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# The Medicine and Public Health Initiative

## Ten Years Later

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**Abstract:** The Medicine and Public Health Initiative (MPHI) was created jointly 10 years ago by the American Medical Association and the American Public Health Association to bridge the nearly century-wide gulf between the respective disciplines. We review the history of MPHI and its growing significance in light of recent terrorism events. We report on current MPHI activities by examining three bellwether states—California, Florida, and Texas—as well as international sites. Upon its inception, MPHI was rapidly embraced and nationally disseminated. Sustainability 10 years later in the post-9/11 world requires renewed commitment by all collaborators. In order to meet the numerous health challenges facing our nation, from terrorism to chronic disease, and for MPHI to be successful, medicine and public health must work in tandem.  
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### Introduction

The Medicine and Public Health Initiative (MPHI) was created jointly by the American Medical Association (AMA) and the American Public Health Association (APHA) to bridge the near century-wide gulf between the disciplines of medicine and public health. These differences, which have been separating the houses of medicine and public health in the United States going back to the late 19th century,<sup>1</sup> have grown during the 20th and early 21st centuries.<sup>2</sup> Since 1910, when Abraham Flexner published his seminal work on U.S. medical education,<sup>3</sup> the practice of medicine has been predominantly grounded in the biomedical model and has focused its resources on the individual patient and physician. Public health, meanwhile, has relied more on the science of epidemiology, and has adopted population-based approaches to resolve societal health issues, emphasizing prevention. Ironically, former AMA leaders were among the founders of the APHA in 1872, and many of the pioneers in American public health were respected physicians.<sup>4</sup> Yet, despite their shared origin and intermittent successful efforts at joint collaboration, for the past hundred years the two disciplines have occupied largely parallel health universes.

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As a vivid example, physicians formally trained in public health, individuals with a stake in both worlds, appear to account for <1% of all U.S. physicians.<sup>5</sup> Although they are the most profoundly affected by the limited interaction across the disciplines, the relative scarcity of preventive medicine specialists has impaired their ability to bridge the cultural divide without additional partners.

With escalating healthcare costs, persistent growth in the ranks of the uninsured, increasing emphasis on healthcare quality and outcomes, epidemics of chronic diseases, ever-widening health disparities, and outbreaks of new emerging infectious diseases, there is growing awareness that greater collaboration between the two professions is not an option, but a pressing mandate. Moreover, because of these shared challenges, opportunities for partnership today are even more auspicious. Nonetheless, underestimating the cultural and institutional barriers separating medicine and public health discounts the enormous labor ahead to bridge these historic gaps. But, in the wake of the threats posed by terrorism, there is an even greater societal imperative, because an optimal preparation for, and response to, terrorist actions must include close coordination between medical practice and public health. Medical professionals play an essential role in surveillance of public health diseases. For example, who can predict what greater tragedy may have emerged from the anthrax events if an alert South Florida physician had not notified his local health department? In order to highlight the importance of strengthening this partnership, this paper reviews the 10-year history of the MPHI, discusses some of the current MPHI activities in three bellwether states (Texas, Florida, and California), as well as internation-

ally, and issues recommendations for a renewed partnership between the fields of medicine and public health.

## History of the MPHI

In March 1994, for the first time in the modern era, the presidents of the AMA and APHA met on behalf of their organizations to discuss mutual interests. The precursor to this historic meeting was a keynote lecture in 1993 delivered by then AMA vice president M. Roy Schwartz, MD, entitled "Medicine and Public Health: A Costly Estrangement."<sup>6</sup> The meeting proved catalytic, and a second meeting on the importance of the new medicine and public health partnership followed in Washington DC. A broad group of medicine and public health organizations was represented, including the Association of Academic Health Centers, the Association of Schools of Public Health, the Association of American Medical Colleges, the Association of State and Territorial Health Officials, and the National Association of County and City Health Officials.<sup>7</sup>

A task force emerged, which met from 1994 to 1996 to define the scope of MPHI. It recommended seven critical shared agendas: (1) engaging the community, (2) changing the education process, (3) creating joint research efforts, (4) devising a shared view of health and illness, (5) working together in healthcare provision, (6) jointly developing healthcare assessment measures, and (7) translating initiative ideas into action.<sup>8,9</sup>

