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Health of the Public
An Academic Challenge

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June 8, 1993

Kristine Gebbie, R.N., M.N., F.A.A.N.
606 Lilly Road, N.E., #723
Olympia, WA 98504

Dear Kris:

Jon Showstack, John Evans, and I wish to provide you with information on our progress as the next phase of HOP activities begins to materialize. Following our meeting in Boston, Jon Showstack and I used your consensus general model for AHC funding and developed an explicit funding strategy for making offers to potential HOP participant schools.

As shown in the enclosed table, we sought to make "optimal funding" offers to ten "new" Health of the Public Program AHCs on a pro-rated basis (after modest selective reductions in the individual budgets based on the Board's perceptions of strengths and weaknesses), offers averaging $300,000 per school for the three-year grant period. Of the original six AHCs provided major funding in the first cycle of HOP, five were offered $200,000 for the next three-year cycle. "Strategic funding" of $150,000 per school was offered to thirteen additional universities. These latter offers were of fixed amounts, because we were (after reflection) unable make meaningful distinctions among the AHCs' funding needs on the basis of their proposal and, furthermore, could not anticipate how they would adjust their proposed activities or deploy a substantially lesser amount of funding then they had originally requested.

We used the advisory board-generated rank order strictly and attempted to enroll a total of twenty-eight schools in our HOP network, since there seemed to be a substantial "quality break" between the twenty-eighth and twenty-ninth applicant. An additional five AHCs will receive assurance of support for their participation in the semi-annual HOP meetings (Emory University and four current participants in the HOP network). The total potential commitment of funds to academic health centers is $6,000,000. Approximately $150,000 is still available on a "set-aside" basis for special initiatives (the "community development" meeting, a meeting of "changemakers" in health, participation in international networks by representatives from the schools, etc.).

I am pleased to tell you that all twenty-eight schools offered programmatic support have now responded to our offers with enthusiastic acceptances. Each of the original HOP universities offered $200,000 assumed responsibility for the full objectives of their program proposal in

spite of radically reduced levels of funding. The "strategic funding" offers produced "downsized" activities but preserved the multi-disciplinary and community nature of their proposed activities. Altogether, we are pleased and encouraged by sponsoring schools willingness to assume financial responsibility for HOP activities in order to supplement and extend Foundation funding.

Yours sincerely,

Thomas S. Inui, Sc.M., M.D.

Enclosure

TSI\sm
g:\shared\693\604\hopab

Draft: 6/2/93

Proposed funding amounts

Score	Rank	ID	Name of AHC	Request	Proposed	Total
1.8	1	42	Johns Hopkins University	$454,467	**$200,000**	$200,000
2.2	2	79	Univ. of North Carolina at Chapel Hill	$402,472	**$200,000**	$400,000
2.3	3	66	Morehouse School of Medicine	$449,164	**$350,000**	$750,000
2.4	4	55	McMaster University	$300,000	**$250,000**	$1,000,000
2.6	5	40	University of Iowa	$300,000	**$250,000**	$1,250,000
2.6	6	71	University of New Mexico	$435,589	**$200,000**	$1,450,000
3.1	7	37	University of Illinois at Chicago	$448,877	**$325,000**	$1,775,000
3.3	8	97	University of South Carolina	$433,938	**$325,000**	$2,100,000
3.5	9	74	City University of N. Y. (Mt. Sinai)	$485,861	**$350,000**	$2,450,000
3.9	10	111	Tufts University	$293,409	**$200,000**	$2,650,000
3.9	11	121	University of Washington	$451,998	**$200,000**	$2,850,000
4.1	12	64	University of Missouri, Columbia	$400,656	**$325,000**	$3,175,000
4.2	13	56	Meharry Medical College	$323,010	**$250,000**	$3,425,000
4.6	14	107	University of Texas, Galveston	$307,832	**$250,000**	$3,675,000
4.7	15	94	Rush-Presbyterian-St. Luke's Med Ctr	$477,400	**$300,000**	$3,975,000
5.2	16	41	Thomas Jefferson University	$324,879	**$150,000**	$4,125,000
5.3	17	11	UCLA/Drew	$412,850	**$150,000**	$4,275,000
5.4	18	49	Loyola University of Chicago	$334,466	**$150,000**	$4,425,000
5.4	19	90	University of Pittsburgh	$297,542	**$150,000**	$4,575,000
5.5	20	69	U. of Medicine and Dentistry of NJ	$438,191	**$150,000**	$4,725,000
5.5	21	127	Wright State University	$450,006	**$150,000**	$4,875,000
5.6	22	19	Columbia University	$411,873	**$150,000**	$5,025,000
5.6	23	39	Indiana University	$336,301	**$150,000**	$5,175,000
5.7	24	104	University of Tennessee, Memphis	$306,300	**$150,000**	$5,325,000
6.1	25	17	University of Cincinnati Medical Center	$441,131	**$150,000**	$5,475,000
6.1	26	83	Northeastern Ohio Universities	$425,042	**$150,000**	$5,625,000
6.2	27	89	University of Pennsylvania	$360,682	**$150,000**	$5,775,000
6.2	28	61	University of Minnesota	$366,858	**$150,000**	$5,925,000
6.9	29	26	Emory University	$447,321	**$15,000**	$5,940,000
7.0	30	16	University of Chicago	$304,409	**$15,000**	$5,955,000
7.0	31	70	U. of Med. and Dentistry of NJ (RWJ)	$304,608	**$0**	$5,955,000
7.0	32	117	University of Virginia	$404,288	**$0**	$5,955,000
7.1	33	43	University of Kansas Med Center	$304,460	**$15,000**	$5,970,000
7.2	34	129	Yeshiva University (Einstein)	$300,000	**$0**	$5,970,000
7.3	35	15	Case Western Reserve University	$308,256	**$0**	$5,970,000
7.5	36	30	Georgetown University Med Center	$300,000	**$0**	$5,970,000
7.9	37	23	Dartmouth-Hitchcock Med Center	$379,068	**$15,000**	$5,985,000
7.9	38	84	Ohio State University	$270,541	**$0**	$5,985,000
8.6	39	29	George Washington Univ. Med Center	$297,500	**$0**	$5,985,000
8.8	40	22	Creighton University	$300,000	**$0**	$5,985,000
9.1	41	109	University of Texas, San Antonio	$352,465	**$15,000**	$6,000,000

			Total	Mean Amt.
Fixed amount: Original Five	**Fixed**	**$1,000,000**	$200,000
Percent reduction: "Optimal" (10 AHCs)	**0.8**	**$2,975,000**	$297,500
Fixed amount: "Strategic" (13 AHCs)	**Fixed**	**$1,950,000**	$150,000
Fixed amount: Participants (5 AHCs)	**Fixed**	**$75,000**	$15,000
	Total	**$6,000,000**	

HEALTH OF THE PUBLIC: AN ACADEMIC CHALLENGE

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April 8, 1993

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Health of the Public
Proposal Review Process

March 2

Proposals due at Program Office.

March 2-15

Proposals reviewed by Tom Inui and Jon Showstack. As many as 40 selected by Program Office on the basis of quality and appropriateness for review by Advisory Board; with others "Not recommended for further consideration (NRFC)." Proposals sent to Advisory Board and foundations.

March 16-April 8

As many as eight full proposals and 32 executive summaries sent to each member of the Advisory Board. Each Advisory Board member will be asked to be the primary reviewer on four proposals, secondary reviewer on four proposals, and to be familiar with the 32 executive summaries. Board members will be asked to score their primary and secondary reviews on a scale from one (best, ideal, no problems, absolutely recommend for funding) to 10 (worst, business as usual, NRFC), and to write a two-three paragraph critique of each primary review. (If review of a particular proposal presents a potential conflict of interest, the reviewer will be asked to exclude herself/himself from the review of that proposal.)

April 8

The four critiques and eight scores due at Program Office. Scores by primary and secondary reviewers (and by Inui/Showstack) compiled by Program Office to present in rank order at April 15th meeting.

April 15 - 16

Meeting of Advisory Board, Foundation representatives, and Program Office ("Review Group") to review proposals and make preliminary recommendations:

Category 1: Recommend funding
Category 2: Recommend deferral for further information/site visit
Category 3: NRFC

Meeting Agenda

Distribute list of preliminary scores and rank order. Discussion of each proposal (in order of preliminary ranking, from best to worse). Primary reviewer describes and critiques proposed program and indicates his/her degree of enthusiasm, whether additional information is needed, and priority score (with suggestion for level of funding, if appropriate). Secondary reviewer and Program Office provide additional comments and priority scores.
General discussion, focusing on whether the proposal should be Category 1 (recommended for funding), Category 2 (additional information sought), or Category 3 (NRFC).
Each voting member of review group writes his/her score and category 1, (recommended for funding), Category 2 (additional information sought), or Category 3 (NRFC) on summary sheet.
Scores are tabulated by Program Office and revised rank order distributed to Review Group.
Further discussion to finalize rank order and placement of each proposal into one of the above three categories. For proposals in Category 1, decide approximate level of funding and, if recommended amount is lower than requested, which activities are to be funded. For proposals in Category 2, decide what additional information is needed and the methods of collecting the information (e.g., written questions and/or site visit).

Structured Reading Guide

ID #/Name of AHC_____

Please take into special consideration three critical attributes of the proposal:

- The likely **impact on the academic health center** of the proposed activities,
- The quality of the **AHC's partnership with the community**, and
- What will be learned from these efforts about **how to advance the Health of the Public objectives** at academic health centers.

Necessary Elements

1. Advance program objectives

Objective	Focus, clarity, plausibility, potential achievement
1. Pop. competency for all students	
2. Enhanced educ for some	
3. Clin prevention education	
4. Pop. science research	
5. Responsibility for defined pop'l	
6. Resource allocation	
7. Sociopolitical involvement	

2. Involvement of multiple health professions.

3. Strength of AHC/community partnership.

4. Strength of contributions to Health of the Public network.

Priority activities present?

- Develop new and innovative approaches to Health of the Public objectives.
- Focus on major societal problems
- Population need/demand-based programs
- Health promotion/disease prevention in minority/disadvantaged populations
- Focus on resource limits
- Health professional preparation for community action
- Promoting curriculum change
- Matching products to buyer's needs

Products (Specificity, scope)

Strengths and weaknesses of proposal:

Budget (High, low, about right; specific items not appropriate/justified)

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Strengths and weaknesses of proposal:

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Raw Scores

11	UCLA/Drew	4	6	5		3		6		4	6	8	6
15	Case Western Reserve University	6	6	5	7	8	10	7	9	5	10	8	7
16	University of Chicago	7	6	6	6	6		7	6	6	10	9	8
17	University of Cincinnati Medical Center	7	6	4	5	7		6	6	4	9	8	5
19	Columbia University	7	2	4	4	6	5	6	6	4	7	10	6
22	Creighton University	9	8	7		9			8	10	10	10	8
23	Dartmouth-Hitchcock Med Center	7	7	7		8			7	8	10	9	8
26	Emory University	7	6	5		8		7	5	6	9	9	7
29	George Washington Univ. Med Center	8	8	6	8	10	10	9	8	10	10	10	6
30	Georgetown University Med Center	8	7	7	8	5		7	8	7	10	8	7
37	University of Illinois at Chicago	5		3	4	1	2	4	2	5	4	3	3
39	Indiana University	6	5	5		5		6	5	5	6	10	3
40	University of Iowa	3	3	2	3	2	1	3	2	2	2	5	3
41	Thomas Jefferson University	6	4	4	5	6		6	6	5	6	6	3
42	Johns Hopkins University	2	2	2	2	2	1	2	1	1	2	2	2
43	University of Kansas Med Center	7	7	6		7		8	6	6	9	8	7
49	Loyola University of Chicago	6	4	3	6	6	2	6	5	6	9	7	5
55	McMaster University		3	3	2	1	3	2	2	2	3	3	3
56	Meharry Medical College	6	4	2	3	3	4	5	3	3	7	6	4
61	University of Minnesota	4	6	5		8		8	7	4	8	7	5
64	University of Missouri, Columbia	5	3	4	4	3		4	5	6	4	4	3
66	Morehouse School of Medicine	4	2	2	2	2	2	3	2	2	3	2	2
69	U. of Medicine and Dentistry of NJ	8	3	5	6	3		6	6	5	8	5	5
70	U. of Med. and Dentistry of NJ (RWJ)	8	6	6	7	6		7	5	8	9	8	7
71	University of New Mexico	2	4	2	2	3	4	2	4	2		1	3
74	City University of N. Y. (Mt. Sinai)	4	6	4	5	2	4	4	2	1	2	5	3
79	Univ. of North Carolina at Chapel Hill	3	2	2	3	3	1	2	1	1	3	3	2
83	Northeastern Ohio Universities	6	5	5		6		7	5	5	8	6	8
84	Ohio State University	9	6	6		8			6	10	10	9	7
89	University of Pennsylvania	8	6	6	7	9		3	4	5	8	7	5
90	University of Pittsburgh	6	5	4	5	3	5	5	7	7	8	5	5
94	Rush-Presbyterian-St. Luke's Med Ctr	4	6	3	3	6	6	4	5	2	8	6	3
97	University of South Carolina	6	2	2	4	2	2	3	3	3	4	4	5
104	University of Tennessee, Memphis	6	5	5		5			5	5	9	6	5
107	University of Texas, Galveston	7	4	3	5	4		5	4	4	5	5	5
109	University of Texas, San Antonio	10	8	8		10			8	10	10	10	8
111	Tufts University	3	3	2	5	6	2	4	4	4	4	5	5
117	University of Virginia	5	6	6		6		9	6	5	10	10	7
121	University of Washington	2	4	2	3	6	4	4	3	4	5	6	4
127	Wright State University	6	4	4	5	6		6	4	8	7	5	5
129	Yeshiva University (Einstein)	7	5	5	7	10	7	8	5	5	10	10	7

