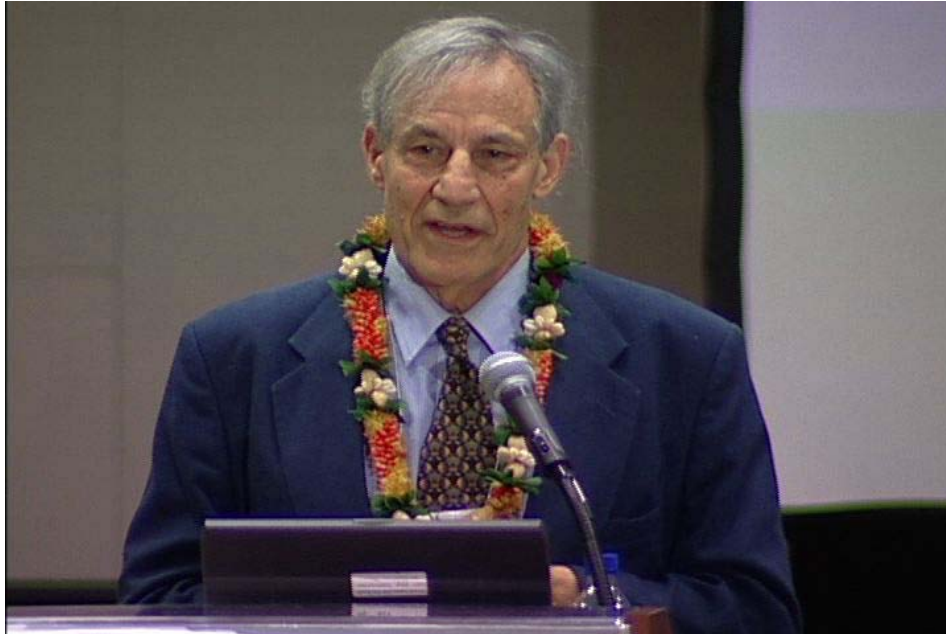


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**Plenary Speaker**  
**Transcript of "Back to the Future"**  
**Global Public Health: Issues and Strategies for Hawai'i and the Pacific**  
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Thank you and I do want to thank everyone for their hospitality and making me feel welcome here back in Hawai'i. I've never been here enough times, but have been here several times... I want to thank Nancy, Pratisha, and Rome for getting my presentation together. I wanted to bring greetings from the APHA of which many of us are members. Hawai'i represents part of the 2000+ affiliates along with part of our 30,000+ members and that is part of what I want to really speak about today in this presentation.

I wanted to refer back to a bit of history because the title of the talk is 'Back to the Future.' I have always been told that a talk should have three parts. The first part is - you discuss how far we have come, the second part; view with alarm what is taking place today and the third part is - express confidence that we will meet these demands. So, I am going to stay with that time honored script. I wanted to keep this talk as informal as possible since people here all know much more about their areas than I do and secondly we're peers and thirdly, there are experiences that I've never had, like what is it like to live in Fiji? So, all of these things, I hope, will get a bit blended in.

If we go back in time and look at the history - it was in July of 1798 that President John Adams signed the Relief of Seamen and Disabled Act into federal law and it was our first federal health care system. It [public health] is an old and honorable role even if we have such mixed feelings about it, clearly. It's also interesting, looking at this [slide] illustration of New York in the 1830's of New York's state began a fund of it's own to start it's own hospital. What happened was seamen had to pay 20 cents a month for their healthcare. For that they were guaranteed what we call today ambulatory care and hospital care and if you look at the act itself; it has several aspects to it.

One is, for example, that when hospitalized seamen got a balanced diet. There was interest in nutrition in those days. Secondly, they were prohibited from gambling while at the hospital; so we had joint commission rules in place. *Laughs*

And thirdly, they had to do work that was as directed, given their medical condition, by surgeons. So, it was definitely managed care. Now, if we look at this... one part of the care aspect from the beginning of our federation and the other part of it... This [slide] is an illustration of the cholera epidemic of 1873; a Harper's Weekly woodcut based on then Dr.

