

But what do you mean by “public health training”?

As an associate medical officer of health, I was initially excited to see the title of the article in the June issue by B-Lajoie and Chartier,¹ but as I read on, I had mounting concerns about the content. My initial concern was a lack of clarity on what additional public health training was being suggested for family physicians. This was compounded by a lack of understanding of what public health physicians do, and a very broad definition of the term *public health* that seemed to be work by a physician involving data, advocacy, or administration, irrespective of where it is conducted.

My first concern was exemplified in the following statement: “Family medicine programs [already] attempt to put some emphasis on public health training.”¹ The authors fail to recognize the importance of terminology. While one can agree that family medicine training programs are increasingly emphasizing public health concepts in patient care, such as advocacy, health equity, and the social determinants of health, suggesting that this is equivalent to “public health training” discounts the specialized training of public health physicians.

The authors’ thought process is not unique; the term *public health work* has been increasingly used as a catch-all to mean anything that is “not clinical,” such as “working with data,” administration, advocacy efforts, or pet research projects.² This is seen in the authors’ conflation of health care administration (a separate field) with public health practice, through their article’s references to the “complexity of the health care environment”¹ and the “effectiveness of health care organizations [and] allocation of finite health care resources.”¹ This creates confusion between the work of public health and preventive medicine specialists, and the work of other physicians, notably family doctors who, although not their primary focus, might employ public health concepts or engage with certain public health issues in their practices.

Public health practice commonly involves balancing conflicting agendas, evidence, and resources to determine optimal population health programming and policy. This work is often separate from the health care system, because health is typically influenced by factors beyond the walls of hospitals and consultation rooms. The suggestion by the authors that family doctors had a “primary” role in driving the 12 public health advancements of the past century further demonstrates a fundamental misunderstanding of the prevention continuum and the work done by public health agencies.³

For example, concerning motor vehicle safety, what role did clinicians play in pushing seat-belt legislation, stricter drunk-driving legislation, graduated licensing, or improvements to road design?⁴ Similarly, around tobacco control, besides providing counseling and

tertiary cessation care, what role did clinicians play in creating smoke-free spaces, plain-package labeling, or tobacco taxes?⁵ History records these achievements as being those of public health physicians working in concert with multidisciplinary teams at all levels of government, in partnership with non-health care stakeholders (politicians, school boards, civil society, private sector, etc). This work created the societal contexts that resulted in improved community health.

The authors also contend that the Canadian public health sector “needs to better engage physicians”¹ in becoming advocates. In promoting the health of the community, to what extent should public health focus on engaging primary care versus other sectors?⁶ Indeed, public health already has robust interactions with primary care around screening and vaccination. If anything, save for surveillance and preventive services, public health agencies and family physicians often have different goals. The work of public health is to keep people out of the health care system, while family doctors represent the first point of entry to the health care system.⁷

The authors also continually state that public health physicians do not practise clinically, as though this is a bad thing. This leads to 2 additional points. First, just because some public health doctors do not practise clinically does not mean they do not have clinical knowledge. The Royal College of Physicians and Surgeons of Canada expects public health physicians to bridge their knowledge of biomedical sciences and diseases with a public health skill set to promote and protect health at a population level.⁸ Second, evidence on what makes Canadians sick means that much of the work undertaken by public health physicians to protect and promote community health is necessarily nonclinical.⁹

One can readily agree with the authors that public health physicians and family physicians must be partners on certain issues. However, their roles and the

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extent of the relationship need to be clear; we must recognize that each specialty serves a different purpose.¹⁰ Certainly, linkages exist that warrant careful attention (eg, around vaccinations, screening, reportable diseases, and using population data in diagnosis). However, suggesting that family doctors should lead on broader population health planning ignores the training and primary work of their public health physician colleagues.¹¹

To that end, I want to believe that the authors intended to call for better exposure to public health concepts in family medicine training, with the goal of improving the existing partnerships between public health and family medicine. Indeed, while I am grateful for the authors' interest, I cannot help but feel that a better understanding of the real work of public health would have helped to clarify many of the concepts as presented in the original article.

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Competing interests

None declared

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Some cold water on the realities of modern public health

As someone who completed the additional training (a Master of Public Health degree through part-time studies) suggested by Drs B-Lajoie and Chartier,¹ and even worked part time for a number of years at an Ontario public health unit, I agree that public health is something of a forgotten stepchild in medicine. However, before initiating an expansion of public health training for physicians, we need to think carefully about what it is we are hoping to achieve.

With regard to the education component, I enjoyed my Master of Public Health program, but would be lying if I thought that most of the curriculum applied to medical work. In fact, a good chunk of the material went well beyond the scope of activities performed in public health work, and bordered on promoting a particular political leaning. *Many* doctors I know are strongly devoted to their patients and their art, but have little patience for being told what to think about tax policy and politics.

The typical job of a public health doctor is also something of an elephant in the room. Yes, there is good work to be done on health promotion, and medical insight is essential in managing an outbreak. But large parts of the job—tedious ministry teleconferences, hostile (often personality-driven) media, political agendas of governing boards, organizational administration, squabbles over budgets—could hardly be construed as medicine. What exactly is the goal of training more doctors in public health, if not to work at a public health unit?

Finally—and this situation might be unique to Ontario—we also have to bear in mind that a pivot to work in public health constitutes a change in scope of practice. That triggers the College of Physicians and Surgeons of Ontario (CPSO) to begin its intensive meddling into one's career. My own experience tells the tale, as the CPSO continually moved the goalposts on me, demanding ever more red tape and supervision, despite my ever greater experience on the job. Had I known the CPSO would see fit to do as it did, I would not have bothered at all.

I suppose we can all champion having more public health content in medical school. But how do you convince a brand-spanking-new class of science-minded medical students that if they really want to save lives, they need to take action on poverty and homelessness? As memory serves, the material and themes were there, and were even stressed in medical school—they were just promptly forgotten once we started rotating on the wards.

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Routine screening pelvic examinations have a negative effect on patients

Jones et al stated that researchers and doctors should not harm patients and should work to help individual patients, not patients in general.¹ In 2016, the Canadian Task Force on Preventive Health Care recommended not performing pelvic examinations in asymptomatic women. Dr Ladouceur proposes that discontinuing