Advancing public health skills and structures: An interview with John Frank

Ross Graham, MSc, CHE

Dr. John Frank

John Frank has played a key role in the advancement of Canadian public health research and education for over 30 years. In addition to his role as a professor (now emeritus) at the University of Toronto since 1983, John served as the founding Director of Research at the Institute for Work and Health and as a Fellow with the Canadian Institute for Advanced Research Population Health Program. Dr. Frank has also worked extensively with policy-makers and practitioners to advance public health research funding, infrastructure, and the application of scientific knowledge to societal problems. He was appointed Inaugural Scientific Director of the Canadian Institutes of Health Research (CIHR) Institute of Population and Public Health in 2000, and has been Director of the Scottish Collaboration for Public Health Research and Chair of Public Health Research and Policy at the University of Edinburgh since 2008. Dr. Frank has received numerous awards, including CPHA's Honorary Life Membership in 2005, and most recently, was elected to the Royal Society of Edinburgh.

Interview

Ross Graham (RG): *What attracted you to public health?*

John Frank (JF): In 1976, when I finished medical school, my wife and I wanted to work in a new African country that was struggling to be egalitarian. This took us to Tanzania where we stayed for 2½ years. I learned an enormous amount about medicine, and human biology in general, as well as culture, since my role there was to see patients [in my capacity] as a District Medical Officer as well as train medical assistants. After graduation from a three-year program immediately after completing secondary school, these assistants would see up to two hundred outpatients daily, often in a bare-bones peripheral health facility with only 5-10 drugs and virtually no lab tests at their disposal. After training two classes (~120 medical assistants) in the spring of 1979, it dawned on me, just as we were about to return to Canada, that the local hospital was just as busy as [on] the day we arrived. This is when I realized that training people to see patients one-by-one wasn't going to change [the latter's] health status in the long run. The patients would be sent back to the same poor villages with the same basic housing (allowing massive mosquito and other disease-vector exposure), inadequate water and sanitation, and their children would still have chronic malnutrition, and so on. I needed to learn how to prevent illness by understanding and intervening on the determinants of health. After returning to Canada, I received a scholarship to the London School of Hygiene & Tropical Medicine where I fell in love with epidemiology, thanks to a great teacher, Professor Paul Fine.

RG: *You've straddled public health practice, education, research, and policy work through your career. Was this a conscious choice?*

JF: Some of it was conscious. I find research that is unrelated to practical problems in society to be of little interest. I am a very applied person. When I was seeing patients or consulting with public health departments, I received lots of fresh ideas about what the actual problems were. Then I was heavily involved from 1991 to 1997 in the initial years of research at the Institute for Work and Health in Toronto, where we were required, to my delight, to engage with policy-makers, practitioners and stakeholders (including labour and management, who rarely saw eye-to-eye). This was great practice for me on how to deal with contentious issues with multiple stakeholders. In 2000, after four years of teaching at the University of California-Berkeley School of Public Health, I was named the first Scientific Director for the CIHR Institute of Population and Public Health, which also had a mandate to translate research into policy and practice. This was of particular interest to me, having trained so many master's-level public health professionals at the University of Toronto who were now

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Editor's Note: This is part of a series of interviews conducted with Canadian public health leaders. The aim of the series is to capture the leaders' personal perspectives, allowing readers to benefit from the former's wisdom and insights gained through a career in public health.

out in practice across the country, asking how research could be of more service to decision makers.

RG: *What have been some of the most exciting experiences of your career?*

JF: It was exciting to be involved in the secret deliberations about the creation of the Public Health Agency in Canada (PHAC) after SARS. The mark left on public health from the SARS epidemic was not all positive, even though some very distinguished leadership pulled us out of it. In the aftermath, there was a clear need for restructuring of public health in Canada, given the absence of anything comparable to the Centers for Disease Control in the US. The public health section of Health Canada had many constraints because they reported directly to the federal Minister of Health, and there was no Surgeon General or Chief Public Health Officer to act as a professional and scientific lead.

