EDITORIAL

From the Editor-in-Chief

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Seven years have passed since the terrorist attacks of September 11, 2001 forced a realization that the United States was not prepared to respond effectively to a public health emergency. To prepare us to face future catastrophic events, significant amounts of financial and human capital have been expended to ensure that health responders are better trained and equipped, that required response resources are available, and that the capacity to initiate and provide an integrated and systematic response effort is realized. Unfortunately, 7 years later we still cannot determine objectively whether these resources have been well or adequately spent. Uncertainties as to our improved preparedness were tragically underscored and magnified by our experiences during and following Hurricane Katrina.

It is all too obvious that lingering, significant gaps in disaster medical and public health preparedness systems persist between local, state, and federal authorities, and between private and public entities. This observation is neither original nor new and represents the one finding upon which there is common agreement among the primary leaders and thinkers in this field of disaster medicine and public health preparedness. Why, then, have well-intentioned, capable, and visionary leaders not been able to translate more than sufficient empirical observations and epidemiological findings into effective public policy in support of viable and sustainable programs?

To provide one assessment of why this has not come to pass, I refer to the observations of Henry Ford on partnership: "Coming together is a beginning; keeping together is progress; and working together is success."

Coming together for most endeavors could be relatively straightforward if the critical partners were readily identifiable. I believe that the initial progress in the evolution of disaster medicine and public health preparedness was severely impeded by a failure to recognize the essential role of all of the health care disciplines in both the public and private sectors as well as the contribution required from government agencies, academia, and commercial/industrial entities to ensure adequate and systematic planning, response, and recovery. Today there is a broader recognition and acceptance of the fact that effective response is a system the components of which virtually span our social and economic constructs.

Keeping together is not only more apparent today but it is also being institutionalized both under law (Pandemic and All-Hazards Preparedness Act [PL 109-417]) and through practice. Multiple representative committees, boards, workgroups, and panels have been formed within the Institute of Medicine, government agencies, private sector associations, and academia that provide cross-cutting initiatives to develop common goals and integrate work efforts. With the issuance of Homeland Security Presidential Directive-21 (HSPD-21),[1] a rough blueprint has been made available to help plot a course. This document may not be perfect, but deconstructing it in terms of those sections that deal directly with disaster medicine and public health preparedness provides us with 3 distinct but interdependent goals that are, I believe, not only worthwhile and achievable but also necessary if we are going to reach Ford's third and most important level of activity—**success**.

HSPD-21 discusses the evolution of a discipline termed disaster medicine and public health preparedness, one united in a common set of competencies with an academic and research base derived from broad multidisciplinary input from the private and public sectors. An initial effort to achieve this goal was accomplished through the publication of *A Consensus-based Educational Framework and Competency Set for the Discipline of Disaster Medicine and Public Health Preparedness*[2]; however, more sustained effort toward defining consensus-based learning objectives are now necessary. The second element is requiring the development of a disaster health system that can integrate all of the components necessary to establish sound planning, effective response, and sustainable recovery. The third element, the creation of a national disaster medicine university function, recognizes the need to ground the discipline and the system in an academic matrix that provides the necessary credibility and validation for success.

The American Medical Association Center for Public Health Preparedness and Disaster Response is working in conjunction with thought leaders representing a wide breadth of disciplines to prepare a detailed white paper that expands on the above items. This white paper will offer a set of concrete steps toward such goals as a multidisciplinary association actually achieving the HSPD-21 objectives and will propose an actual structure to institutionalize the discipline of disaster medicine and public health preparedness and the disaster health system going forward.

About the Author

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