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Commentary

Preventive Medicine: A hidden asset for building a dominant culture of prevention

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ABSTRACT

We explore three issues related to the practice of preventive medicine. First, how does the dearth of preventive medicine physicians on state licensure boards affect quality of medical care? Second, should a process be established to assess the training and skills of candidates for population health positions, like the "credentialing" or "privilege-granting" process used by hospitals and health systems for clinical positions? And third, how should the pervasive lack of recognition of preventive medicine as a bona fide medical specialty be addressed?

In exploring these issues, we conclude that preventive medicine physicians are critical to the US health care ecosystem at every level, and to building a dominant culture of prevention. Preventive medicine physicians are actively engaged in the practice of medicine and should be party to the same licensure, credentialing, and privilege-granting procedures as all other specialties. Further, we raise a call to action to our profession to define and raise awareness of preventive medicine, participate in state licensure boards, and establish clear standards of practice for which we are uniquely trained and capable.

1. Introduction

In this issue of *Preventive Medicine,* Jung and Lushniak question the nature of medical practice today, especially the practice of preventive medicine (Jung and Lushniak, 2018). Responding to state medical boards that ask whether preventive medicine physicians who do not provide "direct medical care" are actively engaged in medical practice, Jung and Lushniak persuade us that preventive medicine is, in fact, the practice of medicine. Their arguments are supported by previous reports, the Accreditation Council for Graduate Medical Education, the American Medical Association, and the American Board of Medical Specialties (Hull et al., 2013) (ACGME, 2017) (AMA, 2010) (ABMS, 2018). The American College of Preventive Medicine (ACPM) has used these arguments to successfully assist physicians seeking full unrestricted licenses in states with laws or policies that require "active practice of medicine." (Braund and Bonta, 2015)

In presenting their arguments, Jung and Lushniak suggest three important issues for further exploration.

1. How does the dearth of preventive medicine physicians on state licensure boards affect quality of medical care?

Jung and Lushniak identify the lack of preventive medicine physician representation on any state medical licensure board as a potential barrier to understanding of the specialty, and thus, to the challenges some preventive medicine physicians have faced in obtaining unrestricted medical licenses. We postulate this lack might also negatively affect another critical function of state medical boards.

State licensure boards are the purveyors of state-wide policies that determine standards of practice for all physicians. For example, many state medical boards are currently writing policies for the proper use of opioid medications and the prevention, identification, and treatment of addiction. Preventive medicine physicians are specifically trained in policy development and ways to use policy to prevent poor health outcomes, including addiction. Addiction Medicine is a recognized subspecialty of the American Board of Preventive Medicine (ABPM), so engaging these content experts on this topic would be beneficial. In addition, preventive medicine physicians bring a systems lens to clinical practice guidelines and can enhance the ability of the board to accurately assess evidence across all specialty areas. On topics pertinent to the public's health, preventive medicine specialists can and should be instrumental in developing and promulgating state-wide practice policies.

2. Should a process be established to assess the training and skills of candidates for population health positions, like the "credentialing" or "privilege-granting" process used by hospitals and health systems for

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clinical positions?

Jung and Lushniak make the case that state medical licensure is the "lowest common denominator" among the various processes used to assure the quality and competence of medical care. We agree with their recommendation that a single set of standards for licensure should be used to assess all physicians regardless of specialty training.

While medical boards do not grant specialty-specific licenses, there is an expectation that physicians will not practice outside their own specialty. In at least one case in which one of us testified, a state medical board indicated concern that an unrestricted license for a preventive medicine physician would allow that physician to then practice "any" type of medicine (Braund and Bonta, 2015). We successfully argued that it is highly unlikely that physicians practice outside their own specialties as they are restrained by integrity and ethics, the risk of malpractice liability, and privilege-granting barriers posed by the hospitals and health systems in which they practice. We also argued that all physicians, not just preventive medicine physicians, should be held to the expectation to not practice outside their specialty.

Ironically, this concern reveals an opposite and troubling problem: public health, health care administration, and other population health positions occupied by physicians with no training in preventive medicine. For most medical specialties, the physician maintains his or her practice within a setting that requires some type of credentialing and privilege-granting process. Health systems and hospitals assess the physician's training, practice history, and skills to grant privileges to practice in that setting.

