

## About the Author:

Reared in a rural community in the upper reaches of Appalachia, the author became enchanted with pursuing a career in health care as a young boy. He would often accompany his father, a general practitioner and public health officer of several small communities, to regional, state, and national meetings where his dad sought support for policies and programs to improve local health systems. He attended Brandeis University for his undergraduate studies and obtained his M.D. from the State University of New York at Buffalo in 1966. As a medical student, he began his own quest to improve community health by obtaining private support for medical student rural health fellowships.

After completing his internship at San Joaquin County Hospital in Stockton, California in 1967, he joined the Indian Health Service, part of the U.S. Public Health Service (USPHS). Over the next few years, he served as a general practitioner and public health officer for Native American communities. His activities included making house calls on horseback at the bottom of the Grand Canyon to care for elderly patients. Awed by the staggering potential of community public health, and the rapid development of health information technology and other “integrating” capacities, he abandoned plans to pursue a clinical career in family practice, emergency medicine, or orthopedic surgery. Rather, he completed three years of specialty medical training in public

health, including obtaining a Masters of Public Health degree from the Harvard School of Public Health. He spent his next 25 years in a variety of assignments within the USPHS, including Deputy Director of Program Operations and Chief Medical Officer of the Indian Health Service, until his retirement in 1997. He also completed many domestic and international special assignments, including serving as Staff Director, Office of the Surgeon General, and as a representative to several health policy organizations.

From this national vantage point, the author observed three decades of tremendous positive advancements in medical sciences and services. However, parallel progress in health informatics and organizational integration (despite continued rapid advances in information technology sophistication and capacity within other sectors) stalled for a variety of political, economic, and related reasons, resulting in marked local health system fragmentation, ineffectiveness, and inefficiency. In 2000, in an attempt to improve a health system from the bottom up, the author returned to the local community level serving as a city–county health officer in Charleston, West Virginia. The perceived impotence of local communities to influence their health systems—and the ceding of ownership to an amorphous “they”—concerned him. He decided to dedicate the remainder of his career as he had started, helping local communities regain ownership of their health systems and drive the health agenda.