K. Gebbie

Revised Scores

Sorted by Mean Score

Rank	ID	Status	Name of AHC	Revised Mean	Request	Cum. Req.
1	42	1	Johns Hopkins University	1.8	$454,467	$454,467
2	79	1	Univ. of North Carolina at Chapel Hill	2.2	$402,472	$856,939
3	66	3	Morehouse School of Medicine	2.3	$449,164	$1,306,103
4	55	2	McMaster University	2.4	$300,000	$1,606,103
5	40	3	University of Iowa	2.6	$300,000	$1,906,103
6	71	1	University of New Mexico	2.6	$435,589	$2,341,692
7	37	3	University of Illinois at Chicago	3.1	$448,877	$2,790,569
8	97	3	University of South Carolina	3.3	$433,938	$3,224,507
9	74	3	City University of N. Y. (Mt. Sinai)	3.5	$485,861	$3,710,368
10	111	1	Tufts University	3.9	$293,409	$4,003,777
11	121	1	University of Washington	3.9	$451,998	$4,455,775
12	64	2	University of Missouri, Columbia	4.1	$400,656	$4,856,431
13	56	2	Meharry Medical College	4.2	$323,010	$5,179,441
14	107	3	University of Texas, Galveston	4.6	$307,832	$5,487,273
15	94	3	Rush-Presbyterian-St. Luke's Med Ctr	4.7	$477,400	$5,964,673
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18	49	3	Loyola University of Chicago	5.4	$334,466	$7,036,868
19	90	3	University of Pittsburgh	5.4	$297,542	$7,334,410
20	69	3	U. of Medicine and Dentistry of NJ	5.5	$438,191	$7,772,601
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25	17	3	University of Cincinnati Medical Center	6.1	$441,131	$9,718,212
26	83	3	Northeastern Ohio Universities	6.1	$425,042	$10,143,254
27	89	2	University of Pennsylvania	6.2	$360,682	$10,503,936
28	61	2	University of Minnesota	6.2	$366,858	$10,870,794
29	26	3	Emory University	6.9	$447,321	$11,318,115
30	16	2	University of Chicago	7.0	$304,409	$11,622,524
31	70	3	U. of Med. and Dentistry of NJ (RWJ)	7.0	$304,608	$11,927,132
32	117	3	University of Virginia	7.0	$404,288	$12,331,420
33	43	3	University of Kansas Med Center	7.1	$304,460	$12,635,880
34	129	3	Yeshiva University (Einstein)	7.2	$300,000	$12,935,880
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36	30	3	Georgetown University Med Center	7.5	$300,000	$13,544,136
37	23	2	Dartmouth-Hitchcock Med Center	7.9	$379,068	$13,923,204
38	84	3	Ohio State University	7.9	$270,541	$14,193,745
39	29	3	George Washington Univ. Med Center	8.6	$297,500	$14,491,245
40	22	3	Creighton University	8.8	$300,000	$14,791,245
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Revised April 15, 1993, 7:53 AM

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25	17	3	University of Cincinnati Medical Center	6.1	$441,131	$9,718,212
26	83	3	Northeastern Ohio Universities	6.1	$425,042	$10,143,254
27	89	2	University of Pennsylvania	6.2	$360,682	$10,503,936
28	61	2	University of Minnesota	6.2	$366,858	$10,870,794
29	26	3	Emory University	6.9	$447,321	$11,318,115
30	16	2	University of Chicago	7.0	$304,409	$11,622,524
31	70	3	U. of Med. and Dentistry of NJ (RWJ)	7.0	$304,608	$11,927,132
32	117	3	University of Virginia	7.0	$404,288	$12,331,420
33	43	3	University of Kansas Med Center	7.1	$304,460	$12,635,880
34	129	3	Yeshiva University (Einstein)	7.2	$300,000	$12,935,880
35	15	3	Case Western Reserve University	7.3	$308,256	$13,244,136
36	30	3	Georgetown University Med Center	7.5	$300,000	$13,544,136
37	23	2	Dartmouth-Hitchcock Med Center	7.9	$379,068	$13,923,204
38	84	3	Ohio State University	7.9	$270,541	$14,193,745
39	29	3	George Washington Univ. Med Center	8.6	$297,500	$14,491,245
40	22	3	Creighton University	8.8	$300,000	$14,791,245
41	109	2	University of Texas, San Antonio	9.1	$352,465	$15,143,710

Revised April 15, 1993, 7:09 PM

JOHN R. EVANS, M.D., D.Phil.

The "Health of the Public" Approach to Medical Education

Abstract—The author examines the growing discontinuity between medical education and the general health needs of society. He explains and illustrates this failure of the academic medical center in several ways: by a parable; by reporting the results of his informal survey of faculty and residents; by presenting the findings of an international conference on medical education; and by giving a detailed description of the design and impact of the "Health of the Public" program, launched by the Pew Charitable Trusts and the Rockefeller Foundation in 1986. He maintains that there is an imbalance in the training of physicians and other health professionals because academic medical centers are dominated by supply-side thinking—which is driven by new knowledge and technology and the resulting need to find patients to fit the interests and technical capabilities of specialists and the equipment and services of hospitals—and have underemphasized demand-side thinking, which concerns the patient and the health expectations, needs, and trends in the community. The author maintains that academic medical centers can continue to achieve the recognition they seek, but can do so by making the changes needed to better balance the driving forces of supply and demand. Only by doing this will they fulfill their fundamental mission of fostering the health of the public. *Acad. Med.* 67(1992):719–723.

A century ago, a remarkable Baptist minister, the Reverend Frederick Gates, persuaded John D. Rockefeller not only to endow the University of Chicago but also to found the Rockefeller Institute for Medical Research and to support research-oriented medical schools generously. Gates became convinced that strong support of medical research and education could do more for humanity than any other use of Rockefeller's money.

Perhaps what medical education needs most in 1991 is another wise and persuasive Baptist minister. Unfortunately I am not of that cloth! But I do have a sermon, one in the hell-fire-and-brimstone tradition. It deals with sin—the sin of omission of what I judge to be a critical dimension of contemporary medical education.

A Parable

Let me begin my sermon with a parable—a landmark case before the Florifornia Supreme Court. The legatees of the great medical educator Lowell Coggeshall were the plaintiff and appellants. The regents of the University of Florifornia and its distinguished chancellor were the defendants and respondents. The issue was negligence of the academic health center in the discharge of its institutional responsibilities for the health of its public. The defendants based their case on the principle of eminent domain—the responsibilities of the university reside only in teaching and research and not in the health of a population. The State Supreme Court sustained the decision of the appellate court that the academic health center was guilty of negligence on the following grounds:

- Absence of an information base on the health of the population and on the effectiveness of preventive and therapeutic health interventions on which to base policy, priorities, and resource allocation
- Absence of suitable content in its undergraduate and graduate clinical educational programs in the health sciences
- Failure of full and fair disclosure of alternatives for patient care and effective use of limited public and private resources
- Failure to disclose economic, research, and career-advancement interests of faculty that influenced program priorities and resource allocation in a manner adversely affecting and unrelated to its health mission
- Failure to address ethical, economic, and equity issues fundamental to the health of the public in the operational *mainstream* of the center's programs of research and training

In disposition, the court invoked the following sanctions and remedies:

- The academic health center was placed in trusteeship for a period of five years, during which key decisions on policy, management, and resource allocation would be subjected to the oversight of a committee representing the population served.
- The court ordered that the evaluation of each health professional trainee graduating from the academic center include evidence of competence in understanding population-based health needs, the effective use of health resources, and the means of influencing the health of the community as well as the care of the individual patient.
- The court ordered a reorganization of the structure and programs of the academic health center to meet population-based health objectives in addition to traditional objectives.

In response to the sanctions and remedies, the academic health center engaged in a fundamental reorganiza-

A preliminary version of this essay was presented as a lecture at the University of Chicago Centennial Conference, "The Future of American Medical Education: The Legacy of Lowell T. Coggeshall," held October 17–18, 1991.

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tion, sentenced the dean of medicine to service in the post for the rest of his natural life, and appointed as the new vice-chancellor of health sciences a veterinary psychiatrist, the only health discipline judged capable of understanding and managing the deans of the various health professions.
Here endeth the parable!

Discontinuity between Education and Need

Flexner brought to medical education in North America professionalism in the scientific method and laboratory diagnosis. This has flourished in the biomedical sciences and has contributed immeasurably to the understanding of disease and to the discovery of powerful new technologies for diagnosis and treatment. But the care of patients and effective management of health resources require additional knowledge and skills. In most academic health centers the sciences underlying the social, economic, environmental, and behavioral determinants of health and the evaluation of the effectiveness of treatment interventions have remained relatively underdeveloped and in some cases separated from clinical medicine. Few clinical role models exist and the curriculum experiences are inadequate to ensure these critical aspects of the formation of a physician. The setting for clinical experience has migrated to the most technically demanding aspects of hospital care, which may have only a marginal relationship to the subsequent pattern of practice of many of the trainees. Clinical experience in the community and understanding of factors influencing the health of that population have not received the same attention. Diagnosis, treatment, and prevention must address not only the individual patient but also the community, where the determinants of health and the factors influencing the severity of illness resulting from disease can be measured and modified. Furthermore, the type of research underpinning population-based medicine and a host's response to diseases depends heavily on epidemiology, biostatistics, and the environmental, social, and behavioral sciences—sciences that do not enjoy the visibility, recognition, and resources they warrant in relation to their importance to medical education and health care.

Academic medicine has not yet responded to this challenge in the way that it has adopted the enormous contribution of the biomedical sciences. But if we are to realize the full potential of the achievements in biomedical science and medical technology, we need to apply the same scientific rigor in evaluating their effectiveness and in matching the supply of technology with the health needs of the population in resource allocation decisions. We need to recognize the difference between disease and illness and ensure that those factors that have an impact on health but that are not specific to individual diseases receive the attention they deserve in teaching and clinical care. And surely a small part of each physician's responsibility should extend beyond the care of individual patients to the advocacy for changes in the community's policies and practices that influence determinants of health, causes of disease, and the effectiveness of health services. Population-based information on disease trends and professional advocacy may assist communities and political jurisdictions not only to meet today's needs but also to design preventive strategies to deal with the causes of ill health in the future.

My experience overseas with the World Bank and the Rockefeller Foundation has illustrated the international implications of trends in North American academic medicine. These trends are the predominant influence shaping medical education and the technology of medical care throughout the world. There is reasonable doubt that we have evolved the ideal model for a country with vast resources such as the United States. There can be no doubt, however, that our model is inappropriate for countries in the Third World where the annual public expenditure on health is $10–20 per person.

In 1988, participants at the World Conference on Medical Education in Edinburgh, Scotland, described with concern the growing discontinuity worldwide between medical education and the general health needs of society. It identified a series of priority actions to broaden the horizon of medical education from high-technology, curative, and palliative procedures in teaching hospitals to a wider vision that "truly meets the defined needs of the society in which the [medical school] is situated." It was an unmistakeable plea for medical schools to balance their obsession for international standards of technical eminence with attention to the health needs of greatest relevance to the local populations.

"Health of the Public" Program

Some two years earlier, in 1986, building on two decades of influential work by Kerr White and others (summarized recently by Dr. White in his book, *Healing the Schism: Epidemiology, Medicine, and the Public's Health*[1*]), the Pew Charitable Trusts and the Rockefeller Foundation launched the "Health of the Public" program to strengthen the population perspective of health care in medical education and to encourage academic health centers to respond to changing health needs. The Rockefeller Foundation's support was strongly motivated by the need to have some American medical centers provide a more appropriate environment for training Third World health personnel.

From a two-stage national competition involving proposals from 89 academic health centers, six were selected for program support. A key issue in their selection was their apparent willingness to make the Health of the Public objectives part of the mainstream of their activities in education, patient care, and research. Dr. Steven Schroeder, who now is president of the Robert Wood Johnson Foundation, was selected as program director.

*This book is reviewed elsewhere in this issue.

Dr. Schroeder and his colleagues outlined the Health of the Public perspectives in an excellent article, "Academic Medicine as a Public Trust."[2] It is a tribute to him and to the leaders of the six original programs that over the next four years an imprecise concept was transformed into a distinctive program in each of the academic health centers. A common mission statement was forged and collaborative activities among the centers inaugurated the Health of the Public Movement. The original group of six was augmented by 11 additional academic health centers in the fall of 1990, substantially broadening the institutional base and spectrum of program approaches.

The Health of the Public mission statement emphasized five goals for the successful integration of a population perspective into clinical medicine at an academic health center.

- Maximize the health of a defined population.
- Achieve collaboration among the broad array of professionals needed to meet the health needs of that population.
- Provide appropriate preventive as well as therapeutic services.
- Conduct population-based research studies and apply the results to shaping and enhancing health care.
- Use the social and behavioral sciences and the humanities to gain a richer understanding of the individual patient, the roles and responsibilities of health care providers, and the performance of the health care system.

