On Public Health Leadership: 1897 - 2012 and Beyond

Address to the Maryland Public Health Association

Joshua M. Sharfstein, M.D.
Secretary, Maryland Department of Health and Mental Hygiene
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Thank you for the opportunity to speak with you today.

The Maryland Public Health Association is a distinguished organization with a fascinating history. In 1897, the Association was the one and only state public health association in the nation ... serving as a model for our neighbors in Pennsylvania, among others.

At annual meetings, more than 300 Marylanders attended -- population adjusted, this would be 1500 people today.

At the turn of the century, the Maryland Public Health Association worked to create school health programs ... supported the funding of the first state laboratory ... advanced the collection of vital statistics ... embraced new protections for the milk supply ... and promoted sewer systems for clean water.

The Association helped to set in motion the environmental changes that would extend average life expectancy by two or more decades.

True, the first Maryland Public Health Association actually shut down after about five years ... apparently because all the excitement was in Tuberculosis. Once the executive director left for the Tuberculosis Commission, no further records of the early MHPA were found.

These first few years, however, still hold lessons for today.

As the nation's first public health association, the MPHA's "general aim" was to "promote the sanitary welfare of Maryland." That was the health part. But it would do so "by uniting the influences of all citizens professing interest in sanitation." That was the public part.

In thinking about public health today, it's easy to skip over the first word and go right to the second. We all care about health outcomes ... and population health ... and the social determinants of health. But "health" is only half the story.

The other half is "public." What is the meaning of public in public health? In thinking about leadership in our century, I will try to make the case that how effective we are at the public part of our job will determine a large part of our success.

Today, I will discuss four senses of the word public -- (1) public as in public service, (2) public as in public space, (3) public as in public process, and (4) public as in public interest. Effective public health leadership requires understanding each of these perspectives.

Public as in public service. In 1897, the Maryland Public Health Association sought to coordinate the efforts of many local boards of health. Early battles were fought to secure adequate resources to fight epidemics. Sound familiar? Then as now, our work to support each other is critical for the health of our communities and the state.

It also is the case that tough decisions are better made with colleagues. When I started as principal deputy commissioner at FDA, it was rare for the agency to share data and consult state and local public health officials before taking an action -- and so, when there was pushback, it was entirely directed at the federal agency. This led FDA to become more risk averse over time.

As a former local health official, I worked to re-engage FDA with the public health community.

I remember a very tough decision in the middle of an E.Coli O157:H7 outbreak. We knew that a high fraction of people who had fallen ill had eaten cheese at a traveling cheese road show. (Before this outbreak, I was not aware there was such a thing as a traveling cheese road show.) We knew that one cheese in particular was suspect, although not proven, to be the source. Should we (1) call for the recall of the one cheese, (2) ask for all the cheeses in the road show to be recalled, or (3) wait for further evidence?

The historic approach of FDA would have been to wait for laboratory confirmation. But we held a call with state officials and a consensus emerged -- based on the data before us -- that targeting the most suspect cheese made sense. It was a soft cheese made from unpasteurized milk. FDA insisted on a recall.

It turned out we were right.

Reaching tough decisions together maximizes the chances for a good outcome -- and also spreads the blame for a miscalculation. My approach has been to move fast to get everyone on the phone, move fast to ask the question about whether action is warranted -- but then stop and listen to the wisdom of the group for the right decision.

It's ok to wait -- if that's what makes sense. But if it's time to move forward, it's far better to have your friends and colleagues by your side.

Public as in the public space. The location where organizations and communities, come together to solve problems. In 1897, the Maryland Public Health Association set a goal of cooperating with "other sanitary organizations" in the private sector to achieve its goals.

Finding allies and developing networks of cooperation is a critical part of public health leadership today. There are voluntary health organizations such as the American Red Cross, medical groups of all types, community organizations mobilizing for a brighter future, and many, many others. Often, these organizations have perspective and influence that public health officials can only dream of.

As the health commissioner of Baltimore, I was interesting in exploring the use of over-the-counter cough and cold medications. I had heard that there were four deaths in the city associated with the use of these products. I knew from my pediatric training that these were both not recommended, and ubiquitous.

I met with Dr. Janet Serwint, a pediatrician at Johns Hopkins, and together we developed the idea of asking the pediatric chiefs in the city to develop a joint statement. All of them agreed to advise parents not to use these products, which had no proven benefit and some potential risks.

We later joined forces with national experts to petition FDA. Our success in this effort was made possible by this alliance with the pediatric community. One person in particular -- Dr. Michael Shannon -- made it possible. As a senior attending physician in the Emergency Department at Boston Children's Hospital, he was one of my favorite professors in medical school. One of the world's foremost experts in pediatric toxicology, Dr. Shannon wore his expertise lightly, but never failed to explain his point of view.

I asked him to join me in presenting to an FDA advisory committee meeting on our petition and he accepted. He flew into BWI and arrived at the meeting with minutes to spare. Tranquil as ever, he stood and said that when there is no benefit, there is no level of risk that is acceptable.

The advisory committee sided with us. The result was a voluntary withdrawal of over-the-counter cough and cold products for children under age 4. Subsequent research has shown enormous drops in poison control calls and ER visits for adverse reactions to cough-and-cold medications in this age group.

After the meeting, I called and thanked Dr. Shannon for giving his time to the public health cause. He told me that he was so proud to have contributed -- words I still recall to this day, now a couple of years after his tragic and early death. He taught me that engagement with public health is not a chore; for many clinicians and others in the private sector, it is a thrill. It has been even easier since then for me to ask for help.

Public as in public process. Early in my time at the Department of Health and Mental Hygiene, I suggested putting out for comment our first draft of leading health indicators as part of the State Health Improvement Process. More than a few people in the Department thought this was strange. How did it make sense to take public comment on these measures, they thought; it was the job of the state health department to set them.

