Community Medicine in the Training of Family Physicians

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Family practice residency programs are encouraged to include community medicine training in their curriculum, but there is little agreement as to what community medicine is or what would constitute appropriate training. Community medicine is most commonly defined as a discipline concerned with the identification and solution of health care problems of communities or other defined populations. The inclusion of training experiences in the identification and solution of health care problems of communities has two basic advantages for family practice residency programs: it fosters a contextual approach in the care of individual patients and it builds knowledge and skills for those who will work with communities in future practices. An example of curricular content is included.

A survey was conducted in order to determine what residency programs teach in the field of community medicine. The results show that few of the responding programs include the areas which most clearly relate to community medicine. It is hoped that the report of these results, the rationale presented for including community medicine in the training of family physicians, and the suggested outline of curricular content will further encourage and assist family practice residency programs to incorporate such training in their curricula.

The accrediting body for family practice residencies suggests that residencies provide training in community medicine and makes these comments[1]:

Community medicine is one of the unique components of family practice. Through proper instruction, the resident should be provided with an understanding of the principles of epidemiology and environmental health, familiarity with the health resources of a community and community organization for health. He should appreciate the roles and inter-relationships of persons in the various professional and technical disciplines which provide health services.

Community medicine should provide the resident with an approach to the evaluation of the health problems and needs of a community and to the improvement of resources to meet community needs more adequately. The experience should assist the resident to understand the role of private enterprise, voluntary organizations, and government in modern health care. The social and behavioral sciences should be used to provide the resident with an understanding of the research tools and methodologies which will be of use to the family physician in discharging his intergrative functions. (Italics added.)

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Table 1. Levels of Practice

The Individual Level
The case approach
The whole person approach
The Family Level
A family orientation
The family (or household) as-a-unit
The Community Level
The practice
Contiguous groups eg, neighborhood, village
Relationship networks
Special groups or communities

A definition of community medicine is inherent in the description of the content area and a curricular direction is also suggested. The content included involves material which is traditionally thought of in the areas of epidemiology and environmental health, then goes further in implying an active role for the physician in seeking "the improvement of resources to meet community needs. . . ." The distinction between such a role and that of Public Health becomes vague.

There is not a commonly accepted definition of community medicine in the literature. To some, community medicine is the provision of medical services in the community.[2,3] To others, it is the consideration of the socioenvironmental factors which affect the health of patients.*[4,5] Another definition equates community medicine with epidemiology, public health, and preventive medicine.[6] The most widely used definition, and the one the authors propose for adoption by academic family practice, describes community medicine as a discipline concerned with the identification and the solution of health care problems of communities or other defined populations.[7-13] (This definition is also used by Kempinski R, Kransmik A in Community medicine and primary health care. Joint Center for Studies of Health Programs, UCLA and University of Copenhagen, July 1974, unpublished.) This definition, in addition to having the advantage of wide usage, seems to come closest to describing the field embodied in the program essentials[1] quoted above.

In this paper it is proposed that this definition of community medicine be adopted by family practice educators and that family practice residents be trained in the discipline. A survey of current efforts to teach community medicine is reported and these findings are related to the proposed definition.

Community Medicine and the Role of the Family Physician

The role of the primary care physician in the community has received recent attention.[14,15] Medalie[16] has made special reference to family practice and has described the increasing levels of practice from individual to family to community (Table 1). He has also developed a "practicegram" through which the levels of practice can be correlated with the patterns of care to produce an instrument for planning and evaluation of primary care services.

According to the definition of community medicine proposed earlier, the process of diagnosis, treatment, prevention, and rehabilitation is followed much as it is in clinical medicine, but the process is directed at factors interfering with optimum health or adequate health care delivery in a defined community. The practitioner of community medicine is as concerned about those who do not come to the physician's office or clinic as those who do. If, for example, a community medicine-oriented physician treated a number of high school students for venereal disease, he/she

*This is not actually offered as a definition of community medicine but, in fact, is the focus of much activity labeled as community medicine teaching.

might consider the entire population of students at risk and join with school officials to plan and implement a VD education program in the school. If he were to diagnose lead poisoning in a worker in a storage battery plant, such a physician would become concerned about other workers in the plant; he might then join with plant administration, union leaders, government officials, and occupational health groups to develop and enforce more stringent health precautions in the plant or, even in the industry as a whole.

