The COVID-19 pandemic has required rapid innovation and adaptation throughout health care services and may lead to lasting change in specific health care practices. One welcome development was the success of the many partnerships that formed between academic medical centers, community-based organizations, and departments of public health to offer COVID-19 testing, vaccination, contact tracing, and public health training, and even conduct pragmatic research. The history of these partnerships remains to be fully explored and written. However, our experiences in the San Francisco Bay Area highlight some of the roles that academic physicians have played and continue to play in these partnerships.1-3 These experiences support the idea that population health is an important function of academic medical centers, and that the role of academic physicians engaged in this work—“physician–public health practitioners”—warrants recognition and development as a distinct academic career track.

Partnerships between academic institutions and state and local departments of public health have long existed and more formal affiliations have been gaining traction. These partnerships may involve formal affiliations of a health department and an academic institution that trains future health professionals—the public health equivalent of the teaching hospital affiliation found between hospitals and medical schools. Such partnerships can enhance capacity for joint education, research, and practice, and increase opportunities for the practice and academic communities to work together to address public health concerns. A recent review of such partnerships4 found them in many parts of the US; in most cases, the academic partner was a school of public health. The pandemic demonstrated the power of even broader coalitions of the willing, uniting community groups, private sector organizations, unions, philanthropy, and faith-based organizations, galvanized by academic medical centers together with local health departments. It is these broad efforts that resulted in innovative and effective work in the San Francisco Bay Area.

Over the past decade, many academic medical centers have come to embrace formal efforts addressing population health,5 driven in part by health care reform and changing incentives in the Affordable Care Act, as well as by a broader recognition of social and structural drivers of health outcomes beyond the walls of clinical practice. Academic departments of population health departments have emerged, organized to bridge the traditional gulf between medicine and public health and engaging all sectors—including health care and public health—in understanding and improving the health of populations. The framework described by Gourevitch and Thorpe6 suggests the essential elements of such initiatives include engaging communities, turning information into insights, transforming health care, and shaping policies. The organization of such efforts is variable, but often involves formal or informal partnerships with departments of public health and community organizations.

These movements in academic medical centers are laudable and, based on our experience, argue for more formal training and recognition of the academic physicians who are leading and partnering with others to advance population health. We urge a physician–public health practitioner role within academic medicine. Such physicians have characteristics that add value to efforts toward advancing population health, including the following:

- **Capacity for leadership and partnership within a collective impact model.** Throughout the first 2 years of the pandemic, physicians played critical roles in multisector coalitions operating within a
Physician–public health practitioners who are skilled at building partnerships, have a population health orientation, and are deeply rooted in principle of health equity can often offer critical skills (often honed in interprofessional clinical work) to the broad coalitions that are necessary to bring about change. In our experience, the involvement of physicians in these coalitions has often been born out of a desire to improve clinical outcomes and work more directly in partnerships with community organizations and other entities who serve community members or whose work impacts community health. Because these academic physicians also play a role within the health system and may have a voice with the departments of public health, such physicians can provide the necessary bridge in these multisector coalitions to enhance effectiveness and impact.

• **Acting as teachers and scientific interpreters.** Physicians are often interpreters of scientific information as they discuss medical interventions with their patients. The pandemic has demonstrated the importance of effective communication about rapidly changing scientific information, as well as the power of misinformation and disinformation in preventing effective communication. Physician–public health practitioners can play a role in translating complex scientific information and dispelling misinformation for the broader public as the US continues to navigate current and future public health crises.

• **Providing technical assistance.** Physician–public health practitioners can offer community-based organizations up-to-date evidence, best practices, assistance in navigating some complex interactions with other institutional partners, assistance with grant writing and obtaining funding, and assistance with staff training. Depending on the needed skill sets—and often in partnerships with others in an academic medical center with more specific technical skills—assistance may be offered in data collection, analysis, or informatics.

• **Developing prototypes and evaluating programs.** At many points in the pandemic, physicians within multistakeholder coalitions were able to help develop new prototypes for care delivery (eg, for vaccine distribution) that spanned traditional health care and public health models. Physician–public health practitioners may have the skills or enlist the help of others at academic medical centers to assist in critical evaluation of existing programs. Physician–public health practitioners trained in implementation science or in the fundamentals of program design and evaluation are particularly helpful in this role.

• **Disseminating effective practice.** Academic physician–public health practitioners are experienced with dissemination through peer-reviewed publications, brief reports, and even public media. Dissemination is often difficult, but when it is achieved, it can lead to adaptation of successful models elsewhere and be instrumental for sustainability.

Public health crises will continue to force physicians at academic medical centers to think and act beyond their clinical walls—such as in addressing the evolving phases of the current pandemic, the crises of the inequities in health magnified by deep imbalances in the social and structural determinants of health, or the current and impending threats of climate change on health. To do so, we can learn from the successful innovations of the last few years and think about the infrastructure, funding, and human inputs needed to create and build on successful partnerships. A key advance in this area will be the development of physician–public health practitioners. Medical schools must provide training for this career path, and academic health centers must encourage and support these careers.

In 1910, the landmark Flexner report, backed by philanthropy, set US medical schools down a path that would lead to excellence in research and the enshrinement of the biomedical model of clinical care. To meet the deep public health challenges of today (from obesity to addiction to emerging infections), it is time to significantly invest in another form of academic clinical leader, one who will join their physician-researcher and physician-educator colleagues to teach, innovate—and above all, practice—as a physician–public health practitioner.
REFERENCES


