Some Thoughts on Community Dermatology and the Pitfalls of Evidence-based Medicine

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What is Community and Community Health?

Community is the hub of Community Health Practice. It is the essential laboratory for practice of teaching, training and research in the subject of community medicine/health. The definition of community has varied because of its diversity and complexity. Community is seen as a group of people living within a common geographical boundary that may not necessarily be of the same origin as in language, culture and practices, but often have joint ownership of issues of common interest and advancement. A community is a whole entity that functions because of the interdependence of its parts or subsystems. It is frequently identified by clothing, such as hats and footwear or jewellery. There is perhaps no more obvious example of the influence of fashion. The community core is made of its history, socio-demographic characteristics, vital statistics and values/beliefs/religions. The subsystems of community are: physical environment, education, safety and transportation, politics and government, health and social services, communication, economics and recreation. The idea of the community as the centre of health services delivery was advocated as far back in the 1960s. From the concept of Basic Health Services, the concept of Primary Health Care has emerged. In this regard, the principle of health services in relation to availability, accessibility, acceptability and appropriateness became important considerations in WHO health policy from the late 1960s and into the 1970s.

Community Health is defined by the following:

1) It is part of medicine which is concerned with the health of the whole population and the prevention of diseases from which the population suffers; 2) It identifies the root causes of diseases and health problems not only from the individual but also from family, the community and the environment; 3) The community resources are utilised principally in solving their problems. The resources from government and private sector can also be used. They need not be medical, hence innovative collaborations must be looked for. The engagement of London College of Fashion in achieving better lives is a good example; 4) It aims at giving the highest level of health for all people in the community, including physical, mental, moral, social and spiritual health.

Community Health consists of principles and practices aimed at achieving prevention of premature death, disabilities and diseases through organised Community efforts, with a view to assuring the promotion of optimal health of members of a Community in the context of their environment. Optimal health is said to mean a balance of physical, emotional, social, spiritual and intellectual health. Community Health parameters are different from health parameters of an individual. Community health can be measured through indicators of economics such as Gross National Product, Gross National Income and Per Capita Income, as well as life expectancy, under-five mortality, infant mortality, literacy level, composite indices like human development index, and maternal mortality rate. The other indicators of community health are environmental indicators, demographic, health services, health care utilisation and health policy indicators. The identity provided by clothing and tattooing contributes to confidence, happiness and well-being. It is studied by anthropologists and underlies the health of communities. Community Health is underused as an intervention to promote well-being. Community Health is the application of
simple, but scientifically sound and culturally acceptable methods and skills in the prevention, promotion, rehabilitation and/or treatment of health conditions in the population. In fact, scientific soundness and the contemporary expectation that every intervention will be based on evidence may be less appropriate in the community health domain, since emotion and even spiritual needs play important roles. Case histories or a photograph that instantly evoke sadness in the observer could have more influence on the introduction of an attitude of care than higher levels of evidence such as double-blind and randomised controlled trials.

Science and Evidence-based medicine

‘Lack of proof of efficacy or effectiveness of all systems of medicine has made development of the most appropriate design for establishing evidence a priority.’ So said Sackett with whom this author debated the problem of complex prescribing in traditional medicine, when he was a visiting professor in Oxford in 1996. Most people seek an intervention at the peak of their illness, a time at which the natural course is to get better. They then credit any intervention with the cure. One must, of course, remember that the natural history of ill health has usually been to heal quickly and rapidly. If a bland intervention has the same result, it is called the placebo effect. Therefore, it follows that intervention is unnecessary and should not be credited with spontaneous healing that it has probably not influenced. It was Cochrane who wrote ‘I know because there is good evidence based on measurement.’ Because of the uptake of his wisdom, measurement has become an expectation of best practice. However, all wise persons in the field will restate that ‘No evidence of effect is not the same as evidence of no effect’. In Cochrane’s interpretation: ‘No evidence that falling in love has broken my heart is not the same as there is evidence that love has not broken my heart’.

It would be good to say that science is always helpful, but sometimes it is not the case. Medicine still listens to the sayings of one of its most admired 20th century physician, Sir William Osler. As this author is now curator of his home in Oxford and in a year tome will be recording the 100th year of his death, here are several relevant quotes.