The broader definition of physician responsibility inherent in such actions is quite different from the more typical role of caring for individual patients. In the office, the family physician acts as a "healer" to those individuals and families who present themselves for care; in the community, the physician can act as a practitioner of community medicine with a focus on health problems of groups of people. The "denominator" of the practice has been expanded from those people who have identified themselves as patients to those who are related by work, risk, geography, etc.

In this paper the two potential roles of the family physician—healer and practitioner of community medicine—will be differentiated. Of course, there are many different types of healers. The three which are defined in Table 2 have different focuses and view their areas of responsibility differently. As the focus and area of responsibility become broader, the physician is more likely to assume the role of community medicine practitioner.

A "specialist healer" is least likely to practice community medicine. He focuses on a specific organ system in individual patients and treats medical problems of that system. A "generalist healer" treats individual patients and is concerned with all of their medical problems. He is also aware of the patient's social problems and how they affect the patient's health, but does not consider these problems to be within his areas of responsibility. The "contextualist healer"—and this is the role seen for the family physician—goes several steps further. His focus is on the whole patient and the family. In addition to treating their medical problems, he recognizes psychosocial problems and assumes responsibility for dealing with them himself or by referral. A contextualist healer is aware of the social contexts relevant to patients and families (eg, work, school, cultural groups) and may intervene in social systems on their behalf. For example, the physician may work with a school counselor to expedite a child's placement in a special education program or may intervene with a patient's employer to facilitate a work assignment that is compatible with the patient's physical condition. Such activities on behalf of individual patients involve interventions in the social systems that affect the patient's health.

Often the healer will find that he is unable to bring about the desired improvement in the lives of patients or of families by treating only the individual. It may also not be enough merely to intervene in social systems or institutions on behalf of an individual patient. It may be necessary to develop new community services or make changes in the system or the institutions themselves. The "patient," ie, the object of the physician's effort, would then be broadly viewed as a group of people having similar characteristics or problems. The healer might then move into the role of practitioner of community medicine, viewing his task as with and/or on behalf of that community, intervening on a community or institutional level for the improvement of health or health care. Thus, success as a healer may depend upon the adoption of the additional role of community medicine practitioner.

Lest it be mistakenly assumed that a radical departure in physician behavior is being proposed, it should be pointed out that physicians frequently fill the role of the community medicine practitioner: serving on hospital committees, working to establish an adequate bloodbanking system, and working with community groups to recruit physicians for an underserved area can all be seen as activities concerned with the broader community and its health care needs.

Community Medicine and the Training of Family Physicians

There are several reasons for emphasizing community medicine as herein defined in the training of family practice residents.

First, training in community medicine fosters a broader view of health and health care issues and favors the adoption of a contextual framework for conceptualizing patient problems. A parallel situation exists in the area of teaching behavioral science to family practice residents. There, trainees

Table 2. Potential Roles of the Physician

Role	Healer			Practitioner Community Medicine
	Specialist	Generalist	Contextualist	
Focus	Individual patients—specific organ systems	Individual patients	Individual patients and families and their contexts	Defined population or specific community health problems
Knowledge and Skills Necessary	•Medical knowledge and skills relevant to the specialty	•Medical knowledge and skills of all body systems •Psychosomatic medicine •Community resources	•Medical knowledge and skills •Psychosomatic medicine •Family dynamics and their relationship to health care •Relationship between social, economic, occupational, environmental factors and health •Relationship of cultural factors to health •Health care and social resources available in the community •Social systems and how to intervene in them for individual patients/families	•Characteristics of the community •Techniques for the evaluation of health care needs of the community •Issues and strategies involved in organizing services to meet community health care needs •Politics and economics of health care
Activity	•Treats medical problems of a specific organ system	•Treats medical problems of individual patients •Recognizes psychosocial problems and their effect on health of patient •Uses community resources	•Treats medical problems of individual patients and families •Recognizes psychosocial problems and their effect on health of patient/family •Treats (or refers for treatment) psychosocial problems •Uses community resources •Intervenes in community systems on behalf of individual patients and families	•Intervenes on community system level (a) to improve health or health care of a specific population, (b) to ameliorate specific community health problems

