Medical Officers of Health, Public Health and Preventive Medicine Specialists, and Primary Care Physicians: How Do They Fit?

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In discussing Loh and Harvey's article,¹ I will focus on the medical officer of health (MOH)* role and training for this role, and also comment on how these relate to primary care practice and practitioners. I note that public health practice as an MOH is only one of many potential career paths for public health and preventive medicine (PHPM)† specialists.^{2,3} Positions in the provincial or federal health ministries or centres of disease control, academic positions as a researcher/teacher, or a career in global/international health or occupational/environmental health, to name the more common ones, can be attractive options.‡

Role

For a physician trained in population health,§ wouldn't it be great to have a job in which you work with local decision makers (from a Board of Health or Municipal Council) and direct a range of public health professionals to plan and implement evidence-based, agreed-upon programs? The fact is, the Medical Officer of Health positions in all the major urban centres of Canada are filled.

I believe there are advantages to having a population health *physician* in the MOH role, for the following reasons: a) their knowledge of disease – the disease process, potential for spread, treatments, etc. – fits well with disease prevention and health protection roles; b) their training in diagnosis, which emphasizes a specific approach to detecting causes, is well suited to analyzing assessment and surveillance information; c) medicine has a focus on curing the health problem, which is essential to success in improving health; and d) a physician often starts with an advantage of being respected by the community and by other health professionals, which is important for effective collaboration and advocacy.

Of course, to be effective in such a complex environment, one needs more than education – one needs some experience in dealing with communities and politicians, as well as leadership and management abilities. One must also be credible with the politicians and with the community – i.e., have a degree of (small p) political accountability.

* For this paper, an MOH is a public health physician employed by the governmental public health system and whose position is recognized under legislation. Associate/Deputy MOH positions also fall into this definition. Some jurisdictions utilize "Medical Officer of Health", while others use "Medical Health Officer (MHO)". For consistency, "MOH" is utilized throughout this paper. In Quebec, the MOH equivalent is the Regional Public Health Director (Directeur de la santé publique).

† PHPM refers to Fellows of the Royal College of Physicians and Surgeons in Public Health and Preventive Medicine. It also includes Fellows in Community Medicine, which was the previous title of this specialty.

‡ I also note that the Royal College is conducting a study on specialist unemployment,³ so I will not address this aspect.

§ The term population health specialist or physician refers to those practicing population health with or without the fellowship designation.

Working in a public forum can be messy. The issues one faces may be quite removed from "scientific" diagnosis and treatment in a controlled setting. However, when a leading politician and the MOH share common goals and have mutual respect for the role and abilities of the other, significant policy and program advances can be made (e.g., non-smoking bylaws, heart health programs, needle exchange programs, etc.) and the rewards, in terms of community health, can be substantial.

To gain experience for the role of MOH, a population health specialist can become an Associate MOH, working under the MOH and responsible for some part of the overall mandate. This also allows him/her to spend relatively more time on technical issues and to be more "hands on" in terms of program implementation. And it can be a permanent career choice.

The rural experience has some important variations from the urban one. The MOH is less likely to have the support of an associate MOH. Also, one's counterparts in dealing with local politicians are likely to be chiefs of police and fire department, municipal planner, finance and transportation directors, etc. They are likely to have moved through the ranks and have years of experience. As the PHPM fellowship program is more oriented to attracting physicians immediately after medical school,¹ PHPM specialists are more likely to be relatively advanced in technical areas, such as data collection and analysis, but less experienced in understanding a community, or working in partnerships or in the policy-making environment.

In such an environment, it may be more desirable for the municipality or Board to have as MOH a local physician (usually a family physician) who understands the community and goes back to university to obtain the knowledge and competencies to practice public health. The need for a fellowship may seem less obvious in this situation as the prospective MOH has already had years of clinical practice experience. Requiring a specialist qualification with four years of training could be a significant disincentive for practicing physicians.

The five functions of public health practice are health protection, disease prevention, health promotion, surveillance, and health assessment.³ MOH/CEO positions (directing a public health division/unit in the five functions) have been reduced over the past years, perhaps in response to the "fit" problem. They exist only in Ontario and Quebec and some health authorities across the country.⁴ In other jurisdictions, MOHs are still responsible for communicable disease control policies, for enforcing environmental health regulations, and for surveillance and assessment activities. However, often they have little or no authority to control disease prevention or health promotion programs, nor do they manage staff in these areas.

Skills and training and relation to primary care

I believe MOHs and primary care physicians should understand and respect each other's roles – and use this understanding for effective collaboration. However, we should not confuse the expertise or responsibilities of each.

The approach of a primary care physician treating an individual patient is clinical and is specifically tailored to that patient. The physician diagnoses his/her patient's condition based on history, examination and relevant test results and communicates directly with the patient in the manner which s/he deems to be most effective for this person.

A physician trained in population health contributes to improving the health of the community. S/he makes his/her decision on the basis of data from samples of the population. In making recommendations, s/he must understand how policies that affect health are developed in the community. S/he must get agreement on his/her recommendations from a number of others – policy-makers, researchers, specialists/practitioners, special interest groups, etc. And the communication is mostly carried out by others – health care professionals, teachers, the private sector, families/friends, etc. So s/he must learn to communicate his/her advice to the public through others. The MOH cannot possibly know the particular situation of every resident.

In addition to knowledge of the five functions of public health, the skills one needs for this work include, among others: epidemiology/biostatistics, policy development, how to work as a partner, advocacy, and mass communications. The competencies required to be an MOH have been developed by a panel.⁴ They coincide

rather well with the competencies as outlined by the Royal College of Physicians and Surgeons of Canada.² There is no reference to clinical practitioners, or to patient diagnosis or treatment in these competencies.

CONCLUSION

In summary, I believe that the article by Loh and Harvey¹ is overly oriented towards the work and relationships of primary care and clinical practice. The scope of practice of an MOH is much broader than primary care: s/he deals with politicians, civil society, the public and private sectors, and the public in addition to physicians and the health sector. When the Royal College² or Working Group⁴ refer to partnerships, they are not only referring to multidisciplinary partnerships, but to *multisectoral* ones, including ones in which the MOH is not the leading figure. Similarly, reference to leadership is not merely to leadership of an organization, but to leadership in the *community*.

REFERENCES

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