HHS Public Access

Author manuscript

Prev Med. Author manuscript; available in PMC 2020 January 01.

Published in final edited form as:

Prev Med. 2019 January ; 118: 352–353. doi:10.1016/j.ypmed.2018.11.018.

Privileging the preventive medicine physician: A solution in search of a problem?

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Keywords

Preventive medicine; Scope of practice; Privileging

As a preventive medicine physician, I appreciate the concern that Drs. Jung and Lushniak have shown for the future of our specialty (Jung and Lushniak, 2019; Jung and Lushniak, 2018; Jung and Lushniak 2017). They have raised critical concerns about the specialty of preventive medicine and helped to draw attention to a field of medicine that is too often overlooked. However, However, I find some aspects of their article in this issue concerning.

My primary concern is that the authors seem to have proposed a solution (privileging) without clearly defining the problem. Taking the time to define a problem clearly is essential to finding the most appropriate solution. However, this article raises at least 13 possible problems without clear evidence that privileging would rectify any of them. For example, it would be reasonable for readers to assume the primary problem under discussion is the ill-defined practice of preventive medicine since it is highlighted in the first sentence, the discussion, and the conclusion. If that is the principal problem, how would privileging address the root cause of this problem?

One could argue that solving this concern through privileging is a bit like the tail wagging the dog. Should we not rely on groups such as the American College of Preventive Medicine (ACPM) and the American Board of Preventive Medicine (ABPM) to define the practice of preventive medicine in a consistent, cohesive and coherent way?

Other potential problems raised in the article include that: preventive medicine physicians hold diverse positions; many of us do not work in direct patient care; preventive medicine physicians claim too broad a slate of preventive medicine skills; other physicians claim too broad a slate of preventive medicine skills; clinical training of preventive medicine physicians varies widely; non-clinical training of preventive medicine physicians varies

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Financial disclosures

None; Betsy L. Thompson is a Fellow of the American College of Preventive Medicine.

widely; health care organizations need to understand how preventive medicine physicians fit into their staffing structure; some preventive medicine physicians face licensure issues; privileging would benefit healthcare organizations and public health agencies; quality of public health practice needs to be assured; and the “general obscurity of the specialty”.

There is certainly logic to support privileging for some of these issues – such as an unwarranted claim of preventive medicine skills by physicians, avoidance of licensure issues, and assuring the quality of public health practice – but empirical evidence is sparse. Specifically, there is little published evidence about the impact of privileging on clinical quality. Therefore, it is hard to imagine a strong empirical argument in favor of privileging for preventive medicine skills, at least at this point in time. In addition, some of the suggestions raise practical challenges. For example, the authors suggest all physicians in leadership positions go through a preventive medicine privileging process. However, physicians who have achieved board certification in healthcare management through the American College of Healthcare Executives might take issue with such a requirement. Third, the costs and potential unintended consequences of privileging do not seem to have been fully considered. For example, imposing privileging could be seen as burdensome by physicians as well as healthcare facilities and create even more identity issues for the specialty. Fourth, privileging is not the only alternative to generate improvement on some of these issues. For example, to address variation in training, whether clinical or non-clinical, residency requirements and board certification would seem to be a more logical route than privileging. Finally, if the underlying issue is the field’s obscurity and the lack of appreciation from potential employers, privileging would seem to be a distant contender for the best solution. We must find ways to both assure we have the skills that are needed by potential employers and market that fact effectively.

Better information might help address some of these gaps. Surveys of preventive medicine doctors, healthcare organizations or public health agencies to determine whether they would find privileging useful would be helpful. Empirical studies of positive and negative outcomes (including costs) related to privileging would help. Finally, a strategy to position the breadth of the field as a strength rather than a problem to be solved deserves discussion, if not implementation. It seems unlikely that privileging would be a principal means of reconciling this.

So, what should we in the field of preventive medicine do? Ideally, better defining the problem before exploring and testing privileging and other solutions would be undertaken. There have been a few commentaries about the issues facing preventive medicine written in recent years (Jung and Lushniak, 2019; Jung and Lushniak, 2018; Zaza et al. 2018; Jung and Lushniak 2017). However, the existential issues for the field of preventive medicine deserve a line of inquiry in keeping with our preventive medicine skills – our training in assessment, epidemiology, statistics, and analysis.

My personal opinion is that the specialty has remained obscure and under some degree of threat because of issues internal to our specialty and not external forces. When Zaza et al. stated, “This is an identity crisis of the specialty’s own evolution” (Zaza et al., 2018), I believe they were on the right track. In fact, one could argue that external forces have

presented tremendous opportunities in recent years with the markedly increased attention on population health in recent years (Stoto, 2013) and the field's relevance to not just public health but also to health care organizations, policy makers, large employers, philanthropic organizations, the pharmaceutical industry, biotech investors and venture capital and others.

However, I do not want to rely solely on opinion to move forward with implementing solutions to our specialty's problems. I would like to see us develop a conceptual framework that we can validate, test and use to make our specialty of preventive medicine what it should be – a field widely recognized and valued by everyone from rural residents to D.C. policymakers. We need to move beyond conversations and commentary and use data, analysis, and design to assure preventive medicine's place in and benefit to society.

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