EDITORIAL

"It's déjà vu all over again"

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This issue of *Disaster Medicine and Public Health Preparedness* represents the first issue published by our new partner, Cambridge University Press. I had sincerely wanted to mark this "first" editorial by introducing you to the nascent but evolving Society for Disaster Medicine and Public Health (SDMPH). Unfortunately, although progress toward achieving this goal has been positive, it has been slow and often unpredictable. I hope that for the April issue we will finally sound the clarion, begin enrolling members, and gather together the necessary infrastructural elements to ensure its success.

Progress on the evolution of the journal has likewise been slower than expected, but it has been palpable and very real. The copyright for the journal was graciously transferred by the American Medical Association to the new society, making *Disaster Medicine and Public Health Preparedness* the official journal of the SDMPH, and all members of the society will receive an electronic subscription as a benefit of membership. In addition, discussions are continuing with the National Center for Disaster Medicine and Public Health (NCDMPH) at the Uniformed Services University of the Health Sciences (USUHS) to formulate an agreement that will provide for continuing editorial support throughout our transition. Ms Lauren Walsh, who is now at the NCDMPH, has provided the critical "glue" necessary to keep all journal systems operational throughout this challenging transition. Through her efforts, and the continuing support of USUHS and the NCDMPH, we have posted a position for Managing Editor, *Disaster Medicine and Public Health Preparedness*, at http://www.hjf.org/careers/open-jobs (Job ID 207972). Finally, with Ms Walsh's efforts and the support of many others, we also have retained the same copyeditor for our journal, an individual performing an indispensable function to maintain overall quality.

Next steps for the journal are to complete the operational details with Cambridge (the negotiations and needed approvals having been accomplished) and to schedule a board of directors meeting this year to review many factors, including the journal's board composition and its vision and mission as well as journal composition and content going forward. In addition to all serving board members, the meeting will be open to others wishing to be part of its future.

The second half of this editorial elaborates on the title quotation: "it's déjà vu all over again," with personal reflections on our journey in preparedness and response from 9/11 to the present. Yogi Berra of the New York Yankees made that remark in reference to the frequency of back-to-back home runs hit by Mickey Mantle and Roger Maris in the early 1960s. In my opinion, it also is all too applicable to the nature of multiple meetings, work groups, committees, and boards with which I have been involved since the World Trade Center and anthrax attacks. This reality occurred to me at a recent meeting of the Institute of Medicine's (IOM) Forum on Medical and Public Health Preparedness for Catastrophic Events. The meeting was a 2-day event that covered a broad range of preparedness and response issues through presentations and discussions. Thinking back 4 or 5 years ago to the first meeting of this forum, I was profoundly struck by the fact that this latest meeting was eerily similar to the first, prompting me to question, How far have we come, and, more importantly, are we making progress?

The latter question proves easier to answer than the first. We have made progress, great progress, as evidenced in the IOM reports, especially those addressing medical countermeasures and crisis standards of care, as well as other important issues. Answering "How far have we come?" is much more difficult, and almost certainly impossible to measure or quantify. This thought brings us to a third, more critical question, Why? In addressing this last question, we could take a hypercritical approach and point fingers at agencies, professions, policies, and individuals and join a seemingly national obsession for placing blame. Alternatively, we could try to provide a solution that addresses the underlying problems.

These problems, from my perspective, are best summed up and addressed through 3 overarching considerations: ownership, advocacy, and inclusion; and 1 remedy, infrastructure. Ownership addresses the continuing need of individual disciplines to consider preparedness and/or response as their personal domain. Preparedness and response, however, is not the individual jurisdiction of public health, first responders, health care, or emergency management; it belongs to all of them, plus myriad other critical and necessary components of what I call a *disaster medical system*.

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The negative impacts of advocacy are perhaps the easiest to define and the most difficult to overcome. The majority of actors in this arena, understandably, represent their individual society, agency, or professional interests, whether it is emergency medicine, nursing, pharmacy, pediatrics, or numerous "other" positions. Until we find a way to put aside these personal agendas and define what is best for the entire population, we will continue to be bedeviled by inadequate solutions that are suboptimal for all. By inclusion, I mean that we need to define ourselves as part of the overall health care system and not as separate stand-alone parts. Our contributions to overall health and wellness need definition, and the value we add needs demonstration.

The remedy, infrastructure, I believe, can be validated by a systems failure that occurred before 9/11. It was the Medicine and Public Health Initiative instituted under then Secretary of Health and Human Services Donna Shalala. Without going into great detail, most of the leaders in medicine and public health involved in that initiative would attribute its ultimate demise to a lack of sustaining infrastructure.

Now, with declining budgets and waning public interest in preparedness and response, we need to provide an infrastructure to sustain our efforts and realistic mechanisms to address the problems of ownership, advocacy, and inclusion. This infrastructure can be provided by a multidisciplinary society that is intended not to compete with existing societies, but rather to complement them, fostering a discipline of disaster medicine and public health that is secondary to an individuals' primary professional focus. This objective can be achieved, and I sincerely hope to present our evolving concept to provide such a preparedness and response infrastructure in the next issue of this journal.

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