In order to meet these goals it was recommended that programs at academic health centers incorporate some or all of the following objectives:

- Provide basic competencies in population-based subjects to all health professions students.
- Provide enhanced population-based education for selected students.
- Include clinical-prevention knowledge- and skill-building activities at all levels of health professionals' education.
- Conduct substantive scholarly studies in subjects related to population medicine.
- Assume institutional responsibility for maximizing the health of a defined population within available resources.
- Involve the academic health center in decision making about the development and deployment of health resources.
- Involve the academic health center in the social–political process as an advocate of the health of its public.

The Health of the Public initiative has produced significant changes at most of the original institutions, thanks to the vision, energy, and ingenuity of those participating in the program. It was intended not to be confined to a department of community or preventive medicine but to involve all clinical programs and some of the programs in the basic health sciences. In spite of considerable progress, the concept is not yet firmly entrenched in the mainstream of institutional thinking. Nor has it been adopted by the national organizations of medical colleges and academic health centers, or the licensing bodies and specialty societies so influential in shaping their programs. These objectives are important elements in the next stage of development, now under the leadership of Dr. Tom Inui, who succeeded Dr. Schroeder as director, and Jonathan Showstack, the co-director.

The Health of the Public approach attempts to expand the horizon of medical education beyond the classical disease-specific paradigm. It identifies individuals, groups, households, occupations, and communities that are at high risk or are underserved. It addresses social and environmental determinants of the incidence and course of illness, which may be as influential as disease-specific determinants, especially in chronic illness and the elderly. It parallels the diagnosis and treatment of the individual with community diagnosis and interventions. It recognizes that concern and communication, the basis of the caring process itself, are important elements in clinical outcomes for individuals and for the community. Central to the strategy is an information system to provide timely evidence about the health needs, resource use, and health outcomes of a defined population. Such information is a critical component of both location-specific health research and effectiveness studies and training programs for physicians and other health personnel.

Balancing Two Kinds of Thinking

The Health of the Public approach invokes a fundamental change in perspective for the academic health center, trenchantly summarized by Kerr White as the "shift from a 'supply'-dominated model of medicine's task, controlled by the country's medical schools, to a 'demand'-dominated model based on the perceived needs and attributes of the individuals and populations served."[3]

"Supply-side" thinking is driven by the need to find patients to fit the interests and technical capabilities of specialists and the equipment and services of hospitals. It tends to overlook those who do not fit supply-side interests. Health of the Public thinking, in contrast, addresses questions from the perspective of the patient and the population of a community. What is the burden of disease in the population? What factors influence the severity of illness or disability? What interventions are most effective in prevention, diagnosis, and treatment? What individuals are being missed? How can available resources be applied more effectively or new resources mobilized to cope better with these needs? How can policies and investment in other sectors influence the health status of both individuals and the community?

Is it fair to say that supply-side thinking dominates the driving forces in medical care, medical education, and research in the academic medical center today? I do not have the results of a statistically sound epidemiological survey, but I would like to share with you the responses from a

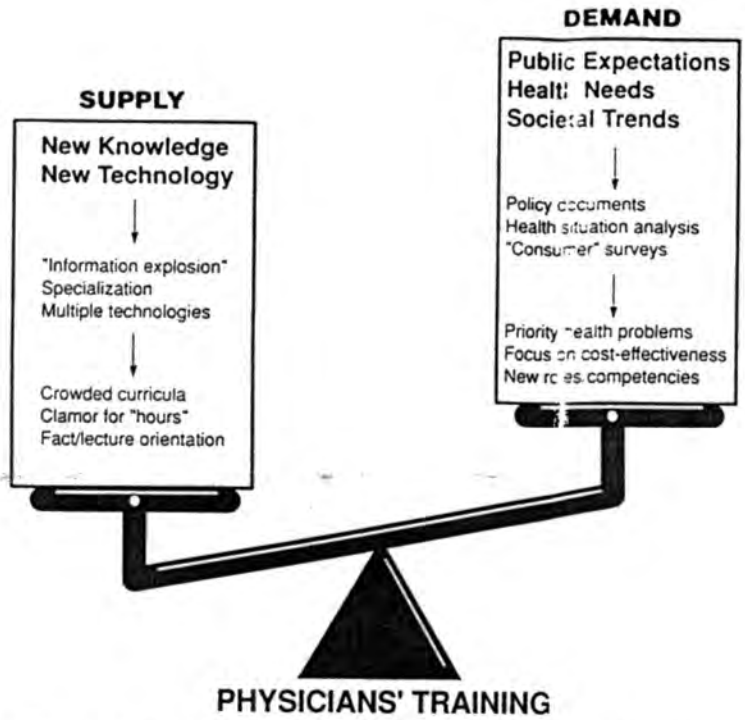

Figure 1. **The imbalance in the influences of two kinds of thinking on physicians' training. Supply-side thinking, which is driven by new knowledge and technology and leads to the six factors listed in the left-hand box, is important but has an undue influence on the design of curricula for medical students and residents. A greater emphasis is needed on demand-side thinking, which includes public expectations, health needs of the community, and trends in society; it leads to the factors listed in the right-hand box. (This figure adapted from a similar figure prepared for a report[4] by the Educating Future Physicians for Ontario project; it is used by permission.)**

small sample of faculty members and residents who were asked to identify the driving forces in academic medicine. These qualitative judgements should be considered as provocation, not declaration!

First, what are the driving forces that influence providers in their choices of health interventions? My informal survey produced this list:

- Perceived needs of the patient
- Professional challenge
- Provider "economics"
- Fear of litigation
- Patient's preference
- Effectiveness of intervention
- Rational use of resources
- Ability to pay

The respondents indicated that the first four factors in the list are more influential than at least three of the last four. The first four are predominantly supply-side forces and the latter four are more in the demand-side category. The driving forces that motivate physicians are particularly significant, since physicians' decisions determine about 80% of health expenditures.

In the same vein, what are the driving forces that influence the training of physicians and other health professionals? My survey of opinions produced this list:

- Scholarly status
- Professional prestige
- Institutional ego
- Accreditation rating
- External examinations
- Burden of illness
- Health care objectives

Those who produced this list indicated that the first five factors, which are predominently supply-side in nature, were more influential than the final two factors, which reflect demand. Thus, it would appear that the supply-side factors are much more important than the demand-oriented ones in the design of the undergraduate medical curriculum and postgraduate clinical training.

Both supply and demand are important in the design of physicians' training, but I maintain that at present, the scales are heavily tilted toward supply. This imbalance is depicted in Figure 1, which is taken from a report by the Educating Future Physicians for Ontario project, a program comprising the five undergraduate medical programs in Ontario and supported by Associated Medical Services, a private foundation, and the Ontario Ministry of Health.[4] To redress this imbalance, the first objective cited by this report is to define the new roles and competencies needed by physicians to meet the health needs and expectations of the public in Ontario.[4]

What are the driving forces that influence the choices of topics for health research? When I asked this question of my survey group, they supplied the following list:

- Investigator's training
- Research funding
- New technologies
- Scientific feasibility
- Global burden of illness
- Effective resource use
- Equity

The responses indicate that the first four factors in this list were overwhelmingly more important than the last three. Equity was not acknowledged by any of the respondents, and burden-of-illness and effective-resource-use studies were not classified by some as research!

The research agenda of the academic medical center is driven by scientific interest, technologies, and feasibility to a much greater extent than by health needs. A former Ontario minister of health remarked to me

that he was eager to expand support for health research at the medical schools in his jurisdiction but found it difficult to be persuasive in making the case when so little of the research related to the most pressing problems facing the health ministry. Clearly, not all research should be driven by local health problems or demand-side forces, but the balance seems to be tipped strongly in the direction of supply-side factors. This is also the case in those developing countries that have the most serious constellations of health problems and the most limited research capabilities. This observation was reinforced recently by the findings of the independently established Commission on Health Research for Development, which noted little relationship between research activity and the burden of illness or the effectiveness of the health system in developing countries.[5] Indeed, research interests in developing countries reflected the patterns in the countries of the industrialized world where most of the scientists had taken their training, a reminder of the profound influence of these countries' academic health centers on research practices throughout the world.

If supply-side factors dominate the academic health center, the measures of success will be peer recognition, institutional ranking, and fund-raising. These goals might be achieved without a significant impact on the health status of the community. But academic health centers can also achieve international eminence by having local relevance, through attention to the health needs of the populations served by the centers. For most academic health centers, this will involve a broadening of perspective with greater emphasis on demand-side factors, restatement of mission, and development of an appropriate implementation strategy. Through a better balance of the driving forces of supply and demand, the academic health center will fulfill its fundamental and enduring mission—fostering the health of the public.

The University of Chicago Centennial Conference at which the earlier version of this essay was presented was cosponsored by the University of Chicago Division of Biological Sciences/the Pritzker School of Medicine, the Association of American Medical Colleges, and the American Medical Association. Partial support for the conference was also provided by the Robert Wood Johnson Foundation, the Catherine and John MacArthur Foundation, the Josiah Macy, Jr. Foundation, and the Field Foundation of Illinois. The views expressed in this essay are not necessarily those of the sponsoring or supporting organizations.

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3

ALVIN R. TARLOV, M.D.

The Coming Influence of a Social Perspective on Medical Education

Abstract—Medical education will change from within in response to continued advances in biological sciences and technology, but changes that are occurring outside the natural sciences can have greater impact, especially (1) the reconceptualization of the meaning of *health*, (2) the increase in the number and range of different health improvement strategies, (3) the growing awareness of the paradox of the relatively low health status of the U.S. population and high per-capita and national health care expenditures, and (4) shifts in the causes of illness and death. These changes make it necessary for medical students to be given a foundation in both the natural and the social sciences, for most ill health has causal roots in both the social and physical environment, even though it is not understood how some of these outside influences are translated into disease or biologic derangements that lead to disease. Consideration should be given to changes in medical education that include (1) interpreting the sociology as well as the biology of health, (2) expanding the horizons of medicine to incorporate health improvement as well as disease cure, (3) training for population-based health care at the community level, and (4) learning to assess medical outcomes with more than biometric measures to include measurements of functioning and well-being. The author presents in detail a health input–output model to show the complex interrelationships of socio-ecologic (i.e., outside) factors and the individual's genetic–biologic makeup (inside factors) that determine the individual's state of health. *Acad. Med.* 67(1992):724–731.

The advancing knowledge and the improved technology within the field of medicine and the natural sciences are forces expanding the curriculums of medical schools. However, changes occurring outside the medical field will have a greater impact on medical education.

In the past, physicians' education in the United States was formulated and developed by the medical school and the teaching hospital, which together emphasized basic biomedical sciences and supervised clinical experience.[1] In the future, it is more likely that the health needs of the population will be a major factor in determining physicians' education. To meet new needs, the hospital's inpatient service as the predominant site for clinical education will be replaced by or at least supplemented with a new venue, and the physician's purview will expand to include not only individual care but also community or population-based care. Medical education and health care will be based on a new formulation that joins the natural sciences with the social sciences. That is, an individual's health is the result of an interaction between his genetic make-up and molecular processes—his biology—and his total physical and social environment.*

Four Changes That Can Affect Medical Education

At least four health-related changes occurring in today's world have an impact upon the medical education curriculum as it is now known. None of these changes should be viewed separately, but inherent in each of them is a unique set of implications for training physicians in new ways. These health-related changes include

1. The reconceptualization of the word *health*
2. An increase in the number and range of different health improvement strategies
3. Growing awareness of the relatively low health status of the U.S. population in contrast to high U.S. health care expenditures
4. Shifts in the causes of illness and death

Reconceptualization of the Meaning of *Health*

In the past half century, the concept of health has shifted from a negative to a positive definition. *Health*, once defined as the absence of disease, has been reconceptualized to mean a positive state of well-being. The 1947 Constitution of the World Health Organization states: "*Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.*"[2]

This definition has become a watershed of ideas on the concept of health, and at least three fundamental ideas about health have emerged since that time:

1. Health is a capacity, a relative ability to perform, and a continuous variable to measure.
2. Health is the use of that capacity to achieve expectations defined in terms of values, tasks, and individualized fulfillment.
3. Individual capacities and expectations operate to negotiate the demands of the social and physical environment.

Health is seen as a state of well-being required by an individual to

A preliminary version of this essay was presented as a lecture at the University of Chicago Centennial Conference, "The Future of American Medical Education: The Legacy of Lowell T. Coggeshall," held October 17–18, 1991.

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*The use of *his* has no sexist intent and was employed for clarity.

Health of the Public
An Academic Challenge

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March 22, 1993

Kristine Gebbie, R.N., M.N.
606 Lilly Road, N.E., #723
Olympia, Washington 98506

Dear Kris,

As you know, the Health of the Public Program Advisory Board will meet in Boston on April 15 and 16, 1993. The meeting will be held at the Omni Parker House Hotel, 60 School Street, Boston, MA 02108 (phone: [617] 227-8600), starting with continental breakfast at 7:30 a.m. on Thursday, April 15, and concluding at 3 p.m. on Friday, April 16. We will be sending you a letter soon that includes an agenda and a confirmation of the reservations that we have made for you at the hotel. If you have any questions about the arrangements for the meeting, please call the San Francisco Program Office, (415) 476-8907.

The Program Office received 55 proposals in response to our solicitation. After review, we have determined that 41 of the proposals have sufficient merit to be reviewed and discussed by the Board in April. With this letter, we have included the materials that you will need to participate in the review process.

