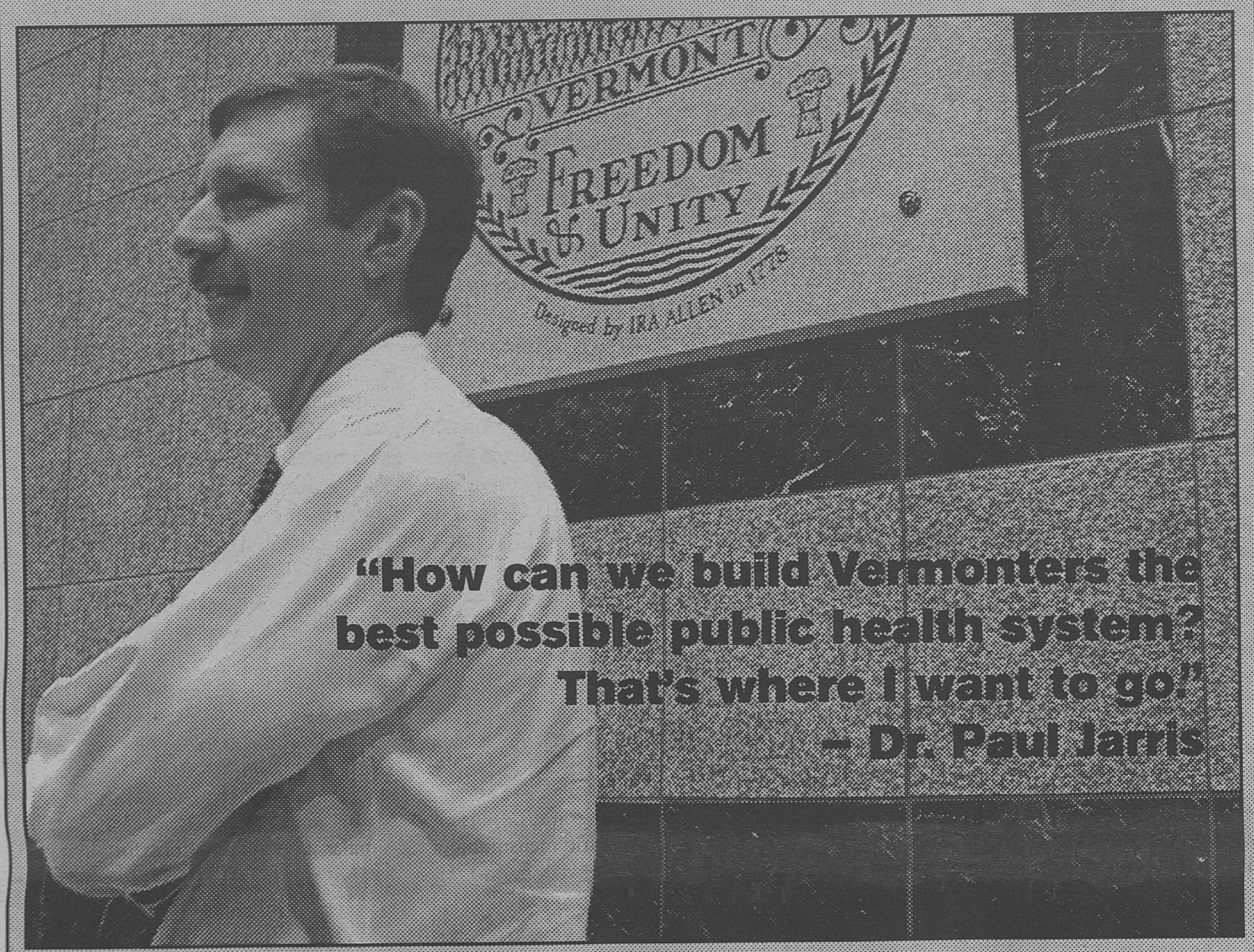
The Doctor Leading the Way:
VT Health Commissioner Paul Jarris



"How can we build Vermonters the best possible public health system? That's where I want to go!"
– Dr. Paul Jarris

Dr. Paul Jarris, the new Commissioner of the Vermont Department of Health, has an impossible job.

"I prefer 'challenging,'" he said. He oversees a department of 520 employees, 12 district offices, and a $74 million budget and is charged with protecting and promoting the health and wellbeing of Vermonters.

"I'm working with our management team to really take a look to see, are we giving Vermonters all they deserve given the resources we have in this department? That's one question and process that has set the direction for public health in the state," said Jarris, who brings years of clinical care and business management experience to the position.

"How can we build Vermonters the best possible public health system?" asked Jarris. "That's where I want to go."

A husband and father of three children, Dr. Jarris grew up outside New York City. He attended medical school at the University of Pennsylvania and has a Master's in Business Administration from the University of Washington. Governor Jim Douglas appointed Dr. Jarris in March of 2003.