John Woodworth's scathing indictment of our public health at the time. This represents an angel holding a shield, standing at the port of New York protecting against cholera, smallpox, and yellow fever.

So, this represents the other aspect of public health we are looking at which is the notion of protection, in a sense a type of military and legal organization and to me, the first two slides illustrate the globalization of everything. We sometimes talk as though global behavior is something new, but it's been going on forever. Mankind has always been curious about what is over the next hill and certainly living here, in Hawai'i, you who live here or on the islands know clearly what that means. It is not what is over the next hill - it is what is beyond the horizon. I sometimes think of that analogy, and I just want to mention that I have been fortunate enough to do two Hawai'i Ironmans and there is no one who is so frightened standing up to his waist in water at 7 o'clock looking out at beautiful seas and thinking that I am going to have to start navigating out there. And I do think back to the Polynesians reading the signs on the waves, the clouds, the birds, things in the water, the ripples and the stars and making their way across the trackless, three-quarters of the blue planet and getting somewhere. Those that didn't make it, of course, were not quite heard from again, I realize that. But I'm very mindful of the globalization and the impact of mankind on this very archipelago. With that in mind, globalization is nothing new, it's really the speed, the size, and the impact of it that is very new and of course, our ability to respond to that.

The APHA was founded in 1872, and that is why the slide from 1873 is quite pertinent. And I just want to fast-forward from then to now and look at the big drivers of what is happening.

One is demography, clearly, the growth of the aging population those of us who are sixty-five and older. It's a worldwide phenomenon. I was fortunate to be in Nepal last year, and I got to visit the first home for elderly ever established in Nepal. They said that these are elderly who have been cast out of their home - something that has been unheard of in Nepalese society, ever. And now this notion of eldercare has become a problem. I'm saying this is strictly a worldwide phenomenon. So, one is the impact of demography and the anvil not only of our age composition but clearly of our diversity.

I live in Houston, TX, a city in which the plurality of the population is Latino, and not just from Mexico but from Central and South America. And we know all through the southern part of the U.S. and elsewhere the 'majority' is the 'minority.' And again, no better place to see this than in Hawai'i.

The other drivers on the other side of it - is where is this \$1.3 trillion dollars coming from and where is it going? Except, we know it is growing and what part does public health have in it? If you look at where the dollars came from, the majority of the dollars come split between public and private. If you look at where it is going - the majority of it is going to hospital care and physician and clinical services and a growing percentage of it to prescription drugs.

And we say, where is public health? Well, public health is somewhere between some 1% of this money. Optimists say 3%. And who provides this money? It is very difficult to get an accounting of even where public health money comes from. The best that I have seen from National Associations of City and County Health Officers (NACCHO) sources is that half comes from the federal government and the other half from local revenues.

So, one of the themes is this clash between what the federal role is - harkening back to the earlier slides. And what the state role is and the strange admixture that we have to deal with in this ambiguity.

Other themes - the uninsured, as we know there are approximately 42 million uninsured persons in the U.S. and it is a curious kind of dichotomy, a kind of paradox really that we have this hypoxia, this great amount of uninsured. In my state, roughly 25% of the population is uninsured and that does not count the underinsured. On the other hand we have medicare, in which approximately 92-94% of the population are enrolled in medicare. That is like national health insurance for an age specific group. So, we go again to this book ends of a state program shared with a federal program, Medicare. Among the 50 plus programs including the District of Columbia and the trust territories - and on the other hand, a real successful national health insurance scheme. This is part of the strange dichotomy in which we live that we go back and forth in our debate over public policy on this.

Another point I want to mention in this melange - the rippling effect of analysis. Where have we gone from the early times of looking at the personal health and expanding it as we do in say, S-Chip and state programs and to begin to include families and then beyond that in public health trying to enlarge the debate into community impacts, measuring that as a focal point. And lastly, the mega picture of economic analyses that holds so much in analyses such as those of the World Bank. The future of Medicare in our country and all of these things produce, what? Well, they produce some good things.