As we discussed, because you will not be able to join us at the first day of the meeting in Boston, we have enclosed four proposals for your information. Also enclosed are a list of submitted proposals, the executive summaries from the 41 proposals to be reviewed, and a "structured reading guide" for your use, if you wish to record salient observations about each proposal as you read. The reading guide reflects the structure and contents of our RFP, including required elements and priority areas.

When you arrive at the Advisory Board meeting on April 16, your colleagues on the Board should have already created a ranked list of the proposals on the basis of their initial reviews, discussion, and priority scores. This list will still be subject to revision, but should have succeeded in identifying three groups of proposals: those highly likely to be approved and funded, those unlikely to be approved and funded, and a third group whose ultimate status has not yet been determined.

On the basis of your reading of the executive summaries, we will ask you to raise any questions you may have regarding the placement of any school in each of these groups. Misclassifications that inappropriately put a school into the "no further consideration" group are especially important to avoid. The principal work of the second day will be to develop a consensus on what additional information is needed for each of the schools still in the running. It is this information we will use to shape our correspondence, site visits, or other forms of inquiry in order to provide information for the Board's further consideration leading to final recommendations in June.

Thank you for your continuing efforts on behalf of the Health of the Public Program. Please call if you have any questions or suggestions about these matters.

Best regards,

Thomas S. Inui, Sc.M., M.D.

Jonathan A. Showstack

Enclosures

Confidential

Health of the Public Proposals

Sorted by Mean Score

Rank	ID	Name of AHC	Scores			Mean	Request	Cum. Req.*
			Prim.	Sec.	P.O.			
1	79	Univ. of North Carolina at Chapel Hill	1	1	3	**1.7**	$402,472	$402,472
2	42	Johns Hopkins University	1	1	4	**2.0**	$454,467	$856,939
3	66	Morehouse School of Medicine	1	2	3	**2.0**	$449,164	$1,306,103
4	37	University of Illinois at Chicago	2	1	4	**2.3**	$448,877	$1,754,980
5	97	University of South Carolina	1.2	2	4	**2.4**	$433,938	$2,188,918
6	19	Columbia University	2	2	5	**3.0**	$411,873	$2,600,791
7	49	Loyola University of Chicago	2	3	4	**3.0**	$334,466	$2,935,257
8	55	McMaster University	1	5	3	**3.0**	$300,000	$3,235,257
9	94	Rush-Presbyterian-St. Luke's Med Ctr	2	4	3	**3.0**	$477,400	$3,712,657
10	111	Tufts University	2	3	4	**3.0**	$293,409	$4,006,066
11	40	University of Iowa	1	3	5	**3.0**	$300,000	$4,306,066
12	71	University of New Mexico	1	3	5	**3.0**	$435,589	$4,741,655
13	121	University of Washington	2	4	4	**3.3**	$451,998	$5,193,653
14	56	Meharry Medical College	2	4	4	**3.3**	$323,010	$5,516,663
15	69	U. of Medicine and Dentistry of NJ	5	2	3	**3.3**	$438,191	$5,954,854
16	64	University of Missouri, Columbia	3	5	2	**3.3**	$400,656	$6,355,510
17	107	University of Texas, Galveston	3	3	4	**3.3**	$307,832	$6,663,342
18	41	Thomas Jefferson University	3	4	4	**3.7**	$324,879	$6,988,221
19	89	University of Pennsylvania	7	2	2	**3.7**	$360,682	$7,348,903
20	127	Wright State University	3	4	4	**3.7**	$450,006	$7,798,909
21	15	Case Western Reserve University	4.5	3	4	**3.8**	$308,256	$8,107,165
22	90	University of Pittsburgh	1	9	2	**4.0**	$297,542	$8,404,707
23	129	Yeshiva University (Einstein)	5	3	4	**4.0**	$300,000	$8,704,707
24	74	City University of N. Y. (Mt. Sinai)	7	4	2	**4.3**	$485,861	$9,190,568
25	39	Indiana University	5	5	3	**4.3**	$336,301	$9,526,869
26	17	University of Cincinnati Medical Center	2	7	4	**4.3**	$441,131	$9,968,000
27	61	University of Minnesota	4	4	5	**4.3**	$366,858	$10,334,858
28	104	University of Tennessee, Memphis	3	5	5	**4.3**	$306,300	$10,641,158
29	83	Northeastern Ohio Universities	5	5	4	**4.7**	$425,042	$11,066,200
30	26	Emory University	5	4	5	**4.7**	$447,321	$11,513,521
31	16	University of Chicago	6	2	6	**4.7**	$304,409	$11,817,930
32	70	U. of Med. and Dentistry of NJ (RWJ)	8	3	5	**5.3**	$304,608	$12,122,538
33	43	University of Kansas Med Center	5	7	4	**5.3**	$304,460	$12,426,998
34	117	University of Virginia	4	7	5	**5.3**	$404,288	$12,831,286
35	84	Ohio State University	6	6	5	**5.7**	$270,541	$13,101,827
36	23	Dartmouth-Hitchcock Med Center	6	8	4	**6.0**	$379,068	$13,480,895
37	30	Georgetown University Med Center	8	7	3	**6.0**	$300,000	$13,780,895
38	11	UCLA/Drew	9	4	5	**6.0**	$412,850	$14,193,745
39	29	George Washington Univ. Med Center	10	4	5	**6.3**	$297,500	$14,491,245
40	22	Creighton University	5	9	6	**6.7**	$300,000	$14,791,245
41	109	University of Texas, San Antonio	8	8	6	**7.3**	$352,465	$15,143,710

Prim: Score of primary reviewer

Sec: Score of secondary reviewer

P.O.: Score of Program Office

* The total allocation for grantees is $6.15 million.

Revised 4/14/93

BIOGRAPHICAL SKETCH OF JOHN ROBERT EVANS

Born in Toronto October 1, 1929. Educated University of Toronto Schools and University of Toronto. M.D. 1952. Rhodes Scholar to Oxford University, D.Phil 1955. Residency training in clinical medicine and cardiology in Oxford, London, England, and Toronto leading to F.R.C.P. (C) 1958. Post doctoral experience in myocardial metabolism at Harvard Medical School 1960. Elected Fellow, American College of Physicians, 1960.

Founding Dean, Faculty of Medicine, McMaster University, Hamilton, 1965 to 1972. Vice President, Health Sciences, 1967 to 1972. Member of Council, Medical Research Council of Canada.

President, University of Toronto, 1972 to 1978. Academic appointment as Professor in the Department of Medicine.

Member of Pepin-Robarts Commission on National Unity, 1977-78.

Defeated Liberal Candidate in Federal By-election in Rosedale, October 1978.

International study of public health and population-based medicine, financed by The Rockefeller Foundation, January to September 1979.

Director, Population, Health and Nutrition Department, a new Department of the World Bank, Washington, D.C., from 1979 to 1983.

In 1983, he returned to Toronto as Chairman and CEO of Allelix Inc., a biotechnical research and development company. He is currently Chairman of the derivative company, Allelix Biopharmaceuticals Inc.

Membership in professional organizations included Member of Council of the Royal College of Physicians and Surgeons of Canada, 1972 to 1978. Regent of the American College of Physicians, 1973 to 1975. Member of Council of the Institute of Medicine of the U.S. National Academy of Sciences, 1976 to 1980. Member, Advisory Committee on Medical Research of the World Health Organization, 1976 to 1980 and expert advisory panel on cardiovascular diseases of the World Health Organization, 1972-. Chairman of the National Biotechnology Advisory Committee of Canada, 1983 to 1988. Chairman of the Ontario Health Review Panel established by the Premier of Ontario, 1987. Chairman, Commission on Health Research for Development, an international, independent Commission 1987-1990. Chairman, Pew Charitable Trusts Program Advisory Committees on International Health Policy, Health of the Public , and Global Strategy Initiative on Population and Consumption.

Member, Ontario Premier's Council on Health, Well-being and Social Justice. Member, Joint Management Committee of Ontario Ministry of Health and Ontario Medical Associates. Fellow, Royal College of Physicians, London, and Lilly Lecturer, 1986. Honourary Fellow, University College, Oxford and London School of Hygiene and Tropical Medicine, June 1988. Fellow, Royal Society of Canada, April 1989. Master, American College of Physicians. Honorary degrees from several Canadian universities, Yale and Johns Hopkins in the United States and Maastricht in the Netherlands and Companion of the Order of Canada, 1978. Wightman Award, Gardner Foundation, 1992.

Trustee, the Rockefeller Foundation since 1982 and Chairman, Board of Trustees since 1987. Trustee, Walter and Duncan Gordon Charitable Foundation since 1991. Past Chairman and Director, African Medical Research Foundation-Canada. Member, Board of Directors of several Canadian Corporations. President, Institute of Clinical Evaluative Sciences, 1992 -.

Married to Gay Glassco, 1954. Six children.

January 1993

Kristine M. Gebbie

Kristine M. Gebbie has served as the Secretary of the Washington State Department of Health since October 1989, when the agency was created. She previously served for 11 years as the Administrator of the Health Division of the Oregon Department of Human Resources.

Ms. Gebbie also serves or chairs several committees and task forces on public health issues, including:

- Chair of the U.S. Centers for Disease Control Advisory Committee on the Prevention of HIV Infection;
- Chair of the Environment, Safety and Health Advisory Committee of the U.S. Department of Energy;
- Member of the Secretary of Energy Advisory Board Task Force on Civilian Radioactive Waste Management;
- Member of the Comptroller General's Health Advisory Committee of the U.S. General Accounting Office;
- Member of the Advisory Committee for the Hanford Thyroid Disease Study of the U.S. Centers for Disease Control; and
- Member of the Editorial Board of the Journal of Public Health Policy.

Ms. Gebbie also is a member of the Institute of Medicine and is a fellow of the American Academy of Nursing. She has been the recipient of several awards, including, in 1991, the Mary Tolle Wright Award for Excellence in Leadership from Sigma Theta Thau International, the international nursing society.

Ms. Gebbie is an adjunct assistant professor at the University of Washington School of Public Health and Community Medicine and the School of Nursing, and at the Oregon Health Sciences University School of Nursing.

Ms. Gebbie holds a Bachelor of Science degree in nursing from St. Olaf College in Minnesota and a Master's degree in nursing from the University of California, Los Angeles. In addition, Ms. Gebbie is a candidate for a Doctoral degree in Public Health in the PEW Doctoral Program in Health Policy at the University of Michigan.

Biographical Sketch for Thomas S. Inui

Thomas S. Inui acquired his Bachelor's Degree in Philosophy from Haverford College, and completed the MD and Masters of Science in Public Health curriculum at the Johns Hopkins University School of Medicine and School of Public Health and Hygiene (1969 and 1973, respectively). At the Johns Hopkins Hospital 1969-74), he served as an intern, resident, and chief resident in internal medicine and was a Carnegie Commonwealth Clinical Scholar (1971-73). After a period of national service as Chief of Medicine at the US Public Health Service Indian Hospital in Albuquerque, New Mexico, he assumed responsibility for the development of a General Internal Medicine staff section at the Seattle VA Medical Center and for the directorship of the VA Health Services Research and Development Program for the Pacific Northwest (1976-86). From 1977-92 Dr. Inui served as Director of The Robert Wood Johnson Clinical Scholars Program, a graduate research fellowship for physicians in non-biologic sciences. In the interval 1986-92, he was Division Head for General Internal Medicine, Department of Medicine, at the University of Washington. By the end of his tenure, this Division had developed major programs in primary care internal residency training, research fellowships for general internists (peaking at 28 fellows per year), clinician/teacher and clinician investigator faculty (more than 80 geographic full-time total faculty in 1992), and special concentrations of excellence in occupational medicine, emergency medicine, cardiovascular clinical epidemiology, clinical health services research, technology assessment, and clinical ethics. In 1992 he assumed responsibility for a new Harvard Medical School/Harvard Community Health Plan department (Ambulatory Care and Prevention), which will oversee community-based ambulatory care education for all HMS medical students and provide oversight for a second-year required course in prevention. Dr. Inui's special emphases in teaching and research have included physician/patient communication, health promotion and disease prevention, the social context of medicine, and medical humanities. His honors include membership in Phi Beta Kappa, Alpha Omega Alpha, a USPH Medal of Commendation, University of Washington recognition award for teaching excellence, serving as a member of the Council and President of the Society of

General Internal Medicine, and election to the Institute of Medicine. His academic appointments are as a Professor of Ambulatory Care and Prevention and Professor of Medicine at the Harvard Medical School. He has participated in the publication of more than 120 manuscripts on a broad variety of topics.

WILLIAM N. KELLEY, M.D.
Biographical Sketch

Dr. William N. Kelley was born in Atlanta, Georgia in 1939 and grew up in Atlanta and Palm Beach, Florida. Following graduation from Palm Beach High School, he attended undergraduate school and medical school at Emory University in Atlanta, receiving the M.D. degree in 1963. As a medical student he was elected to membership in Alpha Omega Alpha and he received the C.V. Mosby Award for scholastic excellence.

