Proceedings of the Medical Educators
Review Meeting

June 1992

TOWARDS A COLLECTIVE COMMITMENT

COMMUNITY HEALTH CELL
Society for Community Health Awareness, Research and Action,
No. 326, Fifth Main, First Block,
Koramangala, Bangalore 560 034.

TOWARDS A COLLECTIVE COMMITMENT

- Proceedings of the Medical Educators Review Meeting, June 1992

(This meeting was organised as the final event of a research project entitled "Strategies for Social Relevance and Community Orientation in Medical Education - Building on the Indian Experience)

Edited by : Ravi Narayan

Community Health Cell
Society ffor Community Health Awareness, Research and Action
326, Fifth Main,
First Block, Koramangala,
Bangalore - 560 034.

A C.H.C. / C.M.A.I. / C.H.A.I. Project

December, 1993

TOWARDS A COLLECTIVE COMMITMENT

- Proceedings of the Medical Educators Review Meeting, June 1992

(This meeting was organised as the final event of a research project entitled "Strategies for Social Relevance and Community Orientation in Medical Education - Building on the Indian Experience)

Edited by : Ravi Narayan

Community Health Cell
Society ffor Community Health Awareness, Research and Action
326, Fifth Main,
First Block, Koramangala,
Bangalore - 560 034.

A C.H.C. / C.M.A.I. / C.H.A.I. Project

December, 1993

PROCEEDINGS BASED ON

Notes of - Madhav Ram, Thelma Narayan,
Ravi Narayan, Sara Bhattacharji.

Group Reports and Session Reports - Madhav Ram, Mani Kalliath,
Dara S. Amar, Shiv Chandra.

Animation - Shirdi Prasad Tekur.

Support Team from C.H.C. - V.N. Nagaraja Rao, M.S. Nagarajan,
M. Kumar, C. James, S.J. Chander,
Xavier Antony, S. John.

Coordinators of
Medical Education Project - Ravi Narayan / Thelma Narayan

Project Advisory Committee - Dr. C.M. Francis
Dr. V. Benjamin
Dr. George Joseph
Dr. P. Zachariah

Project Sponsors

1. - Christian Medical Association
of India,
Plot No.2,A-3 Local Shopping Centre
Janakpuri,
New Delhi - 110 058.

2. Catholic Hospital Association
of India,
P.B. No.2126, 157/6, Staff Road,
Gunrock Enclave,
Secunderabad - 500 003.

C O N T E N T S

A P P E N D I C E S

1. BACKGROUND

A Project entitled - Strategies for Community Orientation and Social Relevance in Medical Education - Building on the Indian Experience was undertaken by Community Health Cell team, (of the Society for Community Health Awareness, Research and Action) from April, 1990 till March,1992. As a sort of 'finale' to this project it was decided to bring together key medical college faculty, and 'medical education' resource persons as well as some representatives of voluntary health sector, coordinating agencies, networks, health policy researchers, community health trainers and others to consider the findings/ outputs of this study and to explore various forms of follow up at individual, institutional and collective level.

The Project had been sponsored by CMAI and CHAI and apart from the 4 CMCs (CMC-Vellore, CMC-Ludhiana, SJMC-Bangalore and MMC-Miraj), it had also established contact with faculty of many other institutions and organisations through an interactive research process that had been evolved over the two years. This research process had included correspondence, surveys, field visits, informal and formal meetings and circulation of many reports and reflections. The main objective of this interactive process had been to increase the collective commitment to the evolution of appropriate medical education more in tune with our social realities and community health needs.

This final meeting entitled Medical Educators Review Meeting (MERM-I) was therefore, both the formal end of the Project (the beginning of the end!) as well as the beginning of a phase of lobbying and collective action (the end of the beginning!)

These proceedings of this two-day meeting in June, 1992 bring together the key discussions and reflections and symbolise the challenges that will face a 'critical mass' of medical educators if they decide to commit themselves individually, institutionally and collectively to an appropriate alternative medical education that is socially relevant and oriented to community needs of India.

*****

..2

2. OBJECTIVES OF REVIEW MEETING

I. To consider the findings / output of the CHC/CMAI/CHAI Medical Education Project and discuss possible follow-up within institutions.

II. To share institutional initiatives in the 1980's and institutional plans for the 1990s in the direction of appropriate medical education.

III. To explore the formation of an informal study group of concerned individuals to carry on collective reflection on key issues.

