American Association of
PUBLIC HEALTH
PHYSICIANS

BULLETIN

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Message From the President-Elect

Dear Colleagues,

As AAPHP navigates its 62nd year since its founding in 1954, I hope to support our mission to be a voice for public health physicians who influence policy that addresses health issues at group and population levels. This goal I aim to accomplish together and will need your experience, energy, and involvement! Please see the Leadership and Professional Development Opportunities Section below to find out more about how you can represent public health physicians and promote the public's health. Thanks for your support as I strive to provide you with outstanding leadership and collegiality in the years to come.

Sincerely,
Katrina Rhodes, MD, MS

Correctional Health from a Public Health Agency Perspective

During my 30+ year career as a public health physician, I have had the opportunity to be a communicable disease control officer, local health director and state health department director. During this entire time, correctional health was an issue of major concern.

Jail and prison inmates, those released into the community, and those whose lives represent a revolving door of repeated incarcerations are at extreme risk of a wide range of health-related problems. They show exceptionally high rates of HIV and other sexually transmitted diseases, tuberculosis and hepatitis. Many of them are in trouble with the law and in and out of jail on a frequent basis due to untreated mental illness. The "frequent fliers" in these systems tend not to take care of themselves in terms of diet, smoking, and substance abuse, automotive, occupational or other safety concerns.

Jails and prisons at least present a controlled environment where inmates can be screened, tested, educated and treated for the disorders noted above. Unfortunately not all penal institutions are sensitive to these concerns and many do an inadequate job of both providing care within the facility or assuring access to care after release from incarceration.

The budget constraints that prevent prisons, jails, health departments and community clinics from serving all who need their care and constrain the quality of care that can be provided make it even more important for the correctional health, public health and community clinic leadership to know each other and collaborate to restrain the transmission of dangerous communicable diseases, identify and reach out to those in most need of mental health support, and give ex-inmates the feeling that someone cares about them and that, if they take the effort to take care of their physical and mental health issues, this care will help pave the way to a happier and more self-sufficient life.

Joel L. Nitzkin, MD, MPH, DPA

2015 Annual Meeting Minutes

AAPHP General Membership Meeting
February 27, 2015
Atlanta, Georgia

We convened at 1:00 pm EST. Present in person were Drs. Joel Nitzkin, William Elsea, Perrianne Lurie, Jacqueline Wheeler-Coleman, Virginia Dato, Torie Cassano, Gary Goldbaum, Ryung Suh, Jonathan Weisbuch, Mary Ellen Bradshaw, Julie Vaishampayan, Diana Torres-Burgos, Kevin Taylor, and Cheryl Iverson, Charlene Brown, Lidia Nelkovski, and Dave Cundiff. Drs. Katrina Rhodes

and Kevin Sherin were present by phone. Drs. Jaspal "JP" Ahluwalia and Erica Frank joined us later.

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Dr. Dato reported for the Membership Committee that we have 130 members. Dr. Suh asked for members' ideas about recruiting new AAPHP members. Dr. Weisbuch noted that we have opportunities with Correctional Health, School Health, and self-identified Public Health physicians nationwide. Dr. Bradshaw noted that there is an American Association of School Health and a CDC Division of School Health. Most School Health professionals are nurses.

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Dr. Cundiff gave the Treasurer's Report. We have a year-over-year surplus of about $4,000. Dr. Lurie suggested that we save half of this surplus. Drs. Weisbuch and Goldbaum suggested that we should budget for the support of our delegates, particularly those whose employers do not pay for their expenses. Dr. Cundiff noted that medical students, residents, and Young Physician representatives may often have greater financial need than the Delegate and Alternate Delegate. Others agreed and asked for a motion. Dr. Cundiff moved that we allocate $2000 for additional savings, and authorize up to $2000 for purposes including delegate representation at all levels. After seconding, this motion was unanimously approved.

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Dr. Cundiff reported for the Resolutions, Policy, and Legislation (RPL) Committee. We are working on several projects including vaccine policy, Health Equity, and public health funding. We hope to revisit prior initiatives on the public health/preventive medicine physician Job Market, and possibly on Teaching Health Departments.

Dr. Dato noted that AAPHP's Policy Development process is open to every member. Dr. Suh asked members for ideas. Dr. Elsea noted that public health directors can be important in Health Planning processes. He asked if AAPHP could catalyze needed action in this area. Dr. Goldbaum noted that Public Health must often concentrate on things that only Public Health can do, so we should beware of "diluting our efforts." Dr. Weisbuch said that Public Health perspectives can improve the health planning process. After discussion, this issue was referred to later Policy Forums and to the RPL Committee.

