IAPSM Declaration 2018: A Promising Beginning

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Abstract :

Community Medicine discipline and role of Department have been debated for long. IAPSM Declaration 2018 attempts to address these issues for developing a better understanding. The strength of declaration lies in the change in focus to basic clinical services, traditional 'Community Medicine' functions, effective community based training and liaison with district health care delivery systems. The definition, overlapping of key functions with 'Public Health' and a focus on curative services, however, need further attention. The Departments have to work closely with Clinical Departments in Medical Institutions, District Health agencies at all levels as well as Communities to achieve these objectives.

Key words: IAPSM Declaration, Defining Community Medicine, Primary role of a specialist in Community Medicine

Introduction:

With changing global and health environment, the confusion of Preventive and Social Medicine / Population Medicine / Community Medicine / Community Health / Public Health Preventive Medicine (PHPM)/ Community and Family Medicine (CFM)/Public Health has added International as well as Global health in its inbox.[1,2] The relevance of Community Medicine to national needs has been addressed time and again including a detailed framework described by Shrivastav Committee.[3] The recommendations have been half heartedly implemented, leaving a scope for non ending search to fill the gaps.[4,5] Few publications emphasized strengthening the roots of subject as envisaged.[6, 7] With growing emphasis on Public Health and Family Medicine and ad hoc changes in some Departments , the IAPSM Declaration 2018 comes as a much needed guiding force.[8]

Defining Community Medicine:

Even Royal Commission on Medical Education did not define it and explained the practice![9] The declaration definition is an amalgamation of century old Winslow's definition of Public Health (***science and art of promoting health, preventing diseases and prolonging life***), definition of Comprehensive Health Services (***promotive, preventive, curative, rehabilitative and palliative***) and Primary Health Care (***with active community participation and inter-sectoral coordination***).[10-12]

> *"....a science and art of promoting health, preventing diseases and prolonging life by range of interventions (promotive, preventive, curative, rehabilitative and palliative) in close partnership or association with health care delivery system and with active community participation and inter-sectoral coordination."*

Initial phrase of Winslow's definition is in fact a goal of all health services. The definition is supplemented by the additional sentence (*focuses on determinants of health... and organization of health care services to attain optimal quality of health*), leaving nothing from Public Health that is not community health. We may argue that community health is but public health limited to a geographic area but then it needs acknowledgement and not integration! The current definition is too complex compared to simple definitions available till now to differentiate the two Specialties.[1,13,14]

Community Medicine focuses on determinants of health, local health issues, community-oriented primary health care, and organization of health care services to attain optimal quality of health.

It is appreciated that palliative interventions are introduced as part of Comprehensive Health Services, keeping in view the growing chronic conditions and geriatric population but palliative care is currently described in context of terminal disease and covers physical, psychological and spiritual aspects that need specific training beyond current training expertise.[15]

Core content of Subject:

It is a welcome change that the core subjects identified include basic clinical training. No one can deny the importance of allied sciences but unless we limit ourselves to defined core areas, we cannot climb higher! [1] Perhaps it is better for us to collaborate for postgraduate training with institutes having experts of allied sciences rather than trying to include all of them in Departments in Medical Colleges where their skills will almost always be underutilized and they are likely to continue to feel out of place![16]

Primary role of a specialist in Community Medicine:

It is defined in terms of placement prospects but misses the Community Medicine expert role as researcher (unless it is implied as health manager), epidemiologist, teacher/educator (including health promotion as part of definition) and wellness expert. Health promotion is our unutilized strength, for example, nutrition is an integral part of current subject curriculum and we are better equipped than clinicians and dieticians to tackle problem of growing obesity.

Key functions of a Community Medicine Specialist:

The first five functions i.e. identify and prioritize health needs, identify determinants, undertake prioritized interventions, organize health care delivery services through community mobilization and lead the health team for primary health care, are the essence of Community Medicine. 'Lead the health team to provide' rather than 'Lead the health team and provide.... 4(e)' would impart sense of ownership to whole health team. Omitting 'study of distribution' while retaining 'determinants' is quite unlike the usual practice of mentioning both as a pair.[17] Advocacy statement falls more in ambit of Public Health. Health promotion and disease prevention functions are omitted Explicitely in this section and the whole focus shifts to be 'disease and cure' oriented.

