlement” proponents formed the “Effective National Action to Control Tobacco” (ENACT) Coalition. This billed itself as a unified coalition for tobacco control legislation. However, coalition leaders claimed that the legislation had to incorporate all key features of the “Global Settlement.” Groups wishing to contest the immunity provisions of the settlement were not to be allowed any influence in the new coalition. In response, advocacy groups formed another coalition called “Save Lives, Not Tobacco” (SLNT). ENACT members were generally large and well-funded. SLNT had just enough organizational clout and funding to be heard. It was uncertain which (if either) group could get the best hearing in Congress.

At the urging of former AMA president Dr. Lonnie Bristow, and despite AMA policy against immunity, the AMA became a founding member of the ENACT Coalition. Several medical specialty groups (including ACPM) followed. AAPHP joined the SLNT Coalition. AAPHP Delegate Dr. Jonathan Weisbuch drafted an anti-immunity resolution for the December 1997 meeting of the AMA House of Delegates.

AAPHP sent an extra representative to the House of Delegates meeting that year. This representative spoke to as many delegate caucuses as feasible, boiling down the anti-immunity case to sixty-second speeches and emphasizing that the anti-immunity resolution was intended to restore the House of Delegates policy that had been violated by the Board and staff actions on the “immunity deal.”

That year, the AMA’s staff and trustees had angered many AMA members and delegates by endorsing the Sunbeam line of personal health care products in return for Sunbeam’s cash payments to the AMA. No scientific evidence demonstrated the Sunbeam line’s superiority. Many people, inside and outside the AMA, perceived this as a sign that the AMA’s leadership was willing to “sell out” patients and physicians in return for money. That perception helped create a favorable climate for anti-immunity efforts in the House of Delegates. Because of this, and because of extraordinary efforts by anti-immunity physicians in several specialty and state delegations, AAPHP’s resolution prevailed despite near-unanimous opposition by the “good old boys” in the AMA leadership.

The AMA never withdrew from the ENACT Coalition. However, because the AMA withdrew its support for immunity, the House of Delegates action weakened the ENACT stand on a key provision of their proposed legislation. In the spring of 1998, the

“Global Settlement” bill was rejected in Congress. The eventual outcome was the much less damaging “Master Settlement Agreement” that was crafted in 1998 without much public health participation.

Dr. Cundiff discussed five lessons from 1997–1998 that may be relevant today:

First, **THE PROCESS SHAPES THE OUTCOME.** The process of secret negotiations virtually assured that the negotiators would ignore the needs of key tobacco control stakeholders. Some tobacco control organizations, many of them with excellent analytic skills, were deprived of the ability to offer input. Because the number of health-related negotiators was small, and consultation within tobacco control was so scant, key disadvantages of the “immunity deal” were insufficiently considered. The tobacco control movement can only maintain unity if it operates in the sunshine of public discussion.

Second, **SIZE ISN’T NEEDED, BUT IT HELPS.** SLNT coalition members were much smaller, less well-funded, and less prestigious than the ENACT coalition members. However, they had enough size and prestige to be noticed. SLNT’s accuracy and courage helped to balance the scales, against much larger organizations, once SLNT began to get its information out.

Third, **IT HELPS TO HAVE THE RIGHT ALLIES AND THE RIGHT ADVERSARIES.** Credible allies included Dr. Koop, the American Lung Association, the American Medical Women’s Association, and many others. The tobacco industry was almost united in their support for the original immunity deal. The tobacco industry’s united stand helped to galvanize grassroots members of all groups against immunity.

Fourth, **IT HELPS TO BE LUCKY.** The Sunbeam scandal, for which the AMA’s Executive Vice President ultimately lost his job, drove a wedge between AMA Delegates on one hand, and many AMA Board members and executives on the other. The timing of the Sunbeam scandal helped anti-immunity forces to carry the day in the AMA House of Delegates. We were also fortunate to have use of Dr. Weisbuch’s parliamentary skills.

Finally, **COUNT THE COST, BUT DON’T BE SCARED.** This episode showed weakness and division within public health, but the public health community would have been fractured by the “immunity deal” regardless of what the AAPHP did. The Board’s extensive deliberations, and the officers’ extensive communication with members, preserved AAPHP’s own unity very well. AAPHP’s resources were diverted from other projects that might have been more universally lauded and might have increased our individual and collective prestige. However, because we were advocating good public health principles and communicating widely about our actions, we gained members throughout 1997–1998. AAPHP was clearly strengthened by the activity, although many members sacrificed a great deal of their time to make this possible.

Dr. Cundiff noted the many obstacles faced by those who would oppose the 2004 FDA regulation proposal on public health grounds. However, if we conclude the proposal should not be enacted, we have the potential to influence both the discussions and the outcome significantly.

