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THE CONCEPT OF COMMUNITY MEDICINE

by

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Introduction

It is a curious and interesting fact that the two extremes of medical care, the basic health services of the rural areas and the highly sophisticated medical services of the large industrial societies share a common aim, the provision of medical care for the community as a whole. The detailed problems to be solved are quite different but the underlying need is the same, namely to make the best use of available resources.

It is for this reason, for example, that the mass campaigns in developing countries are gradually being merged with the basic health services. Similarly the concept of "community medicine" in the context of highly industrialized societies springs from the realization that over-specialization, and the organizations of medical care into separate divisions, each with its own administration, may be wasteful and inefficient. In the British National Health Service, for example, with the tripartite divisions of hospital and specialist services, domiciliary medical services, and local health authority services, the most costly by far are the hospital

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and specialist services, which absorb some 60 percent of the total annual budget in addition to requiring vast sums for capital expenditure.

In this connection it is particularly interesting, therefore, to note the comments of the recent Royal Commission on Medical Education in Great Britain on the likely future pattern of medical care when it was said that "We foresee, however, that the present organization will undergo considerable change, and that the future pattern of and relationship between the main branches of medical practice will be very different in many respects from what it is now. Special medical services for particular groups of the population will doubtless continue to be provided in some form by industry or public authorities, but these services are likely to be much more closely co-ordinated with general medical services than they now are",[1] Similarly a recent report of the US Citizens' Commission on Graduate Medical Education supported the view that there is still a widespread need and demand for a "primary physician" of very broad competence and interests.[2]

Definition of Community Medicine

So far there can be little cause for disagreement, but when we come to define the term "community medicine" we find that there are various interpretations. For some people it means the organization of domiciliary medical care radiating outwards from a district hospital or a health centre, for others it may imply "group practice" by general medical practitioners, yet again it may be taken to imply a speciality practised by a "community physician" (epidemiologist or administrator of medical services) and thus be concerned with broad questions of health and disease in the community at large and not with the care of individual patients.

For the purpose of this paper I suggest that we define community medicine as the health care of the individual and his family within the community of which they form part. This would then include the prevention and cure of personal disease in the individual in addition to the safe-guarding of the health of the community as a whole.

The Problems Involved

If we accept this definition we commit ourselves to considering a wide range of problems, medical, social, economic and administrative. First and foremost we have the changing pattern of disease and the increasing complexity and cost of diagnosis and therapy. Until recent times about 80 percent of the great killing and disabling diseases were due to a faulty physical environment, combined with malnutrition, ignorance and poverty. It was this vicious circle that our forebears began to attack in earnest little more than a hundred years ago (the first effective Public Health Act in Europe was passed in England in 1848), and it is significant that the statutory qualification for a medical officer of health in Britain was, until recently, a diploma in sanitary science, public health, or state medicine.

The advances in the medical and allied sciences of the present century have so reinforced the results of improving the physical environment that the expectation of life from birth in the more advanced countries has increased by about thirty years in my own lifetime. The physical and mental abnormalities which were accepted as part of life's burden are no longer tolerated and the people of every country in the world are now demanding the provision of health services by their governments.

Indeed, the pendulum has swung so far that governments are having to establish priorities and weigh the cost of such recent advances as

organ transplants and renal dialysis units often before they have succeeded in eliminating cholera, plague, smallpox, tuberculosis and chronic malnutrition. It is also becoming evident that purely "medical" care is not enough and that the social components of the human environment are of increasing importance, as shown by the effects of stress, the enormous toll of industrial and road accidents, and the increasing emphasis on mental illness.

The factors which weigh most heavily on governments, however, are economic and linked with these the unsatisfied demands for trained staffs, medical, paramedical and auxiliary. No country, however wealthy it may be, can afford the "bottomless purse" required for free and comprehensive medical care if there are no visible limits to its extent, now or in the future. On economic grounds alone, the emphasis must be on prevention, and this can only be undertaken within the community. Hence the increasing interest in "community medicine",

The Organization of Community Medical Care

As a member of the General Medical Council in my own country, I have had the experience of taking part in a recent review of the teaching of public health and I think you may be interested in our findings and recommendations. We began by pointing out that while the statutes regulating the qualifications to be held by medical officers of health were virtually unchanged for nearly 80 years, their duties and the environment in which they must discharge them had altered greatly and that the medical officer of health now required a knowledge of many subjects beyond the application of sanitary science to the control of infectious disease and the physical environment.

We went on to point out that medical officers of health are now engaged in only one branch of community health practice, other branches of which include the administration of hospital and general practitioner services and industrial medicine, and in future doctors must be equipped to work in situations where the different branches of community health services administration were closely associated. We had in mind primarily the demand, which is likely to increase considerably in future, for medical administrators on whom the success or failure of the organization of medical services will depend.

The principal need for competent medical administrators is found in the central government, especially the Ministries of Health, in local government service, in the hospital and specialist services, in occupational health and industrial medical services, and in the Armed Forces. We had also in mind, however, the needs of developing countries for trained and competent medical administrators.