As the only public health professional on the secret committee to recommend how to establish the new PHAC, this process was a steep learning curve. In an early teleconference with senior civil servants from across Canada, I humbly suggested that when Health Canada's public health staff were brought over to PHAC, anyone with professional responsibilities should have their training properly assessed, and upgraded over time, if necessary, to the master's level or better. Well, the senior civil servants on the committee quickly let me know that I was extraordinarily naïve. When civil servants are transferred between government structures under current regulations, you cannot require anything or forbid anyone from coming along. If you do, you will be taken to court and you will lose. This was a moment of great enlightenment for me. Looking back nearly a decade later, PHAC frequently has not quite had the level of training in its staff that would have been ideal – not because of anyone's fault, but because the rules of public sector employment in Canada are the way they are.

RG: *What skills are most useful for a successful career in public health?*

JF: Public health practitioners should avail themselves of any available communications training, including public speaking. They should certainly learn how to write, including briefing notes in ministerial style (short and straightforward). Those skills are necessary if they ever expect to influence policy. Important associated skills include listening and negotiating. This means learning to put yourself in the other person's shoes when you have a different perspective. Whatever the issue, you usually cannot find solutions without negotiation and compromise. This is not so different from other fields, but public health people often finish their training with a naïve notion that if they have the latest technical training, and can suggest an evidence-based solution, that it will be accepted right away.

RG: *What do you think of the Core Competencies for Public Health?*

JF: There's nothing wrong with good competencies lists and I'm all for guidelines-based practice, including competencies. The part that has been poorly implemented in Canada, and in the

UK, is appropriately funding programs of continuing education (CE) for public health professionals at all levels. Public health professionals, unlike professions that serve patients directly, typically have really poor quality CE offerings: they are limited, often long distances away (and thus expensive to attend), and often insufficiently applied and useful to their work. Some Canadian universities are beginning to provide more such CE offerings, but historically there were almost none until the last decade. In the past, one of the issues was that many public health professionals in Canada worked in municipal or regional government where their colleagues in transportation, police, fire, ambulance, property tax collection, etc. also did not have the right to attend continuing professional education. Fortunately, there is now a widely acknowledged need to continu[al]ly upgrade basic education in the public health professions and I'm hopeful that we're making progress in meeting that need.

RG: *What advice do you give new public health leaders and scientists?*

JF: Something that often comes up is how to be successful without ruining your personal life. Many in public health are driven by very high ideals. They don't do it for the money or because it is easy work. They are idealistically driven. However, some burn themselves out and have unrealistic expectations of what they can accomplish. A good example is population-level behaviour change. There has been a lot of naïveté among public health professionals (historically at least) in thinking that, by communicating knowledge per se, they can change human behaviour, such as food preferences. Food preferences are set, to a large degree, in childhood and youth and then sustained by strong cultural reinforcement systems over decades of life. Does anyone really think that, by giving people nutrition information alone, without changing any other influences on their eating behaviour, they're suddenly going to like different foods? I don't think so! Fortunately, this message has gotten through to the front lines of public health and hardly any health professionals in Canada still believe that health "education" alone can change the key behaviours that make us unhealthy. I've noticed that I only meet those ideas when I go to the far hinterlands of the globe; there I still find people trained 30 to 40 years ago who still believe it is all about health education, in the sense of just providing information, to change human health behaviours.

In order to be satisfied in your work, you have to come to terms with the fact that there are many things about the society in which you live and work as a public health professional that you cannot change. It's a bit like the old promise that Alcoholics Anonymous members have to make: "I will learn to accept the things I cannot change and have the courage to change the things I can." It is much the same in public health. It is important to hone your expectations down to size so that you don't end up cynical (and perhaps even bitter) with how much societal change is possible in one professional lifetime. On the other hand, skilled public health professionals never accept unhealthy aspects of their society passively – they search tirelessly for creative ways to create social change, for the betterment of everyone.