The key functions of a Community Medicine Specialist include:

a. *Identify and prioritize health needs of the defined community*
b. *Identify the (direct and indirect) determinants influencing health and diseases.*
c. *Prioritize and undertake interventions to address the health needs and health determinants of the defined community*
d. *Plan and organize health-care delivery services to address health needs through community mobilization to achieve community empowerment*
e. *Lead the health team and provide community-oriented primary health care*
f. *Advocate for equitable, quality, accessible, cost-effective and appropriate health care services, as the basis for achieving Universal Health Coverage (UHC)*
g. *Conduct health system research to evaluate health-care services and recommend measures to improve their effectiveness and efficiencies*
h. *Understand the role of other sectors which influence health and work with them to improve health status of community.*

Effective training in Community Medicine:

Development of Intensive Field Practice Area , urban as well as rural, is a prerequisite to effective training in discipline and the operational guidelines are available.[18] Somehow urban primary health care

concept fails, probably due to higher community expectations, presence of multiple competing providers and easy access to higher levels of health care. We need to explore alternatives, for example collaborating with preexisting urban health delivery system and upgrading clinical services or providing specialist services from mobile clinics with the help of clinicians from Medical College. ROME scheme emphasized reorientation of students as well as medical college faculty to primary health care. We have failed to involve and reorient colleagues from other Clinical disciplines and their reorientation though it should not be difficult, observing their keenness to become Public Health Experts.

For effective training in Community Medicine, every department should have an Urban and a Rural Health Training Center; where the undergraduates and postgraduates get an opportunity to learn and practice the discipline. Wherever possible, departments should aim to establish model health care delivery system at primary care level.

For rural training area, it is usually the junior faculty who is delegated the task of teaching in community setting. Reluctance is obvious as there is lack of role models. One has to recall that at most of the Departments, the interest in community based training developed with initiatives of Senior Faculty and hence there is need for commitment from Senior Faculty of all departments, including the clinical ones.

Close association with local health systems:

Reiteration of stronger liaison with district hospitals for postgraduate training is strength of Declaration. Post graduates need to sharpen clinical skills if they have to train undergraduates, act as 'eyes' of community and take up role of an epidemiologist.[2] This can be possible only if we move from PHCs to District/Sub district Hospitals. Failure to do so has resulted in perceiving Community Medicine as a non clinical subject. On the other hand, merely posting them in alien environment can be a waste unless the learning is promoted. This support can come from clinical department colleagues and it will fulfill our responsibility of reorienting faculty and residents of other Clinical Departments to the district health services. The activity is expected to result in strengthening and bringing credibility to Department in eyes of colleagues at Medical College as well as District Hospital Staff. At almost all the medical colleges where community medicine departments command recognition and respect from students and fellow clinical faculty, the free hand they got 'to manage cases they could not touch at a tertiary level institute during residency' is well appreciated! There are other benefits too like rapport building between residents as well as faculty of different specialties.

Achieve Universal Health Care (UHC) in India:

IAPSM strongly supports the concept of UHC. It believes that to achieve UHC in India, a post of Community Medicine specialist should be created at every Community Health Center (CHC), alongside other specialists. At CHCs, Community Medicine specialist would be responsible for mentoring and monitoring the referral linkages between primary, secondary, and

Many esteemed colleagues continue to argue that the Department should limit to train post graduates and not waste time in undergraduate teaching. It has been the view in other countries too due to which undergraduate medical education in subject has suffered a lot. [19] Undergraduate orientation to real world is only through Community Medicine. If we see MCI regulations, we find that almost all the objectives for training of medical graduates are in fact related to Community Medicine. [20] Still the discipline lost its position from clinical to be treated as a para clinical discipline due to our inclination towards public health, research and health management sciences at the cost of developing field practice areas.[6,7,21] The subject has a great role to play in reorienting medical curriculum itself.[4] If our undergraduate training in Community Medicine achieves its objectives, we will always have trained public health force to meet the demands of future, wherever they work! If we orient them properly, only then Universal Health Care can be possible.

Our post graduates are mostly interested in managing big projects, research and some teaching as we prepare them for these activities only. Unless the learning opportunities reflect what they are expected to do in real world, this disconnect will always remain.[22] This puts a huge responsibility on shoulders of current Faculty for building bridges between Department and clinical colleagues, the local health care delivery system as well community, to create an appropriate learning environment.

Last but not the least, most of us are members of both professional bodies related to the disciplines of Community Medicine and Public Health and a joint IAPSM – IPHA declaration would have endorsed the clarity and a common understanding amongst all the stakeholders. On a personal note, the write up was written almost an year back and was suggested to be published in journal of the other association as it was thought to be more relevant to 'them'.

Conclusion:

The Declaration' is an important step towards defining the future of the discipline as a part of Medical Institution and curriculum. However more clarity to define the subject would clear its similarities and differences from public health. It is need of the time, in view of commitment to objectives laid by MCI, rolling out of competency based curriculum as well as UHC, to put our efforts unanimously in line with the Declaration to not only improve the quality of medical education and health care delivery but also to gain the deserved status of Department and the discipline as a part of Medical Institute.

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