In a follow-up to the task force's work, a national congress was convened in Chicago during March 1996, with >400 delegates from across the nation in attendance. They represented a broad mix of interests from medicine and public health practice, academic leaders from both disciplines, and the insurance industry. The focus of the national Congress was small group work designed to build action steps for future MPHI activity upon the participants' return home. Ultimately, 19 states were funded via a competitive process under the rubric of the Cooperative Actions for Health Program provided through the Robert Wood Johnson (RWJ) Foundation and the federal Agency for Health Care Policy and Research.<sup>10</sup> The University of Texas–Houston Health Science Center received funding to serve as the national MPHI program office. A profile of each state's project, as well as lessons learned through a formal evaluation, are documented in an MPHI monograph.<sup>10</sup>

There were some impressive accomplishments from these early grants, including some that have stood the test of time. For example, in New York improvements in the reporting of infectious diseases to public health authorities led to the early identification of the first outbreak of West Nile virus in the Western Hemi-

sphere. Additionally, a bicycle helmet campaign in Washington State increased helmet usage rates over 300%. However, even with these notable successes, many states lurched forward in halting steps.

The New York Academy of Medicine was commissioned to examine the history of collaboration between medicine and public health, and to search for models across the nation in which collaboration was successful.<sup>4</sup> A total of 414 discrete examples of collaboration were identified; each of these "cases" was categorized into one of six groupings of synergistic results: (1) improved health care by coordinating services for individuals; (2) improved access to care by establishing frameworks to provide care for uninsured and underinsured; (3) improved quality and cost effectiveness of care by applying a population perspective to medical practice; (4) used clinical practice to identify and address community health problems; (5) strengthened health promotion and health protection by mobilizing community campaigns; and (6) shaped the future direction of the health system by collaborating around policy, training, and research. A monograph describing their findings was developed and sent to all medical schools in the United States.<sup>4</sup> Subsequently, a pocket guide tool was created and made available through the Internet.<sup>11</sup>

In the course of only 4 short years, MPHI developed from a concept resonating with faculty and leadership mainly at one health sciences center, into a flexible model with widespread dissemination and active participation in states and localities across the country. Although MPHI was embraced in some states and localities, it was unable to bridge the cultural and institutional divide in others. Perhaps the chief hallmark of MPHI was its reliance on and recognition of locally initiated activities. MPHI at the state and national level was established to provide infrastructure and support for innovative problem-solving approaches developed locally, and to share relevant information with others similarly situated. But by 2001, even as meaningful activities continued in many local venues, changes in organizational leadership and shifting association priorities at national, state, and local levels, foreshadowed difficulty in sustaining the momentum of MPHI.

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related  
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## Recent and Ongoing MPHI Activities

The shocking events of September 11 and the fall of 2001 have served notice of the necessity to rekindle the fires of collaboration between medicine and public health. Certainly, it is equally true that the burden of chronic diseases with their complex multifactorial etiology have created incentives for the curative and preventive disciplines to form effective partnerships. However, there is an immediacy to the specter of

terrorism which serves notice that anything less than full commitment to collaborate from all sectors of the healthcare system exposes the nation to unjustifiable danger.

In October 2002, spearheaded by the presidents of the AMA and APHA, several organizations reiterated their dedication to the purposes of MPHI at a meeting in Houston TX. A new, more focused agenda emerged, reflecting the health concerns facing our nation, with an emphasis on disaster preparedness and readiness training to address the imminent terrorism threat.<sup>12</sup> Activities were also envisioned to reduce health disparities and to improve patient safety. Ongoing commitments to promote healthcare access for the uninsured were renewed. The presidents of both organizations made MPHI a cornerstone of their presidential platforms.