We are looking at the text of the foreword to the World Health Report 1999, so this represents the official worldview. Talking about in its opening paragraph; "this global transformation in health unmatched in history" - a very positive beginning, talking about rising life expectancy, but then it goes on to say, in the introduction, what is causing this. It goes through this long litany, in truth and good scholarship, the role of demography, its link to changes in agriculture, and industrial revolution, the effect of urbanization, which can be positive and negative, and facilitating the spread of infection. This is somewhat counterbalanced by increased nutrition, improved sanitation and water supply, and higher economic levels. So, do we wonder that we have a problem telling people what public health is? And I think this is another facet that the APHA is very concerned with, along with our confreres like the Associations of Schools of Public Health, state and territorial and county health officers. We need a broad identification. We need something the public can relate to because it is so confusing to shift back and forth between these many aspects of public health.

So given that context I want to jump back to the four aims that Steven Smith and his confreres, the other seven who founded the APHA in 1872, four years before the telephone was patented by Alexander Graham Bell, shortly after the civil war that tore this country apart - and in the midst of this, cholera, smallpox, yellow fever in New York City. These eight got together and talked about what a public health association ought to do. They essentially came up with four major tasks. One, to awaken and maintain the active and permanent interests of the people in sanitary administration - and we can read them as public health officers. Two - facilitates the enlightenment of the public on this topic. Three, promote the appointment of more competent health authorities. And fourth, the promotion of science and measures for practical application to public hygiene.

I think this is an amazing agenda, because what I am going to argue is that this is still our agenda today. I think it is very telling, as is found in the footnote, that the founders of the APHA included physicians, a superintendent of health i.e. a health officer, a medical and legal specialist, an architect, a health statistician and an urban housing specialist. So, I would even say that our history shows that what we are going today (looking at the slide of the CDC Vision for the 21<sup>st</sup> Century) - we are still working, as we should, on this same agenda and hence, partly, the title of the talk, "Back to the future." Because we are still striving to do no what we did then, with its founding.

I've listed some of how this whole palette of tools has expanded. From surveillance to statistics, epidemiology, risk reduction, laboratory, technology transfer, prevention strategies, and health communication - all of which lead up to where we were then at the time of 9/11. And it is now a time, 9/11, and anthrax in the mail, for a retooling of public health. But at the same time I think, in recent memory and speaking to those who have a longer memory, in which public health is seen as a foundation of health and in turn health is seen as essential to national security. This has been one of the great moments of recognition and the question is where does public health go from here? The positives and the negatives, it's almost like a "Tale of Two Cities" - 'these are the best of times, and these are the worst of times.' And I remember a definition that Yogi Berra said - "the future is a lot like the present except it goes on longer." And I think that's the challenge laid upon us, to push public health to the fore. Is this an easy task? The answer is no because bioterrorism now raises the possibility that anything is possible. If you or I stood up a year ago and talked about the idea that a crop duster could be hijacked and dusted people with a variety of things - anthrax, small pox, botulism, or a cocktail that exists in the bioterrorism and biowarfare armamentario, we would have been called at best, alarmist, and at worst, terrible troublemakers and really out of our gourd.

But now, anything is possible and that also is part of the challenges- the trust in and importance of the public health system. Ludlum said of terrorism that a terrorist, if he or she harms one they terrorize thousands and that is part of what we need to think about.

The two bookends of terrorism, as I am suggesting here and for the purposes of summarizing are on the one hand traditional terrorism - which is big, like the World Trade Center, has a boom and a flash, and fourthly, it's brief, it happens in a short time period; not saying it doesn't have long term effects. For lack of a better phrase I called it postmodern terrorism. If we look at bioterrorism, it's really the opposite. It's small, it's silent, not seen at first or recognized. It can be done by a single person or a device, a letter in the mail and it is sustained, it begins to amplify beyond that. And we are now trying to deal with these bookends that are now real probabilities that we have to meet the challenges of.

