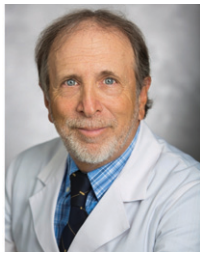
The Specialty of Public Health and General Preventive Medicine to Modernize the Public Health Workforce



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The public health workforce is in dire need of reinforcement. Despite the large burden of preventable chronic conditions, infectious diseases, injuries, and other major health problems, growth in the US medical workforce's capacity to prevent and control many of these problems at the population level has lagged substantially in relation to the magnitude of need. In 2007, a report issued by the Institute of Medicine (now the National Academy of Medicine) estimated that the number of physicians needed in governmental public health agencies ranged from 17 000 to 23 500, a number far beyond the 2475 physicians board certified in the medical specialty of public health and general preventive medicine (PHGPM) as of 2019. This contrasts with the explosion of graduates with bachelor's and master's degrees in public health—an estimated 1000% increase between 2001 and 2020. The medical specialty of PHGPM, therefore, can be viewed as representing a "missing link" between clinical medicine and public health.

To effectively modernize and expand the public health workforce, there is a need to increase the number of physicians with training and competencies in population and public health, specifically via training in PHGPM.

Training in PHGPM is unique among both postgraduate medical training programs and public health–training programs. PHGPM residencies are available to physicians (doctor of medicine or doctor of osteopathic medicine) after they have completed a minimum of one year of a clinical residency, although many PHGPM trainees have completed a full clinical residency in other specialties (e.g., internal medicine, pediatrics, family medicine). Training consists of clinical rotations focused on preventive medicine, primary care, and conditions of public health significance. PHGPM trainees are also required to spend time in rotations in local, state, or federal public health settings to obtain experience in frontline public health practice. Additionally, trainees must complete coursework for a master of public health degree or equivalent; to our knowledge, PHGPM is customarily the only medical specialty that requires a specific degree beyond a doctor of medicine or doctor of osteopathic medicine to become board eligible. PHGPM is also the only pathway for physicians to receive formal training in public health that results in certification by a board recognized by the American Board of Medical Specialties (e.g., the American Board of Preventive Medicine), making PHGPM

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HISTORY CORNER

11 YEARS AGO

Felon Disenfranchisement in the United States

The ability to vote is one of the most fundamental rights of citizenship. It affirms one's sense of collective identity and provides an opportunity to influence public policy. Despite the seemingly intuitive nature of ensuring a political voice for those most in need of social change, approximately 5.3 million Americans, 1 in 45 adults, are ineligible to vote because of a felony conviction. . . . The rate of disenfranchisement is 7 times higher among African American men than it is among other groups. . . . Following the ratification of the 15th Amendment in 1870, which granted African American men the right to vote, the number of states with felony disenfranchisement laws increased dramatically. . . Along with literacy tests and poll taxes, disenfranchisement laws were enacted to systematically eliminate African Americans from the electorate and uphold White power structures. The laws continue to have this effect today. . . . When a group is exposed to pervasive and chronic violations of human dignity—and feelings of ignominy, disrespect, and social exclusion are prevalent—elevated rates of mortality, morbidity, and disability often follow.

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training unique among public and population health–training programs, including the Centers for Disease Control and Prevention's Epidemic Intelligence Service Program. Because of the requirements for training in PHGPM, physicians trained in this specialty logically and arguably have unique expertise in helping to prevent and control the array of public health problems that occur in and pose threats to the US population and serve as a critical pathway to expanding and modernizing the public health workforce.

Although supporting and expanding training in PHGPM is not the sole answer to the myriad challenges facing the public health workforce, it is a critical piece of the puzzle. First, PHGPM-trained physicians are unique among both public health professionals and clinicians in their ability to work at both the patient and population levels. Because every PHGPM-trained physician also has a clinical background, they can easily pivot from thinking about an individual patient to addressing populations and can evaluate the impact of research, preventive screening, and therapies on both. This makes PHGPM graduates well suited to work as clinicians or public health officers, among other career trajectories, in a range of settings. Second, PHGPM-trained physicians are trained to use limited resources for maximum benefit; because of their ability to work upstream at the population level, physicians with PHGPM training are uniquely poised to deliver major returns on small investments.

The challenges facing those trained in the PHGPM specialty mirror those facing the entire US public health system. Like the public health system in the United States, PHGPM training programs face significant challenges, the foremost of which is limited funding. Because substantial portions of PHGPM training occur outside the health care system (e.g., local, state, and federal public health agencies, schools of public health), traditional means of funding residency training are not available for these critical (and, as prescribed by the Accreditation Council for Graduate Medical Education, mandatory) training experiences. This leaves PHGPM programs to create a patchwork of alternative funding drawn from their parent institutions, external grants, and donors. For example, of the 72 accredited PHGPM programs, as of 2021, only 17 received funding from the Health Resources and Services Administration, the specialty's largest funder. Additionally, knowledge of the specialty of PHGPM is limited. For example, some applicants to our program (the Emory University PHGPM Program) share that they have been told by other physicians that the specialty "doesn't exist." Finally, the number of physicians with board certification in PHGPM is nowhere near the size it needs to be to address the needs of the US public health system; the current gap is estimated at nearly 15 000 physicians. Although addressing the challenges discussed may increase the supply of PHGPM physicians, additional avenues to develop population and public health competencies among physicians should be pursued. These issues are significant barriers to growing the specialty of PHGPM and the workforce of PHGPM-trained physicians as well as expanding the public health education and competencies of physicians, particularly those with training in internal medicine and other primary care specialties.

We urge medical organizations and others that advocate a stronger public health workforce to include training in PHGPM in their advocacy. For clinicians who wish to obtain competencies and board certification in the primary medical specialty of public health, PHGPM training is an exceptionally relevant opportunity and should be a cornerstone of efforts to maintain the currency and effectiveness of the public health workforce.

[Note: For additional reading, see the supplemental references, available as a supplement to the online version of this article (at https://www.ajph.org).] AJPH

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HISTORY CORNER

56 YEARS AGO

Compliance of Hospitals and Health Agencies With Title VI of the Civil Rights Act

[D]uring the past year (1966), a deep and significant change has taken place in the way hospital care has been offered to the millions of people in this country who are members of minority groups. In hundreds and hundreds of hospitals in all parts of the country, but most particularly in the southern and border states, Negroes are being admitted and treated as anyone else for the first time. . . . In hundreds of hospitals Negro physicians are being allowed to practice as full staff members for the first time, and what is more important, to admit and care for their own patients instead of referring them to a white doctor who had staff privileges. . . . We are still working with 100 hospitals to see if they can be brought into compliance voluntarily, and 215 hospitals have decided not to accept federal funds. . . . The road to compliance was not an easy one but change did come-significant change-and once the bandwagon started to roll it came fast and with less pain and chaos than many had predicted.

From *AJPH*, and the Nation's Health, February 1968, pp. 246–247