We got more than 250 comments, many of which changed our direction.

In recent months, we've taken public comments on whether the Department's books hold unnecessary regulations -- and we identified about 50 to eliminate or drastically scale back.

We took public comments on abortion clinic regulation -- and developed a proposal that earned praise from across the political spectrum.

We have taken comments on the safety of crib bumpers, standards for investigating low-level lead exposure, hospital policies to promote breastfeeding and, informed consent for tanning beds.

We're now even taking comment on the professional dispute between physical therapists and acupuncturists over dry needling.

Would it have been possible to move forward without some of these comment periods? Perhaps, but it would not have been wise.

Public comment helps inform sound policy. To lead effectively, you have to be careful about what you don't know. Public engagement is an insurance policy against a really embarrassing mistake. The act of responding to each and every point made about a proposal will always sharpen thinking and make that proposal better. It is especially important to reach out to communities that may be affected by key decisions so that they have an opportunity to be heard.

Seeking public comment also is an incredible opportunity to educate.

At FDA, I learned an important lesson -- when you can explain a public health issue before taking action, you can win people over to sustain a tough decision. But when you try to explain as you are taking action, good luck.

Through publicly released white papers, requests for comment, and advisory committee meetings, it is possible to frame a specific question so that the public can understand what is at stake.

When I was at FDA, a group of attorneys general asked the agency to ban caffeinated alcoholic beverages. Rather than take an immediate action that would have caused a knee-jerk backlash, we released their letter and initiated a public comment period. Numerous press stories explained the public health issues at stake. Later, when the agency did act against the products, there was wide understanding of the risks they posed.

Public as in the public interest. On my first day at work for Congressman Henry Waxman, I was invited into his office. It was very exciting. I told him I hoped to help him pass national health insurance. And he looked and me and something to the effect of "you'll have to find something else to do here, or you won't last long."

The year was 2001. President Bush was in the White House, the House of Representatives was controlled by Republicans, and as Congressman Waxman explained to me, there was no chance that national health insurance was going to pass anytime soon. He wanted me to make things happen -- to move the ball forward on issues that mattered to people. He did not want me to draft long letters and write speeches that in the end would amount to nothing.

So I helped him reduce head trauma in youth Tae Kwon Do, stop the sales of unsafe nicotine lollipops, improve labeling for rice-based beverages, and keep an important NIH study of HIV on track. I learned that accomplishing something is a lot more fulfilling than doing nothing. And I also saw that winning on small issues can help generate momentum to take on bigger challenges.

From Congressman Waxman, I absorbed the lesson that advancing the public interest requires getting things done. It was another elected official, however, who taught me about the relentless focus needed to succeed against difficult challenges.

During my first week of work for Mayor O'Malley, I received multiple blackberry messages about buprenorphine. From the Mayor. When I had interviewed for the job, I told him that one of my goals was to establish a buprenorphine program to help mobilize the medical community against heroin addiction -- buprenorphine being a highly effective treatment that can be prescribed in regular medical offices.

But here I was on day one, and I had the sense that the Mayor was dissatisfied with me already. What was the plan? he asked. I told him I would wait for the next board

meeting to bring it up. Don't wait, he responded. I told him all the money for the fiscal year was allocated. Re-allocate it or ask for more, he said.

So I found some allies, put together an effort, and launched within a couple months. Baltimore became the only city to offer to pay for the required training of every doctor to prescribe buprenorphine. We set up a system for patients to start therapy in the drug treatment system and transition to primary care. And we helped a large number of patients get Primary Adult Care insurance to pay for it all. I could give a six hour lecture on the obstacles that our effort faced -- but with a coalition of organizations and a great team, we took each of them on one by one.

Now about six years later, we can see that the major expansion in buprenorphine access has been associated with major reductions in heroin overdose rates in the city.

It is easy to identify health challenges, easy to spot the failures of others, easy to ask for someone to do something ... but not so easy to get things done yourself. Leadership requires a relentless focus on moving the needle. We hope that the State Health Improvement Process provides an avenue for this kind of progress across the state.

Let me conclude by talking about a challenge facing all of us that exemplifies the opportunities for public health leadership -- health care costs.

It is no secret that health care costs are rising too quickly for the rest of the economy to pay for them. From the perspective of public service, this is a major budget challenge for Medicaid and Medicare. It is a key reason for the current budget crisis and helps explain why local public health grants of all kinds are being cut.

From the perspective of the public space, many organizations and citizens are focused on rising health care costs. For example, employers are stuck between paying more for health coverage and investing in innovation and technology. They are looking for creative ways to improve the health and lower the costs for their workforce.

In part through public comment, we have identified some solutions -- which involve changing the way health care is delivered and paid for. We can expect that as financial incentives evolve, health care organizations will be rewarded for heart attacks avoided, not just heart attacks treated. In public health, we know how to avoid heart attacks, creating opportunities for creativity, innovation, cost control, and better health. At meetings of local health improvement coalitions, many great ideas for working together are surfacing. Creative use of health information technology can help us deliver effective interventions right at the point of impact.

But to serve the public interest, we will have to deliver on this knowledge. We will have to implement these ideas. We will have to change the way public health does business. We will have to push through obstacle after obstacle to develop new coalitions, imbed public health principles in provider, payer and employer decisions, establish new services, and track different kinds of data. The Health Enterprise Zone program, for example, seeks to harness this innovation in public health to have a direct impact on unacceptable health disparities.

Our success will be measured not by our commentary from afar, but from whether we can roll up our sleeves and be a part of the solution.

Whether 115 years ago or today, our goal remains health, and it is the public that is the secret to our success.

Thank you for inviting me today, and I look forward to your questions.