Virginia Dato

From: Virginia M. Dato MD MPH [vmdato@pitt.edu]
Sent: Saturday, August 31, 2002 7:45 PM
To: vdato@aol.com
Subject: AAPHP News: Part 2 - Preventive Medicine Action Plan Draft - Request for Comments

vdato@aol.com
AAPHP News
News Items
1. Draft action plan to straighten Preventive medicine by Joel Nitkin - Comments to jln-md@mindspring.com See Item 3
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From Joel Nitkin Draft Preventive Medicine Action Plan

August 31, 2002
MEMORANDUM
To: Mary Ellen Bradshaw, Dorry Lane, Bob Harmon, Jud Richland, Mike Barry and Art Liang

From: Joel Nitzkin
Subject: Preliminary Draft Action Plan to Maintain and Strengthen the Specialty of Preventive Medicine
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INTRODUCTION
This memo is a follow-up to the discussions that took place July 16, in Chicago, at the annual meeting of the Preventive Medicine Leadership Forum, and a follow-up chat I had with Art Liang, in his role as ACPM Public Health Regent.
This communication is based on the resolutions adopted by the ACPM Board early in 1991, relative to the Job Market Initiative, and experience gained through the Initiative since that time. This memo represents my perceptions and my recommendations as to action to be taken by ACPM and other PMLF-affiliated organizations - in addition to the Job Market Initiative already under way. This memo is framed from the perspective of the GPM and PH constituencies within the PM community. Those representing Occupational Medicine and Aerospace Medicine will need to separately consider which elements pertain to their constituencies - and the relative importance of each issue. BACKGROUND The Problem With the rarest of exceptions - PM gets no respect as a medical specialty - even within the PM community. Non-physicians, physicians who are not trained in PM, and many clinicians within the PM community consider the role of a physician to be the diagnosis and treatment of patients, one at a time.
There is but little respect for the possibility that there are a wide range of administrative, policy, research and other roles that require a physician's knowledge of human biology, the causation and natural history of diseases and the efficacy of both preventive and therapeutic measures. To add insult to injury, especially in managed care

and other healthcare delivery settings, a physician who cannot claim five years of experience in clinical practice beyond medical training is not considered a "real doctor." Without exception, as far as I have been able to research this issue, every one of the PM physicians who now enjoy leadership positions in managed care settings secured his or her job on the basis of his or her clinical training and experience -- with the PM specialty training seen as secondary. This, despite the fact that most of the success they have enjoyed in these roles is based on their PM skills. During this past decade, both physicians and non-physicians have come to recognize the importance of preventive services, quality assurance and the importance of medical knowledge in managing medical and public health services. Non-PM-clinicians and non-physicians have aggressively marketed themselves for these leadership roles - effectively outcompeting PM for these jobs. When it comes to leadership positions, especially in health care, - non-physicians are usually preferred to physicians by most employers because physicians, as a group, are seen as administratively inept - part of the problem - people who couldn't possibly be part of the solution because they are egotistical and they are not team players. In addition, in most roles, non-physicians are seen as less expensive to hire. Most employers, especially in healthcare delivery systems, cannot imagine that there might exist a group of physicians specially trained for leadership roles in health and medical settings (other than directing the activities of other doctors). Those employers who do recognize the potential value of physicians as organizational leaders - see only budget and management skills as important - not the PM skill of being able to address health (rather than financial) issues at a population level. In summary:

* PM is invisible as a medical specialty
* Where PM is recognized, PM physicians are often seen as inferior to conventional clinical physicians (which is why almost all PM physicians who are also clinicians identify themselves as clinicians)
* Most PM jobs (jobs that could best be filled with physicians with PM specialty training) that do not have hands-on patient care as part of the job - prefer non-physicians
* We, as a specialty, suffer greatly from the mediocre job performance by non-PM-physicians who have taken on PM jobs in both public and private sectors.
* We now have very powerful enemies in the form of many groups of non-physicians who seek jobs that should be PM physician jobs - and have had substantial success in taking over these jobs (hospital administrators and public health directorships are the best examples) - largely on the basis of the poor performance of previous physician incumbents.
* This is most clearly visible in the Job Market - where PM credentials (residency and board certification) are of almost no value in securing PM-related jobs (Anyone not familiar with the published justification for this background statement should contact me)

Implications of this Problem Statement 1. Funding is hard to secure for training programs that are not valued in the job market. 2. Physicians are reluctant to enter a medical specialty that they see as irrelevant - or, worse, as a badge of mediocrity.
3. Correcting these problems will require more than the usual sort of marketing and advocacy program - it will require effective strategies to overcome the forces of our enemies and a substantial effort by the national organizations representing GPM and PH physicians - and possibly Occupational Medicine physicians (I don't think that these problems exist for Aerospace Medicine).

