



Frontiers in Public Health Services and Systems Research

Volume 1 | Number 2

Article 4

July 2012

Keeneland Conference Plenary Sessions: Harvey V. Fineberg

Harvey V. Fineberg
Institute of Medicine, fineberg@nas.edu

Follow this and additional works at: <https://uknowledge.uky.edu/frontiersinphssr>



Part of the [Public Health Commons](#)

Recommended Citation

Fineberg HV. Keeneland Conference Plenary Sessions: Harvey V. Fineberg. *Front Public Health Serv Syst Res* 2012; 1(2).
DOI: 10.13023/FPHSSR.0102.04

This Article is brought to you for free and open access by the Center for Public Health Systems and Services Research at UKnowledge. It has been accepted for inclusion in *Frontiers in Public Health Services and Systems Research* by an authorized administrator of UKnowledge. For more information, please contact UKnowledge@lsv.uky.edu.

Keeneland Conference Plenary Sessions: Harvey V. Fineberg

Abstract

Healthy communities are essential for healthy individuals. Healthy communities can only exist when preventive measures are taken. When prevention programs are implemented, negative health outcomes can be avoided before they even start. A necessary part of these successful prevention methods requires great research and evidence based practice. Dr. Harvey Fineberg, president of the Institute of Medicine and keynote speaker at the Keeneland Conference, addressed the audience on why good science is imperative to the public health community. It cannot just left up to chance on whether an intervention will work or not; rather it needs to be thoroughly reasoned, grounded in evidence, and be assured to have positive outcomes. Fineberg tells us not to be afraid of using good science and packaging it in a way that will make sense to both policy makers and the general public alike.

Keywords

public health services and systems research, phssr

Cover Page Footnote

This manuscript edited from the plenary session given by the author at the fifth annual PHSSR Keeneland Conference. See the full version at: <http://bit.ly/KQ22v5>

Now I know that you already spent a lot of time today hearing discussion about recent work at the Institute of Medicine related to public health, and I also know that you have here in the audience folks like Martha, Lloyd, others who presented earlier today and described that work. It makes me feel a little bit like the chauffeur in the story of the senate candidate in the Midwest who was driving around from grange hall to grange hall, giving the same stump speech while he was trying to get the nomination for his party. It got so exhausting for him. He finally got to one hall at the end of the day, and he turned to his chauffeur, and he said, "You've heard me give this talk 50 times. Do you mind?" He handed the chauffeur the paper. He said, "I'm beat. I'll sit in the back, and you give the talk." So the chauffeur said, "Okay, but let's switch jackets." So they switched jackets, and the candidate took the hat and sat in the back of the room. The chauffeur went up to the podium, and he started to deliver the speech. The candidate started to perk up because the chauffeur had exactly the right cadence, the right pauses, the right laugh lines, and the right points of emphasis. He ended on a dramatic high. There was wild applause, and the questions began. The first question they had heard a dozen times. The chauffeur answered that right off the bat. The second question came up, and finally someone raised a question about the United States foreign policy at the time that we were leaving Lebanon. Well this had never come up. So the chauffeur without missing a beat looks at the questioner and says, "You know, that is so elementary that my chauffeur will answer that question." Just in case you have any questions about the work at the Institute of Medicine, we have some real experts here in the audience who will be able to handle them.

When I started at the Institute of Medicine, now about 10 years ago, I called in the senior staff to get acquainted. At the end, I called aside the person who was a deputy executive officer. I said to him, "You know what would really help me is if you could go back and talk to all of the board directors and bring me examples of the best work we've done because I think I can learn from the best that we've done." He left the room, and I was making some notes and working away. About a half hour later is a knock at the door, and he is back. I am thinking, "Boy, that was fast." It wasn't to give me the answer. He said, "I have a question about the assignment." I said, "Well, what's the question?" He said, "What exactly do you mean by 'best'?" I said, "What do you mean 'what do you mean by 'best'?" He said, "Well, when you say 'best,' do you mean the study that has the soundest base of evidence that most exquisitely argues, that has conclusions that follow from the line of logic, that is clearly written and is expressed exactly with precise language or do you mean the study that had the greatest effect on decision-making in the world?" I said, "Well, I guess I meant both." Sure enough within a couple of days I had 2 lists of studies, and I am very pleased to report there was some overlap. However, I learned a very important lesson from that little exercise, which is if you want to have effect, it is not only by doing excellent work; it is not enough. The lesson that I tried then to convey from then on to our staff is that the reason to make every study as good as you can, as correctly argued, as grounded in evidence, as thoroughly reasoned, and as clear as you can make it is not because that guarantees it will have an effect. It is because just in case it does have an effect, you want it to have been right. Now, that may be too modest an aspiration.