Dr. Rhodes noted that the Health Equity Working Group heard that training on prevention and health equity would be very important in the country's health care education and training system. Dr. Rhodes also noted that the Maintenance of Certification (MOC) process is of concern to public health and preventive medicine physicians, who are always at risk of being subject to licensure and certification policies that were designed for personal health clinicians, not for population health.

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Dr. Brown asked about the relationship between AAPHP's mission and its current policy and outreach efforts. Dr. Nitzkin clarified that AAPHP began in 1954 as the professional organization for physician directors of governmental public health departments. Dr. Nitzkin and others noted that as physician director positions in public health departments have dwindled, AAPHP has shifted its focus to advocacy for public health physicians in all venues. Dr. Weisbuch said AAPHP has previously achieved AMA policy that all large jurisdictions should have physician public health directors. Dr. Bradshaw noted AMA policy that public health directors should be ex officio members of their state or local medical society's Executive Committee; this implies that public health directors should be physicians. Dr. Bradshaw also noted that her medical school encouraged home and community medical visits as part of students' training in Community Medicine; she hopes that today's medical students are getting experiences of similar value.

Dr. Sherin noted that AAPHP's PSTK curriculum can be a foundation for training programs at multiple levels. Dr. Weisbuch noted that public health departments have wonderful training opportunities for medical students; we should encourage departments and students to find each other.

Dr. Brown asked if it is time to ask younger Public Health physicians what they want from AAPHP. Dr. Lurie said she hopes we will reach out to Preventive Medicine residents. Dr. Bradshaw noted that pediatricians were "the original preventionists" and she hopes we can reach out to the American Academy of Pediatrics (AAP).

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Dr. Suh reported for the Nominating Committee. We recently elected several younger physicians to our Board, and some have been active. Dr. Suh nominated Drs. Scott Cherry and Karsten Lunze for new Board terms as their first terms expire, and

nominated JP Ahluwalia, Ellen Alkon, Jim Felsen, and Kevin Sherin for four open Board positions. These were approved unanimously. Dr. Suh also nominated Dr. Katrina Rhodes for President-Elect, Doug Mack for Treasurer, Jonathan Weisbuch for Delegate, and Dave Cundiff for Alternate Delegate. These were also approved unanimously.

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Dr. Cundiff reported for the Health Equity Working Group. AAPHP's Health Equity Working Group was formed in January 2015 and has met twice by teleconference. Current members are Kenneth Thompson MD; Kevin Sherin MD; Katrina Rhodes MD; Poornima Oruganti MS-3; Virginia Dato MD; and Dave Cundiff MD. Additional participants are welcome.

We recognize health disparities and the social determinants of health in all spheres of medicine, health care, and public health. "Health equity" addresses equity in social determinants — often the root cause of poor access and outcomes — and in health care services.

Health Equity is about the achievement of equitable health status between groups of people that differ in socially determined ways — i.e., through the exercise of social power. Health Equity is achieved by the just exercise of social power to ensure that all have living conditions that support well-being, and that everyone has opportunities to flourish, building on their capabilities and capacities.

Julian Tudor Hart observed that the largest share of health services flow to those who need them least; he called this the "Inverse Care Law". Privileged people also benefit first, and disproportionately consume more resources, from most attempts to improve health care.

Sir Michael Marmot studied the health of British civil servants in the mid-20th century. Marmot found pervasive health and mortality differences between members of different social classes. Occupational class determined health outcomes and was, in turn, based on variations in social determinants such as education, poverty, crime in the community, and stress. Though all had equal access to the National Health Services, class differences were dramatic and striking.

Other studies have linked ill health — and inadequate access to health services — to race, ethnicity, religion, sexual orientation, and membership in other "disfavored" or less-valued groups.

In France, studies found large populations who were using fewer French government resources than others. French scholars began using the term "les exclus" — the excluded ones — to describe these people, whose exclusion could be based on age, gender, race, ethnicity, religion, or other factors. This led to Social Exclusion theories of health inequity, often used in European cultures where governments explicitly recognize the expense and burden of inequality.

A newer French term, recognizing the impact of globalization, is "les precariat" — "the precarious ones".

Greater exclusion increases health care costs and escalates the burden on national health services. Greater inclusion is needed — not only in health services, but in all social policies. Health services can be tailored to excluded populations. Social policies can reduce exclusions. Cultural competency building (including skills training) can increase everyone's willingness and ability to practice social inclusion in their work. Inclusion policies may include (among many other initiatives) policies such as healthy food security, education, and housing security.