Unfortunately, no such process occurs for the population-based roles in which preventive medicine physicians practice. This can lead to individuals with no formal training filling positions within health systems and local, state, and national public health systems. These positions have health impacts across entire populations and require knowledge of population health management to be effective.

While not in the purview of state medical boards, the issue of verifying the qualifications of individuals holding population health positions – possibly through a privilege-granting process – requires additional investigation. Establishing such a process would enhance health outcomes, improve health system effectiveness, and assure the judicious use of health resources.

3. How should the pervasive lack of recognition of preventive medicine as a bona fide medical specialty be addressed?

The current paper by Jung and Lushniak is the second by these authors regarding the pervasive lack of recognition of the preventive medicine profession (Jung and Lushniak, 2017). In many ways, this is an identity crisis of the specialty's own evolution. Preventive medicine enjoys a "big tent" philosophy and encompasses many types of physicians to our profession, with additional training and experience provided in a variety of settings. The variability and diversity of roles that preventive medicine physicians fulfill is one of our greatest strengths and a potential liability, as it makes establishing a succinct definition of our specialty extremely difficult. That lack of a definition makes it more challenging to educate others about preventive medicine and its important role in evolving health and public health systems.

Another challenge is that almost all other specialties practice some forms of clinical prevention – it is part of the physician's creed. Many physicians counsel patients about preventive measures and offer vaccines and preventive screenings. This is excellent medical practice, but it does not make them preventive medicine specialists. The provision of clinical preventive services is not the totality of preventive medicine training and expertise.

Preventive medicine physicians are residency-trained in one of three disciplines: public health and general preventive medicine, occupational medicine, or aerospace medicine. Each discipline is unique, yet they share a common core of clinical and population health competencies. The foundation of biostatistics, epidemiology, clinical preventive medicine, environmental health, behavioral health, health systems, health policy, management and administration integrated with clinical training leads to a powerful and comprehensive focus on population health.

2. Call to action for preventive medicine physicians

The core values and common approaches that define preventive medicine as a specialty should be codified into a clear and comprehensible definition. Such a definition will facilitate acceptance by our medical boards and health institutions.

Such a definition can emerge through a concentrated and multidimensional effort.

- We encourage Jung and Lushniak and other authors to continue to raise these issues about the identity of preventive medicine.
- ABPM, ACPM, the Aerospace Medical Association, and the American College of Occupational and Environmental Medicine, with input from our subspecialty organizations, should work together to develop a clear and comprehensible definition of preventive medicine.
- ACPM should work with other primary care specialties to distinguish the specialty of preventive medicine from the critical clinical prevention elements required of all primary care doctors, and to build consensus with our own and other specialty societies on a common definition.

Prevention is more important than ever. Longevity and health improved dramatically in the 20th century largely due to prevention strategies such as vaccination, control of infectious diseases, clinical and lifestyle measures to reduce heart disease, motor-vehicle safety, and tobacco control (Ten Great Public Health Achievements - United States, 1900-1999). But current challenges – out-of-control health care spending due to preventable chronic conditions, new infectious disease threats and antibiotic resistance, the opioid crisis – require an even greater turn toward a culture of prevention. There is no medical argument against prevention as the best way to dramatically reduce the nation's medical bill and protect our nation. But there is lack of awareness and recognition of preventive medicine physicians as an integral part of the health care ecosystem to help create this transformation.

- ACPM should advocate for preventive medicine specialists in key public health and health system leadership positions, particularly those required by law, regulation, statute, or tradition to be held by a physician.
- ACPM and supporters of preventive medicine should advocate for sustained funding of preventive medicine residencies to assure sufficient numbers of population health trained physicians.
- ACPM should work with the National Association of City and County Health Officials, the Association of State and Territorial Health Officials, and the Public Health Accreditation Board to develop standards of practice for public health physicians, identify a mechanism to assist untrained public health officials in attaining that skill set, and explore a privilege-granting process for population health positions.
- Preventive medicine physicians should seek positions on state medical boards, and volunteer to assist with writing and reviewing state policies that govern medical practice.

3. Conclusion

Preventive medicine physicians are critical to the US health care ecosystem at every level, and to building a dominant culture of prevention. Preventive medicine physicians are actively engaged in the practice of medicine and should be party to the same licensure, credentialing, and privilege-granting procedures as all other specialties. As a profession we can and should do more to define and raise awareness of our specialty, participate in state licensure boards, and establish clear

standards of practice for which we are uniquely trained and capable.

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