In the months since the regeneration of the MPHI, efforts have continued on the national and state level. However, another promising trend is also emerging—international interest in MPHI. Encouraging collaboration has taken place in China, the United Kingdom, Canada, and Mexico. During the 2003 and 2004 APHA annual meetings, sessions were held to update national as well as state, local, and international partners on the current status of MPHI activities. Several states, notably California, Florida, and Texas have maintained their longstanding commitment to a partnership between medicine and public health, while other states appear to be interested in expanding their commitment to this initiative. Below, we summarize MPHI history and activities in these states and internationally.

## California

In California, an MPHI Steering Committee has been meeting quarterly since 1998. Its inception followed a statewide MPHI conference sponsored through a RWJ Foundation mini-grant. What began as a meeting between California Medical Association leadership and local health officials has evolved into a much more inclusive steering committee with attendance by numerous community-based organizations as well as its charter members, medicine and public health.

The focus of the California MPHI Steering Committee has been on joint legislative issues and policy concerns.<sup>10</sup> Moreover, it fills a communication vacuum on “hot button” issues, and prompts joint action as warranted. Discussion is frank and open, often resulting in a consensus. Even when agreement cannot be reached, there is a greater basis for mutual understanding among the participating organizations. Although there are no formal by-laws, member groups abide by a memorandum of understanding.

Members have agreed that high-level policy discussion across their organizational boundaries is the primary contribution that the steering committee makes.

But early in its genesis, other interest groups came to the MPHI table and have been successful medicine and public health progeny. For instance, an environmental health interest group formed and recently held a statewide conference. Likewise, an adult immunization task force has been established and is currently working to increase immunization rates among the adult population of the state.

## Florida

With support from the RWJ Foundation, Florida convened a statewide medicine and public health summit in 1997. The summit was preceded by data gathering through statewide focus groups. Follow-up initiatives were centered on building strong working relationships between county medical societies and local county health departments. Toward this end, meetings were held in the four quadrants of the state. Numerous memoranda of agreement resulted, heralding an improved local understanding of respective roles of the medical and public health communities. In July 2003, a Florida MPHI summit was held with national, state, and local medicine and public health leaders in attendance.

Another example of the collaboration between the Florida Medical Association (FMA) and public health was the 1997 creation of a separate, free-standing Department of Health, carved from the largest health and human services superagency in the United States. If not for the involvement of organized medicine in advocating for the new department (it was a top priority for the FMA president), public health would still be embedded in a less-effective mega-agency. More recently, advocates from medicine and public health together sought support to create a museum of medicine and public health. The building, the original state Board of Health structure in Jacksonville FL, has been restored, and was dedicated in November 2002.

Finally, both medicine and public health have worked together to help solve one of the most dire problems in health care, access to health services for indigent patients. In order to increase physician involvement in charity and low-income care medicine and public health coordinated an intense lobbying campaign for passage of the Access to Healthcare Act in the Florida legislature. This statute now provides for medical liability protection through sovereign immunity for health professionals who volunteer to offer services to low-income uninsured and underinsured residents in the state. Donated health services reached the \$66-million per year level within just a few short years after startup,<sup>13</sup> and have provided over \$300 million in total uncompensated care in the state.

## Texas

Texas was the site of the inauguration and early formation of the MPHI movement, and was among the

recipients of the RWJ Foundation Cooperative Actions for Health Program grants. The Texas project was a partnership of the Texas Medical Association, Texas Public Health Association, and the Texas Department of Health. The partners conducted state and local level continuing education programs to focus medicine and public health collaborative efforts on health priorities within Texas. Early accomplishments included courses on bioterrorism, as well as several featured publications on MPHI.

In addition, Texas has begun to explore a collaborative program in Mexico, building on a student-led initiative at the La Salle University Medical School in Mexico City. The program's emphasis is student-led outreach to rural communities to provide public health, medicine, nutrition, and mental health services.

### International

Recent events like the severe acute respiratory syndrome (SARS) outbreak have demonstrated that health must be viewed through a global lens. Appropriately, international interest in MPHI is increasing, with encouraging collaboration occurring in China, the United Kingdom, and Mexico. In January 2004, a memorandum of understanding was signed that links the China Preventive Medical Association with the national MPHI. A joint conference was held in September 2004 in Beijing, producing a "call to action" for local and national MPHI pilot projects within China.