Speaking of back to the future - there has been re-ignited interest in the influenza pandemic of 1918 because this is seen as one possibility. One story I have heard that illustrates that it need not all be bioterrorism happened about a few years ago. A strain of influenza was popping up in the U.S., about 50- 60 cases, and serotyping shows that it was due to an outbreak that not been seen since the 1950s. It began to be traced back - without naming the name of the country, it was someone very far from the U.S. in a lab. They dropped a vial of this influenza in their laboratory, so, the spread can be 'accidental.' We are dealing with public health in it's classic sense as well as old scourges returning in the weaponized versions.

So all of these things are really on our plate. The question, as you all know well, the warts and bumps of the public health system came out as a result of 9/11 - the power failure at the CDC, that prevented them from examining specimens, as a result of antiquated equipment. Horror in the Senate, watching C-SPAN, of the fact that many states didn't have a state epidemiologist, or that a lot of health departments didn't have a fax machine or a regular way of communicating. All of these things came to be thought of as very difficult things to contend with - real facts on the ground.

And so we come back to - do we do it the old way? This is [a slide] of the patron saint of Palermo. She appeared during a plague in 1624 to a shepherd and told him that if he would go to a cave where her bones were and take them back to the city, the plague would end. He did that, notifying a bishop, and the plague did end. So, my question is - maybe we should go back to the old days. We do need some measures of faith, but I also want to say, this slide is symbolic of building trust back into the public health system as well as confidence and building up our workforce.

Winston Churchill, when looking to the future, said the future was just one damn thing after another. And I agree with that, I think we all would. I think the point we are all trying to make now - that we can't just "prepare for bioterrorism" we can only prepare by having a strong public health system. In that sense, one size does fit all, it fits 'natural' outbreaks, it fits everyday concourse in building health, and it is what is necessary for bioterrorism and that is the point we have to make. If you look at [a slide of an abstract of the Conference on Public Health Security and Bioterrorism Preparedness and Response Act] one of the major acts we have been working under now, H.R. 3448. Notice the diversity of things that it calls for. Because aside from only preparedness plans for bioterrorism it talks about special populations such as children and community education, and vulnerable populations. And of course, shades of dirty bombs, which is in the news now. What happens in some kind of radioactive chemical attacks? It also goes on to raise the question of agricultural bioterrorism and the importance of the food supply.

In Houston, I know that at certain times of the year, over half of our food comes from abroad, it may be Mexico, Peru - it may be tomatoes from the Canary Islands. It's now recognized that bioterrorism, public health covers all of these things. And it also includes, of course, the protection of the water supply and the emergency response. When I was in Canada, they talked about a crisis in Canada. They said that problems of the U.S. probably have little to do with us in Canada, but then they talked about a Walkerton water outbreak in which there was a highly pathogenic bacteria in their water supply. So, we sat and compared the response to this waterborne outbreak to bioterrorism and guess what - it came out to be the same number of steps needed to deal with this problem.

So, all of these things, including trying to keep up with the welter of money that seems to be flowing to public health. Just a little informal list of what I might call budget sightings shows the vast amount of money pumped - relative to what public health has, over a billion dollars for emergency medical supplies, these push packs that are in secret locations that will be flown in - in case of any kind of bioterrorism attack. Thirty million dollars to the CDC; but also earmarking \$1.6 billion to states and localities, all of these going down the line, including also legacy problems of

antimicrobial resistance and food and water supply protection. Well, the list goes on and on. Of course, the breaking news from President Bush is that we will have a department of Homelands Security. Well, what is going to happen with this?

This last minute slide is taken from some news reports talking about the four main divisions this department of homeland security will have.

No. 1 - Chemical and biological and nuclear countermeasures

No. 2 - Emergency preparedness

No. 3 - Information analysis and infrastructure protection

No. 4 - Water and transportation security.