‘Magic and religion control the uncharted sphere—the supernatural, the superhuman: science seeks to know the world and through knowing it, to control it.’

‘A devotion to science, a saturation with its spirit, will give you that most precious of all faculties—a sane, cool reason which enables you to sift the true from the false in life and at the same time, keeps you well in the van of progress.’

‘Science is organised knowledge, and knowledge is of things we see. Now the things that are seen are temporal; of the things that are unseen science knows nothing, and has at present no means of knowing anything.’

‘The human heart has a hidden want which science cannot supply’.

‘With reason science never parts company, but with feeling, emotion, passion, what has she to do? They are not of her and owe her no allegiance. She may study, analyse and define, she cannot control them, and by no possibility can their ways be justified by her.’

This author works in countries where Traditional Health Practitioners are first on call. One can teach, for example, the modern facts of how to manage snake bites. One can learn how to reassure someone who is convinced that spirits are the cause of their ailments. But, one must focus on low cost solutions and instead of teaching Traditional Health Practitioners the names of
diseases, it would be more useful to teach them how the skin functions as a barrier, how it senses the environment and may feel pain, itch or numbness, how it regulates the temperature and how it communicates. The International Foundation for Wound Healing, which this author has established in Oxford, has attracted some 20 years ago the best young medics chosen and funded by the Chinese Military. They are now a dozen generals in charge of China’s best funded hospitals. Faced frequently with persons affected by 100% burns, they can care for their heart, lungs, liver and kidney with the highest technology and later replace their skin with stem cells. However, the survivors, sometimes with loss of limbs and sight, other have to return to their dysfunctional one-child families. This is what science can and cannot do.

Compassion and Kindness

There is much concern that we live in a world in which there is a lot of inhumanity. There is little doubt that man tends to show inhumanity to fellow man, and there are few souls like St Frances. The survival of the fittest (and most beautiful) is a known phenomenon. Man’s inhumanity has often been faith-based, with crusades, inquisitions, fatwas and beheadings. There is also male social and religious dominance. There is domestic violence, women with facial acid burns, bullying, racism, and land-mine planting by the thousand each day. Children learn to draw witches as ugly, with deformity, facial warts and baldness.

The ethics within the medical and nursing professions have also lapsed badly and there are many reports of cruelty. Davis Weatherall of Oxford wrote for the Lancet in 2011 about his view on the practice of the Art of Medicine. He referred to previous Oxford based practitioners of the Art of Medicine, Sydenham and Osler and the vast difference between the best and the worst of practitioners. Like Osler, he doubted whether science always determined good practice. He discussed the basis for differences in persons and their practice and looked for environmental influences on genes; he had learned with surprise that those have rather less influence than he had originally expected.

The environment includes ‘the ability to listen to a patient, appreciate what they have said, and in leaving them in no doubt that the doctor has understood precisely what has been said. This seminal skill requires a friendly and sympathetic approach, time and above all humility on the part of the doctor.’ Many scientists would abolish some of the best listeners which are to be found in traditional, alternative and complimentary medicine. In studies of integrated medicine in India, Ryan and Narahari have emphasised the value of time given to counselling. It is from this experience that Ryan has learned to appreciate other disciplines such as that at LCF, which give time and advice to disfigured persons in need of help when medical interventions have been exhausted.

Encouraging reading can be found in the opinions of a medical student, David Jeffrey in the article ‘A duty of Kindness’ (JRSM; 2016; 109:261-263). Amongst medical students there is often a passion for the practice of medicine before the experience of hospital medicine, evidence-based demands and the reductionist approach of science has had their effects. Kindness has now been relegated to an attribute of losers, rather than being an integral part of a doctor’s duty to a patient. Jeffrey points out that the Practice of Medicine today favours technology, evidence-based medicine and targets – the intellectual rather than emotional or spiritual approach. We are reminded that the profession has bullies and macho practitioners, i.e. institutional unkindness, and that it often leaves patients feeling isolated and having little time spent on their anxieties. Kindness is linked to compassion or concern. Jeffrey recalls Plato, Hume, Darwin and Osler. As the history of care evolves and as vulnerability is recognised, it needs to be embraced.