### Recommendations

In order to build on the foundation laid in a decade of work, and to strengthen the relationship between medicine and public health, we propose the following recommendations. First, medicine and public health need to continue to visibly renew their shared commitment to partnership through MPHI, in a manner that demonstrates enhanced collaboration and joint involvement of the disciplines. This is best done at the national level by the leadership of key professional organizations such as the AMA and APHA. Ironically, these same organizations must also address internal institutional barriers that de-emphasize partnership and collaboration across the medicine-public health divide. In addition, vision and energy must emanate from the primary organizations representing preventive medicine: the American College of Preventive Medicine and the Association of Teachers of Preventive Medicine. Leadership in public organizations is also critical. Of note, the Centers for Disease Control and Prevention (CDC), the leading federal public health agency in our country, is modeling just such action. Prominently featured in its new "Futures Initiative" designed to shape its goals and organizational structure, CDC has made reaching out to the practicing

medical community a cornerstone of its new strategy.<sup>14</sup> CDC showcased this commitment by co-hosting with the AMA the First National Preparedness Congress in 2004. Across the nation, MPHI has been most successful in locations where a professional organization has assumed ownership and taken charge. It is time for more organizations to step forward and promote a shared agenda.

Second, communication across disciplines must be facilitated by a common lexicon and a shared understanding of principles. This should be accomplished through professional education by integrating elements of public health and medicine into each other's curriculum. The good news is that we have already seen some progress in this arena. Schools offering combined MD-MPH degrees have more than doubled since 1994, and now total 75.<sup>15</sup> This has been accompanied by an increase in the numbers of participating students.<sup>15</sup> However, medical school curricula are already overcrowded due to required content and the explosion of scientific knowledge; for that reason, it is important to integrate public health concepts into existing courses. Several frameworks exist for accomplishing this within the current educational milieu. For instance, the Association of American Medical Colleges has made specific recommendations to emphasize public health principles regarding bioterrorism in medical schools.<sup>16</sup> The Association of Teachers of Preventive Medicine has developed an inventory of core competencies for disease prevention and health promotion that underscore critical public health concepts within medical education.<sup>17</sup> Building on these efforts, recent work has been completed to extend clinical prevention concepts across health professional education as part of the *Healthy People 2010* planning.<sup>18</sup>

Conversely, the same holds true for imbedding medical concepts into training programs in public health, as was recently recommended by the Institute of Medicine.<sup>19</sup> This is likely to be challenging, given the broad spectrum of graduate public health education and the multiple and divergent backgrounds of the student population. Nonetheless, despite its inherent complexity, this should be a high-priority challenge for the Association of Schools of Public Health and the Council on Linkages Between Academia and Public Health Practice. Cross-referencing the work of the Healthy People Curriculum Task Force for comparison within public health curricula is a logical starting point. Alternatively, some professional schools have utilized *Medicine & Public Health: The Power of Collaboration* as a text for current courses (Roz Lasker, New York Academy of Medicine, written communication, March 2005).

Third, we renew the call for research into effective strategies that improve understanding and overcome barriers across the medicine-public health chasm. What methodologies enhance interaction, integration, partnership, or collaboration between the disciplines?

Although important groundwork was laid by the New York Academy of Medicine,<sup>4</sup> considerable research remains to be completed in order to establish an evidence base for successful interaction. This may be promoted by revisiting early MPH/PHI partnerships that have demonstrated sustained collaboration and success. Similarly, there is a need to explore optimal approaches to disseminating best practices, especially ones emerging from local communities employing innovative techniques to tackle long-standing problems. Schools of medicine and public health, in partnership with the practice community, would make excellent laboratories for such research.

Although national leadership is crucial, local ownership and leadership are imperative as well. Our collective experience has shown us that efforts demonstrating added value to the community are rapidly embraced. It remains for the local medical and public health communities to translate the MPH/PHI into meaningful action, whereby the lives and well-being of our fellow citizens are measurably enhanced. Recent events have offered the opportunity to again strengthen the collaboration between medicine and public health. The contour of the future health landscape is our collective responsibility. Medicine and public health must together shape that vista.

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