Because of our terms of reference our main interest was centred on the future specialist in community medical care, the "community physician" as he has been called in some countries. In other words, the person who will have to plan, organize, co-ordinate and administer the health services of the community for which he is responsible. We accepted that the future specialist in this field should preferably have had several years of experience in clinical medicine before beginning his specialized training and we welcomed a new development whereby some authorities provided for medical officers to continue to be paid during their period of post-graduate academic study.

Post-graduate Training in Community Medicine

It was generally accepted that a uniform basis of post-graduate training is essential for doctors engaged in all branches of medical care

involving administrative responsibility. In other words there should be a common academic core in the various training schemes. This academic core would require to be supplemented by vocational training depending on the branch of community medicine in which the doctor plans to make his career.

The obvious academic courses on which to build for the future are those which already exist for degrees or diplomas in public health. The curriculum for many of these was laid down at a time when the medical officer of health was expected to be an authority on all aspects of the control of the physical environment, and many of you will remember, as I do, the long hours spent on chemical and bacteriological bench work even though the actual practice had already passed into the hands of the non-medical expert in water supplies, waste disposal, analysis of food and drugs, and so on.

Future requirements will be very different, and it was for this reason that we said "the Council (i.e., the General Medical Council) regards it as important that courses of study for the Diploma in Public Health should be designed to lead candidates to the study of scientific methods so that, when they come to assume responsibility for decisions of importance, they will be adequately trained to assess the relevant factors. It follows that curricula and teaching methods should in general pay less attention than hitherto to the imparting of factual information and more to the stimulation of individual thought and critical assessment."

The traditional titles of degrees and diplomas in public health are also becoming outmoded and indeed can under certain circumstances be a handicap, for example when dealing with clinical colleagues to whom possession of a D.P H. signifies some past expertise in "chains and drains".

While it would be foolish to go to the other extreme and allow a multiplicity of titles the General Medical Council has indicated that it will be prepared to recognize on its merits and irrespective of its title any qualification for which the curriculum is substantially that indicated in the new Recommendations of the Council. These recommendations allow a substantial measure of freedom in arranging the curriculum, but the Council has announced that it proposes to keep the situation under regular review in the light of the possibility of far-reaching changes in the administrative structure of the community health services, so that the recommendations as to the curriculum can be suitably modified to ensure that doctors who will within the next few years enter the field of community medicine receive appropriate training. It hardly needs saying that the repute of a degree or diploma course depends ultimately on what it does and not what it is called.

The current trend of thought in my own country is best illustrated by the General Medical Council recommendations on the curriculum in which they said that the courses should include the study of the following subjects:

a) The quantitative sciences appropriate to the study of community health, including medical statistics and epidemiology;
b) The behavioural sciences as applied to community health; the scientific study of human behaviour, including the health education of the public and the psychological and social factors in community organization and in health services utilization;
c) Genetic and environmental (including micro-biological) factors in health and disease; methods of prevention and control as applied to physical and mental disease; and

d) Health services organization, including the ascertainment of the health needs of the population, the provision, deployment and evaluation of health services; the economics, staffing and utilization of health services and the principles of administration and management.

Under-graduate Teaching in Community Medicine

It may, at first sight, seem odd to discuss undergraduate teaching after post-graduate but it is logical in this instance, for undergraduates cannot be taught without suitably trained teachers. It is significant that in many countries medical students are themselves demanding instruction in the wider aspects of community care. This presents a difficult problem for established medical schools whose primary function is to train and produce "safe" doctors and in which there is only limited room to experiment with the curriculum. It is interesting, however, to reflect that in the four Regions represented at this meeting the opportunities for adapting teaching to future requirements are much greater, for many of the medical schools are new and some are still in the planning stage. It would be invidious to select examples but I have been impressed by the proposed teaching programme for the new University Centre for Health Sciences in the Federal Republic of Cameroon, where it is intended that there should be three major units grouping together all activities concerned with planning, research and community health care, under the heading of Biomedical Sciences, Community Health Care and Health Research and Training.

The Unit of Community Health Care will include services and activities relating to individual and community health care, social welfare, and environmental health, under the comprehensive title of total health care. For teaching purposes this Unit will deal with the service training of all kinds of personnel, auxiliary as well as professional, and would thus allow all members of the health team to develop an effective understanding

of each others' activities. By this means it is intended that the Unit would provide an example of comprehensive health care applicable throughout the country.

Conclusions

I will not pursue further the concept of community medicine, for I know that you have already given much thought to this. My reason for introducing it at this time is that the developments I have outlined will have a profound effect on Schools of Public Health. If medical men are not trained to become the organizers and administrators of the new developments in community medical and health care, their place will be taken by laymen. Already University Departments of Sociology, Public Administration and the like are having to organize courses in special aspects of health services administration, including hospital administration. The basic need for the coming years is for expert administrators or "managers". The majority of these must, of necessity, be non-medical but it seems to me essential that in his own field the medical man must retain the leadership and that it would not be in the interests of the community for him to become merely a technician, no matter how highly skilled, responsible to lay administration.

REFERENCES

1. Report of Royal Commission on Medical Education 1965 - 68. London. HMSO Cmd. 3569 at p.32

2. The Graduate Education of Physicians. Report of the Citizens' Commission on Graduate Medical Education. American Medical Association, 1966. Quoted by the Royal Commission on Medical Education.