"I'm a family doc," said Jarris. "I've always practiced until a couple of months ago when I took this position." Dr. Jarris maintained a family practice while serving as President and CEO of Vermont Permanente Medical Group, and CEO of Primary Care Health Partners, two large primary care groups. Before that, he was Medical Director at Community Health Plan, the state's largest health maintenance organization.

"What I loved about HMOs was we had a fixed amount of resources to care for a population. You do that through prevention, early identification of disorders, trying to help people deal if they had an illness in the most efficient and highest quality fashion," said Jarris. "It really is not that different than a public health approach."

In spite of his extraordinary experience with both the practice and business of medicine, Dr. Jarris is quite humble about his new job.

"I don't pretend to be an expert," said Jarris. "I've been in this job for six months and most of what I've been doing is learning, which is what I love. I like to take the approach of letting people know what I don't know instead of pretending." Through his practice, Dr. Jarris has developed an approach to diversity and working with the gay, lesbian, bisexual, and transgender communities.

"I've had patients come to me from many communities, including gay men, lesbians, transsexuals. I think I am comfortable dealing with issues," said Jarris. As a doctor, "if I have a transsexual patient, I will say, 'Help me tailor what we're doing specifically to your needs.' So I think I've learned a lot from practice. I've learned to be compassionate and that everybody has a story. You don't judge them. It's not your job."

AIDS aside, public health has never been a high priority for Vermont's gay political leadership and caring for the public health needs of queer Vermonters has never been an area in which the Vermont Department of Health has excelled.

"The needs of the gay, lesbian, bisexual, and transgender population are important," said Jarris. "It's important to me, it's important to the department. It's not going away." ▼

Ric Kasini Kadour last wrote about the National Gay Men's Health Summit in the July 2003 issue of OITM. *He lives in Shoreham.*

continued from p. 1

deliver to the general smoking population effective for gays or not or do they require a specific message? And I don't know the answer to that.

"If in fact we can deliver a message that hits 60 percent of the entire population, that's a bigger bang for the buck than targeting to a smaller group. There's a lot of research [into] tobacco use. I don't know the answer to this, but generally that's the question: To what extent can you develop a message that is effective for everyone versus specifically a targeted population."

Have you ever played the telephone game? That's when a group of people sits in a circle and one person whispers a sentence into the ear of the person next to them and the message travels around until it is repeated to the originator. Inevitably, the message is different. 'Mary takes a walk to school' becomes 'Mary pokes a hole you fool.' The game works because people do not hear things the same way. The same thing happens with health messages.

One of the reasons for health disparities among minority populations is that health messages aimed at the general population (read: straight, white, and middle class) fail to reach non-white, queer, poor populations. We are a diverse society. We think differently when it comes to health. For example, Centers for Disease Control research on tobacco control suggests messages that demonize smokers as social misfits or outcasts are an effective way to discourage smoking. However, in focus groups conducted in Seattle, I found that such messages are ineffective for an lgbt population. Gay men and lesbians already feel demonized. Furthermore, social marketing research suggests sexual minorities are often non-responsive to negative campaigns and perceive them as anti-gay.

The Bang-for-the-Buck approach is one way public health officials dismiss the needs of minorities. It's the idea that resources should be spent in such a manner as to reach as many people as possible. This is like building a school where the greatest concentration of children is and dismissing the educational needs of those children who live too far to walk to school every day. While education in the United States abandoned this practice years ago – the Supreme Court ruled it unconstitutional – public health officials routinely justify policy and programming based on this approach.

In 1999, I was a member of the Seattle/King County Tobacco Council. We were able to create a funding allocation formula that divided the financial pie in a more equitable, inclusive manner. Using data gathered locally, we were able to prioritize populations whose tobacco use rates were disproportionately higher than those of the general population. We are also able to provide additional funding for communities that lacked the infrastructure to execute an appropriate program. As a result, we were able to work with the diversity of the population and choose quality over quantity.

The words 'gay' or 'lesbian' do not appear in *Vermont Best Practices to Cut Smoking in Half by 2010*, the state's road map for tobacco control. DoH's tobacco control program has made no grants to gay community organizations and the only gay-specific project being funded is a video being produced by Chittenden Community Television.

Back to HIV

Dr. Jarris said, "I am also very concerned about youth, gay and lesbian youth. My understanding is that it's a very significant risk factor for alcohol and drug use, perhaps more so than other populations. We know alcohol and drugs leads to risky behavior which gets us back to STDs and HIV."

Nationally, more sexual minorities are dealing with depression or some other form of mental illness than with HIV. The leading causes of death for adult sexual minorities are not AIDS, but heart disease and stroke. Gay youth are much more likely to become addicted to alcohol or drugs than become HIV positive.

When pressed on the issue, Dr. Jarris could not provide an example of something DoH was doing for sexual minorities outside the AIDS program.

"There's a lot we do for the population in Vermont based on risk >>