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SPECIAL COMMUNICATION

Preventive Care: Cornerstone or Constraint for Family Medicine? How Much Should We Prioritize Clinical Preventive Services?

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In August 2025, family physicians gathered for the Family Medicine Leaders Consortium to share perspectives on whether family physicians should continue to prioritize clinical preventive services amid rising patient complexity, documentation burdens, policy constraints, and post-pandemic challenges. This paper synthesizes competing perspectives and overarching commentary from the consortium meeting. One viewpoint argues that preventive care remains essential to family medicine's core values, patient expectations, and economic viability. The opposing viewpoint contends that preventive services are increasingly algorithmic, delegable, poorly reimbursed, and, while important, are no longer core to family medicine. Together, these perspectives illustrate the need for ongoing, future-focused discussions about family medicine's identity as a specialty.

Keywords: Comprehensive Health Care, Family Medicine, Family Physicians, FMLC 2025, Leadership, Preventive Medicine

Much of what family physicians do is primary, secondary, and tertiary clinical prevention. The 2002 Future of Family Medicine project urged the specialty to champion prevention.[1] Today's healthcare landscape offers new challenges and opportunities. Barriers to access, the burden of documentation, governmental healthcare policy, and lingering consequences of the COVID-19 pandemic challenge family physicians' capacity to provide preventive care.[1] Concurrently, information technology and team-based models of care can support integration of preventive care services.[1] The decision to maintain preventive care within the specialty's portfolio must be an affirmative one. Presented next are competing viewpoints on the degree to which family medicine should prioritize clinical preventive services.

Viewpoint: Family medicine should recommit to routine clinical prevention, such as vaccination and counseling about primary and secondary prevention.

Family medicine's commitment to routine clinical prevention is rooted in the values of our specialty—continuity, comprehensiveness, compassion, and personal care provided within the context of family and community.[1] The patient is best served by receiving the full basket of family medicine services, including preventive care, within this context and by the clinician and team committed to providing it. Is it time to take preventive clinical services out of the family medicine basket? Can patients receive equal or better preventive care from another specialty or healthcare entity?

The main argument to recommit to preventive care is that it is inconsistent with our core principles to abandon the provision of preventive care (primary and secondary) to our patients unless an equal or better option is available. Abdicating our responsibility, in a decentralized healthcare system marked by inequities, lack of public health infrastructure, and primary care practices that lack teams of non-physicians to do this work, is abandonment of our principles and our responsibilities. Until there are alternate ways for patients to receive primary and secondary care, including vaccinations, we must commit to providing these services to our patients.

A second, economically pragmatic argument, is that the economics of primary care rely on clinicians providing preventive services. A quarter of all clinician visits to primary care are for preventive services.[2] Committing to a model of family medicine that does not include preventive care will economically disrupt primary care practices unless there are mechanisms for reimbursing nonclinicians for these services.

This argument is supported by a third, similarly pragmatic argument, that delegating preventive care to nonclinicians is not what our patients want. Even if we had payment reform that reimbursed and incentivized nonclinicians to provide preventive care, our patients would still want to see "their doctor" for preventive visits. For example, at Kaiser Permanente Washington, a capitated integrated care system for the past 80 years, 20% of primary care visits to clinicians in 2024 were preventative.

A fourth and equally pragmatic argument is that it is impractical to expect the US healthcare system to develop the infrastructure necessary to provide preventive care beyond

the primary care office. It is highly unlikely that our nation or our states are going to commit to the required primary care funding, universal coverage, and/or increased public health infrastructure needed for such a transition. Similarly, seeking solutions from capitated systems and countries with universal access, where nonclinicians provide preventive care and resources to the health of the population, is not applicable. Until we have health reform, primary and secondary prevention will lie with primary care. There is nobody else to do it.

The final argument is one of timing. We need to consider the timing and impact of not committing to preventive care, vaccinations, and chronic disease, in this era where science, research, vaccinations, and public health are all being questioned.[3] If family medicine signals that preventive care is no longer important, then we risk the health and trust of our patients and communities.

Viewpoint: Family physicians should prioritize other clinical services over preventive care in a modern healthcare system.

The main argument in favor of removing preventive care from the family physician's plate has to do with resource allocation. Primary care patients have become much more complex in general. Therefore, the argument goes, family physicians need to focus on complex chronic disease management and acute medical issues. Family physicians only have so much time during a clinic visit, therefore, something must be taken off the agenda.[4]

Much preventive care seems largely algorithmic. Patients become eligible for a vaccination, or other preventive service, when they reach a certain age or when a certain comorbidity is present. For instance, it is recommended that average-risk patients get a shingles vaccination at age 50. In today's world of artificial intelligence, it is possible for a machine to identify many of a patient's preventive needs.[5]

This argument is bolstered by a second argument, which is that other healthcare professionals can do preventive care. Prevention is certainly done in other venues and by other healthcare workers routinely. Population health nurses, nurse practitioners, and physicians' assistants could be focused on prevention, and thus leave more time for physicians to focus on more challenging clinical decision making.[6] In this model, there would still be times when a physician should be involved in preventive care; for instance, if a patient does not fit into the algorithm neatly or when a patient is hesitant to accept a preventive care recommendation.

A third more cynical and transactional argument against family physicians doing preventive care is that it simply is not reimbursed well enough to properly pay for a physician's effort.[7] The American healthcare system continues to pay physicians more for diagnosing and treating disease than preventing it. This argument would advocate for family physicians focusing on what the system values most and letting what it does not value, in this case preventive care, fall to others.

Discussion

Preventive care has long been woven into the identity of family medicine. Yet the specialty now faces a pivotal moment. The future of family medicine may depend on a willingness to break with traditional assumptions to rebuild a more resilient model of care.[8] The competing viewpoints in this paper highlight a shared truth: Family physicians face mounting pressure from the complex, evolving healthcare landscape in which prevention occurs.[8] Whether framed as a moral obligation rooted in continuity and equity, or as a task that can be delegated in an era of complexity and technological support, preventive care remains central to how family medicine defines its purpose. Ultimately, the specialty must balance core values, system realities, and patient expectations to make a definitive choice about its role in prevention.

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Conflicts of Interest

None.

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