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The Scope of Social and Preventive Medicine

Community Medicine Section

R.S. BHARATWAJ, P. RAJARAM

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INTRODUCTION

The term, 'medicine' encompasses all the activities which are directed towards enriching the health of the beings on this planet (humans and other species as well). With particular focus on the human wellbeing, the W.H.O definition of health which states that, "Health is a state of total physical, mental and social well being and not merely the absence of disease or infirmity" [1]is a fair representation of the multidimensional aspects of the state that we refer to as, health. This leads us to the definite understanding that 'medicine' is not merely the art and science of healing alone, which concerns itself predominantly with the physical aspect and a little bit with the mental aspect of humans, though incompletely [2].

In the past, all the focus in terms of budget allocation and infrastructure development was primarily directed at the sick population in the community, which accounted for a maximum of 3 to 5 % of the total population. This left the apparently healthy group of nearly 95 to 97% people unattended. Once the awareness of this aspect of the policy came into being, there was a need to shift the focus from "Disease to Health". This heralded the birth of community medicine.

The evolved understanding:

1. The treatment of patients without due consideration about the hygiene and the sanitary aspects is bound to be unsuccessful.

2. Taking into consideration the hygiene and the sanitary aspects alone, without reference to the patient's living (social) and working (economic) conditions is again an incomplete and partial solution to the complete return of health.

For e.g. An unemployed patient of the lower strata of society, with gastroenteritis, living in a contaminated environment and having unhygienic habits, will never get a lasting cure if he is just seen as a case of diarrhoea in a clinic setting alone. The hygiene, sanitation and the social and economic aspects are so interlinked that they form very essential factors in the web of causation of the disease in question. Hence, none can be studied or resolved with the isolation of the others and the disease itself is purely an indicator which points to an imbalance in the above mentioned factors. Hence, its cure in an individual is certainly not an end point in the activities which are directed towards the health of all, but rather a beginning point, in the sense that it warrants a further probe towards identifying the imbalance and taking corrective measures, which might prevent the disease from ever happening or at least might arrest its spread to a larger group of people. Herein, comes the role of social and preventive medicine.

For a medical practice to be wholesome, the practitioner must be;

- A good clinician i.e. with skills in diagnosis and treatment
- Abreast of the knowledge regarding the role of hygiene, sanitation and social and economic factors in the various stages of disease evolution in the community.

In this kind of practice of medicine;

- The social diagnosis completes the disease diagnosis
- The social treatment supplements pharmacotherapy
- The social hygiene fortifies the individual hygiene

The concept of prevention is often misconstrued even amongst the medical fraternity as an action that happens only before the disease onset, but in the true sense, it encompasses the whole possible range of all the activities which are directed towards health care from primordial prevention (Even before the risk factors for the disease even enter into a community), primary prevention (Immunization activities, etc), secondary prevention (early diagnosis and treatment) to tertiary prevention (disability limitation and rehabilitation) Hence, social and preventive medicine is not apart from the so termed clinical medicine. It is an inseparable part and in fact, an extension of clinical medicine from its constrained hospital/clinic set up into the community, which is the multi faceted ground on which the pollens of disease flower and spread. Simply chopping out the revealed portion of the weed will not solve the problem. What is needed is an approach to uproot it from its root, to study and nurture the soil and to correct the imbalances which are detected, for it is the soil which is the very source of life and health. The soil that we refer to as the society (living beings and nature).

Social and preventive medicine is thus a tool of enhanced responsibility (that meets the needs of an individual from womb to tomb) that is laid on the shoulders of the physician, so as to deliver true health to the community, the same community to which the physician belongs to and the same community which has laid its faith upon making the physician what he is.

In the training of a medical doctor, it is the inculcation of this "clinico-preventive" attitude which is aimed at. Any physician who had ever practiced medicine was a community physician; It is so now and it will be so forever. Hence, for the wholesome practice of medicine, the understanding of the basic tenets of health and the influencing factors is of utmost importance The whole sphere of social and preventive medicine concerns itself with this aspect. In medical education for undergraduates, the department of

community medicine can be integrated with the department of general medicine and teaching /training activities can be carried on in hospitals as well as in the field practice areas. Since, in a majority of institutions, the community medicine department has no hospital out-patient set-up, integrating community medicine with general medicine helps not only by adding to the variety of cases which can be used for training the students in the aspects of communicable and non-communicable diseases, but also to immediately identify the potential cases by using better diagnostic facilities that might require a field follow up for the disease control activities.