And this is a \$37 billion, budget neutral, a pulling together of existing resources including those that will have components that come from energy, agriculture, as well as Department of Health and Human Services. And then talking some from various sources, on June 7<sup>th</sup> - since this is an evolving activity - the CDC Bioterrorism Preparedness and Response Programs and the National Pharmaceutical stockpile will all go to this new department of Homeland Security. CDC, and this is from the Atlanta Journal, might lose as many as 300 employees and \$4 billion from the budget. So, just when we start to get our own house in order to build our confidence - now comes this late breaking development.

It is also going to include a number of other departments including the agricultural department animal and plant health service will come over. And people are saying, well, not all that this department does is related to bioterrorism, but that's where it's going. This is the situation we are in now, clearly a state of flux. With everything that I've read it appears that there will become a department of Homeland Security because as I've checked with some who are more knowledgeable than I, what representative is going to vote against an entity, that if it were turned down and a biological or terrorist attack takes place, she or he would have no shelter from criticism. So, more of the opinion is not IF but WHAT it will be. Again, this is a kind of happening in the Richter scale of events in public health.

I just wanted to quote a comment about the money that is flowing in. I remember Senator Everett Dirksen said, 'Well, you know what they say about the federal budget, a billion dollars here and a billion dollars there and before long it adds up to real money.' So there is a cascade of additional money still coming and now what is going to happen? This is just a little of my being a neo C-SPAN junkie and watching hearings on the kind of money still flowing into these programs - including incidentally, in the midst of all this, more money for AIDS, protection for children and mothers, and more money into the global fund. I remember, in keeping with the third optimistic part of my talk, it is interesting to see, just continuing with the list of things here [on this slide] - including first responder, secret service, U.S. postal system, and other very surprising nontraditional things, nuclear non-proliferation. So, among these things, there is some hope.

The question is, as public health professionals - how do we take on some of this new spirit of patriotism and service that is extant in this country? People are now turning back - American citizens are saying government and public health are important. APHA has had some discussions about, can there be a volunteer corps? What if there is a bioterrorist attack? What if all people in a community needed to be immunized against smallpox? How could this be done? Our health system would be quickly overwhelmed. So, the question is - is there a place for the training of a volunteer corps?

Another example I want to give is, I've given a few talks, like we all have, to communities in Houston. I've participated in four different panels, church and civic service sponsored, and people there in the question period say two things uniformly. What should we as citizens know about public health and what do we need to do? And the second is; how can we help support public health? Tell us what we need to do. What messages should we send? And yes, included in all of these drivings like operation "top-off" that was a simulated attack at the Denver Symphony was exposed to plague in May 2000 and resulted in a plague epidemic. And Dark Winter in June 2001, a simulated smallpox release where 20 cases of smallpox appeared in Oklahoma City and within seven days there were 2,000 cases across 15 countries, Mexico and Canada.

The question is, between these things the new awakened public health interest, the real dangers, and unpreparedness that we have to face these, what role will we play? Is it back to the future? Such as this 1890's woodcut of a public health

officer standing with his stick of sanitation keeping [infectious disease away] all with this military cantonment. Do we go back to reinforcing that role? In part, the answer is yes. But then what do we do with our notion of humanism? What do we do with our expansion of the notion of public health? Those things that go beyond the support and advancement of all the community in terms of communicable disease as well as acute diseases. A quick story, one of the great unsettled issues in public health, now in this role of being part of the protector, a historical role, but being involved now in the criminal justice, police and military system. The quick story I want to tell is, I have a daughter that works for NBC dateline as a field producer. She's on the second floor of Rockefeller center and is friends with Tom Brokaw's assistant who received the anthrax letter in the mail. She described, she was 7 months pregnant at the time, the sheer chaos of the response. People came in from state, local, CDC, others unnamed who she knew to be FBI agents because she had worked on the unabomber story for many years. She described that and she said no one had any protective gear, clothing - they were looking around and taking samples and that's the way it was there. Yes, we've advanced somewhat. But the main thing was, she said it was declared a crime scene and they were embargoed from reporting it, they wanted to give out information to the public on what anthrax was, but they were told not to do this because it was a police investigation. And that is what I mean, again, that was the early days, but I want to go back to the Department of Homeland Security.

