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Clinical Community Health: Revisiting "The Community as Patient"

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Abstract

Introduction—A little over fifty years ago, Edward McGavran, Dean of the University of North Carolina School of Public Health, articulated the concept of treating the community as if it were a patient. Although McGavran was addressing public health practitioners, the concept has applicability in academic medicine and reflects contemporary thought in patient care, research, and education. The goals of this paper are (1) to present a framework through which clinicians can conceptualize the community as an appropriate level of intervention to improve health, to conduct research and to educate students, and (2) to illustrate the framework by presenting information on how programs at Morehouse School of Medicine have used it to organize community-focused initiatives. The concept may be called *Clinical Community Health.*

Clinical Community Health and Its Applications at Morehouse School of Medicine —Health problems of communities are more readily understood by clinicians when analyzed in the same way that clinicians analyze the health problems of individual patients: by gathering subjective and objective data, formulating an assessment that is expressed as a problem list, and developing a plan ("SOAP"). The plan is created in consultation with the community, much as a modern physician engages in shared decision-making with a patient rather than issuing "doctor's orders." Similarly, community-based participatory research creates a relationship between the researcher and the community that parallels the relationship between the researcher and the individual research participant in traditional clinical research. When viewed through this lens, the education of students in the community resembles the education of students in the hospital or clinic – both are a type of service-learning. Hence, the community work of faculty is best evaluated and rewarded in a fashion that parallels evaluation of faculty work in the clinic or hospital.

This paper reports on our experiences at Morehouse School of Medicine (MSM), a historically black institution in the United States whose mission focuses on primary care and the health of the underserved. We report on our efforts to apply the model in service, research, and education.

Conclusion—Viewing the community as a patient provides a useful conceptual framework for primary care physicians and other clinicians, since it allows them to recognize that it is not necessary to learn a different conceptual framework to diagnose and treat the community; rather, one can think of the community as a patient and apply a similar approach to that used in the care of individuals.

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Keywords

Community Health; Community Medicine; Public Health; Community-based Participatory Research; Clinical Community Health

Introduction

Over 50 years have passed since the publication of Edward McGavran's landmark paper on the "Scientific Diagnosis and Treatment of the Community as a Patient" (McGavran, 1956). McGavran, then the Dean of the School of Public Health of the University of North Carolina in the southeastern United States, argued that physicians in public health should regard the community as their patient and should diagnose and treat health problems in the community as they would in an individual. He wrote of "This concept of public health as the scientific diagnosis and treatment of community health needs and status, this concept of the community as the patient of public health…" In explaining the concept of the community as a patient, McGavran invoked what we would now call population health, stating, "Our patient is more than a mere aggregation of individuals, just as the individual is more than an aggregation of cells or segments."

The relationship between physicians and individual patients has evolved over the past 50 years, as has the relationship between academic health centers and communities. In clinical medicine, decisions are now ideally shared by physician and patient rather than formulated as "doctor's orders." In clinical research, "participants" have replaced "subjects." In clinical education, patients are no longer viewed as "teaching material." These concepts have application in the relationship between academic medical centers and communities and in the evaluation of faculty who work in communities. Hence, a new look at the idea of community-as-patient is called for. The goals of this paper are (1) to present a framework through which clinicians can conceptualize the community as an appropriate level of intervention to improve health, to conduct research, and to educate students, and (2) to illustrate the framework by presenting information on how programs at Morehouse School of Medicine (Atlanta, Georgia, USA) have used this framework to organize community-focused initiatives. The framework applies the clinical approach at the community level and it hence may be called "Clinical Community Health (CCH)."

Clinical Community Health

Community Service

Public health practitioners have traditionally relied primarily on "health status indices" such as morbidity and mortality data to characterize the health of a community. These objective data are certainly important in community diagnosis. But one would not ordinarily attempt to diagnose a patient on the basis of objective findings alone, without subjective data obtained from a history; nor can one diagnose a community in that way.