"Community medicine", as a subject for post graduation, faces the confusion whether it comes within the realm of clinical medicine or not, albeit the fact that it was declared as a clinical medicine field by the Supreme Court. The exact role which is played by a specialist in community medicine is not at all clear and well defined. She/he faces the dilemma of not being a wholesome part of the specialists of the out-patient and the in-patient services, but at the same time, of being asked to cater to the community needs in terms of field activities like camps, etc. Now, this community activity towards the collection, compilation and the analysis of data requires more administrative and statistical skills with a basic supervision by a doctor, as the facts which are concerned are medical. So, a three year degree course as a specialization for this kind of work is not necessary at all. As far as the exposure to the research aspects is concerned, all other degree specialties are also taken through the grind of research activities as the medical students work on their thesis. This means that it would add to the efficiency of the health delivery services if we could revamp the way community medicine is perceived and implemented in society.

There are two plausible alternatives [1]. A post graduation degree as MD in Community Medicine can be scrapped and the doctors who have done their MBBS can be made to go through a short training for administration purposes and to enable them to handle the peripheral health departments. The doctors who have completed their post graduation in different clinical specialties like paediatrics, ophthalmology, etc and who have an inclination for community service, can be offered a course of a year or two, towards orienting them to community aspects in their respective specialties and to the overall health management [2]. The other viable option is to refine the action field of a community medicine specialist. A community medicine specialist is expected to have basic understanding and skills, not only to provide general primary health care to the community, but to also possess an in-depth knowledge of the epidemiology of communicable and non-communicable diseases, to be familiar with the principles of social and behavioural sciences and to possess management skills for organizing health services to promote health in the community [3]. The doctors who have undergone their post graduation in community medicine, with the kind of skills that they already have, could be provided with further opportunities to continue their specialization in the fields of their interest, like paediatrics, ophthalmology, etc as a one or two year course and to enhance their expertise in specific disciplines . The second option would be easier to implement without disturbing the current system of medical education in India and without conflicting the interest of the already existing community medicine specialists. By doing this, we shall have a group of medical specialists like community paediatricians, community ophthalmologists, etc who are more trained and qualified to take mass decisions for their respective specialties.

In the health system, we will then have MBBS graduates who are trained in the delivery of basic health care and in simple data management skills for taking care of the peripheral health set up. The specialists of different specialties, as community health specialists at the decision making levels in a tier system, as a team, can plan programs for the corresponding health issues. This will serve in eliminating the mystery and the lack of clarity that exists around the functionality and social applicability of community medicine, not only amongst the medical professionals, but also among the policy makers. This can make their roles a lot better defined and at the same time, the community field activities will also happen at a much more effective level for the well being of humans.

Above all, it needs to be seen that the doctor or even the medical industry, in isolation, cannot fulfill the commitment towards the delivery of overall health to the community at large. We are discussing this here with the firm background, that medicine and its deliverers are created and promoted by the society towards it's own well being and hence they are not some kind of elite group who are special in the society. The support of a whole lot of other people who do seemingly smaller things are extremely essential while the multidimensional aspects of health are being considered. These include the pharmacists, the biotechnologists, the farmersin their fields, the honest grocer, the timely milkman and even the sincere menial worker.

Hence, it is essential to consider the fact that a physician is a team member in the social structure, who is given a certain position and responsibility by the society to cater to its health needs, and the respect, recognition, privilege and money that he gets, must be justified by his knowledge, motive and actions concerning the well being of the community at large

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AUTHOR(S):
1. Dr. R.S. Bharatwaj
2. Dr. P. Rajaram

PARTICULARS OF CONTRIBUTORS:
1. Assistant Professor Dept of Community Medicine,
2. Epidemiologist, Dept of Community Medicine,
Sri Lakshminarayana Institute of Medical Sciences,
Pondicherry, India.

NAME, ADDRESS, TELEPHONE, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Dr. R.S Bharatwaj, Assistant Professor,
Dept of Community Medicine,Sri lakshminarayana Institute of Medical Sciences, Pondicherry, India.
Phone: 9629834189; E-mail: resure2@yahoo.com

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