Formal and Structured Partnerships in Community Medicine: A New Beginning?

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Community Medicine in its current form has evolved from the concept and practice of public health. However, there are frequent concerns and explicit queries leading to confusion in the minds of the post graduate students as well as some faculties as to... 'What is our role in improving or influencing the health situation in our area/ state/ country?' Many a times I have heard students say that they cannot exactly explain their branch to their friends, relatives or parents.

I think we are at a cross roads where we need to define our role with precision. Taking a step back always gives us a better and expanded viewpoint. If we relook at the definition of Public Health and try to understand its essence - "the science and art of preventing disease, prolonging life and promoting health and efficiency through organised community efforts....." Thus, we have to think of strong partnerships at different levels to develop this organised community effort.

We, as a standalone theoretical branch, in the confines of our academic institutions shall always fall short of the expectations. As a counter viewpoint, we cannot and should not become a complete service delivery sector. Thus, to complete our vision and mission, we need to work together with multiple agencies (both government and nongovernment), who share a common purpose for improving the health situation, to give momentum and contribute synergistically.

The next questions would be when, what, how, where and who!! As epidemiologists, we know that they are the 'honest serving men' who shall help us in learning.

To address the variable when, there is nothing better than the immediate present. Now, that 'when' has been taken care of, looms the 'what'. Only a select few places have the option of field based, hands on training in Community Medicine. A redeveloped curriculum defining the rational and practical approaches to the teaching and practice of Community Medicine is needed. The good part is that it is happening at the national level under the aegis of IAPSM. To execute it, we would need good teachers, with a grip on the basic understanding of the subject as well as have vast and varied field experience to inspire the post graduate students to redefine the future of the subject. To take it from a least understood branch to an intellectually stimulating branch, bettering the lives and health of people. Sounds good on paper, but near impossible to deliver alone. As Community Medicine experts, we do not seem to have a boundary and are expected to plan, develop, execute, monitor and evaluate anything that is envisioned by anybody who matter!! Not bad as a compliment to our broad spectrum skill sets but the vagueness has led to the current confusion. We have strong people who are working for a very long time in these varied fields and by partnering with them, we reduce the wastage of time and resources by avoiding duplication. Working together we contribute synergistically and compliment each other's growth.

The first concern raised is always about '**Clinical Skills**' ... the broadness of the term itself is daunting as it encompasses more than 20 specialties and super specialties. Which skill subset would be considered adequate for our specialty? Thus, instead of the Community Medicine teachers trying to impart it, a regular structured partnership with the major clinical branches in the teaching hospital needs to be fostered for one term during PG studies. Clear cut learning objectives with expected outcomes should be defined and maybe a list of 'basic medical officer

level' or other skill sets be framed. This structured partnership with our clinical faculties would also lead to better communication, respect and understanding between faculties and inspire multidisciplinary research. The confidence to deal with clinical cases may reduce a bit of the anxiety associated with becoming rusted in patient care and actually serve better in our community visits, surveys and health system monitoring. This partnership with clinical care could leverage referral systems from the field areas and increase our acceptability in the outreach areas. Private practice in the field of Community Medicine is another neglected area. Preventive cardiology, non communicable diseases like Diabetes, Hypertension, Rehabilitative care, Antenatal / Post natal care, Adolescent / Youth health, Immunisation, Communicable disease care are all potentially viable areas for a thriving practice. Field postings in RHTC and UHTC, shadowing clinicians as well as medical officers in their routine activity would strengthen practical skills. Learning by doing would result in more robust, confident and skilled specialists.

The next often quoted grievance is our exclusion from the **'Policy decisions'.** This could be bridged by an active partnership with the 'health and health service' department. We have a well established hierarchy with defined roles in health care delivery system. This partnership needs to be formalized in the lines of Regional Monitoring Team with specific terms of reference and role definition to generate important data and exemplify our role in generation of much needed evidence. In immunization we have allowed the paediatricians to take a pivotal role in policy making by our absence in effective positioning. We have faltered in terms of cutting edge research and documentation. Our health system research partnership with both the government and international agencies like UNICEF and WHO, could lead to stronger proposals relevant to the current needs and lead to the generation of new and relevant evidence on important contemporary issues affecting health. This proactive stance in turn would influence the decision makers and make them aware about our valued presence. These formal partnerships would work for our value addition in policy making. Similar partnerships with NGOs working for health would be valuable as we would be getting a third perspective. Such formal and sustainable Health System Partnerships would reduce the load at all levels by preventing work duplication and at the same time strengthening each other.