In fact, the entire "SOAP" paradigm (Weed, 1968), an acronym for the subjective, objective, assessment and plan organization of information about a patient which is routinely applied to individual patients, can also be applied to the community. "Subjective data" at the

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community level are obtained from surveys, focus groups, and key informant interviews. “Key informants” include community leaders as well as public officials, public health experts, and others who do not live in the community, although the community voices are the more important.

From a review of the subjective and objective data, an assessment is developed, a problem list created, and a plan developed to address each problem. The problem list for a community, especially an economically disadvantaged community, is likely to be longer than that for most individual patients. For that reason, the “community clinician” – the practitioner of Clinical Community Health -- in partnership with the community must prioritize the problem list. The subjective component of the assessment will guide this prioritization; it is the community that will appropriately play the lead role in identifying its most important health problems. Ideally, there will be a community organization or coalition to represent the community and serve as the partner in this process. This parallels the “shared decision-making” approach that most appropriately guides contemporary physician-patient relationships.

McGavran’s presentation of the concept of the community-as-patient preceded Kark’s (1981) formulation of community-oriented primary care (COPC), but the latter has become more well-known. COPC is a five-step model combining primary healthcare, public health and community data and resources. The involvement of community members is a crucial element (Art et al., 2007). The two fit neatly together: for the COPC practitioner, the CCH paradigm can provide a framework for the analysis of community health problems. For practitioners of public health -- the audience to which McGavran directed his analysis – the two approaches could be considered opposite sides of the same coin. COPC uses public health approaches to inform the practice of clinical medicine, while CCH uses a clinical approach to inform the practice of public health.

Research

The concept of research conducted in a “community laboratory” is no longer acceptable; this construct reduces community residents to the status of guinea pigs. Just as individuals will be more willing to participate in research if viewed as “participants” rather than “subjects,” so a community will be more willing to participate in research if viewed as a *partner* rather than, for instance, a “target population.” This is a guiding principle of community-based participatory research (CBPR), an approach that has recently gained widespread acceptance. In CBPR, the community is involved in every stage of a research project, including identifying the research question, designing the project, gathering the data, and analyzing and reporting the results (Israel et al, 1998). Community-based research projects are typically trials of new interventions to prevent a disease or condition, although many other designs are possible. They are a type of translational research (Association of American Medical Colleges, 2006), taking the “bench to bedside” model one step further – “bench to curbside” or “bench to countryside.” For instance, community-based participatory research may identify ways to induce the public to take advantage of a new screening test or accept a new vaccine.

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CBPR is primarily an ethical construct, designed to prevent exploitation of the community, just as ethical guidelines for clinical research involving individual humans are intended to prevent their exploitation (National Commission, 1979). Hence, CBPR is Clinical Community Health as applied in the domain of research. The community has autonomy and must give its informed consent if it is to be a participant in research. The challenge lies in identifying an appropriate representative body to provide consent.

Education

Medical students at any medical school assigned to a clinical clerkship diagnose and treat illness in individual patients under the supervision of faculty. Hence, they are providing a service to the patient while learning. They are engaged in *service-learning* even though the term is not usually employed in that context. Rather, "service-learning" commonly refers to students learning about community health by providing service to the community (Seifer, 1998). Students assigned to a service-learning experience, then, are practicing Clinical Community Health in the domain of education; they are providing service to their patient, and their patient is the community (as a whole).

Preparation and evaluation of faculty

Individual patients value clinicians who have an excellent "bedside manner" – an ability to empathize with the patient and understand and respond to the patient's point of view. Similarly, community members will value the community practitioner who empathizes with the community and understands and responds to its point of view. Many clinicians who have outstanding diagnostic and treatment skills in the care of individual patients lack "people" skills, and many health workers who have an outstanding knowledge of health promotion theory and practice lack community skills. It is incumbent on the academic institution to recruit faculty who possess the needed skills, or, failing that, offer continuing education that will provide those skills.

Medical schools frequently view community service by faculty as charity work or as a public relations gesture. Clinical service, on the other hand, is seen as an essential function of the institution. But if the community is the patient, then faculty service to communities will appropriately be evaluated in the same way as clinical service in the hospital or clinic. This may include an evaluation of quality of care (including patient/community satisfaction or improvement in community health) and income generated (usually through grants in the case of community service, since communities cannot readily be charged a fee).

