The Specialist Public Health and Preventive Medicine Physician: System Roles and Training Challenges

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In their commentary, Lawrence Loh and Bart Harvey have described the evolution of the medical specialty in Canada currently named public health and preventive medicine. However, the role of this specialty within the larger public health system is still not clear in Canada. There remains lack of consensus about the role and necessary qualifications of the public health physician within the public health system. This lack of consensus is both within government and in the broader public health community. There is not even consensus among physicians currently in public health practice, who understandably regard their own path into the discipline as well as their particular level of training as adequate.

The future of the specialty and its ongoing role within public health in Canada will depend on developing a common response to the following inter-related issues:

The requirement for specialty certification to exercise regulatory authority under public health legislation

Specialty certification, i.e., FRCPC, is not the minimum qualification for being a medical officer of health (MOH) or provincial chief MOH in most provinces in Canada. Most jurisdictions require a medical licence and a 1-year Masters of Public Health (MPH) or equivalent. The fact that this policy is changing slowly, if at all, is due to a number of factors, including difficulty in recruiting specialists – particularly in rural areas – and a belief among many politicians and even many practitioners that most public health decisions are mostly common sense and that the necessary expertise can be acquired on the job with a minimum of formal training. The argument that the job now requires a stronger scientific and technical base has not yet won the day. Many larger urban units with greater ease of recruiting do require specialty certification for their positions.

The tension between technical/scientific vs. administrative/leadership functions

The greatly differing roles of public health physicians in the different provinces and territories have led to challenges in designing training objectives and a curriculum for a Public Health and Preventive Medicine (PHPM) specialist program in Canada. In some provinces/territories, the role is predominantly a technical consultant; in others, there is an additional leadership/management role.

The vesting of public health regulatory authority in physicians

In most jurisdictions, there is recognition that the MOH's regulatory role and obligation to inform the public about threats to public health and safety are a professional responsibility, not requiring prior bureaucratic or political approval. Thus, an MOH has some defined independence even if their position is nested well down in

the bureaucracy. This delegation of authority and decision-making assumes expertise, judgement and professional ethics which will put the public interest and safety before any institutional or political self-interest.

Historically, society has judged the medical profession as having the appropriate training and professional approach to play this role. The recent emphasis on the CanMEDS roles of collaborator, communicator, advocate and professional in medical training suggests the continuing appropriateness of this delegation. This presumes that the physician also has adequate scientific and practical training to inform population-based decision-making.

Clinical training vs. public health training

Currently, most PHPM training programs in Canada consist of two years of clinical training leading to certification in Family Medicine, one year of academic training and two years of applied public health training. These last two years represent a short period of time to achieve mastery over the many domains of public health practice. Population practice is fundamentally different from clinical practice, requiring an entirely different toolkit. Even with recent revisions of the undergraduate medical curriculum, the vast majority of undergraduate training is in the clinical domain. Virtually all population knowledge and skills need to be taught at the postgraduate level.

Most graduating physicians interested in public health practice wish to obtain a general medical licence as part of their training. This is partly an issue of income and job security, there being a limited number of public health positions. Also, recent graduates have spent four years of their life immersed in acquiring specific patient diagnostic and treatment skills. They are naturally reluctant to abandon these for a purely population-based practice.

There is also increasing interest in combining clinical and population practice within a community health centre or a predominantly clinical practice focused on preventive medicine where PHPM certification may be the most appropriate pathway.

Through the pressures of maintaining competence and the rigours of a demanding full-time public health position, many public health physicians do abandon clinical practice or practice only in a limited clinical area such as sexual health. Still, many believe that ongoing clinical practice is an important asset for a medical officer of health.

There is currently no consensus about the exact importance and influence of clinical practice within a population-level practice and therefore within PHPM specialty training.

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Questions going forward

There has been an explosion of knowledge in the population sciences, and recognition of the complex web of causes and influences that make a population healthy or unhealthy. The medical profession seems well placed to continue to play a key role in the public health systems designed to improve population health. However, the medical specialty of public health and preventive medicine, as opposed to medical training, has not yet achieved full recognition as the minimal qualification to play that role effectively. I would suggest that achieving consensus on the following questions would lead us a long way to resolving this:

- Is public health practice for physicians something best entered after a period of clinical practice, with one to one and a half years of additional training in the public health sciences, or a specialty best learned through five years of formal training immediately after medical school?
- Are two or three semesters of academic training in the public health sciences (an MPH or equivalent) in conjunction with basic medical training sufficient preparation for a technical leadership role in a modern public health system?
- Does the leadership of a modern public health system within a larger health system require a deep technical knowledge of the public health sciences or does it require an ability to manage and coordinate professionals with that knowledge?
- Based on past trust in the appropriateness of medical training and professional ethics, will politicians and the public continue to vest public health regulatory power and the authority to warn the public of public health threats in a physician? If so, will the modern demands and expectations on these physicians for advanced expertise and technical knowledge lead to a move for specialty certification of all these individuals, as is the case for most other areas of medical practice?
- Given the extensive and very wide-ranging expertise required for modern public health practice, is it reasonable and sustainable to expect that most specialty physicians in this field master and maintain a full range of clinical practice as well as a specialty level of public health practice?

As described by Loh and Harvey, the medical specialty of public health and preventive medicine has come a long way. Definitive answers to the above questions would clarify its position within the larger health system.