Following two years of training in Internal Medicine at the University of Texas Southwestern Medical School and Parkland Memorial Hospital in Dallas, he joined the staff of National Institutes of Health as a Clinical Associate in the Arthritis and Rheumatism Branch. During his two years in the laboratory of Dr. J. E. Reegmillor, Dr. Kelley played a major role in the discovery of complete hypoxanthine phosphorlbosyltransferase (HPRT) deficiency in patients with the Lesch-Nyhan syndrome, of partial HPRT deficiency in some patients with gout and of adenine phosphorbosyltransferase deficiency in patients with 2.8 dihydroxyadenine kidney stones. Based on this work, he received the John D. Lane Award of the United States Public Health Service, and he was the co-recipient of the first Geigy International Prize of Rheumatology. Following completion of his work at the National Institutes of Health, he finished his clinical training at the Massachusetts General Hospital and the Harvard Medical School, where he was Senior Resident in Medicine.

In 1968, Dr. Kelley joined the faculty at Duke University Medical Center. Over the next seven years he rose through the ranks to Professor of Medicine, Associate Professor of Biochemistry and Chief of the Division of Rheumatic and Genetic Diseases. Awards received while on the faculty at Duke include the Clinical Scholar Award of the American Rheumatism Association, a Research Career Development Award from the NIH, the Heinz Karger Memorial Foundation Prize, and the Josiah Macy Foundation Scholar Award. The latter award supported his position as Visiting Professor in the Sir William Dunn School of Pathology at Oxford University, Oxford, England, in 1974 and 1975.

Dr. Kelley assumed the position as the John G. Searle Professor and Chairman of the Department of Internal Medicine and Professor of Biological Chemistry at the University of Michigan in Ann Arbor, Michigan in 1975. He served in this role until October 1, 1989. On October 1 Dr. Kelley assumed his current position as Executive Vice President of the University of Pennsylvania with responsibilities as Chief Executive Officer for the Medical Center and Dean of the School of Medicine.

Over the years, Dr. Kelley has played an important personal role in research, patient care, and teaching. At the time of his

move to take the position as Executive Vice President and Dean at Penn, he had served continuously as a Principle Investigator on Investigator initiated (RO-1) grants from the NIH, Principal Investigator on the Michigan Multipurpose Arthritis Center, which was funded at a level in excess of $1,000,000 per year, and as Principal Investigator on the Program Project proposal entitled "Experimental Models of Gene Therapy" which was the first program project funded by the NIH in the field of gene therapy. Over the years he had served as a regular member of several NIH study sections, as a member of the National Advisory Council of the NIADDK, and later the NIDDK, and as a member of the Director's Advisory Council at the NIH. Most recently, he has served as a member of the Human Gene Therapy Subcommittee as well as of the parent Recombinant DNA Advisory Committee (RAC) of the NIH. He had served as a member of the editorial boards of 12 different medical journals including The Journal of Clinical Investigation, the Journal of Biological Chemistry, The Annals of Internal Medicine and Medicine. His bibliography lists in excess of 230 publications as well as 8 books. He has been asked to participate in a number of Visiting Professorships, he has been selected to memberships in several honorary societies, and he has served as faculty advisory and/or counselor to a number of medical student societies, including AOA. He was also selected by the medical students at the University of Michigan to receive the prestigious "Golden Shovel" Award for outstanding teaching. He is the founder and senior editor of The Textbook of Rheumatology, which is now in its 3rd edition, and he is the founder and Editor-in-Chief of The Textbook of Internal Medicine, published in its first edition in December 1988. In the practice area, he has been named as one of America's outstanding physicians by both Good Housekeeping and Town and Country.

In the national leadership arena, Dr. Kelley has had an opportunity to serve in several capacities. He has served as President of the American Federation for Clinical Research, President of the American Society for Clinical Investigation, President of the American College of Rheumatology, Chairman of the American Board of Internal Medicine, President of the Central Rheumatism Society, President of the Central Society for Clinical Research and Vice-Chairman of the Federated Council of Internal Medicine. In addition, he served as Secretary-Treasurer of the Association of Professors of Medicine. He is presently Chairman-elect of the Residency Review Committee in Internal Medicine. Based on his contributions to American Medicine, he was elected to membership in the Institute of Medicine of the National Academy of Sciences where he now serves as Chairman of Section 4 (Internal Medicine, Dermatology and Pathology) and as Chairman of the Membership Committee, he received the Distinguished Medical Achievement Award from the Medical Alumni Association of Emory University, and he was named a Master of the American College of Physicians. In 1990, he received the John Phillips Memorial Award and medal of the American College of Physicians for his contributions to American medicine.

MI JA KIM, RN, PhD, FAAN

Mi Ja Kim, RN, PhD, FAAN, is currently Professor and Dean of the College of Nursing at the University of Illinois at Chicago. Dr. Kim received her B.S.N. from Yon Sei University, Seoul, Korea and her Ph.D. in Physiology from the University of Illinois at Chicago.

Dr. Kim is a noted researcher and scholar, having received funding as Principal Investigator, "Nurse managed inspiratory muscle training of COPD patients," "Training in biologically based nursing research" (an institutional pre- and post-doctoral research training grant) from the National Center for Nursing Research of the National Institutes of Health, and "Increasing Minority Representation through Educating and Developing Youth (I'M READY)" from the Robert Wood Johnson Foundation. She was one of eighteen chartered members of the Study Section for reviewing proposals submitted to NCNR and served for four years in this capacity. She has served as the Secretary General, Global Network of the World Health Organization (WHO) Collaborating Centres for Nursing and Midwifery Development. She has been a member of the Board of Directors for the Chicago Lung Association, Chicago Heart Association and the North American Nursing Diagnosis Association, and has been active in research and education of nursing diagnoses since its inception. She has numerous articles published in the area of respiratory physiology and nursing diagnoses as they impact on the nursing profession and was an invited member to the first Minority Congress sponsored by the Division of Nursing, Department of Health & Human Services.

She has received numerous awards and honors including the University Scholar Faculty Excellence Award, University of Illinois; Book of the Year Award, American Journal of Nursing for: Classification of Nursing Diagnoses: Proceedings of the Fifth National Conference and Pocket guide to nursing diagnosis; She was a Distinguished Lecturer, Sigma Theta Tau International Honor Society of Nursing; Recipient of the Award for Outstanding Contributions to Nursing Diagnosis for NANDA; for "Meritorious Service in the Fight Against Heart Disease" from the Chicago Heart Association; and for Women's Honors in Public Service from Minority Fellowships Programs and Cabinet on Human Rights of the American Nurses Association. Dr. Kim was listed in the Chicago Tribune as one of the 100 Most Influential Women in Chicago in 1991.

Dr. Kim is known nationally and internationally for her scholarly approach and her unfailing devotion to nursing education, practice, research and health care issues.

WILLIAM J. LINDER, Ph.D.
233 W. Market Street, Newark, NJ 07103
(201) 623-2800 Fax (201) 482-2137

William J. Linder is a Catholic priest and Pastor of St. Rose of Lima Parish, an inner city parish in Newark, New Jersey. He received his Bachelor of Arts degree from Seton Hall University and his Ph.D. from Fordham University. His dissertation is **An Urban Community Development Model.** He has attended Centro Intercultural de Documentacion (CIDOC), Cuernavaca, Mexico and has taken engineering courses at Manhattan College and business and real estate courses at Wharton School, Institute for Professional and Executive Development, Rutgers University, and the National Real Estate Development Center in Washington, D.C.

In 1966, Linder founded and presently directs the New Community Corporation, one of the largest community development corporations in the United States, which provides economic development, housing, education, health care, social services, day care to a poor urban minority population.

His experience includes board memberships and chairmanships of over two dozen organizations, committees, and task forces in housing, finance, education, planning, and social concerns at levels up to and including the national.

Linder has over twenty years experience as a planner, dating back to a term as senior planner in the Essex County Planning Office (1970-75), continuing as a member of the Criminal Justice Planning Board - Essex County (1974-77); and Director of Research and Planning - Archdiocese of Newark (1976-79). Involvements from 1981 to the present include memberships on: Advisory Board of the N.J. State Planning Commission; N.J. Commission on Employment and Training; Task Force on At-Risk Youth; and the Governor's Committee on Children's Services Planning; member/chairman of United Hospitals Medical Center Board of Trustees. He is a member of the New Jersey Housing and Mortgage Finance Agency; President of the N.J. Housing Assistance Corporation; Chairperson of the Affordable Housing Council for the New York Federal Home Loan Bank; and in 1993, member, National Advisory Committee, Health of the Public.

His accomplishments have generated awards as well, including: **New Jersey Pride Award for Community Development - 1987; The Governor's Gold Medal - 1990; Person of the Week: ABC World News Tonight - 1990; William M. Ashby Community Service Award - 1991; The Human Dignity Award from Kessler Institute - 1991; Leadership in Community Service Award from Rutgers University - 1991.**

The latest of Msgr. Linder's honors include the **John D. and Catherine T. MacArthur Foundation Fellows Award, June 1991; Honorary Doctor of Laws, Seton Hall University, New Jersey, May 18, 1992; and Honorary Doctor of Laws, Bloomfield College, New Jersey, May 28, 1992;** Face of Hope at the presidential inauguration (1/93); **Victoria Fellowship - Rutgers University (1993).**

3/93

BIOGRAPHY OF RUSSELL L. MILLER, M.D.

On November 16, 1990, Dr. Russell L. Miller, vice president for health affairs, became a senior vice president at Howard University in Washington, D. C. As senior vice president, Dr. Miller assumes the responsibilities of the president of the university in his absence.

As vice president for health affairs since 1988, Dr. Miller oversees the most comprehensive health sciences complex in the District of Columbia. Its components include Howard University Hospital; five colleges--Allied Health Sciences, Dentistry, Medicine, Nursing, and Pharmacy and Pharmacal Sciences; two major research centers (focusing on cancer and sickle cell disease); and a student health center.

He began his career in the College of Medicine at Howard in 1974 as an associate professor and director of the clinical pharmacology program in the departments of pharmacology and internal medicine, and also served, from 1977 to 1979, as director of research in the department of internal medicine. He was made a full professor in 1979, the same year he was named the college's dean. He served as dean for nine years before becoming a vice president.

Dr. Miller received his B.S. from Howard in 1961 and his M.D. in 1965. In between his years as a Howard student and a Howard teacher/administrator, he was an intern and resident at the University of Michigan Medical Center in Ann Arbor, Michigan; a research fellow at the Cardiovascular Research Institute attached to the University of California's department of internal medicine in San Francisco; and a visiting scientist at the Roche Institute of Molecular Biology in Nutley, New Jersey.

From 1969-71, he served as a major in the U.S. Army, holding the positions of acting hospital commander, chief of professional services, and chairman of internal medicine at a surgical hospital in Vietnam. His services earned him a Bronze Star.

Through the years, Dr. Miller has held membership and leadership positions in numerous professional and governmental organizations. Presently, he serves on the Executive Board of the National Board of Medical Examiners and on the Board of Directors of the Association of Academic Health Centers. He has written or coauthored more than 60 articles or abstracts.

Gordon T. Moore MD, MPH

Dr. Moore is a graduate of Harvard College and Harvard Medical School. He did his residency training in Internal Medicine at the Massachusetts General Hospital, after which he received a Masters in Public Health from the Harvard School of Public Health. He served as the Director of Evaluation at the Bunker Hill Health Center until 1972, at which time he joined the Harvard Community Health Plan (HCHP) as a health center director. From 1979 to 1983, he served as the Plan's Medical Director and Chief Operating Officer. HCHP is the country's largest and oldest academically affiliated HMO. In 1983, Dr. Moore became the Director of Teaching Programs at HCHP and, shortly thereafter, The Director of the New Pathway Project at Harvard Medical School, a position he held until late 1987. In that capacity, he was responsible for the design and administrative direction of Harvard's new curriculum. He directed a federal grant to evaluate the New Pathway curriculum from 1988 to 1991. Dr. Moore is the outside evaluator for the Health of the Public Program of the Rockefeller Foundation and the Pew Charitable Trusts and is the project director of the evaluation of the Robert Wood Johnson's initiative for "Preparing Physicians for the Future."

Dr. Moore is currently the Director of Teaching Programs at the Harvard Plan, which is playing an increasing role in designing and delivering innovative educational programs for Harvard's medical students, post-graduate trainees, and CME for practicing physicians. Dr. Moore is a graduate of the Advanced Management Program at Harvard and is an Associate Professor of Medicine at the medical school.

BRIGHAM AND WOMEN'S HOSPITAL

H. Richard Nesson, M.D.
President

75 Francis Street
Boston, Massachusetts 02115
(617) 732-5503

BIOGRAPHICAL SKETCH

H. Richard Nesson, M.D., has been President and Chief Executive Officer of Brigham and Women's Hospital since 1982. He first joined the hospital in 1976 as Director of Ambulatory Services and was named Vice President of Ambulatory and Community Health Services in 1979.

Dr. Nesson holds a Bachelor's degree from Harvard College and graduated cum laude from Boston University School of Medicine. He completed his internship and residency at Beth Israel Hospital in Boston, and was a research and teaching fellow in nephrology at the Boston University School of Medicine.

Dr. Nesson has a long record of innovations in health care management, having been an originator and the first Medical Director of the Harvard Community Health Plan. From 1979-1982 he also directed the Teaching Hospital General Medical Group Practice Program, a grant program established by the Robert Wood Johnson Foundation to improve hospital ambulatory services at 15 sites nationwide.

He was appointed an Associate Professor of Medicine at the Harvard Medical School in 1972 and a Professor of Medicine in 1990. During the past 15 years, he has visited Britain, Sweden, Israel, the Soviet Union, Japan and the People's Republic of China to study their health care delivery systems, and has applied this broad knowledge to the development of cost-effective ambulatory programs in the United States.