Clinical Community Health at Morehouse School of Medicine

Morehouse School of Medicine is a historically black school founded in 1975 to address the underrepresentation of African Americans and other minorities in the field of healthcare within the United States. Its mission calls for it to graduate primary care physicians, public health workers, and biomedical scientists to meet the needs of medically underserved communities. The majority of its students and faculty are African Americans and other underrepresented minorities. The school has been especially recognized for its programs of community engagement.

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Community Service

Faculty at Morehouse School of Medicine who are utilizing the Clinical Community Health model in community service frequently first address the "social history" component of the subjective findings. Health problems with social roots, such as violence, teen pregnancy, drug abuse, and AIDS are often the highest priority health issues described by members of underserved communities. This has led to the *Community Organization and Development for Health Promotion* model that is the basis of much of the faculty's community service (Braithwaite et al, 1989). This model is Clinical Community Health as applied to community service. As suggested by the model's name, community organization and community development – addressing the community's social and economic problems – are major foci of faculty activity. The patient's chief complaint must be addressed before taking on the other problems.

Research

As mentioned earlier, one of the major challenges in conducting research in the community is identifying an appropriate representative body to provide informed consent on the community's behalf. At the Morehouse School of Medicine Prevention Research Center, this function is assumed by the Center's "Community Coalition Board," which is comprised of representatives of two academic institutions in addition to Morehouse, representatives of six public agencies, including the state and local health departments, and representatives of 13 contiguous inner-city neighborhoods. Each of the 13 neighborhoods has developed a community organization where residents meet to discuss local issues, plan neighborhood improvement projects, etc. Each of these organizations has accepted our invitation to appoint a representative to the Board. The Board's bylaws state that a majority of the Board must always consist of neighborhood representatives and the Chair of the Board must always be a neighborhood representative.

A committee of the Board, consisting of three to four neighborhood representatives, considers all protocols to be implemented by the Center, and for technical assistance the Committee usually consults with a public health professional who is not a member of the Board. The Board has articulated a set of values against which protocols are evaluated (Blumenthal, 2006). The Committee has the authority to require changes in the proposed research protocol or to reject it (the former has occurred often; the latter, never). Review by the Committee supplements review by the school's Institutional Review Board (IRB, the research ethics committee required of all US institutions conducting research on humans).

In the first two years after the Center's establishment in 1999, the Committee required many changes in protocols presented to it and was quite critical of proposed recruitment methods and interventions. More recently, the committee has been generally accepting protocols but has directed its attention to the location of projects, insisting that they focus on the partner neighborhoods when projects are proposed to take place in a broader area. This is largely because the committee – and the full Board, when research projects are discussed there – feels the projects represent service to the community. Hence, a trial of a health education intervention is generally viewed favorably, since health education is a community service. The Board views observational studies less favorably than it does intervention trials; it has

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established as a policy that any proposed observational study must specify how it may later lead to a service for the community.

Education

At Morehouse School of Medicine, medical students are taught the Clinical Community Health approach in the required Community Health Course in their first year (Blumenthal et al, 2000). The approach is presented in an introductory lecture. Subsequently, groups of eight to ten students assigned to a community gather subjective data through surveys, focus groups, and key informant interviews; and gather objective data in the form of demographic and morbidity and mortality statistics from various official sources available on the Internet. They use this to develop a problem list and create a plan to address one or more of the problems – chosen primarily on the basis of "subjective" community input – for a health promotion intervention. The problem list is developed in the first semester, and the intervention is conducted and evaluated in the second. Each student group is supervised by a team of two faculty members: a clinician and a non-medical specialist such as a behavioral scientist or a health educator.

A collateral lesson taught to students in this course is that conducting a needs assessment without intervening to address at least some of the problems identified is inappropriate, just as it would not be suitable to diagnose an illness in a patient but not treat it. Hence, a course limited to (for instance) "Community Diagnosis" would be inappropriate, except as a classroom exercise.

