Opinion

Exploring the boundaries of Community Medicine in Sri Lanka: a conceptual model for service delivery

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Community Medicine (CM) is the postgraduate medical specialty in Sri Lanka related to public health. Trainees, successfully completing the training and examination process of the degrees Doctor of Medicine (MD) and Master of Science (MSc) in CM are recruited as consultant community physicians (CCPs) to the Ministry of Health or as academics to the university system (1).

The medical background enables CCPs to act as technical experts and medical administrators in public health services. Key functions of CCPs outlined in the job description (2) include public health programme management, policy analysis/development, strategic planning, advocacy, raising awareness on health, surveillance monitoring, evaluation, research, quality assurance, training, capacity building and fund mobilization. CCPs who function as medical administrators too, implement above functions as per relevance to the intuitions, directorates or programmes. Although public health has a well-agreed definition (3), there seems to be many definitions for CM and conflicts about roles and professional identity of CCPs. It is a timely requirement to explore evidence to illustrate a model of service delivery for CCPs.

A thorough literature search and a narrative review based on the content revealed the following four main themes related to CM:

- "What is CM" – This can be regarded as the medical version of public health. Kadri (2017) described the origin of CM as 'an approach focused on preventive, promotive, and primary clinical care with effective health-care delivery system for addressing local public health problems besides working on environmental and social factors' (4). CM bridges the gap between curative services and the community.

- "Misnomers on CM" – CCPs need to be competent not only in preventive and promotive services but also in relevant curative and rehabilitative services as well. Without appreciating this, CM is often incorrectly criticized as a mere paraclinical specialty (5).

- "Defining roles" – CCPs need to identify themselves as medical professionals. Lack of identification of potential roles has been a reason obstructing growth and thriving of CCPs.

- "Collaboration with curative services" - Role of a CCP must extend across preventive as well as the curative settings with a greater contribution delivered in the former. They must be concerned more on the promotion of wellness of individual/community, but their role in the illness-end should not be forgotten.

A model depicting the role of service delivery of CCPs was developed by a multi-disciplinary team (Figure1). We propose that CCPs could involve in delivering service at all three levels (primary, secondary and tertiary) of healthcare. At the primary level, they would work by strategically managing and guiding the other staff members of the public health system such as MOH field staff. They could render their service in secondary healthcare at national, provincial and district levels as well as at hospital settings. Opportunities for subspecializing are being identified, and when available CCPs could engage in tertiary healthcare.

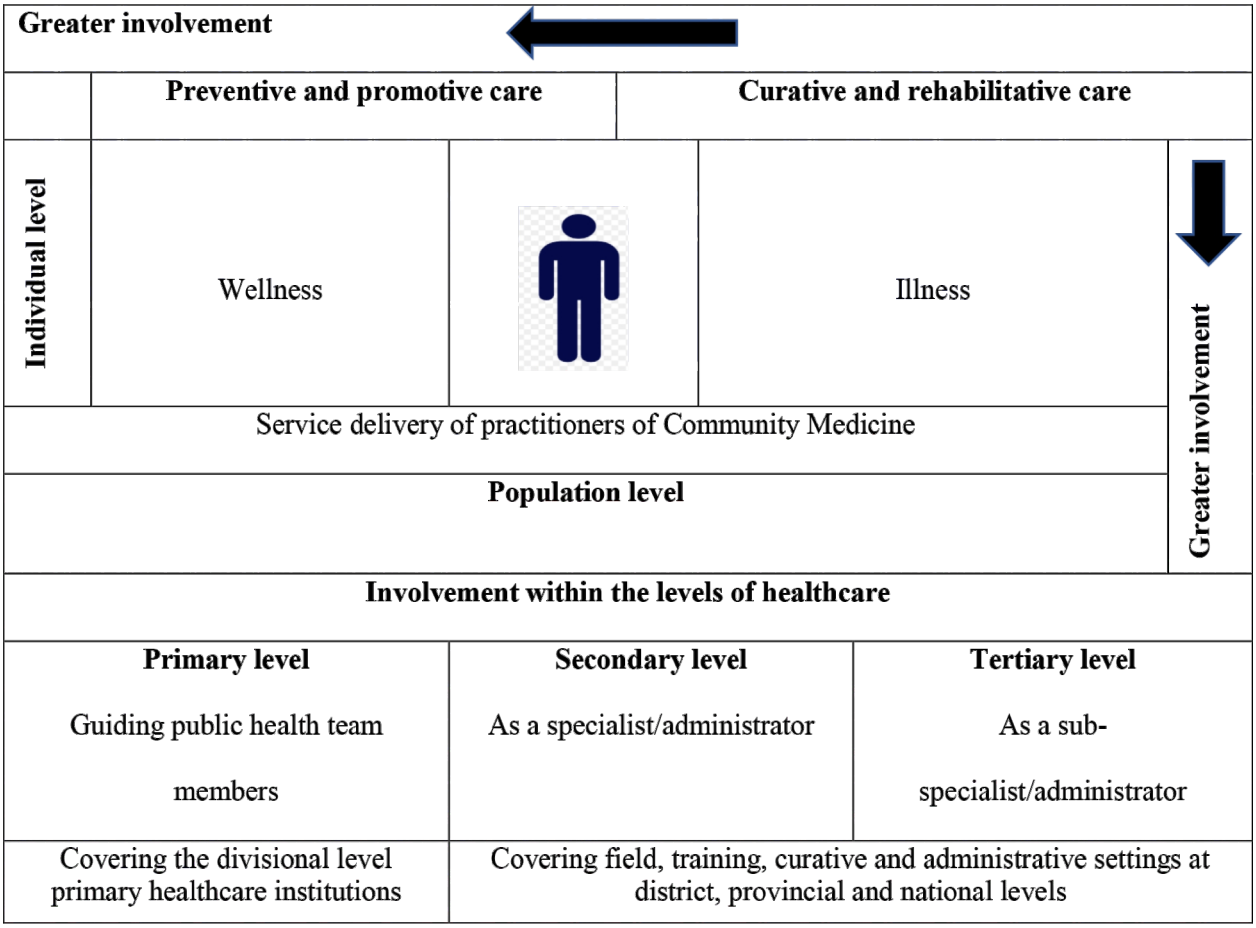

Figure 1: Proposed model of authors for service delivery in Community Medicine

Community Medicine must evolve as a medical specialty bridging the curative services with wellness promotion. This should be focused on needs-assessments for curriculum development and in revisiting the service-boundaries. Knowledge on curative services should be ensured in trainees of CM, to provide holistic and integrated care for the public.

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