Dr. Nesson has served as a Director of the Massachusetts United Way. He currently is a member of the Policy Advisory Committee of the Supreme Judicial Court. He serves on the Board of Directors of the Risk Management Foundation of the Harvard Medical Institutions, the Academic Medical Center Consortium and the Health of the Public, a program of the Pew Charitable Trusts and the Rockefeller Foundation. He currently serves as chairman of the Harvard Medical Center AIDS Committee and as Treasurer of the Executive Committee of the Massachusetts Hospital Association.

June E. Osborn, M.D.

Dr. June Osborn received her undergraduate degree from Oberlin College and an M.D. from Case Western Reserve University in 1961. After training as a pediatrician at Harvard hospitals and as a virus researcher and infectious disease specialist at Johns Hopkins and the University of Pittsburgh, she joined the faculty of the University of Wisconsin Medical School in 1966. In 1984, she was chosen by the University of Michigan to become Dean of the School of Public Health. She is also Professor of Epidemiology in that school and Professor of Pediatrics and Communicable Diseases in the Medical School.

Dr. Osborn has played advisory roles for the U.S. Public Health Service since the early 1970s and has been involved in both scientific and policy developments since the outset of the AIDS epidemic. She chaired the NIH advisory committee on AIDS and the U.S. blood supply from 1984 until 1989, and also chaired the AIDS Health Services Advisory Committee for the Robert Wood Johnson Foundation from 1986-1990. She is a member of the Global Commission on AIDS of the World Health Organization, and since 1989 has served as the chairwoman of the U.S. National Commission on AIDS.

CONDENSED CV: SHEILA A. RYAN, PH.D., R.N., F.A.A.N.

Dr. Sheila A. Ryan received her Ph.D. from the University of Arizona and has held positions as Assistant Professor, Acting Dean, Associate Professor and Dean of Nursing at Creighton University in Omaha, Nebraska. At present, she is Dean and Professor at the School of Nursing and Director, Medical Center Nursing at the University of Rochester.

Dr. Ryan has developed and conducted numerous funded research projects, and has published extensively in books and journals about faculty practice, computer systems and future models of alternative delivery systems; she has lectured and consulted nationally and internationally. Dr. Ryan serves on many Boards of Directors of community and health related organizations, locally, regionally and nationally. She is considered one of the nursing profession's national orators.

Dr. Ryan is a Fellow of the American Academy of Nursing and a member of Sigma Theta Tau, International Honor Society for Nursing, and was recently elected to the Institute of Medicine. She was a member of the Curriculum Revolution Ad-Hoc Committee of the National League for Nursing. Currently, she is a member of the Pew Health Professions Commission, and Commonwealth Fund Program Director for the Executive Nurse Fellowship Program.

7/92

KENNETH I. SHINE

BIOGRAPHICAL SKETCH

Kenneth I. Shine, M.D., is President of the Institute of Medicine, National Academy of Sciences, and Professor of Medicine Emeritus at the University of California, Los Angeles (UCLA) School of Medicine. He is UCLA School of Medicine's immediate past Dean and Provost for Medical Sciences.

Both a cardiologist and a physiologist, Dr. Shine received his A.B. from Harvard College and his M.D. from Harvard Medical School. Most of his advanced training was at Massachusetts General Hospital (MGH), where he became Chief Resident in Medicine. Following his postgraduate training at MGH, he held an appointment as Assistant Professor of Medicine at Harvard Medical School. He moved in 1971 to the UCLA School of Medicine and became Director of the Coronary Care Unit, Chief of the Cardiology Division, and subsequently, Chair of the Department of Medicine. As Dean at UCLA, Dr. Shine stimulated major initiatives in ambulatory education, community service for medical students and faculty, mathematics and science education in the public schools, and the construction of new research facilities funded entirely by the private sector.

Dr. Shine is a member of many honorific and academic societies, including Phi Beta Kappa and Alpha Omega Alpha, Fellow of the American College of Cardiology and American College of Physicians, and was elected to the Institute of Medicine in 1988. He served as Chairman of the Council of Deans of the Association of American Medical Colleges from 1991-1992, and was President of the American Heart Assocation from 1985-1986.

Dr. Shine's research interests include metabolic events in the heart muscle, the relation of behavior to heart disease, and emergency medicine. He participated in efforts to prove the value of cardiopulmonary resuscitation following a heart attack, and in establishing the 911 emergency telephone number in the multijurisdictional Los Angeles area. Dr. Shine is the author of numerous articles and scientific papers in the area of heart physiology and clinical research.

EDWARD J. STEMMLER, M.D.

Edward J. Stemmler is Executive Vice President of the Association of American Medical Colleges (AAMC), an organization in which he had been an active volunteer since 1976, serving as Chairman of the Assembly, the Association's highest elected official, 1986-87.

After earning a B.A. from La Salle College in Philadelphia and serving with the U.S. Army Chemical Corps in Korea, Dr. Stemmler graduated first in his class from the University of Pennsylvania School of Medicine. Today he holds honorary degrees from Ursinus, La Salle College, Rush University, and Philadelphia College of Pharmacy and Science.

Dr. Stemmler completed an internship and residency in Medicine and a fellowship in Cardiology at the Hospital of the University of Pennsylvania and received an NIH postdoctoral fellowship in Pulmonary Physiology. Appointed an Instructor in Medicine at Penn in 1964 and Professor in 1974, Dr. Stemmler also took on many administrative duties. He served for six years as Chief of Medicine on the University Medical Service at the VA Hospital in Philadelphia.

Dr. Stemmler was appointed as Acting Dean of the School of Medicine in 1974 and Dean in 1975 and served in that capacity until 1988. In 1981 he became the first incumbent of the Dunlop Professorship. In 1986 he was named Executive Vice President of

a new University entity, the Penn Medical Center, which includes the Medical School, the University Hospital and the Clinical Practices and served in that capacity until 1989. He was named "Dean Emeritus" of the University of Pennsylvania Trustees in 1989. He began his responsibilities at the AAMC on July 1, 1990.

Under Dr. Stemmler's tenure as Dean, innovative academic policies and programs were developed. He led the establishment of the Clinical Practices of the University of Pennsylvania and the Clinician Educator Faculty line. Academic and institutional planning systems were developed and the School of Medicine at Penn prospered. He also led the tremendous growth in biomedical research and in the construction and modernization of academic, research and clinical facilities. Throughout his career he has been a strong advocate for medical students and medical education.

Dr. Stemmler has extensive professional activities beyond his responsibilities in regional and state organizations. Among those of note, he is currently Chairman of the National Board of Medical Examiners; a Master of the American College of Physicians; and a member of the Institute of Medicine of the National Academy of Sciences.

May, 1992

Biographical Sketch for Zoila Torres Feldman

Zoila Torres Feldman is the Executive Director of the Great Brook Valley Health Center in Worcester, Massachusetts, a position she has held since 1983. She obtained her Nursing Degree from St. Elizabeth Hospital School of Nursing, Youngstown, Ohio, acquired her Bachelor's Degree in Liberal Studies from Boston University, and completed her Masters of Science in Health Policy and Management at Harvard School of Public Health, Boston, Massachusetts (June 1979). At St. Elizabeth Hospital she was a Staff Nurse in Medical-Surgical Ward (1967-1968). In the interval 1968-1980 she was a Staff Nurse in the Clinical Research Unit and a Nurse Epidemiologist in Medullary Carcinoma Protocol at Tufts-New England Medical Center, Boston, Massachusetts. From 1980-1983 she served as Director of Professional Services and Director of the Great Brook Valley Health Center.

Her honors include Summa Cum Laude (1975), four-year Scholarship and Best Clinical Nurse Award (1967), Outstanding Massachusetts Health Center Director Award (1987) and Kathleen Crampton Award (1990) from the Massachusetts League of Community Health Centers, Recognition Award for Leadership from the City of Worcester and the State of Massachusetts (1980), Recognition Award from the Massachusetts Public Health Association (1991).

She has served as a member of the Board of Directors for a number of organizations and currently is on the Boards of the Greater Worcester Community Foundation and the Massachusetts League of Community Health Centers. She has also served as a member of multiple Advisory Task Forces, Advisory Committees and Advisory Councils on issues of Primary Care, Reimbursement, and Systems Development. She presently Co-chairs the Massachusetts Department of Public Health Task Force on Prevention of Low Birthweight and Infant Mortality and is on the seven member Hospital Payment System Advisory Commission (HospPAC), an appointment by Governor Weld.

Ms. Feldman has made several presentations on community health and health policy and has authored or co-authored scientific publications. She recently co-authored an article in the National Institute on Drug Abuse (NIDA) Research Monograph 127 on the Development and Implementation of an Interorganizational Case Management Model for Substance Users.

BIOGRAPHICAL SKETCH

BAILUS WALKER, JR., Ph.D., M.P.H.

Dr. Walker is currently a Professor of Occupational and Environmental Health and the Dean of the College of Public Health at the University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.

From May 1987 to July 1990, he served as Professor of Environmental Health and Toxicology at the School of Public Health, State University of New York at Albany.

From June 1983 to May 1987, he served as Commissioner of Public Health for the Commonwealth of Massachusetts; prior to that he was the State Director of the Michigan Department of Public Health.

From 1979 to 1981, he was Director, Occupational Health Standards, OSHA, U.S. Department of Labor. Dr. Walker also served as Environmental Health Scientist and Administrator for the Environmental Health Services, District of Columbia 1972-1979.

Dr. Walker is a past President of the American Public Health Association, the oldest and largest organization of public health professionals in the world. He is a member of the U. S. Department of Health and Human Services Secretary's Council on Health Promotion and Disease Prevention and also serves on the National Academy of Sciences Commission to Study the Future of Public Health in the United States.

Dr. Walker was a member of the Physicians for Human Rights Mission to South Korea in June 1987 to study health effects of "crowd control chemicals." In August 1988, he was a member of the Mozambique Health Assessment Mission, a Ford Foundation project to study adverse health and environmental effects of violence and low-intensity warfare.

While heading the occupational health standards program for the Department of Labor, he was instrumental in the development of the nation's first policy for the classification and regulation of potential occupational carcinogens. He wrote the first federal hazards information rule deigned to inform workers of the chemical composition and hazards of workplace chemicals.

In the Labor Department assignment, he also headed the 1980 U.S. Exchange Mission to Japan on Collaborative U.S. - Japanese efforts in occupational medicine, a program established jointly by the U. S. Secretary of Labor and the Minister of Labor for Japan.

Dr. Walker holds a master's degree in occupational and environmental health from the University of Michigan, and a Ph.D. in occupational and environmental health at the University of Minnesota at Minneapolis where he graduated with honors. He is the recipient of numerous honors and awards, a member of Delta Omega--the Public Health Honor Society, and a Fellow, the Royal Society of Health (London, England). Dr. Walker was elected into the Institute of Medicine, National Academy of Sciences in 1990.

BIOSKETCH

William H. Wiese

Education: BA - Yale 1960
MD - Harvard 1964
MPH - Harvard 1971

Residency to Internal Medicine, Boston City Hospital 1964-69.

PHS: - NIM/NIAID Laboratory of Infectious Disease 1966-68

Fellowship: Harvard Center for Community Health and Medical Care: 1969-71

University of New Mexico,

Department of Family and Community Medicine, Faculty: 1971 - present
Department Chair: 1972-82
Director Division of Community Medicine: 1972 - present
Assistant Dean Medical Education: 1971-73

Also - Chair Curriculum Committee 1985 - present
AHEC Project Director: 1972 - present

Other:

US Preventive Services Task Force: 1984-89
Association of Teachers of Preventive Medicine, President: 1991-92.

HEALTH OF THE PUBLIC: AN ACADEMIC CHALLENGE

Addresses and Telephone Numbers

April 8, 1993

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Chairman, Dept. of Ambulatory Care and Prevention
Harvard Medical School/
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Orneata Prawl
Program Associate

Health of the Public
An Academic Challenge

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March 4, 1993

Kristine Gebbie, R.N., M.N., F.A.A.N.
Secretary
Department of Health
1122 S.E. Quince Street
Olympia, WA 98504

Dear Kristine:

Jon Showstack, John Evans, and I look forward with eager anticipation to the meeting of the Health of the Public Program Advisory Board in Boston on April 15-16, 1993 to review and select among the proposals submitted in response to our solicitation.

Our preliminary news about our solicitation is encouraging; fifty-five proposals have arrived at the national program office, suggesting that the Board's principal challenge will be to choose a substantial number of outstanding proposals from among the many in competition. The overall proposal review and selection process we will pursue is outlined in the enclosed internal document ("Proposal Review Process"). This approach was developed by the national program office in discussion with John Evans in his capacity as Chair of the Advisory Board and with representatives of the Pew Charitable Trusts and Robert Wood Johnson Foundation. This approach should allow the Advisory Board to concentrate your attention on a somewhat smaller group of "semi-finalists." Please expect to receive your proposal packet and review instructions in the third week of March.

We enclose the roster of Board members with this mailing. Please send a brief (no more than one page) autobiographical sketch now to the Health of the Program office in Boston. We will circulate this information to each member of the Advisory Board and use it to describe the Advisory Board to program participants.

Best regards,

TSI

Thomas S. Inui, Sc.M., M.D.

Enclosure

TSI/sm
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Health of the Public
Proposal Review Process

March 2

Proposals due at Program Office.