Challenges in Communicating Public Health Evidence

I would say that in public health we should not just leave it up to chance as to whether the results of our work will make a difference. Let's face it. We in public health start with some very significant handicaps in having an effect. Public health is all about prevention. It is about stopping things before they occur. When prevention succeeds, it is invisible. So the first challenge that we have in public health is that we have to find ways to make the invisible tangible—visible, real—for people. The reason why so many people today question the wisdom of immunizing their children is because they have never seen a case of measles. They don't know what pertussis can still do. They don't understand the consequences of mumps. And you know in the United States of America today we will have outbreaks of thoroughly preventable infectious diseases simply because people do not understand the consequences.

Public health is about having an effect today to prevent something that will occur otherwise in the future. How many of you here (this is perhaps too young an age group to speculate), but how many of you here did not have a heart attack because you either stopped smoking or never started, got exercise as you should, have eaten a reasonable diet, and otherwise maintained good blood pressure? Do we know? None of us can know that we did not suffer the consequences of what on average we can be absolutely sure would have occurred in the population. How do we make that remote effect present and real?

Targeting Audiences for Scientific Communication

Beyond communicating to one another, which is what we so often emphasize in learning how to do sound reports, good science, and clear communication, we must reach out to 2 different parties. We must reach policymakers, and we must reach the public at large. Actually, those two are sometimes not so different. I am sometimes asked, "What's the difference between our Congress and a cross-section of the public?" My personal answer is, "They are exactly like a cross-section of the public except they are a little more outgoing than average, a little more personable, a little more gregarious. Otherwise, they are us." Reaching the policymaker and reaching the public have a lot in common.

Here is an insight from someone who spent his whole life learning to do sound health services research and believes in science and data, it is this. It is true that the plural of anecdote is not evidence. At the same time, do not be afraid of using personal stories to persuade those who need to be persuaded. Do not be afraid to take the good science and package it in a way that is real for people. It is sometimes said that a health statistic is a number with a tear attached to it. Let people see the tears. Let people understand the difference that it makes in the lives of individuals and families and communities so that the messages of the science of public health can be absorbed and acted upon. If out of this conference you take not only a renewed and deepened appreciation for the importance of the research that you are engaged in, but if you also can bring a renewed commitment to convey that where it needs to be understood at the policymaker and at the public at large, then you will have made a real difference for public health. You will be

both the best in the sense of the quality of your work and you will be the best in terms of the difference that we together can make for the health of everyone in this country.

Directions for the Future of Public Health

I am getting to the age now where I can look back over 24 years of Institute of Medicine work starting from the classic 1988 report on *The Future of Public Health*. This was the IOM report that declared public health in disarray. It is no longer in disarray. It is arrayed. This field of research is an example of a growing arrayfulness. However, we know that is not enough. The recent Institute of Medicine reports sponsored by the Robert Wood Johnson Foundation call attention to the need for better measures, methods and data to drive public health action; the importance of using strong legal foundations and tools for public health work; and the need for enhanced organizational design and funding to improve public health delivery. And another recent Institute of Medicine report points to opportunities for realizing greater synergy in the work of public health and primary care.

As one looks ahead to the future of public health, there are several fundamental and necessary directions for progress. Number one is to consider health in all policy decisions. Public health as an aspiration is not synonymous with the work that we currently think of as performed by public health departments. We need to be thinking about the objectives of the health of communities and people in ways that, yes, are spearheaded by our public health departments but that incorporate the private sector, and that incorporate the work of other arms and agencies of government. We need to bring together organizations and community-based activities that are not traditionally thought of as part of the health enterprise but have a truly critical role to play in the environments that enable us to be healthy, the programs that reinforce making it easier and cheaper to do the healthy thing, and enabling public health to fulfill its full mission. That is a very clear direction for the future.

Number two, we need to think more clearly about the cost of public health work in connection with its quality and performance. What do we get for what we are investing? Another way of saying it is bringing business-like attitudes to the functions of public health. We have to get better at this.

A third direction that I will mention follows directly from the Institute of Medicine's primary care and public health report. We need to end the cold war between medicine and public health. The problem is as much public health as it is anybody else. I used to say that if only we could combine the values and the objectives and the principals of public health with the money and the stature and the professionalism of medicine, we would have the problem solved. I still sort of feel that way. I think we have to combine forces in a way that is open-minded, appreciative, mutually respectful, and engaging in truly shared solutions. If we can do that, I think that we will really make progress. Public health in partnership with our clinical delivery system; public health with a business-like attitude for investment that repays every dollar in health terms; and public health in all policy—those would be my three goals for the future.