Biostatistics, Computing skills and Analytical skills are often discussed with fear and trepidation by a new post graduate registered for Community Medicine and sometimes by faculty too (if we are honest to ourselves). This is compounded by the fact that we do not have statisticians in most of our Community Medicine departments. The current recruitment rules for appointing post graduates of statistics in our department is restrictive and do not help our cause. So, a formal documented partnership with the department of statistics in the university to which the medical college belongs to, a good computer science department in the friendly neighbourhood engineering college could be thought of. A good back ground check would bring forward names who could additionally teach specific medical field related statistics or biostatistics as we prefer to call it. Another partnership could be the pooling of talent. The really strong teachers in these fields could be systematically invited as a part of long term partnerships where regional workshops could be done for developing skills in these areas.

Financial skills, Administration, Management and Logistics skills are another area where external mentors could help. The burgeoning fields of cost–benefit and cost-effectiveness analysis, mathematical modelling, grant writing, submitting utilization certificates and statement of expenditures, writing a budget proposal, tendering procedures, writing a final project report, inventory and condemnation procedures are becoming relevant when we are looking at jobs other than academics.

Formal partnership again is thus needed as most of the senior/ mid level teachers would not have had an exposure in these recently recognised fields. Not everyone needs to be an expert in everything. The concept of super specialization needs to be introduced in post graduate teaching where one term maybe designated to the advanced pursuit of the topic the candidate is interested in for help in his future job prospect. Some of the newer job opportunities can be seen in Medical Ethics, Mathematical Modeling, Health Economics, Health Insurance, Public Private Partnerships, Hospital Management and Geographic Information System in Health. Standard operating procedures, developing plan of action have become routine in hospital and field work.

Research Methodology, Writing skills and Comprehension skills are other fields in Community Medicine that is becoming more and more relevant in academics as well as private job ventures. Formal partnerships with the nationally recognised institutions leading to regular discourses at the regional level would help bridge this gap and lead to a thriving culture of academic excellence. Good research and generating evidence is the key strength of our discipline. The most important word here is 'GOOD' … thus; one has to strive for excellence and skill development.

Last but not the least – **teaching skills!!** We all mostly become teachers as a preset option when we join academics. We do not have the formal training to develop or hone our teaching skills. Thus formal partnerships have to be initiated with the medical education units, state level nodal centres for faculty development, education department in the university. We have to create opportunities to learn from stalwart teachers – who are role models to emulate. This would give a chance to strengthen one's teaching capacity and build confidence. Partnerships with leading institutions give exposure to the newer tools of technique and technology. This in turn would lead to more interesting, interactive and stimulating lectures or tutorials and minimize the stigma of 'boring lectures' in PSM.

While discussing 'what', much of 'where' and 'who' has been discussed. This leaves us with 'how' ….. Formal and well thought out systems have to be put in place for these partnerships to flourish. Strong advocacy at the state level needs to be done to expedite the process. State compliance is needed for formal permissions and budgetary support to keep these partnerships sustainable. Structured partnership requests needs to be drafted with our long standing partners like the UNICEF, WHO, PHFI, NGO partners, state and national nodal centres of excellence and relevant departments in the government and concerned university. In my opinion, IAPSM would be the best agency to draft, negotiate and execute these formal partnerships with inputs from experts. Mentors could be identified for each skill by the state chapters who could liaison for drafting formal and sustainable partnerships. National experts in each field maybe roped in for partnerships to develop a systematic and uniformly structured format. International partnerships also could be generated and the existing MoUs could be strengthened to enable them to conduct training for our faculties as part of their projects. Necessary modifications in university rules may also be thought of where experts from other institutions (state, national or international) could be enlisted as Co-guides to facilitate stronger study designs in research and dissertations.

We have to remember that many topics in Community Medicine can also be mastered by people from other fields too. Thus, one has to remember that mediocrity would bring one down; hence a proactive motivation towards excellence has to be there in oneself to be a leader in one's field. To keep our spirits up, we should realize and glorify that any success in health globally, be it from small pox eradication to polio elimination, is a direct outcome of the public health efforts and partnerships. So, now again we need to reiterate that "United we Stand".