March 2-15

Proposals reviewed by Tom Inui and Jon Showstack. As many as 40 selected by Program Office on the basis of quality and appropriateness for review by Advisory Board; with others "Not recommended for further consideration (NRFC)." Proposals sent to Advisory Board and foundations.

March 16-April 8

As many as eight full proposals and 32 executive summaries sent to each member of the Advisory Board. Each Advisory Board member will be asked to be the primary reviewer on four proposals, secondary reviewer on four proposals, and to be familiar with the 32 executive summaries. Board members will be asked to score their primary and secondary reviews on a scale from one (best, ideal, no problems, absolutely recommend for funding) to 10 (worst, business as usual, NRFC), and to write a two-three paragraph critique of each primary review. (If review of a particular proposal presents a potential conflict of interest, the reviewer will be asked to exclude herself/himself from the review of that proposal.)

April 9

The four critiques and eight scores due at Program Office. Scores by primary and secondary reviewers (and by Inui and Showstack) compiled by Program Office to present in rank order at April 15th meeting.

April 15 - 16

Meeting of Advisory Board, Foundation representatives, and Program Office ("Review Group") to review proposals and make preliminary recommendations:

Category 1: Recommend funding
Category 2: Recommend deferral for further information/site visit
Category 3: NRFC

Meeting Agenda

Distribute list of preliminary scores and rank order. Discussion of each proposal (in order of preliminary ranking, from best to worse). Primary reviewer describes and critiques proposed program and indicates his/her degree of enthusiasm, whether additional information is needed, and priority score (with suggestion for level of funding, if appropriate). Secondary reviewer and Program Office provide additional comments and priority scores.
General discussion, focusing on whether the proposal should be Category 1 (recommended for funding), Category 2 (additional information sought), or Category 3 (NRFC).
Each voting member of review group writes his/her score and category 1, (recommended for funding), Category 2 (additional information sought), or Category 3 (NRFC) on summary sheet. Scores are tabulated by Program Office and revised rank order distributed to Review Group.
Further discussion to finalize rank order and placement of each proposal into one of the above three categories. For proposals in Category 1, decide approximate level of funding and, if recommended amount is lower than requested, which activities are to be funded. For proposals in Category 2, decide what additional information is needed and the methods of collecting the information (e.g., written questions and/or site visit).

April 16-May 15

Program Office formally communicates the results of the meeting to foundations and takes the following actions:

Category 1: Compile priority scores and assign tentative funding amount.
Category 2: Send letters requesting additional information and/or arrange site visits.
Category 3: Send regret letters to NRFCs.

May 21

Information due/site visits completed.
Program Office compiles and distributes information to each member of Review Group.

Early June

Conference call with Review Group to make final recommendations.

John R. Evans, M.D.
Chairman & Chief Executive Officer
Allelix, Inc.
Mississauga, Ontario

Zoila Torres Feldman, R.N., M.S.
Executive Director
The Greatbrook Valley Health Center
Worcester, MA

Kristine Gebbie, R.N., M.N., F.A.A.N.
Secretary
Department of Health
Olympia, WA

William M. Kelley, M.D.
Executive Vice President & Dean
School of Medicine
University of Pennsylvania
Philadelphia, PA

Mi Ja Kim, Ph.D.
Dean
College of Nursing
University of Illinois at Chicago
Chicago, IL

Rev. Msgr. William J. Linder, Ph.D.
Paster, Saint Rose of Lima Parish
Newark, N.J.

Russell L. Miller, Jr., M.D.
Vice President for Health Affairs
Howard University
Washington, D.C.

H. Richard Nesson, M.D.
President
Brigham & Women's Hospital
Boston, MA

June E. Osborn, M.D.
Dean, School of Public Health
University of Michigan
Ann Arbor, MI

Sheila Ryan, Ph.D., R.N., F.A.A.N.
Dean, School of Nursing
Director, Medical Center Nursing
University of Rochester
Rochester, N.Y.

Kenneth I. Shine, M.D.
President
Institute of Medicine
National Academy of Sciences
Washington, D.C.

Edward Stemmler, M.D.
Executive Vice President
AAMC
Washington, D.C.

Bailus Walker, Jr., Ph.D., M.P.H.
Dean, College of Public Health
University of Oklahoma
Oklahoma City, OK

William H. Wiese, M.D.
Director, Division of Community Medicine
University of New Mexico
Albuquerque, N.M.

Health of the Public
An Academic Challenge

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March 24, 1993

Kristine Gebbie, R.N., M.N.
606 Lilly Road, N.E. #723
Olympia, Washington 98506

Dear Kris:

Tom Inui and I look forward to our Health of the Public Advisory Board meeting to be held in Boston, April 15-16. The meeting is scheduled to start at 8 a.m., Thursday, and end on Friday afternoon about 3 p.m. We plan to dine at Parker's Restaurant located in the hotel on Thursday evening.

Your nonsmoking room at the The Omni Parker House Hotel (Address: 60 School Street, Boston, MA 02108) has been guaranteed for late arrival: Thursday, April 15, 1 night.

Should your plans change, please call the reservation desk (617-227-8600) by 6 p.m. on the day of arrival (listed above) so the Program Office will not be charged for a "no-show."

Enclosed are a tentative agenda and a travel reimbursement form to accompany your receipts.

You should have received your set of applications to review early this week. We look forward to getting your faxed ranking sheet on or before April 8.

Best wishes,

Jonathan A. Showstack, M.P.H.

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Health of the Public
Advisory Board Meeting
April 15-16, 1993
The Omni Parker House Hotel
60 School Street, Boston, MA 02108
Emergency Phone Number: 617-227-8600

Tentative Agenda

Thursday, April 15

7:30 am	Continental Breakfast
8:00 am	Begin Meeting
noon	Lunch
4:30 pm	End of First Day
7:30 pm	Dinner at Parker's Restaurant, located in hotel

Friday, April 16

7:30 am	Continental Breakfast
8:00 am	Resume Meeting
noon	Lunch
3:00 pm	End of Meeting

Health of the Public Travel Reimbursement Information

After your business trip, please turn in this information and original receipts for all expenses over $24.99 to: Elizabeth Hirose, UCSF Health of the Public, 735 Parnassus Avenue, San Francisco, CA 94143-0994.

The Health of the Public Program Office will reimburse for amounts *actually incurred* for travel within the continental U.S., meals and incidentals up to a maximum of $37 per day.

Traveler's Name:
Address:
(for Mailing Check)

Social Security Number:

Home Address, if different:

	Date	Date	Date	Date	Date	Date
Trip Data:						
Departure City:						
Time left from home/office:						
Destination City where you lodged:						
Time returned to home/office:						
Transportation:						
Private Car Usage						
# of miles:						
Car License Plate #:						
Airfare (coach) (attach original receipt)						
Other (e.g., rail, bus)						
Taxi						
Parking						
Rental Car (no CDW coverage)						
(Explain how it saved money below)						
Subsistence:						
Lodging paid by you (Room & Tax only)						
Meals paid by you, including gratuities (attach original receipt if >$24.99)						
Breakfast						
Lunch						
Dinner						
Incidentals						
Daily total M& I						
Other (describe):						
Business Telephone Charges:						

THE PEW CHARITABLE TRUSTS

One Commerce Square
2005 Market Street, Suite 1700
Philadelphia, Pennsylvania 19103-7017

Telephone: 215.575.9050
Facsimile: 215.575.4939

I called in
2 "yes"

January 14, 1993

Kristine Gebbie, R.N., M.N., F.A.A.N.
Secretary
Department of Health
1122 S.E. Quince Street, ms: 7890
Olympia, WA 98504

Dear ~~Ms. Gebbie~~ Kris

On behalf of The Pew Charitable Trusts and The Robert Wood Johnson Foundation (RWJ), we are pleased to invite you to serve on the National Advisory Committee of the successor program to *Health of the Public: An Academic Challenge*. Jointly funded by the two foundations, the Health of the Public program challenges our nationally respected academic health centers to return to an emphasis on addressing the health care needs of populations in their communities. Since its inception in 1986, with co-funding from the Trusts and the Rockefeller Foundation, the Health of the Public program has assisted 17 academic health centers in adapting to a changing demographic and health care environment by integrating population perspectives in educational, research, and services activities. The successor program will build upon this approach by providing funding to academic health centers through a competitive application process. Additionally, the Rockefeller Foundation, which now confines its health grant-making to international efforts, plans to collaborate with the Trusts and RWJ in this program through support of the International Clinical Epidemiology Network (INCLEN.) The program will be directed by Thomas S. Inui and Jonathan A. Showstack, who so ably guided the initial program, and John Evans has again agreed to serve as the national advisory committee chairman.

A Request for Proposals is attached which outlines in more detail the second phase of the HOP program. This solicitation was recently sent to CEOs of all academic health centers and to the deans of all health professions schools in the United States and to invited institutions in Canada.

As a member of the Committee, you will be asked to serve in an advisory capacity to the foundations and program office. This will include reviewing and recommending applications for site selection and funding by the two foundations and attending annual grantee and advisory committee meetings for the three year grant period. Comprised of experts from the health professions and the public, the National Advisory Committee makes recommendations on the program generally, as well as on activities at specific sites. The program office will cover all committee expenses and will provide an honorarium of $500 for committee work and for attendance at National Advisory Committee and annual Health of the Public meetings. The first, and critically important, meeting is scheduled for April 15-16, 1993 in Boston during which the committee, program office directors, and foundation representatives will convene to review recommendations for funding of the second phase of Health of the Public. Applications are due on March 2, 1993 and the program office plans to send out applications for review as soon as they have completed a preliminary screen.

Your experience and expertise will strengthen our work invaluably as we embark on the next phase of the program. Please contact Tom (at 617-421-6011) or Jon (at 415-476-4917) with any questions or to discuss specific responsibilities further, and to let them know whether you will be able to join us in this successor effort. We sincerely appreciate your commitment to improving the health of the public and hope you will be able to join us in this important initiative.

Sincerely,

Rebecca W. Rimel
Executive Director
The Pew Charitable Trusts

Steven A. Schroeder, M.D.
President
The Robert Wood Johnson Foundation

Health of the Public:
An Academic Challenge

Request for Applications

Supported by

The Pew Charitable Trusts

and

The Robert Wood Johnson Foundation

November 16, 1992

Introduction

Health of the Public: An Academic Challenge was established in the Spring of 1986 by The Pew Charitable Trusts and the Rockefeller Foundation to help academic health centers adapt to the changing demographic and health care environment. A national Program Office administers Health of the Public with the advice and direction of a national Advisory Board. The Director of the national Program Office is Thomas Inui, Sc.M., M.D., of Harvard University and the Co-Director is Jonathan Showstack of the University of California, San Francisco. John R. Evans, M.D., serves as Chairman of the Advisory Board.

Health of the Public is based on three premises. First, academic health centers are entrusted by society with the mission of improving the public's health through such activities as education, patient care, and research. Second, the major forces affecting academic health centers are external to those centers – in particular, the changing demographics of the general population, the increasing prevalence of chronic conditions, the public's growing interest in health and health care, emerging social priorities for research, the need for a different mix of human resources for health, and the constrained economic environment. Third, institutional responses designed to manage the effects of these forces within academic health centers must be focused on specific objectives and predicated on the need to achieve fundamental change in the relationship between academic health centers (AHCs) and the public.

With support from The Pew Charitable Trusts and the Rockefeller Foundation, seventeen AHCs have initiated programs related to Health of the Public objectives. Support for this new initiative is provided by The Pew Charitable Trusts and The Robert Wood Johnson Foundation, with the continued collaboration of the Rockefeller Foundation.

Intent of Solicitation

Health of the Public seeks to enhance the constructive influence of AHCs on the health of populations that they serve through their programs of patient care, research, education, and social action. Health of the Public believes that AHCs will be successful in this endeavor only if vital partnerships are forged between the AHC, communities, and government. These partnerships should be congruent with the AHC's mission and structure and supported actively by AHC leadership. In such partnerships AHCs will contribute to new knowledge through balanced programs of scientific inquiry, including health services, social, behavioral, population and biomedical research. Through such partnerships for education, training, and social action AHCs will produce health professionals able to enhance the health of populations and individuals, work effectively in interdisciplinary teams, and assume

vital roles in assuring that their communities are healthy places for all to live, learn, and work.

This reframing of the tasks of academic health centers has been the central concern and ambition of the present Health of the Public Program. This program's "mission statement" is best understood as specification of developmental pathways to the academic health center of the future (Table One). The stages of development within each mission objective (Table Two) are conceived of as sequential steps. Health of the Public believes that AHC development of this nature is best undertaken with the assistance and collaboration of other AHCs working in networks.

The intent of the present solicitation is to provide resources to academic health centers to advance and disseminate the Health of the Public Program mission. Health of the Public is especially interested in receiving applications for support of programs and activities responsive to the following necessary elements and priority areas.

Necessary Elements of Proposed Activities

- An explicit focus on one or more of the Health of the Public mission elements (described in Table One);
- Direct involvement of multiple health profession disciplines;
- Active partnership between academic health centers and communities; and,
- A commitment to participate in the Health of the Public network to assist, collaborate with, and learn from other institutions working toward these goals.

