Community Medicine in India — Which Way Forward?

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ABSTRACT
Today, the Community Medicine professionals in India feel both “confused” and “threatened” by the mushrooming of schools of public health and departments of family medicine. The phenomenon of identity crisis and low-self esteem is not a recent one, nor is it restricted to India. The disciplines of community medicine and public health have evolved differently and despite some overlaps have differences especially in the need for clinical training. The core of the issue is that while the community medicine fraternity is keen to retain its clinical tag, what differentiates it from clinicians is the use of public health approach. I believe the strength of community medicine is that it bridges the gap between traditional fields of public health and clinical medicine and brings community perspective into health. The perceived threat from non-medical persons led public health is largely a result of us undervaluing our strength and our inability to foster partnership on equal footing with non-clinicians. While departments of community medicine have a fully functional rural or urban field practice area used for training at primary level care, these can serve as an excellent platform for training in secondary level care required for family medicine. National needs dictate that all three disciplines are required for improvement of population health, whether these are housed together or separately can be left to individual institutions to decide as long as they enable collaborations between them. We need to strengthen community medicine and market it appropriately to ministries of health.

Keywords: Community medicine, family medicine, public health

“One day Alice came to a fork in the road and saw a Cheshire cat in the tree. “Which road do I take?” she asked. “Where do you want to go?” was his response. I don’t know,” Alice answered. “Then,” said the cat, “it doesn’t matter.”

— Lewis Carroll from Alice in Wonderland

Context of the Oration
The reason why I chose this topic for my oration is that I think community medicine in India is at a fork today. The current situation can be summed up by two words - “confusion” and “threat”. Junior colleagues and students have often asked me as to what constitutes our discipline and more recently, what is our link to disciplines of public health and family medicine. Many of the Institutions including the new AIIMs have departments of Community and Family Medicine and plan to have a School of Public Health with a lot of ambiguity between roles and functions of these departments. There is also a sense of threat from mushrooming of schools of public health and their MPH graduates which was voiced in the last general body
meeting of our association. In this oration, I present my views on this issue, fully cognizant of the fact that it is a controversial issue and evokes strong feelings on all sides. I think that these issues need to be debated openly and hope that my oration will cause an introspection and debate among our fraternity.

Evolution of community medicine and public health
In order to understand the differences between community medicine and public health, it is important for us to know how these disciplines evolved. One of the first use of the term “community medicine” that I found in my review was in the context of United States in 1920. It defined it in opposition to individualistic practice into a group/co-operative medicine with the aim to increase access to care and promote equity. In United Kingdom, the move towards community medicine occurred in 1974 with almost the same aims. It also defined the role of community medicine specialty as i) Organizing health and allied services to the community; ii) Setting priorities in communities using epidemiology and biostatistics and; iii) Addressing social determinants of the disease. It is clear that this captures the current scope of the departments of community medicine in India very well.

If we look at evolution of Public Health, two main nineteenth-century phases of public health are usually described: The environmental sanitation phase lasting from around 1840 to 1890, and the period of the scientific control of communicable disease, based on bacteriological discoveries and the germ theory, from 1890 to 1910. This was followed by using legislation as a tool for public health, whether it was to protect factory workers or to use quarantine to prevent the spread of diseases. While the initial advances in public health occurred outside the medical sector, as medicine advanced, the focus of prevention and public health moved from governments to individuals and accordingly, the emphasis on clinical medicine became stronger.

While in UK, medically trained people always had the upper hand in public health, in the United States, it was initially led by engineers, biologists and few social scientists. However, the credit for establishing public health as a separate profession by creating training for public health professionals goes to the Welch-Rose report which led to the establishment of Schools of Public health in United States in 1916. This report clearly distinguished between public health professional (maintenance of health) and clinical medicine (cure of disease). This distinction between public health and clinical services and their organization has, in my opinion, facilitated a broader and stronger development of public health in United States. My experience in India is that discussions in public health forums focus only on the organization of health care services almost to the complete exclusion of all other aspects of public health. Such a clear cut-division, in my opinion will bring clarity to such discussions and will contribute to betterment of public health scenario in India. The Faculty of Public Health Medicine (current fashionable name for Community Medicine) in UK has now opened its membership to non-medically qualified public health practitioners, something that we are not keen on in India.