in many programs are taught the "basic science" of family behavior in order to encourage *individual* patient care that reflects recognition of the importance of family relationships to health. Fundamental information is taught concerning family dynamics, family life cycle, and family function, not necessarily to prepare family physicians to do family therapy but to train family physicians to appreciate how greatly the patient's family context can affect his health and health care and to consider the context in which the individual patient lives. An assumption important to many working in family practice training is that being able and willing to think of the patient in his various contexts—such as family and community—and to understand some of the rules by which the contexts function can greatly improve the care of the patient. Training in the "basic science" of community medicine helps to develop a more effective healer who can care for individual patients with a fuller understanding of the social and community contexts important to their health and health care.

The second reason for including community medicine in family practice training is that some residents may decide to include working with the community as part of their future practices. To return to the parallel with behavioral science education, just as some residents will elect to extend their skill with families in order to include psychotherapy in their future practices, some may wish to become sufficiently experienced in community medicine to assume the role of practitioner of community medicine. There are skills and knowledge in problem analysis and intervention needed for the competent execution of the community medicine practitioner role just as there are for the role of healer. Since many residents may choose to define their roles to involve more specific activity in community medicine, the residency curriculum should ideally make possible the development of further skills in this area.

It is often assumed that training in community medicine is somehow more relevant for programs that train residents who intend to practice in inner-city areas, eg, San Francisco General Hospital and Montefiore's Residency Program in Social Medicine. Inner-city physicians, however, will have available to them a wealth of community resources not available to physicians practicing in remote areas. The ability to perform in the role of community medicine practitioner, therefore, may be even more important to the rural practitioner than to his urban counterpart.

In order to achieve the training goals described, the family practice residency programs would include training in the following suggested areas:

A. Gathering Community Data Base
   1. Approach to obtaining demographic information (Socioeconomic descriptors, occupational groups, cultural groups, etc)
   2. Approach to evaluation of health status and needs of the community
      a. Community health indices (Endemic and epidemic health problems)
      b. Epidemiological approach
      c. Community health care resources and barriers to their use

B. Assessing Community Health Care Needs (Defining health care needs not being met in the community)

C. Developing and Improving Health Care Services in the Community
   1. Health care policy
   2. Health care planning
   3. Politics of health care
   4. Intervention based on knowledge of community dynamics and power structure as they relate to provision of health care services.
   5. Mobilization of and/or cooperative work with community groups or existing agencies.

D. Evaluating Results of Intervention

What is Being Taught in Family Practice Residencies?

A questionnaire was sent by one of the authors (JD) to the directors of 122 family practice residencies. The programs chosen for the sample were university-affiliated residencies, other large residencies, and those known to have developed community/social/cultural curricula.

The purpose in sending the questionnaire was: (1) to gather general information on community/social/cultural subject areas covered in family practice residency curricula, and (2) to learn what teaching methods were being used. The directors or their designees were also asked to send copies of their goals and objectives, descriptions of the relevant curricula, and seminar schedules, so that specific information on curricular goals and teaching methods could be obtained.