The Issue of Career Tracks within the Specialty of PM "Preventive Medicine" is probably the only medical specialty for which the name of the specialty gives no clue as to the work to be done by the doctors within it. Our greatest strength and greatest weakness is the wide range of jobs and occupational settings that this training makes possible. We need to develop a standardized list of career tracks within the specialty - so that we can then market our specialty to each of the respective sets of employers in terms that they value. Our residency training programs already reflect such career paths. Tracks 1-7 would not be sub-specialties (at least not for many years) - in that PM physicians could easily transition from one track to another with no supplemental training, or training limited to a single-year fellowship. There are lots of ways to lump and divide PM jobs into career tracks. I propose the following as an initial proposal: 1. Public Health Leadership - direction of state and local health departments, federal public health agencies, and/or major programs within those departments and agencies 2. Medical Epidemiology - science and service delivery as state and local medical epidemiologists, and similar positions in federal, academic and private sector settings. Most pharmaceutical industry jobs would probably fall into this category. 3. Clinical Preventive Medicine - full time jobs or part time roles for clinician/preventionists in health care and academic settings dealing with implementation of clinical preventive practices, disease management, quality assurance, and related population-medicine roles. 4. Health Care Leadership - full time jobs that are at higher levels within larger managed care, health center and academic settings with titles such as CEO or Medical Director. Here, PM would be in either collaboration or

direct competition with ACPE 5. Health-Related Planning and Policy Analysis - these high-level jobs within major government agencies and large private-sector healthcare settings would use epidemiology as a tool to guide program and policy decision-making and direct research in these areas. Individuals with these skills could also play major leadership roles in national voluntary health-related associations (Heart, Cancer, Lung, etc) or serve as consultants to large-scale public and private organizations.
6. Wellness and Health Promotion: This is an arena that could benefit from leadership by physicians with well-honed population-health skills. This includes health risk assessment, implementation of wellness (smoking, diet, exercise, stress, safe behavior, etc) programming in clinical, public health and community settings, alternative medicine, and "wholistic medicine." Here the PM physician role would be seen primarily as agency/program policy development, program evaluation and program management. 7. Correctional Health -- management of jail and prison health services. 8. Occupational Medicine 9. Aerospace Medicine The Issue of Administrative Activities being Recognized as the Definitive Practice of Medicine - and receiving the same respect as conventional clinical practice
Once the career tracks have been decided upon, PMLF (with ACPM as the most logical lead agency) would then embark on a PMLF/JMI (Job Market Initiative) outreach program to potential employers. The goal will be to change the conventional wisdom and organizational culture of the "house of medicine" and the world of health and medical agencies. The change to be made in the conventional wisdom is to establish the concept that policy, management and leadership roles should be considered the definitive practice of medicine. Some of these jobs would be considered the definitive practice of the specialty of Preventive Medicine. The job would be considered medical practice if decision-making in the job would benefit from a physician's knowledge of human biology, the causation and natural history of diseases and the efficacy of both preventive and therapeutic measures. The job would be considered appropriate for a PM physician if decision-making in the job would substantially benefit from a well-developed ability to assess health need, develop health policy and implement health programming in pursuit of health status (as opposed to purely financial) goals.
PROPOSED ACTION AGENDA
Actions to be Taken by All Boards Representing PMLF Member Organizations (with the possible exception of Aerospace) 1. All such boards should immediately declare that an emergency exists that threatens the future of the specialty of Preventive Medicine, and that urgent action to address this emergency. 2. On an interim basis, between now and March, 2003, ACPM should be designated as the lead agency to develop and coordinate plans to address this emergency on behalf of all PMLF membership. 3. Formally adopt a standardized set of PM "Career Tracks" 4. Develop the outreach programming appropriate to its natural constituencies. 5. Each PMLF member organization should designate a single member to be long-term representative of that organization to the PMLF, in addition to the current President and Executive Director. 6. Each PMLF member organization should amend its bylaws to formally recognize the PMLF as an action-oriented organization dedicated to the strengthening of the specialty of Preventive Medicine.
a. This should be with bylaws provision that PMLF decisions and action plans will be accepted by all member organizations as if they were decisions and action plans by the organizational board.
b. This should be with provision that -- for an individual organization to opt out of a policy or item on the action agenda - the organizational board must act and must inform the PMLF of both the opt-out and the reasons for this opt-out.
Proposed Staffing and Process for ACPM-Based Outreach Program 1. ACPM should act immediately to designate 20% of the time of one of its key staff to work with Dr. Nitzkin and with the PMLF to implement the recommendations from the July 16 2002 PMLF meeting in Chicago, and the recommendations in this memo. 2. This staff person, working with the PMLF shall develop a plan and proposal to each of the PMLF member organization for the staffing to be needed for full-scale implementation of the July 16 recommendations and the outreach programming described herein - beginning March, 2003 (immediately following the February ACPM meeting in San Diego). Proposed Future PMLF Process The PMLF shall meet by conference phone call at least five times per year, and in-person at least once a year - and see itself as an action-oriented organization. JLN:jln 080902PMLF Action Agenda .doc