OPINION: FDA Tobacco Legislation

Philip Morris and Health Groups Applaud Re-Introduction of FDA Tobacco Legislation



Respectfully submitted by: JOEL L. NITZKIN, MD, MPH, DPA and MICHAEL SIEGEL, MD

The nation's largest tobacco company and four prominent health groups today joined together to support legislation that would give the FDA authority to regulate tobacco products. In statements issued today, Philip Morris USA and a coalition of the Campaign for Tobacco-Free Kids, the American Cancer Society, the American Heart Association and the American Lung Association expressed support for bills introduced today concurrently in the Senate and the House. The Altria website provided a link to the Campaign for Tobacco-Free Kids press release, emphasizing the nexus between the tobacco manufacturer and some members of the public health community on this issue. Philip Morris also noted that it has "worked diligently with the public health community" in reaching this "policy solution."

Among the bill's provisions cited by both Philip Morris and the coalition of health groups as benefiting the public's health are strengthened cigarette warning labels, full ingredient disclosure, authority for FDA to eliminate terms like "light" and "low-tar," authority for FDA to require removal of certain harmful tobacco smoke components, a ban on candy and fruit flavored cigarettes, and authority for FDA to help prevent the sale of tobacco to minors.

The Rest of the Story

Based on a detailed analysis of the specific provisions of the legislation, it is clear that it fails to protect the public's health in any substantial way, and that in fact, it would be detrimental to the public's health in a number of ways:

- The way in which the bill frames the problem of tobacco use in our society is inconsistent with the public health paradigm. The bill stringently regulates new products and reduced risk products, but essentially allows existing, high-risk products to continue killing hundreds of thousands of Americans each year.
- The bill completely ties the hands of FDA in terms of complying with the very legislation that sets requirements for its action. The loopholes in the legislation are huge, and not only benefit the tobacco industry, but institutionalize tobacco and addiction to tobacco products in our society. The fatal flaw of the legislation is the unacceptable degree of restriction of FDA's potential actions which makes it impossible for FDA to act appropriately within the legislative mandate it is given.
- Tobacco companies will benefit from this bill because they will be able to use the fact of being regulated by FDA to achieve improved public opinion by taking advantage of the public perception that the tobacco problem is basically taken care of. The public's perceived level of the health risk posed by ordinary tobacco products will decline as the public perceives the fact of FDA regulation as automatically meaning that the product must be reasonably safe, or at least safer. The bill will likely result in increased deaths compared to no legislation at all, as the bill will:

- make it virtually impossible to research, develop, introduce, and market new potentially less hazardous tobacco products;
 - undermine current and future litigation and the public health remedies that are likely to result from such litigation, as tobacco companies will be able to successfully use the argument that they are already thoroughly regulated; and
 - reduce the public's perception of the inherent harms of cigarettes.
- Additionally, there are no documented mechanisms by which the legislation will save lives:
 - Research has documented that the kinds of marketing restrictions imposed by the bill are not effective in reducing youth smoking, or even in reducing youth exposure to cigarette advertising. The more stringent of the advertising restrictions will certainly be challenged in court, and may be found to violate the First Amendment.
 - Performance standards and disclosure requirements of the bill will not improve the public's health. It is simply not known which specific carcinogens of the 40+ carcinogens in tobacco smoke and which specific toxins of the 4000+ chemicals in tobacco smoke are responsible for what diseases, what quantities of these chemicals produce what effect, and what the effect of removing these chemicals will be.
 - The Modified Risk Product section of the bill would make it virtually impossible for modified risk products to enter the market, while at the same time, allowing reduced exposure products to essentially be falsely marketed as reduced risk products. In effect, it protects the existing high-risk products on the market and precludes any harm reduction approach to tobacco control.

The basic approach taken by the legislation is quite absurd from a public health perspective:

- The measure would stringently regulate new and potentially less hazardous tobacco products while doing little to prevent the most harmful form of tobacco—existing cigarettes—from continuing to cause the deaths of nearly half a million Americans each year.
- Although the bill would enable the FDA to prevent the introduction of new cigarette brands that falsely claim to reduce the risk of disease, it would permit Marlboro and the other most popular existing cigarette brands to continue business as usual.
- The bill bans the use of strawberry, grape, chocolate, or similar flavoring additives in cigarettes but does not mandate the elimination (or even reduction) of toxic gases like hydrogen cyanide or the more than 40 known cancer-causing constituents of cigarette smoke such as benz(a)pyrene, benzene, and radioactive polonium.