In India, our brush with this discipline, which was earlier called as Preventive and Social Medicine (PSM), originates with the recommendation of the Joseph Bhore Committee in 1946. This committee recommended the need for training of “basic doctors” as those who will not only provide basic clinical care but will also engage with the community in priority setting and identifying solutions to common health issues. For this, it recommended setting up of departments of PSM so that medical students can be oriented to the community by developing field practice areas, teaching of basic biostatistics and epidemiology and social and behavioral sciences for assisting in interaction with the community to investigate community health issues. In mid-seventies, the members of Indian Association of Preventive and Social Medicine (IAPSM) wanted an image makeover as PSM was identified with latrines and mosquitoes. In the Udaipur Conference of IAPSM in mid-seventies, there was a debate to choose between Community Medicine and Community Health and finally Community Medicine was adopted. The choice of “Medicine” over “health” reflects our keenness to emphasize the clinical nature of our discipline. We did not even consider changing to Public Health, which categorically recognizes the involvement of non-health care providers. We have worked very hard for this discipline to be called as a “clinical” discipline in the undergraduate curriculum and we take pride in being called a “clinician”.

Public health, community medicine and family medicine - differences and overlaps
One of our senior colleague has opined, to which many of you agree, that community medicine and public health are same and only differ in semantics. While I beg to differ from him on the definition and scope of these subjects (elaborated later), I wholeheartedly agree with his call that we should work together. In other words, while he argues that we should work together because we are same, I argue that we should work together because we are different! While, I do not propose a definitive answer on commonalities and differences between these two disciplines, I am proposing a way to look at this issue.

Broadly, public health and clinical medicine can be seen as two entirely different disciplines with no overlap.
People practicing clinical medicine are care providers to individuals. It can be practiced at three levels - primary, secondary and tertiary depending upon the degree of specialization. Public health practice in turn, looks at population level issues that affect health and a clinical training is not necessary. I propose here that public health practice can also be practiced at three levels — first at community level (micro), second at an organization or district level (meso) and; finally at province, national or global level (macro) where issues like legislations, trade, fiscal measures are included. However, unlike clinical medicine, this division is not hierarchical. One could work at all the three levels simultaneously, as many of us indeed do. Most trainings in public health are not linked to a community or health system as is a hallmark of community medicine training. Community medicine, in my proposed model, borrows two levels from Public Health (micro and meso) and includes primary level clinical care [Figure 1]. Family Medicine goes beyond primary level to secondary level (not fully) in clinical care and includes micro level public health competencies to it [Figure 1]. In order to understand the differences, I have tried to use the example of non-communicable disease prevention and control below [Box 1].

At undergraduate level, we teach the micro level of PH (working with the community) and facilitate (in contrast to teach) students’ learning and practice of clinical skills at community and primary care settings. We do not teach macro levels of public health as a part of community medicine teaching nor do we teach secondary level clinical care to our postgraduate students. It should be acknowledged that components of public health legislation, policy development and evaluation, health economics, international negotiations are critical for public health practice today and do not need clinical background. While, I agree that being clinically trained provides us better insight into health issues, I do not think it “defines” us. At the same time, we also need to acknowledge that our clinical training narrows our perspective on many health issues. It is indeed paradoxical that many of us think that community medicine and public health are same and, yet do not want to include non-clinicians in this discipline on an equal footing.

Our obsession with the need for clinical background is because we practice only clinical medicine. I do not believe that community medicine is about providing clinical care to disadvantaged communities. That is a
responsible all health workforce shares and is not really a discipline or a specialization, but an attitude or an approach. I believe that many of us do not even comprehend public health approach at all. In one of my earlier papers, I have tried to distinguish between clinical and public health approaches. Clinicians aim to cure or control the disease using tools available to them like medicines, vaccines, surgeries etc. Public Health specialists use tools like policies, legislations, programs, guidelines etc. to control/eliminate/eradicate a disease from the community. While clinicians individualize treatment in order to provide best treatment for individual, a public health approach standardizes treatment in order to increase quality and access to care for most in the community. While clinical approach progresses by super-specialization, public health approach believes in task-shifting to lower levels of health workforce. I have been asked many times to describe in one sentence the discipline of community medicine. I think it would be “We work with communities to improve their health”. I think it is time that we stopped our obsession with being a clinician and start practicing real community medicine by working with communities and not individuals.

Rivalry between disciplines within Institutions

Should we feel threatened by the emergence of family medicine and inclusion of non-medical people in public health in India? Some concerns and challenges have been voiced by others before me. The experience of many of our medical schools grappling with departments of community medicine, family medicine and schools of public health is not unique to India. A similar experience has been reported from Shiraz University of Iran recently by Ronaghy and has lessons for us. The starting of School of Public Health with an existing Department of Community Medicine resulted in split in the faculty with both not having sufficient qualified personnel. The community aspect of the Community Medicine department was undermined. In the early 2010s in Iran, restrictions were imposed and the patients could not directly go to specialists and had to be referred by primary care physicians or general practitioners. University administrators were hard put to distinguish between “Family Medicine specialists”, Community Medicine Specialists and a General Practitioner who is a medical graduate, with no postgraduate training.