One of the greatest challenges is working out the role of public health within this kind of national security system- where we in public health have as our first response to tell all and tell the truth, what we do know and what we don't know. It is well known that David Sacher, then Surgeon General of the U.S., was not allowed to go on television when the first cases of anthrax came up. Jeff Copeland was not allowed to make statements on behalf of the CDC. The statement that David Sacher wanted to make was "we are not sure what this means, we have not seen patterns like this before," that was deemed unacceptable. Again, this is a clash we are all going to face. Telling what we do and don't know, our public health response, against the fact that government's always need to seem to be in control even when they are not. I want to suggest that is one of the great clashes we are all going to have to work out in this kind of new age.

To fast forward just through a few things, within this we don't want to forget our other parts of public health and this is what many of us are concerned about - that public health and it's new awareness in the public cannot be seen as just bioterrorism. It is all these other things that we value and work on day by day but this is not without problems. What happens if there is an outbreak? And most people say that there will be more. This [slide] is a graphic of Marine Hospital quarantine. There was a riot in New York City in terms of people being quarantined. What would happen if we tried to enforce public health laws about quarantine? I was told by several health authorities in Texas that they thought they would be shot because so many people have guns - that if they tried to drag them out of their houses, there would be a gun battle. Secondly, they didn't think the officials would want to do it anyway. And thirdly, a very important point I want to raise from our public health viewpoint, suppose there is a good sense of quarantine? What do we do to provide food and supplies to people who have very little money, have no medical care, are uninsured, the hospital system and the indigent care system are overwhelmed. How would we handle this? So far, to my knowledge, no one has spoken to these issues. So again, there are in all of this both dangers and opportunities.

But I want to come back to our other task of reminding people that public health is more than control and containment of contagious diseases, natural and manmade. Public health is much more. This [slide] is the old 1964 picture of '100,000 doctors have quit smoking.' In Sicily, at a regional meeting was four physicians smoking. And I said that if a picture was ever taken and published back in the U.S. I would lose my president elect status. But the surgeon gladly explained to me that he knew personally that second-hand smoking never harmed anyone. I told him that old story about the surgeon who says a surgeon is always certain and sometimes right. *Laughs*

But we have a long way to go on smoking. This [slide] is the cover of the most recent issue of the American Journal of Public Health, and it shows the ads brought forward by groups including the Coalition for Tobacco Free Kids. What if cigarette ads told the truth? We know smoking is an enormous global problem.

We also know obesity, in terms of catastrophic proportions - and those looking the slides from CDC, 1991, 1995, 2000 - where red is bad - it shows the epidemic of obesity. Houston has the dubious honor of becoming the fattest city in the

nation. I've been receiving messages of congratulations, especially from colleague in Philadelphia which was the fattest city in the last survey. *Laughs*  
So all these things are in play.

I want to also mention the notion of accountability. A recent survey said that in Medicaid, for example, only 20%, 1 out of 5, Medicaid children under the age of 6 are receiving the compulsory lead screening tests that are to be carried out under medicaid legislation. So, our agenda is writ large for us. As I said, we face the known and the unknown. I want to say this is not a picture of the local county board commissioners at all, or of public health.

I wanted to remind us of the old verities- that public health has gone through four stages. One, sanitation, which was our founding. The age of bacteriology, where the work of Pasteur and Pope led to the eradication of malaria, yellow fever, and small pox in many areas. Then in the third age public health began moving into the health behaviors and life style issues, and how we intervene in that. And also, the role of the environment in terms of health. This is one of the classic kinds of pictures of what influences public health and where money is spent. Somewhat like the World Health Organization talks about the 90/10 percent. Where 90% of the world's funds for health care goes to the 10% most affluent in the world. So, we live in a planet 3/4 water, as we know in Hawai'i, and 3/4 of that living in poverty. All of this part of the clashing of dichotomies.