We are trying to translate these insights into "action steps" for AAPHP. One possibility is to adapt AAPHP's existing Preventive Services Tool Kit (PSTK) models to include health disparities, social determinants, and health equity as learning objectives. Another is to use AAPHP's traditional policy and education channels to educate Public Health professionals and others. Another is to support existing efforts, such as a curriculum on lesbian, gay, bisexual, and transgender (LGBT) health developed by medical students (including Ms. Oruganti).

Many forward-leaning healthcare delivery systems are seeking partnerships for community preventive services, and for strategies that address social determinants of health. It is increasingly obvious that "health care", by itself, cannot efficiently support health. This creates opportunities for well-trained Public Health physicians who understand Health Equity.

Sometime during this presentation, the in-room speaker stopped working, so Drs. Rhodes and Sherin could not contribute their own comments to the group's discussion after this. Dr. Sherin later E-mailed comments: "The issue with social and health equity is solved by community democratization. Convene the low power groups and let them rank their needs. Help folks to make needed connections and work with community organization

folks. Get decision makers to the table. [California public health staff mentored a local organizer] who ended up leading change for a number of communities. (Imperial Valley and children's asthma). The physician can call a meeting of the stakeholders also."

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Dr. Suh had to leave and catch a plane. At Dr. Suh's request, Dr. Dato chaired the rest of the meeting.

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Dr. Dato reported on immunization policy recommendations that are working their way through the RPL Committee. Dr. Lurie recommended that we consider the writing style and organization of this policy, as well as the load that it may place on public health physicians if adopted. Dr. Lurie also noted that the policy, as drafted, may elevate pediatric recommendations above those of other specialties such as Family Practice, OB/Gyn, etc. If our intention is to translate our policy into AMA policy, we should consider that AMA may be unlikely to agree that "physicians should be held accountable for the consequences of their vaccine-related advice…."

In response to process questions, Dr. Weisbuch noted that it is generally best to submit a very strong policy resolution to the AMA, because the AMA process is more likely to dilute a strong resolution than to strengthen a weak one.

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Dr. Nitzkin spoke on Tobacco Harm Reduction. This topic is important partly for its direct impact, because we must reduce the morbidity and mortality caused by cigarette smoking. This topic is also important because, unless public health messages are perceived as consistently truthful, the credibility of all public health officials on all topics is placed at risk.

AAPHP's recent involvement in tobacco control issues began when the original FDA regulation bill was introduced to Congress. We discovered that this bill, which was negotiated secretly between the Campaign for Tobacco-Free Kids (CTFK) and Altria/Philip Morris, had serious defects that would make it essentially useless for public health purposes. AAPHP and others made recommendations for improvement, but Congressman Waxman's office treated our reasonable suggestions as "poison pills" and the bill was eventually passed without serious amendment.

Dr. Nitzkin's research shows that all smokeless tobacco/nicotine products currently available in the USA pose health risks that are much lower than cigarettes. If smokers switch to smokeless, their health risks decline dramatically. CDC and NIH won't fund or publicize research about the potential benefits of switching to smokeless, because their goal is a "tobacco-free society" (as distinct from a "smokefree society", which would save almost the same number of lives and could be more easily achieved).

Dr. Nitzkin stated that original CDC statements implying high danger from smokeless tobacco were based on products only used by white women >65 years old in Appalachia and the Southeast. Current CDC statements implying high danger from smokeless tobacco are based on products only used in India and other South Asian countries. CDC data show e-cigarettes are used almost exclusively as a path OUT of smoking and almost never as a path INTO smoking. CDC statements, stating that e-cigarettes are a gateway INTO smoking, are profoundly — and, Dr. Nitzkin believes, intentionally — misleading.

Vigorous discussion ensued. AMA testimony has included anecdotes, from multiple specialties, about nonsmokers who became addicted to the nicotine in e-cigarettes. There are measures, such as limiting sales and limiting the place of use, which don't require any distortion of the truth. Some members encouraged Dr. Nitzkin to publish his findings as an individual, without drawing AAPHP into an institutional dispute for which we may not be fully prepared.

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After discussion, we adjourned at 3:10 pm EST.

Respectfully submitted,
Dave Cundiff MD MPH
AMA Alternate Delegate and
recording secretary pro term

Leadership and Professional Development Opportunities

AAPHP is seeking representatives for the American Medical Association's (AMA) Resident and Fellow Section (RFS) and Young Physician Section (YPS). AAPHP is also seeking volunteers for Health Equity, Global Health, Environmental Health, Physician Education (CME), and Bylaws. If you are interested in these opportunities or have any suggestions on representing public health physicians and promoting the public's health, please contact krhodes@aaphp.org.

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New Member or Renewal Form

The Voice of Public Health Physicians – Guardians of the Public's Health – http://www.aaphp.org

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- Promote the Public's Health.
- Represent Public Health Physicians.
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