In short, people who advocate a move towards a broader discipline of public health feel that community medicine has medicalized public health with a narrow focus on health services and ignored the multi-disciplinary nature of the subject. The trainings have been restricted to medical schools, thus reducing its access to others and resulting in lack of expertise in many critical aspects of public health like policies, legislations etc. On the contrary, people who are in community medicine feel that public health training is largely theoretical and does not have either a community or a health system at its base. Also, the fact that anybody can become a public health specialist reduces the status of public health specialist as compared to other clinical disciplines.

Understanding the perception of threat

Because we have emphasized our clinical roots and we are definitely lower in the pecking order of clinical disciplines, we have low self-esteem. Yet we do not want to open this discipline to non-medical disciplines and be ranked higher to them and get over this issue of low-self esteem. It is indeed strange that we are threatened by both clinicians as well as non-clinicians! Why is it so difficult for us to accept that we are not care providers but managers of care providers? Only the acceptance of this fact can bring clarity and peace of mind to us.

To correct the low self-esteem, we need to strengthen our discipline to address current and future health challenges like climate change, international trade and treaties etc. This can happen only if we embrace people who are trained in these disciplines, irrespective of their background. I do not think that we have done enough to get social sciences and other non-clinical partners on board. While we have statisticians and social scientists in our departments due to Medical Council of India regulations, they are clearly treated as second-class citizens. At the same time, there is no doubt that these faculty members are ill equipped to participate and integrate with the departments of community medicine.

My contention is that our perception of threat is based on our perception of weakness. Should we feel threatened that epidemiology (which is considered as a core discipline of public health) is now taught by many including clinicians and non-clinicians. In my opinion, basic epidemiology (like computers and management) is a way of rational thinking and is essential for all. However, most community medicine specialists in India today, do not know beyond basic epidemiology and therefore feel threatened. If we have to stand up to these threats, we need to strengthen our epidemiological backbone in a big way.

The public health environment in India has been changing slowly for a long time, but we have taken cognizance of it only now, as the speed of change has accelerated. If we do not take action now, we may not survive. As Charles Darwin said “it is not the strongest or most intelligent who will survive, but those who can best manage change.”
How do we move forward?

My suggestion is to move forward at four levels — discipline, association, institution and finally at individual level.

Disciplinary level: The only way forward is to embrace change. The greatest strength of Community Medicine is that it uses a public health approach and not clinical approach. It is important that we promote it rather than emphasize our clinical lineage. Our strength is that we bridge the chasm between public health and clinical medicine, our motto has to be to work together. I think that this policy of exclusion has to go. We have to get out of the hospitals and work with communities and governments as that is our strength. Do we want to be a “primary care” physician or become a public health “specialist”?

We need to redefine our discipline at undergraduate and postgraduate levels. A critical question to ask is whether the concept of “basic doctor” as enshrined in the Bhore Committee Report is still relevant. What role does the subject of community medicine play in undergraduate medical curriculum in today’s context? How do we strengthen teaching of macro-level subjects of public health to our postgraduates? We need to think of developing sub-specialties (Doctor of Medicine or DrPH) courses in epidemiology, infectious/chronic disease, environment, nutrition etc.) and not restrict ourselves to just post-graduation.

We also need to market our discipline better. For this, we need to be clear whether we are a “niche” product aimed at a small but distinct market or a “mass” product aimed at the whole community. Should we accordingly, go for “placement” or for “numbers” during our marketing? If we feel that our strength is in numbers, then why do we want to alienate non-clinician public health partners? Why not strategically identify numbers as our strength and work with them?

Institutional level: Within Institutions, we need to respect the differences and overlaps between the departments of Community Medicine, Family Medicine and Public Health and let all of them flourish, but not at each others’ cost. We need to create departments with loose boundaries but formal arrangements for division of work and responsibilities. In addition, I plead for non-clinicians to be given full partnership in the department.

Association level

Indian Association of Preventive and Social Medicine (itself an anachronism) is primarily a body of teachers of community medicine and has to take the responsibility of strengthening and standardizing teaching of this discipline in the country, including creation of sub-disciplines. It also needs to encourage diversity and debate and evolve consensus on these contentious issues. IAPSM has to embrace other public health stakeholders to form a strong coalition to advocate solutions to the public health problems of the country. It also has to undertake marketing of our discipline to the state and national ministries of health, identify and propagate role models to improve our self-esteem.

At individual level, I would like to say that public health, community medicine and family medicine are all appropriate choices to make in ones career as long as one is true to the approach chosen. Individuals should choose depending upon their strengths and aspirations. If you decide to choose community medicine or public health, practice a public health approach. But ultimately, all three converge to improve peoples’ health and we have to learn to treat them as friends and partners and not as rivals.

In the end, I request all the members introspect individually and collectively at departmental level to strengthen our discipline and association. Thanks for your encouragement and support.

I cannot say whether things will get better if we change; what I can say is they must change if they are to get better.

— George C. Lichtenberg

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