Priority Activities

- Developing new approaches for making progress on Health of the Public mission elements, including activities designed to improve the environment in which academic health centers and their graduates work.
- Undertaking activities specifically intended to ameliorate major societal health problems; for example, inadequate access to care, spiraling costs, human resource maldistribution (by specialty and geographic area), deficiencies in disease prevention/health promotion, inadequate research on the social determinants of health, and lack of participation by academic health centers in the social management of health resources.
- Measuring the distribution of health and disease in populations and communities and translating this information into academic health center programs that address identified needs.
- Developing effective new approaches to health promotion/disease prevention in minority/disadvantaged populations.
- Developing, implementing, and sharing widely applicable approaches to preparing health professionals and the public to deal effectively with constrained resources and resource reallocation in health.

- Incorporating population-based concepts and community action skill training into curricula for health professionals.
- Developing and disseminating curriculum change strategies and materials for the further development of clinical population science and community-based teaching and learning.
- Developing strategies for matching "products" of academic health centers to the needs of major "buyers," e.g., generalist providers for HMOs.

Application Requirements

Only one application will be considered from each academic health center.

Application contents

The following outline is suggested:

1. Executive Summary (Maximum three pages [750 words], plus cover page). The executive summary should have its own identifying cover page and be understandable when separated from the main text of the application.
2. Text of application (Maximum 20 pages [5,000 words], plus cover page). Please see the outline below for necessary elements of the proposal narrative.
3. A detailed timetable, with specific milestones to identify program progress.
4. Proposed budget, including detailed justification. (Instructions for completing the budget are given below.)
5. Appendix materials (20 pages maximum).

The text of the application (section 2) must include:

2.1 The results of a "self-study" of how your academic health center currently addresses each Health of the Public mission statement objective (Table One), including a description of your center's current stage of institutional development (Table Two) and the stage of development expected by the end of the proposed project.

2.2 A description of the central issue/problem to be addressed under the auspices of the proposed program and the explicit linkage between this issue/problem and one or more Health of the Public mission statement objectives.

2.3 A description of the community partnership serving as the basis for progress in this initiative and a description of the population(s) that will benefit.

2.4 A description of the importance of the proposed initiative's activities to creating an emphasis at the AHC on the needs of communities, including a description of how this emphasis and specific activities will be sustained beyond the term of this grant.

2.5 Specification of the role of key decision-makers in this initiative, including individuals at the academic health center, in the community, and in government (if applicable).

2.6 A description of specific "products" (e.g., documents, programs, workshops, curricula, informational resources, new organizations, etc.) anticipated from the proposed activity.

2.7 Evidence of resources contributed to the proposed project by the host institution in the form of protected faculty time, direct sponsorship of project support or administrative personnel, and/or flexible resources for use by the program.

The Health of the Public Program is providing materials as important background information for your AHC's response to this solicitation. These include copies of the 1991 program brochure, *Challenge* (the program newsletter), two Health of the Public Program articles from the *Journal of the American Medical Association* describing the rationale and objectives of the program,† and a new document produced by participants in Health of the Public entitled "Academic health centers and the community: A practical guide for creating shared visions." This latter document and a recent 1992 publication, "Enhancing health status: The role of the academic health center," edited by M. Osterweis and S. Eichhorn (that can be obtained from the Association of Academic Health Centers, Washington D.C.), provide more extensive information about the nature, purpose, and varieties of AHC/community/ government partnerships.

Budget Instructions

The Health of the Public Program will provide support for up to three years at up to 30 sites. The expected start date for these awards will be between July 1 and October 1, 1993. Grant size will vary, but awards will range from approximately $25,000 to $150,000 per year, depending on the scope and potential impact of the project. The modal award will commit $300,000 or less to a site for activities over three years.

The grants made under this program will be administered through contracts between the University of California and the grantee institution. All substantive progress and accounting reports will be submitted to the University of California. Indirect costs may not be included in proposed budgets and will not be paid.

Detailed budgets should be submitted for each year of requested funding. All budget information should employ definitions and categories, and be submitted in a format similar to, Public Health Service (PHS) form 398, pages DD and EE. The PHS format

† Schroeder SA, Zones JS, Showstack JA: Academic medicine as a public trust. *JAMA* 1989;262:803-12. Showstack JA, Fein O, Ford D, Kaufman A, et al.: Health of the Public: The academic response. *JAMA* 1992;267:2497-2502.

and definitions are suggested because they are generally available and familiar; PHS accounting definitions and standards will also be expected to be followed by grantees.

In addition to any other travel expense requests, please include $2,500 each year for expenses for travel to the Health of the Public annual meeting. Space rental may not exceed 5% of total personnel costs. Equipment expenses are limited to $5,000 for the entire length of the project.

All items listed in the first budget year, and any substantial changes in subsequent budget years, must be described and justified in an attachment no longer than 3 pages. Section 2.7 of the application text will serve as the description of resources provided to the proposed project by the applicant institution. The budget and budget justification should show how these "matching resources" are to be deployed.

Timetable

Action	Date
Applications due at Health of the Public Program Office, University of California, San Francisco.	March 2, 1993
Review of submitted applications by Advisory Board, requests to candidate programs for additional information, and site visits (if required).	Between March 2 and June 30, 1993
Notification of grants recommended for funding.	By July 1, 1993
Expected start of funding.	Between July 1, 1993 and October 1, 1993

Questions regarding this solicitation should be directed to the Health of the Public Program Office (phone: [415] 476-8909).

Applications are due March 2, 1993. Please submit **10 complete copies** of your application and appendix materials, plus 2 additional copies of your Executive Summary to:

Jonathan Showstack
Co-Director
Health of the Public Program
University of California, San Francisco
735 Parnassus Avenue
San Francisco, CA 94143-0994

(For overnight mail to the San Francisco office by any carrier other than the U.S. Post Office, please use the following zip code: **94122**.)

Phone: (415) 476-8909

Table One
Health of the Public Mission Statement

Goals

Academic health centers, concerned with the health of the public, should adopt a broad construct of health that emphasizes individuals' social and personal resources as well as physical capacity. Institutions dedicated to the health of the public seek to establish a thorough integration of population and clinical perspectives into their educational, research, and service programs.

The successful integration of a population perspective into clinical medicine at an academic health center has five goals:

1. Maximize the health of a defined population.
2. Achieve collaboration among the broad array of professionals needed to meet the health needs of that population.
3. Provide appropriate preventive as well as therapeutic services.
4. Conduct population-based research and apply the results to shaping and enhancing health care.
5. Use the social and behavioral sciences and humanities to gain a richer understanding of the individual patient, the roles and responsibilities of health care providers, and the performance of the health care system.

Objectives

The achievement of the above goals can be reached through the development of programs at academic health centers that meet some or all of the following objectives:

Achieving change within the academic health center

1. Provide basic competencies in population-based subjects to all health professional students.
2. Provide enhanced population-based education for selected students.
3. Include clinical prevention knowledge and skill-building activities at all levels of health professional education.
4. Conduct substantive scholarly research in subjects related to population medicine.

Achieving change in an academic health center's role in the community

5. Assume institutional responsibility for maximizing the health of a defined population within available resources.
6. Involve the academic health center in decision-making about the development and deployment of health resources.
7. Involve the academic health center in the social/political process as an advocate of the health of the public.

Table Two

Stages of Institutional Development

A conceptual, hierarchical scheme for institutional development in each Mission Statement objective may be specified as follows:

- Stage One ..... No explicit activity.
- Stage Two ..... Organized, but limited activities, such as elective courses.
- Stage Three .... Organized, systemic activities (for example, a required curriculum).
- Stage Four ..... Stage Three activities, plus evaluation of immediate outcomes (e.g., knowledge gained, attitudes changed).
- Stage Five..... Stage Four activities, plus evaluation for impact on health and health care outcomes (e.g., changes in community practice and health status).
- Stage Six..... Stage Five activities, plus explicit, planned programs of technical assistance to support similar developments at other institutions.

The stages of institutional development may be applied to achievements under each Mission Statement objective. The following list provides examples of achievements for *selected* stages for each objective:

Objective 1. *Provide basic competencies in population-based subjects to all health professional students.*

Stage Two: The provision of a basic curriculum in critical appraisal of the professional literature sufficient to enable health professions students to read and understand population-based constructs in this literature (e.g., incidence, prevalence, evidence of causation, etc.)

Stage Three: Providing, and requiring health professions students to take, courses in clinical epidemiology and a general course in the roles and responsibilities of health professions in society.

Stage Four: Inclusion of a structured evaluation of the outcomes of the curriculum required in Stage Three.

Objective 2. *Provide enhanced population based education for selected students.*

Stage Two: Provide opportunities for student to matriculate and receive advanced degrees in population-based subjects at other institutions without loss of standing in their basic degree program.

Stage Three: At the host institution, create capacity for full degree-granting program(s) in public health, health systems management, public policy, or other population-oriented fields of study.

Objective 3. Include clinical prevention knowledge and skill-building activities at all levels of health professional education.

Stage Two: Assure health professional students' access to consensus materials describing primary and secondary prevention activities within the purview of clinicians.

Stage Three: The sponsorship of institution-wide clinical prevention education and training, including the integration of clinical prevention into core health professional curricula, practice experiences in the skill-building activities of clinical prevention, and community-based experiences in health promotion/disease prevention.

Stage Four: Inclusion of a structured evaluation of the outcomes of the curriculum required in Stage Three.

Objective 4. Conduct substantive scholarly studies in subjects related to population medicine.

Stage Two: Presence of faculty investigators pursuing careers in population-related fields.

Stage Three: Population-based research is an explicit part of the academic health center's mission. Adequate institutional resources are devoted to this activity, including intramural seed money, space, the development of interdisciplinary centers, and the integration of high-priority subjects from these fields into the research agenda of the institution.

Objective 5. Assume institutional responsibility for maximizing the health of a defined population within available resources.

Stage Two: Identification and acknowledgment of institutional responsibility for a defined population, and involvement of this population in dialogue and study to establish institutional, local, and regional health care programs.

Stage Three: In response to the needs identified in Stage Two, revisions are made in the basic health professional curriculum and provision of health care services.

Stage Five: Evaluation of the impact on the population's health of the changes instituted in Stage Three.

Objective 6. Involve the academic health center in decision-making about the development and deployment of health resources.

Stage Two: Tracking the career choices of health professional who have trained at the host institution in an effort to conduct institutional self-assessment.

Stage Three: Changes in institutional admissions policies and/or curriculum to assure production of health professionals appropriate to the human resources needs of society.

Stage Four: Evaluation of the long-term outcomes of Stage Three, such as the career and specialty choices of graduates.

Stage Five: Evaluation of the effect on community services and health status of changes instituted in Stage Three.

Objective 7. *Involve the academic health center in the social/political process as an advocate of the health of the public.*

Stage Two: The presence of faculty who participate in public processes as advocates of the public's health needs.

Stage Three: The development and long-term support of a dedicated academic unit with the responsibility for analyzing, and disseminating the results of analyses of, health care needs and policy.

Stage Five: Evaluation of the effect of advocacy efforts on community services and health status.

Stage Six: The dedication of institutional resources to implement and sustain programs of collaboration with peer institutions and advocacy on behalf of the public's health needs.

KC

Health of the Public
An Academic Challenge

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February 16, 1993

Kristine Gebbie, R.N., M.N., F.A.A.N.
Secretary
Department of Health
1122 S.E. Quince Street,
Olympia, WA 98504

Dear Kristine:

I deeply appreciate your willingness to participate in the next chapter of the Health of the Public Program, a joint venture of the Pew Charitable Trusts and the Robert Wood Johnson Foundation with ongoing participation of the Rockefellar Foundation. Over the next three years, the HOP academic health centers will attempt to demonstrate how they can enter into partnerships with communities in advancing the population-oriented mission of the Health of the Public Program.

John Evans, Jonathan Showstack, and I request your participation in a two-day meeting in Boston, Thursday, April 15 and Friday, April 16, 1993 to rank and select grantees for the new program. This will be the first meeting of the new Health of the Public Advisory Board for this next chapter of Health of the Public.

The meeting location will be the Omni Parker House Hotel (60 School Street, Boston). By March 10, please notify Elizabeth Hirose, program coordinator, (phone 415-476-8907) concerning you hotel reservation (see the enclosed room reservation form). We will reimburse you for your travel expenses, and you will be provided an honorarium of $500 for your participation.

By the third week of March you will receive a packet containing the proposals that we would like you to review and a description of the review process.

We look forward to seeing you in Boston.

Best wishes,

TSI

Thomas S. Inui, Sc.M., M.D.

RECEIVED
FEB 22 1993
DEPT. OF HEALTH
OFFICE OF THE SECRETARY

cc: John R. Evans, M.D.
Jonathan Showstack, MPH

TSI/sm

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Room Reservation Form
Health of the Public Advisory Board Meeting
to be held April 15-16, 1993
Accommodations at The Omni Parker House Hotel
(Address: 60 School Street, Boston, MA 02108)

(Deadline: Must be received by March 10, 1993)

Please send this form to:

Elizabeth Hirose
Program Coordinator
Health of the Public
University of California, San Francisco
735 Parnassus Avenue
San Francisco, Ca 94143-0994

Or Fax to: (415) 476-3429 or call (415) 476-8907

Name:_____

Institution:_____

_____

Phone:_____

Date and Time of Arrival of Flight:_____

Date and Time of Departure of Flight:_____

Number of nights:_____

Single accommodations? Yes or Other:_____

Will Share with:_____

Special Note (e.g., "I don't need a hotel room on _____." or "I will miss dinner on _____." or "I am a vegetarian."):_____

_____

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