

# Editorial Comments—A Graduate Curriculum in Emergency Public Health

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## Introduction

Public health departments and organizations have responded to disease outbreaks, water system contaminations, and other events as a matter of routine. In contrast, the emergency response world apparently equated “health response” to “EMT and ambulance response” without consideration of broader public health issues. Over the last 10–15 years, the role public health plays in emergency planning and response has emerged into public consciousness as a significant contributor to the health of a community during and following any large-scale emergency event. The paper by Rottman, Shoaf, and Stratton clearly describes the evolution of a specialized track within a school of public health to prepare Master of Public Health (MPH) students as specialists in emergency public health. This commentary focuses on three areas of potential impact associated with such a specialty: with the general emergency preparedness community, within public health organizations, and within the MPH curriculum generally.

## Public Health and Emergency Preparedness Organizations

Organized community response to emergencies probably began with volunteer fire companies. The centrality of fire departments to emergencies of all kinds is reflected in the modern attachment of ambulance services to fire departments, apparently based on either the potential for injury in a fire, or the rapid response capacity of a fire service. Other uniformed service offices such as police or sheriff also are at the top of the list, either as primary responders or to support traffic and crowd management at the scene of an event. In the experience of the writer, the attention to hazardous materials and transportation injuries in the latter half of the 20<sup>th</sup> century contributed to the creation and strengthening of generic offices of emergency preparedness. These offices also were able to coordinate multiple agencies in the event of problems created by the forces of nature such as extreme storms, earthquake, or volcano. From a health perspective, the attention was on transport of those injured to emergency departments, and the maintenance of hospital services. To the extent public health organizations were recognized as the monitors of hazardous materials, they were brought to the table; if HAZMAT had been assigned to another group, the public health agency might not even be aware of meetings. In the event of an emergency, public health might be asked questions of a technical or epidemiologic nature (how do you treat this condition; is this likely to spread), but not be expected to be at the center of activity.

The combination of substantial anxiety about severe acute respiratory syndrome (SARS) and the near-panic about anthrax made the centrality of public health thinking and public health professionals to effective emergency response visible across the nation. The subsequent massive population upheaval following Hurricane Katrina and subsequent Gulf Coast flooding further underscored the public health issues of displaced populations and mass shelters, apart from the need to provide ongoing primary and specialty medical care. All of these forces have pulled public health departments to the broader preparedness table. Instead of thinking in classic public health terms of outbreak recognition and control, health officials have had to master speak-

ing in the acronym-rich language of the first responders and uniformed services. They also have had to learn a hierarchy of command, and learn how to fit within a structure far different from the historical response of “the commissioner of health calls the mayor to alert her to the outbreak, which the health department is stopping”. Having a cadre of public health professionals who are fluently bilingual in health-speak and emergency-speak can lead to two critical improvements in emergency response: the planning done will more fully reflect the capacity and responsibilities of public health, and the mobilization for response will include public health as a preventive measure for all kinds of emergencies.

#### **Emergency Public Health within Health Departments**

Because public health agencies have been pulled into the realm of more comprehensive emergency planning and regular participation in a range of drills and exercises, it is to the advantage of a public health organization to have at least one staff member whose energies can be dedicated to this work, and who has the specialized competency. Unless emergency preparedness and response are in someone’s position description and work plan, it is far too easy to let the planning process, training, exercises, and quality improvement in response be minimized. The work will get done when deadlines loom, but it will not be of the highest quality. Further, having a well-prepared specialist to represent public health at jurisdiction-wide planning, exercise oversight, and quality improvement improves the way public health is included, and provides a good framework for the subsequent activities within the health agency itself.

The fact that emergency public health specialists prepared at the MPH level are available, however, does not assure that there are career openings for these graduates. While there were substantial funds available for the creation of emergency-specific positions in the first years of public health emergency response buildup, these funds are not likely to continue indefinitely. Only the largest (and best-funded) local public health agencies are going to be able to afford having someone dedicated to these activities. It is more and more likely that the generalist portion of this specialist’s education will be tapped, as other work is assigned. The alternative, that the emergency planning agency would employ a full-time public health emergency expert out of that budget, also seems unlikely, other than in very large jurisdictions. The situation probably is a bit better at the state level, where planning and organizational development are key parts of the public health agency mission, so that a dedicated staff member could be sustained even in the face of declining federal fiscal support. The ability to maintain the focus on emergencies might also be easier, as the pull into immediate response to a wide range of individual citizen concerns is at least slightly abated.

#### **Emergency Public Health and the Curriculum**

The third area for consideration is how yet one more specialized area fits within the MPH, which is held out as the basic professional degree in public health. No other profession of which this author is aware allows for specialization within the basic curriculum; physicians, dentists, attorneys, nurses, pharmacists all are exposed to the breadth of the profession and all core competencies that allow for beginning practice. Designation as a specialist in any one area of the discipline or field is left to post-graduate fellowships or residencies. The emergency public health curriculum as described adds one more possible distracter from the preparation of a competent generalist who fully understands the basic role of a public health practitioner, including emergency response. The Pandemic and All Hazards Preparedness Act requires development of a core public health emergency curriculum based on competencies needed by all public health workers. As referenced in the Rottman article, this would suggest a public health curriculum with emergency preparedness as a required content area, not an elective. Once the competencies are available, UCLA should be able to move quickly to identify the needed course content. Given the pressures already put on curricula to meet accreditation standards, this material might not be included as an additional course or courses, but integrated into several. This presents the additional challenge of assuring that the integrated material is properly presented in a way that the student can put all of the parts together.

This leaves the question of how to continue the energy and impetus that led to this rich set of specialized courses. Should the emphasis be to establish a certificate program for already-in-practice public health professionals? Is emergency public health a doctoral specialty to be attained following the MPH? How do we assure sufficient depth in emergency public health that the needed research is carried out? It may be that most schools of public health do not need an entire “department” of emergency public health specialists, or sufficient depth to do more than the required core education. Not all schools of public health have the same strengths or focus on the same public health challenges. Having a few who do advanced emergency public health well, conducting the research, refining the core competencies and the methods of teaching them, and collaborating with all of those seeking to improve our planning, response, and continuous quality improvement might be the most desirable. The long-established Centers for Disease Control and Prevention-funded Centers for Public Health Preparedness are a logical core for such development.

There have been a substantial number of publications about training public health workers (and students) in emergency preparedness. Rottman and colleagues present a cohesive narrative of the evolution of courses in emergency public health that is well-grounded in an academic setting. This experience can guide others as they confront the challenges of adequately preparing public health workers to the best level of preparedness within the context of assuring the full range of public health services to communities. This one size will not fit all, but it can inform many and perhaps minimize missteps along the way.