EDITORIAL

Extending the role of Community Medicine into clinical sciences

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Well into the yester years of medicine it got divided in public health and clinical medicine. Battered and fearful of the raging epidemics which decided history and fate of human endeavors' and congregations, public health quickly developed the science of counting and using numbers to make decisions to preserve health, the science of Epidemiology. Definitions became precise including definitions of abnormality. Need to act before the disease hit became well known as simple things like full pants, full sleeved shirts and mosquito nets protected armies from malaria out breaks. Epidemiology blossomed as the knowledge of distribution and determinants of disease making huge differences on disease burdens and saving millions of lives. But response to disease, clinical medicine, still remained an important determinant of what should be done in the health sector as it was the diseased, not the healthy who controlled the decisions on what should be done on health. Costly corporate, highly technical medical institutions with cutting edge treatment and investigation technology swayed decision makers mood on what to invest in regardless of the magnitude of impact that the intervention would have on health versus the resources being spent on ensuring it. Liver transplants in Cirrhotic patients costing crores looked more glamorous then a 10 rupees Chloroquin strip which could prevent a correctly diagnosed malarial death. Also fanning the tilt towards the less cost effective was aggressive marketing of the developers of the cutting edge technology. Medicine stood Hijacked. Divorce between the science of talking numbers, Epidemiology, the probability paradigm and the plausibility based arguments became more and more complete. The rationality of the science of numbers soon become a back seater in front of the more lucrative, glamorous, powerful and money driven advertising of the more costly, sophisticated but less available, less affordable and less effective treatment and investigation modalities.

Clinical history taking and examination stood defeated against CT Scans and MRI. ½ and hour of exercise stood defeated in front of stents even though the reduction they produce in a second heart attack was 88% as compared to 70% by stents and even plausibility wise they affected the whole cardiac circulation rather than one vessel at one place. This is where we stand today and if the trend continues we may be at a greater risk of dying or getting disabled if we go to a hospital than if we don't and not even know it.

The divorce between clinician, the decision makers for the diseased and the rationale science of numbers developed in community medicine must be broken. Clinicians, to remain loyal to their patients must become better users and producers of medical research and less vulnerable to marketing strategies of the rich and resourceful. The science of epidemiology must become more interesting and more used by them. Medicine must be made more effective, safer and more affordable for the patients. Community Medicine must impregnate all branches of clinical medicine with the science of understanding numbers for the practice of medicine to become safe, effective and affordable for the last man in the queue. A new role for community medicine from the traditional role of effecting policy to affect community health, to affecting practice to alter outcome of disease has emerged.

Community medicine departments in medical colleges should develop Evidence based medicine units to teach in undergraduate medical paramedical and nursing courses subjects related to the "What did happen paradigm" rather than "what should happen". Their interaction with other departments should increase. Faculty should be helped by these units to write better projects and better papers and students, better thesis.

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Faculty should contribute to convert research to action by contributing to systematic reviews and help develop good clinical practice guidelines. Online tele-medical education packages should be developed to be accessible to common practitioners. CME's should be organized on evidence based medicine. The face of medicine should quickly change from plausibility based decision making to probability based decision making. Decisions should become algorithmic to remain defensible in an increasingly skeptical environment of consumer protection law. Credibility of being loyal to the patient rather than succumbing to pressures on his pocket must be saved.

This is an emergency. The outcome is a crisis of faith. And there is no better determinant of outcome in an emergency than timely action.