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Letter to the Editor

Authors' response to Letters to the Editor re: Clinical public health: harnessing the best of both worlds in sickness and in health

Bernard C. K. Choi, PhD (1,2,3); Arlene S. King, MD, MHSc (1); Kathryn Graham, PhD (1,4); Rose Bilotta, MD, MHSc (1); Peter Selby, MBBS, MHSc (1,4,5,6); Bart J. Harvey, MD, PhD (1); Neeru Gupta, MD, PhD (1,7,8); Pierrette Buklis, MHSc, RD (1); Donna L. Reynolds, MD, MSc (1,5)

We are pleased that our paper on clinical public health[1] received support from Dr. Shah,[2] who also provides important historical aspects of clinical public health. Dr. Shah was the inaugural director of a newly created residency program (Community Medicine, now known as Public Health and Preventive Medicine) at the University of Toronto in 1976. Although he claims to have failed to "bring clinicians and public health professionals together to define the common elements and synergy needed,"[2] we believe he did not fail, because his efforts ignited sparks among his students (including several co-authors of this paper[1]). Building on his important legacy, subsequent generations of clinicians and public health professionals have made strides towards effective collaboration of clinical medicine and public health.

Dr. McLaren rejects the formation of clinical public health because it is insufficient "to address complex health problems and improve health for all," and instead proposes political-economic public health that includes wider intersectoral collaboration.[3] We recognize that clinical public health is insufficient to accomplish all health goals, yet humbly assert that the collaboration envisioned through clinical public health will facilitate feasible, principled progress. Sometimes we need to start incrementally, as progressing too ambitiously could result in the best becoming the enemy of the better. Clinical public health is a new starting point that we hope will eventually help leverage broader collaboration across professional and advocacy sectors. Also, while clinical public health cannot address all health problems, we would argue that political-economic public health, per se, will equally not solve all the problems resulting from the shortcomings in current political and economic systems—although it could be an important step along the way.

We concur with Dr. McLaren that "curative and preventive ('upstream') activities" are not equal in power.[3] We note that public health is often the "poor cousin of clinical medicine"[1] and suggest that adoption of a clinical public health collaborative model is one way to achieve a healthy power balance.

Dr. McLaren suggests that our paper "adopt[s] a narrow version of public health as an arm of the health care/medical system focussed primarily on service delivery and surveillance."[3] On the contrary, we view public health in a broad sense. Our paper[1] is the second in our clinical public health paper series. Our first paper, "Defining clinical public health,"[4] surveyed clinicians, researchers and public health professionals. It was apparent that the concept of clinical public health subsumes the broadest understanding of public health, including socially based health issues caused by "shared social and commercial determinants."[4,E75]

Our first paper[4] led to two letters to the editor: one that rejected[5] and one that supported[6] the idea of clinical public health. This second paper[1] has also led to two letters: one supporting[2] and the other questioning[3] our idea. We hope that these papers and the resulting letters in response will lead to further discussion and debate on the feasibility and future development of clinical public health, and perhaps a broader understanding of and action on the political and economic determinants of health.

References

1. Choi BCK, King AS, Graham K, et al. Clinical public health: harnessing the best of both worlds in sickness and in health [commentary]. Health Promot Chronic Dis Prev Can. 2022;42(10): 440-4. https://doi.org/10.24095/hpcdp.42.10.03

Author references:

1. Division of Clinical Public Health, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada
2. Public Health Agency of Canada, Ottawa, Ontario, Canada
3. School of Epidemiology and Public Health, University of Ottawa, Ottawa, Ontario, Canada
4. Centre for Addiction and Mental Health, Toronto/London, Ontario, Canada
5. Department of Family and Community Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
6. Department of Psychiatry, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
7. Department of Ophthalmology and Vision Sciences, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
8. Keenan Research Centre for Biomedical Science, St. Michael's Hospital, Unity Health Toronto, Toronto, Ontario, Canada

Correspondence: Bernard C. K. Choi, Division of Clinical Public Health, Dalla Lana School of Public Health, University of Toronto, 678-155 College Street, Toronto, ON M5T 3M7; Email: bernard.choi@utoronto.ca

2. Shah CP. Re: Clinical public health: harnessing the best of both worlds in sickness and in health [letter]. Health Promot Chronic Dis Prev Can. 2023; 43(4):200. https://doi.org/10.24095/hpcdp.43.4.06

3. McLaren L. What we need is a political-economic public health [letter]. Health Promot Chronic Dis Prev Can. 2023;43(4):199. https://doi.org/10.24095/hpcdp.43.4.05

4. Choi BCK, Pakes B, Bilotta R, et al. Defining clinical public health. Clin Invest Med. 2021;44(2):E71-E76. https://doi.org/10.25011/cim.v44i2.36479

5. Young K. Can public health be "clinical"? [letter]. Clin Invest Med. 2021; 44(2):E77. https://doi.org/10.25011/cim.v44i2.36449

6. Ramsay T. On "Defining clinical public health" [letter]. Clin Invest Med. 2021; 44(2):E77. https://doi.org/10.25011/cim.v44i2.36449