So what is needed? Here is my metaphor for leadership [slide]. The surgeon general Koop, talking about HIV/AIDS as a problem when under a conservative administration who said if it is a problem, it is only a problem for those who transgressed morally. But he said no. - Smoking is another problem - he stood up and spoke out. I'm thinking about this kind of leadership that we can begin to exercise in our communities. Back to the important of enlisting the public on our side. We know the hazards of leadership. This [slide] is a cartoon at the time about the surgeon general. Where it says in there about HIV/AIDS, that Koop says, "casual sex can be hazardous to your health" and one of the grizzled reporters saying: "where will they put the sign?" with the obvious implications thereof.

Back to something that we in the room and in APHA do so well. We must not only advocate but advocate from the basis of science. We lose track of that sometimes - that we have in this room and in public health and in APHA and the affiliates - we really have the preeminence of science and practices. We are the ones who can speak authoritatively on public health.

This [slide] was taken from a 1992 report card on health that APHA published which showed Hawai'i...Nationally, Hawai'i is in really good shape. At least in 1992, Hawai'i was one of the healthier places to live in the U.S. and that is judged by those major axes of access to health care, health environment, healthy neighborhoods, healthy behaviors, and community health services. Out of embarrassment I didn't include the Texas slide. *Laughs*

These are important tools to engage the public using our science and our fact in an excellent advocacy role of where we are in public health - raising all the components of public health. Now a short story, when this came out in 1992. Bill Clinton had just become the President of the U.S. There was a firestorm in the white house because Arkansas looked really bad. So again, these things are not without hazard but they are things we should do.

I wanted to emphasize the role of partnership, another major area. We cannot do this alone. We have to work on alliances. I want to summarize some of the alliances APHA is engaged in now and hope to engage more of our affiliates and people in the room in this time of e-governance and e-commerce. I want to list a few of these things - eliminating health disparities. Before 9/11, we have formed a coalition between EMS and public health, bring together all EMS and public health people; EMS docs, nurses, firefighters, and public health to talk about how we need to work together for better emergency responses. This was in April 2000, without 9/11 or anthrax scares in mind at all.

The medicine and public health initiative, AMA and APHA and other confreres working both nationally and at the state level. Health workforce standards, human rights, building a health curriculum - these are all places we are going...

Some final points - not only must we build alliances, I hope we will pay more attention to the public health workforce. The workforce has been stagnant in the U.S. at about 480,000 compared to a survey in the 1970's. We are about the same throughout those last 30 years. We have to point to needs and shortages and some of these alliances.

How can I summarize my argument for where we need to go? What we need to do is equivalent to building an interstate highway system. We need a public health system that is uniform and connects communities everywhere, lines to standards. Yes, there can be plenty of local initiatives, plenty of feeder roads. But the signage should all be the same. Starting out in one community - we should have the same benefits where ever we move. A little historic footnote on this - this came in under Eisenhower's first term as the president of the U.S. And it turned out that, in 1919 when he was a young lieutenant he went across the U.S. to look at U.S. mobility and what he said about this was that we needed a national highway system because together the united forces of communication and transportation are dynamic elements in the very name we bear, the United States. Without them, we would be a mere alliance of separate parts. And this, I think is what we need to do with our own health care system.

I will close with one more quote which is what Steven Smith, at age 98 and he died at 99, addressed to the 50<sup>th</sup> anniversary of the founding of the APHA. What he said, from those days in 1872-1921, he said "let us on this most auspicious anniversary look backward and learn the lessons of experience which teaches before we take a step into the uncharted future." And my last tagline to myself, if I ever become disappointed, if I ever become disillusioned, if I ever feel cynical about; are we able to do this?; are we up to the task?; will the American people join us and all that live in these countries and lands? I think that if Steven Smith and his associates could found the APHA in those conditions of 1872, and we could come as far as we have and face the challenges that we have, that I too should be up to it and I think all of us are will be. Thank you very much.

*Transcribed by Bianca Isaki  
July 16, 2002*