Similar courses are uncommon or absent in US medical schools but are offered in medical schools in some other countries in Africa (Jinadu et al., 2002), Europe (Art et al., 2008), and Asia (Vaidya et al., 2008) and in other professional curricula, such as nursing.

Students who achieve an "A" in the course (primarily on the basis of required papers, presentations, and participation), and meet certain other criteria, are eligible to enroll in the Honors Program in Community Service. The Honors Program gives community health a permanent presence in all four years of the MSM curriculum. To achieve the Honors designation, students must perform at least 60 hours of community service in their second year of medical school; plan an independent community project in their third year and gain approval for the project from the faculty Honors Committee; and conduct the project in their senior year, culminating in a scholarly paper and its defense. The community service and the project are usually conducted either at the site of the student's Community Health Course or in another community with which a faculty member has a relationship. In either case, the initial steps in the CCH model will have been accomplished. Those who complete the Honors Program are recognized at commencement.

Preparation and Evaluation of Faculty

In the school's Department of Community Health and Preventive Medicine, we attempt to recruit faculty members with community experience. However, most new faculty members benefit from working with one of the department's veteran faculty members, either as a co-investigator on a research project or as a co-group leader in the Community Health course.

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We appoint faculty in the clinical track if the “service” component of their position will be either in the community or in the hospital or clinic, and their job description specifies the percentage of their time that they are expected to commit to service activities. Clinical faculty are evaluated on revenue generated, quality of care, and leadership positions achieved. Faculty serving the community are evaluated similarly. However, communities do not carry health insurance, so reimbursement for faculty time must generally come from grant funding; faculty spending more than 10% of their time in community service are expected to generate funds from grants sufficient to cover the “service” portion of their salary. “Quality of care” is based on feedback from the community. Leadership positions often accompany extramural funding; for instance, a faculty member may secure a grant to support a center for community service, and thus become a center director.

Challenges and Limitations

One of the most challenging aspects of applying this model has been the preparation and maintenance of skills of faculty. For the most part, we have attempted to recruit faculty who have experience working in the community, but this has not always been possible. Some faculty have had to be relieved of community teaching responsibilities and assigned to other duties. Some who seemed to have the background to mount an independent community-based research program have proven unable to do so. We are now exploring approaches to including community skills in faculty development.

Funding is a second challenge. As noted earlier, community service must be supported by grants rather than fees, but grant opportunities in this area are comparatively scarce. Similarly, funding to support community-based research is much less available than support for traditional clinical research or basic science research.

Teaching in the community is faculty-intensive. A single faculty member can deliver a lecture to a very large number of students in an auditorium but can supervise only a small number of students who are engaged in a service-learning project. The institution must be committed to this mode of instruction to support it despite its relative inefficiency.

Conclusions

The mission of Morehouse School of Medicine calls for its graduates in medicine to pursue primary care careers in medically underserved communities. Physicians practicing in such settings must be prepared not only to address the health problems of individual patients who present in the doctor’s office or clinic, but also to address the health problems of the community as a whole. The latter task may appear less daunting if the physician recognizes that it is not necessary to learn a different conceptual framework and set of skills to diagnose and treat the community; rather, one can think of the community as a patient through the Clinical Community Health paradigm and apply the same framework used in the care of individuals.

The faculty, of course, must model this approach if the students are to be persuaded. Hence, faculty behavior in teaching, conducting research, and providing community service must

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also follow the Clinical Community Health paradigm, and in each sector treat the community as a partner, not as a “classroom,” “laboratory,” or “charity case.”

The application of this concept need not be limited to the academic setting, nor to primary care physicians, nor to physicians working in underserved communities. It can be employed by subspecialist physicians or non-physician clinicians such as nurse practitioners. The former could apply it within the context of their subspecialties, focusing, for instance, on the diagnosis and management of infectious or cardiovascular disease problems in their community. Indeed, it is our hope in teaching the approach to our students that they will employ it in whatever setting they eventually practice.

The CCH concept has wide applicability in academic as well as practice settings and in education and research as well as in service. Periodic updates are appropriate to insure that we treat the community with the same respect and set of ethical precepts that we apply to individual patients.

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