Philip Morris now stands shoulder to shoulder with the Campaign for Tobacco-Free Kids, the American Cancer Society, the American Heart Association, and the American Lung Association in lobbying for passage of this legislation. Even if a detailed analysis of the bill did not reveal the reasons why Philip Morris supports the legislation, one would have to question the judgment of the health groups in helping the leading tobacco company achieve the federal policy result it most desires.

If this bill passes, it will be devastating for the tobacco control movement as well as for the public's health.

Past AAPHP Resolutions

AAPHP Resolution Regarding Flu and Other Vaccines considered by AMA in December 2004

ADVOCATING SECURE NATIONAL VACCINE POLICY



Respectfully submitted by: AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, ARVIND K. GOYAL MD, DELEGATE

WHEREAS, An ounce of prevention is safer, cheaper and more desirable than a pound of cure for most diseases;

and

WHEREAS, After many years of research and hard work by many in our profession, effective and relatively safe vaccines have been developed for prevention of many transmissible diseases; and

WHEREAS, Our AMA, its many component societies and individual members, as well as our Government via many of its agencies have continually educated our patients and communities regarding the importance of timely immunizations, raising their expectations regarding healthier and longer lives; and

WHEREAS, Several Immunizations have been required for entry to schools, international travel, residence in a nursing home, employment in a health care facility, etc.; and

WHEREAS, Many vaccine shortages in recent years, those involving TETANUS, MEASLES and FLU have stressed physicians, other health care workers and health departments, put patients and communities at risk, and disappointed those we exist to serve; and

WHEREAS, The cost of vaccines for our patients goes up substantially, each time there is a shortage, making it a bigger hardship for those without coverage, yet we are repeatedly told that the shrinking pool of manufacturers indicates there isn't enough of a profit margin for them, although their usage is assured; and

WHEREAS, The non availability of timely flu vaccine again this year has highlighted the failures of our existing free market approach: risked public's health, panicked millions, price gouging allegations in some places, Government sanctioned rationing and even extended Presidential debates; BE IT THEREFORE,

RESOLVED, That our AMA advocate and support in requiring the US Government to assume responsibility for production, quality assurance and timely distribution, at cost, of those Vaccines recommended by the Centers for Disease Control (CDC) to U.S. population at risk.

Fiscal Note: Nominal = Communication only.

RESOLUTION 709 – SECURE NATIONAL VACCINE POLICY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 709 be amended by insertion and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for and support programs that ensure requiring ~~the U.S. government to assume responsibility for~~ the production, quality assurance and timely distribution, at cost, of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention (CDC) to the U.S. population at risk.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 709 be adopted as amended.

Resolution 709 asks our AMA to advocate and support requiring the U.S. government to assume responsibility for production, quality assurance and timely distribution, at cost, of those vaccines recommended by the Centers for Disease Control and Prevention (CDC) to the U.S. population at risk.

Your reference committee heard extensive testimony in opposition to governmental control of vaccine production, including testimony from government officials. However, testimony indicated that a recent MemberConnect survey found that 91 percent of AMA members agree that the AMA should work with the federal government to ensure adequate vaccine supply to address the needs of at-risk patients. The Committee supports the need for government involvement in ensuring that the vaccine supply meets the criteria specified in Resolution 709. Therefore the Committee recommends the adoption of Resolution 709 as amended.

COMMENTARY

Vaccine Crisis

**Chicago Tribune, Saturday,
November 6, 2004**

Multiple news reports published in the Chicago Tribune recently have described a potential public-health crisis waiting to happen this winter from a lack of timely influenza vaccine even for high-risk individuals so defined by the federal Centers for Disease Control and Prevention.

Once again.

This would not be the first time. It appears to have become an annual event.

That an ounce of prevention is safer, cheaper and more desirable than many pounds of cure for most diseases is something many Americans have been led to believe, as more and more medical information barriers have been broken in recent decades. It is common knowledge now that effective and relatively safe vaccines have been developed for prevention of many communicable diseases. Significant efforts, and many public and private dollars, have been expended in recent decades in continually defining the at-risk populations. That, combined with education of our communities regarding the importance of timely vaccinations, has raised their expectations of healthier and longer lives.

Several vaccinations are now required for entry to schools, admission to nursing homes, for international travel and for employment in various health-care settings. Many vaccine shortages of recent years, those involving tetanus, measles and flu have placed millions of our panicked patients and communities at risk, and forced them to look for alternatives and to look elsewhere. It is no wonder they continue to lose faith and confidence in our health-care system.

Many of those for whom we exist to serve have experienced a sense of neglect, price-gouging and even government-sanctioned rationing. The stress on practicing physicians, other public-health workers and health departments, especially with this year's non-availability of flu vaccine, has been unprecedented.

