The Past and Future of Public Health Practice

Two challenging articles in this issue of the Journal raise questions about public health practice, especially as we look from the past to the present and the future. By "public health practice," we mean not so much the details of implementation or evaluation of specific programs, or the many other particulars that make up the daily tasks of public health practitioners; instead, we are thinking of practice in 2 broader senses. First, "practice" as "praxis" means the total framework of one's professional life, including the ideology or worldview that guides one's actions, the framework of values used to set priorities, the commitment to translate these values and ideas into daily activities, and the expectation that by doing so consistently, one can transform the world in which one lives. Second, "practice," in the sense of "vocation," means acting according to a sense of calling or mission.

The Qualities of a Public Health Officer

In these broader senses of practice, Fitzhugh Mullan's provocative article provides a typology of the characteristics needed by successful public health practitioners, vividly presented in terms of the personality types of Don Quixote, Machiavelli, and Robin Hood.[1] Each public health officer needs a bit of Don Quixote's unflappable idealism, a bit of Machiavelli's political cunning, and a bit of Robin Hood's quest for distributive justice. Of course, these character types should not be taken too literally, as each has some unavoidable negative associations: Don Quixote is dreamy and naive, Machiavelli is cynical and manipulative, and Robin Hood is a violent outlaw. They are, however, imaginative constructs whose characteristics can be usefully recombined by wedding Machiavelli's pragmatism to Don Quixote's idealism and Robin Hood's sense of justice. If ideals are always dismissed as quixotic, we will never engage in the hard political struggles needed to produce significant change. If our search for greater equity is not joined to an intelligent structural analysis of the barriers to change, we may be left tilting at windmills. If the ideal of justice is abandoned by public health insiders, we have lost the very purpose of our mission.

Medicine and Public Health

Many important questions are raised by Allan Brandt and Martha Gardner, perhaps none more important than the question of what has become of public health practice and what will become of it in the future.[2] What will public health careers look like? How are students being educated in schools of public health? Is there increasing collaboration between medicine and public health, and, if so, what are the characteristics and implications of this collaboration?

Brandt and Gardner outline the initial tacit alliance between medicine and public health in the 19th century and the deepening fracture between them in the 20th century. They note that as the medical profession became more tightly organized in defense of its collective interests in the early decades of the 20th century, it came to see an ambitious and increasingly independent public health profession as a threat to those interests. (See also historian Richard Meckel's discussion of organized medicine's attack on public health through its red-baiting strategy of invoking the label "state medicine" to denounce the Sheppard-Towner provision of health education to mothers and children.[3])

Schools of public health, for the most part, guarded their independence from medical schools on the one hand and from public health bureaucracies on the other. As schools of public health remained suspended between the worlds of the academy, clinical practice, and public agencies, they found themselves increasingly stressed for sources of funding. In the political context of the 1950s, the underfunded and politically contentious world of public health practice became even less attractive to public health academicians.

It was perhaps not surprising that in these postwar years, as the funding stream for biomedical research from the National Institutes of Health became ever richer and more generous, public health faculty were inclined to follow their medical school colleagues, who were in turn following the dollars into the laboratory. As Brandt and Gardner note, the biomedical paradigm uncoupled disease etiology from its social roots. Public health faculty adopted a statistical variant of biomedical individualism and built it into modern epidemiology, which marginalized the difficult-to-measure social context of disease in favor of more measurable "risk factors." Brought into the laboratory—or calculated on adding machines and computers—public health research could be shorn of messy or controversial political connotations, made scientifically respectable, and used for the building of careers.

Theory and Practice

One slight difficulty with the shift of public health schools toward intensified scientific models of research and training was the fact that they became ever more divorced from public health practice, in the sense of the activities and priorities of public health departments.[4] For students who were thinking

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Editor's Note. See related articles by Mullan (p 702) and Brandt and Gardner (p 707) in this issue.

ahead to realistic careers, facility with statistical and, later, economic analyses became more important than the characteristics—even in combination—of Don Quixote, Machiavelli, and Robin Hood. Students of public health moved into research positions or took jobs in federal, state, or municipal agencies, private foundations, insurance companies, or hospitals and clinics in a diverse and dispersed health care system. Public health practitioners might not be able to solve the problems of poverty and ill health, but they could count the numbers of cases and publish the results, and that was what organizations and agencies seemed to want them to do. In the 1950s and 1960s, statisticians were in the ascendancy. In the 1970s and 1980s came the economists, calculating reimbursement rates and cost-effectiveness measures. In the 1990s, the clinical evaluative sciences of health services research focused on managed care organization and medical care effectiveness, outcomes, and measures of quality. Idealism and justice seemed very distant—and soft—concepts.

Mullan's typology of public health practitioners assumes a model of public health in which the practitioner works closely with an elected official—whether president, governor, mayor, or county executive—and is in a position to exercise considerable, if delegated, power because of the technical nature of public health decisions. We imagine Mullan's public health practitioner as a physician, a state health commissioner perhaps, or a director of some important public health agency. But we also know that the people graduating from schools of public health rarely move into such highly visible positions in public health departments. Few are working directly with elected officials, and relatively few are working in any job that fits easily into traditional definitions or images of public health. By the same token, most of the people employed in public health departments have received no specialized training in schools of public health. Thus, theory (education and training) and practice (the everyday activities of public health departments) often have only the most tenuous connection.

We might improve the prospects for public health practice by creating better articulation between schools of public health and public health departments and agencies across the country. Working to ensure appropriate recognition (including financial compensation) to attract the most able and idealistic graduates would be a valuable endeavor for professional leadership groups. This endeavor would include pressing legislatures to ensure proper funding for the public health mission. These collective efforts could send a powerful message to current and future practitioners, recalling them to the vocation of public health in the fullest and richest sense of the term. □

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References

1. Mullan F. Don Quixote, Machiavelli, and Robin Hood: public health practice—past and present. *Am J Public Health.* 2000;90:702–706.
2. Brandt A, Gardner M. Antagonism and accommodation: interpreting the relationship between public health and medicine in the United States during the 20th century. *Am J Public Health.* 2000;90:707–715.
3. Meckel R. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality.* Baltimore, Md: Johns Hopkins University Press; 1990.
4. Lasker RD, Committee on Medicine and Public Health. *Medicine and Public Health: The Power of Collaboration.* New York: The New York Academy of Medicine; 1997.