Table 3. Areas of Sociocultural/Community Training Offered by 47 Family Practice Residencies

Area of Training	Percentage of Programs Responding Affirmatively
Education for Role of Contextualist Healer	
Use of community resources	94
Relationship between social, economic, occupational, and environmental factors and health, health care, and disease	77
Relationship of cultural variables and health care	64
Education for Role of Community Medicine Practitioner	
Politics and economics of health care	55
Characteristics of community surrounding program's hospital	47
Techniques for evaluating health care needs of a community	38
Issues and strategies involved in organizing services to meet community health care needs	36

Forty-seven completed questionnaires (38.5 percent reply) and ten other items of printed information were returned.* Of these ten, two clearly related to community medicine curricula—the curriculum from the Social Medicine Program at Montefiore Hospital and a paper by Stephen Smith from the University of Connecticut, "Community Medicine and Health Care as an Integral Part of the Graduate Education of Family Practitioners." The other eight included six descriptions of behavioral science curricular goals and/or training programs, one description of goals in practice management and preventive medicine training, and one general description of a residency program. Thus, the goal of learning in a detailed way what other programs are doing in the area of community/social/cultural teaching was not achieved. From the returned questionnaires it was only possible to get an idea of areas of interest that were emphasized in 38.5 percent of the contacted programs. In addition, the low rate of reply to the questionnaire prevents any but the most tentative conclusions to be drawn.

When the topics are separated into those relating to the role of contextualist healer and those relating to the role of practitioner of community medicine, it is clear that a majority of those programs responding teach the community/social/cultural topics necessary for the role of contextualist healer and a smaller percentage include topics that relate to the role of practitioner of community medicine (Table 3). The two least frequently taught topics were those which most clearly relate to the definition of community medicine cited earlier. "Techniques for evaluating health needs of the community" was reported to be covered by 38 percent of the responding programs and "Issues and strategies involved in organizing services to meet community health needs," by 36 percent.

It is likely that even the low percentages of programs reportedly teaching topics related to the community medicine practitioner role may be

*Information related to the residency where the inquiry originated (SFGH) is not included.

exaggerated. Of the programs that sent prepared information on goals and curricula, most stated that they included training in these areas, but the written information did not usually support the assertions. In addition, several respondents answered in the questionnaire that they taught "Techniques for evaluating health needs of the community" and "Issues and strategies involved in organizing services to meet community health needs" by case consultation or by having residents deliver patient care in a community setting. These topics are elements of community diagnosis and intervention that would not seem to be taught through individual patient care activities. It appears that a number of respondents interpreted the community medicine topics in a patient oriented manner.

Discussion

One result of the inclusion of community medicine in family practice training is to make explicit to residents that there are options from which they may choose in defining their relationship to the communities in which they will practice. They may function as healers, caring only for those patients who seek them out. They may be generalist healers who are aware of, but do not intervene into, their patients' psychosocial problems. They may be contextualist healers who view psychosocial problems as so closely associated with their patients' health that they will also deal with these problems. Or, they may elect to function as practitioners of community medicine who are concerned with the health of larger groups of people—of communities. As community medicine practitioners, they may engage in varied types of activities. They may serve as a resource to the community, contributing knowledge and skill on request with a limited commitment. They may become advocates for the community, representing its needs, especially in health care related areas, to the appropriate institutions or social bodies. Or, they may participate in the organization of action groups seeking to improve the lives of people by developing new services or by instituting change in social systems, institutions, or public policy. A specific set of knowledge and skills is required to perform the functions of a community medicine practitioner, and, according to the survey, most residency programs are not training residents in these areas.

In recent years there has been a general movement toward broadening the focus of patient care. In the period of initial romance with the biomedical sciences and their important contributions, physicians concentrated on the level of organ pathology, if not cellular disorder. General internists and pediatricians later began to speak of the need to treat the "whole patient," meaning all of the organ systems within, and including, the skin and to recognize the importance of individual psychology. Family practice then appeared and claimed that the focus was still too narrow: that the patient should be viewed in the context of his family or, better yet, view the family as the patient. Community medicine can make an important contribution to this expanding focus of attention. At the level of healer activity, it contributes to the delivery of patient care in a way which reflects understanding of the patient's context—the broader community as well as the immediate family relationships. It also supports the development of those, who, through the role of community medicine practitioner, wish to view the community as their patient.

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