The cost of vaccines goes up substantially each time there is a shortage, making it even a bigger hardship for those without coverage. We are repeatedly told there is a shrinking pool of manufacturers. That is supposed to imply there isn't enough profit margin for them. And that conclusion defies logic.

With successive years of flu vaccine shortages, we have been asked to pre-book our needed dosages months in advance to assure timely deliveries. So the companies that distribute or manufacture this product have no marketing expense and their profit margins, however small, are assured even before the plant lights go on. That profit on millions of dosages should add up to something, if not an obscene amount.

The non-availability of timely flu vaccine again this year has exposed the vulnerability of our public-health network, its weakness at the seams, and the failure of our existing free-market approach.

Isn't it time to require the United States government to step in and assume responsibility for production, quality assurance and timely distribution, at cost, of those vaccines recommended by the Centers for Disease Control and Prevention to the U.S. population at risk?



*Arvind K. Goyal, MD
President, American
Association of Public
Health Physicians,
Rolling Meadows, IL*

AAPHP MEMBERSHIP BENEFITS

AAPHP website: Located at www.aaphp.org, this website includes valuable links to excellent websites, a discussion forum, and a members only section.

AAPHP News: An electronic newsletter sent out whenever several items of interest to members accumulate. Members are encouraged to submit items of interest. Open Public Health Physicians positions are often listed.

Two meetings per year.

Network with colleagues.

AMA Representation: As a recognized specialty organization AAPHP keeps public health on the agenda of the AMA.

AAPHP Bulletin: Issued two to four times per year with minutes of meetings and reports.

Membership in AAPHP is open to licensed active physicians, retired physicians, and residents, willing to self-designate as Public Health Physicians.

Public Health Physicians are dedicated to helping guide a community, agency, health organization, medical office or program in pursuit of group or community health goals.

The MISSION of the American Association of Public Health Physicians (AAPHP) is to:

- Promote the Public's Health
- Represent Public Health Physicians
- Educate the nation on the role and importance of the Public Health Physician's knowledge and skills in practicing population medicine.
- Foster communication, education, and scholarship in Public Health

The OBJECTIVES are to:

- Advocate for public health and preventive services
- Advocate on behalf of Public Health Physicians
- Serve as a forum for Public Health Physicians, and by doing so, strengthen sense of "community" and facilitate exchange of ideas among geographically dispersed Public Health Physicians
- Provide and facilitate career enhancement support services for Public Health Physicians
- Serve as the voice of Public Health Physicians to the American Medical Association (AMA), sister public health organizations, news media, government, and the general public
- Facilitate recruitment and retention of Public Health Physicians into the AMA

To become a member, complete the form on the back page or join and pay online at www.aaphp.org.

2005 AAPHP Member Meeting

Join us for the Annual AAPHP member meeting in Chicago!

Saturday, June 18, 2005
6:00pm—8:00pm, Room 4-D
Chicago Hilton and Towers
720 S. Michigan

The program will include reports of AAPHP activities in the past year, Bylaws revisions as posted on the website and elsewhere in this Bulletin, elections for available Officer and Board positions and brief presentations by the AMA President, Dr. John Nelson and AMA President Elect, Dr. Edward Hill.

Details will be posted on the AAPHP website one week in advance of the meeting. Advance registration is not required and there is no charge to attend.

American Association of Public Health Physicians – 2005 Membership Form

Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Medical Degree: <input type="checkbox"/> MD <input type="checkbox"/> DO	Other Degrees or Licenses:
Organizational Title:	
Organization/Company Name & Department:	
Business Address:	
Business/Day Phone:	Business Fax Number:
Primary E-mail:	Secondary E-mail:
Home Address:	
Mail Preference? <input type="checkbox"/> Home <input type="checkbox"/> Business	
Medical School & Year Graduated:	
Medical Specialty:	
Board Certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
AMA Membership: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Membership Category: Active (\$85) Resident (\$30) Medical Student (\$30) Retiree (\$30) Lifetime (\$850) Honorary	

PAYMENT OPTIONS:

Please refer to the membership categories below to calculate the amount due.

- Active (\$85) Resident (\$30) Medical Student (\$30) Retiree (\$30) Lifetime (\$850) Honorary
- Check made payable to the American Association of Public Health Physicians (AAPHP) in the amount of \$ _____ .
- Please bill my MasterCard Visa American Express in the amount of \$ _____ .

Name as shown on the card (please print): _____

Card # _____ Expires: _____

Billing address: _____

Signature _____ Date _____

* Note your credit card statement will read: American College of Preventive Medicine for this charge.

Please return this form to:

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**American Association of
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