IV. To begin to build a collective commitment to change by networking and communicating informally.

***

..3

3. PROGRAMME

20.06.1992	8.00 A.M.	Breakfast
Saturday	8.30 A.M. - 09.30 A.M.	Registration
	9.30 A.M. - 10.30 A.M.	Introductory Session
		Welcome & Introduction;
		Getting to know each other/self introductions;
		Framework of Meeting.
	10.30 A.M. - 10.45 A.M.	- TEA -
	10.45 A.M. - 1.00 P.M.	Session I Chairperson:Dr.N.H.Antia
		i) Objectives and Methodology -Dr. Thelma Narayan
		ii) Key Findings - Innovations, promoting factors and obstacles to change - Dr. Ravi Narayan
		iii) Some perspectives and outputs (animations) - Dr. Shirdi Prasad Tekur.
		Discussions.
	1.00 P.M. - 2.00 P.M.	- LUNCH -
	2.00 P.M. - 3.00 P.M.	Discussions
	3.00 P.M. - 4.30 P.M.	Session II, Chairperson:Dr.Alfred Mascarenhas
		Innovations in Medical Education: Reports by participating institutions.
		1. CMC-Vellore: Dr. Chellam Kirubhakaran
		2. NHLMC-Ahmedabad - Dr.Shubha Desai.
		3. CMC-Ludhiana-Dr.Mohan Verghese;
		4. JLNMC-Ajmer-Dr.Shiv Chandra;
		5. SJMC-Bangalore-Dr.Dara Amar.
		6. BMC-Bangalore - Dr.M.K. Vasundhra;
	4.45 P.M. - 6.00 P.M.	Session III, Chairperson:Dr.Alfred Mascarenhas

..4

7. VHAI RDP Education - Dr.Mira Shiva
8. MMC-Miraj Project -Dr.P.Zachariah
9. GK Medical College Project - Dr.Zafarullah Chowdhry
10. Consortium Process-Dr.Ragini Macaden
11. NIMHANS - Dr. Mohan Isaac
12. CMC Network and Whitefield Document - Dr. V. Benjamin.

8.00 P.M. - DINNER -

21.06.1992
Sunday

9.00 A.M. - 09.30 A.M. Session IV Chairperson:Dr. George Joseph

i. Report on Day 1-Dr.Shiv Chandra

ii. Reflections by Participants -Dr.Deepak Kamle, Dr.Mani Kalliath, Dr. Ranade.

9.45 A.M. - 10.45 A.M. Session V, Chairperson:Dr.George Joseph

CHC Project : Graduate Feedback on Medical Education -Dr.Thelma Narayan.

11.00 A.M. - 12.00 Noon Session VI,Chairperson: Dr. George Joseph

-Reflections of a Development Trainer 'Medical Education for the real India'
- Mr. Desmond D'Abreo

12 Noon - 1.00 P.M. -Discussion on Graduate Feedback and Reflections.(Session V/VI)

2.00 P.M. - 3.00 P.M. Session VII - Group Discussions (Group A, B and C)

Identifying tasks at individual levels, institutional levels and collective levels.

3.00 P.M. - 5.00 P.M. Session VIII, Chairperson: Dr. C.M. Francis

Plenary: Group A Report
Group B Report
Group C Report.

Discussions

Concluding Remarks.

4. LIST OF PARTICIPANTS

NOTE: While the main focus of the Review Meeting was on present faculty of medical colleges, we had a few invitees who also represented the coordinating agencies of the voluntary health sector, health policy research centres, development training, networking agencies, etc., apart from a few retired faculty who had shown deep commitment to medical education during their career and had helped the Project in an advisory capacity. This mix of participants added a richness to the dialogue.

MEDICAL COLLEGE FACULTY

A. Christian Medical College, Vellore - 632 002.

*1. Dr. Abraham Joseph, Professor and Head, Department of Community Medicine.

2. Dr.Chellam Kirubhakaran, Professor, Department of Child Health.

3. Dr. Sara Bhattacharji, Professor, Department of Community Health.

4. Dr. Molly Thomas, Professor and Head, Department of Pharmacology.

5. Dr. B. Madhav Ram, PG Registrar, Department of Community Health.

B. Christian Medical College, Ludhiana - 141 008.

6. Dr. Mohan Verghese, Professor of Surgery.

*7. Dr. Alex Zachariah, Principal.

D. Smt. NHL Medical College, Ahmedabad - 380 006.

9. Dr. Shubha S. Desai, Professor of Medicine.

*10. Dr. Varsha J. Patel, Assistant Professor, Department of Pharmacology.

E. St.John's Medical College, Bangalore - 560 034.

11. Dr. Prem Pais, Professor, Department of Medicine.

12. Dr. Dara S. Amar, Professor and Head, Department of Community Health.

13. Dr. Ragini Macaden, Professor and Head, Department of Microbiology.

14. Dr. G.D. Ravindran, Assistant Professor, Department of Medicine.

F. Miraj Medical Centre, Miraj

15. Dr. R.G. Shinde, Professor and Head, Department of Medicine.

16. Dr. Deepak M. Kamle, Associate Professor, Department of Surgery.

17. Dr. R.G. Ranade, Associate Professor, Department of OBG.

..6

18. Dr. Shashi Ranade,
Department of Paediatrics.

G. Bangalore Medical College,
Bangalore - 560 002.

19. Dr.M.K. Vasundhra,
Professor and Head,
Department of PSM.

H. JIPMER, Pondicherry-605 006

*20. Dr. Asha Oumachigui,
Professor,
Department of OBG.

*21. Dr. D.K. Srinivasa,
Professor,
Department of PSM.

I. King George Medical College,
Lucknow - 226 003.

*22. Dr. Siddarth Das,
Associate Professor,
Department of Medicine.

J. MGIMS, Sevagram - 442 102.

*23. Dr. Ulhas Jajoo,
Associate Professor,
Department of Medicine.

K. CMET-AIIMS, New Delhi - 110 029.

*24. Dr. Usha Nayar,
Organising Secretary,
Centre for Medical Education
and Technology,
A.I.I.M.S., Ansari Nagar,
New Delhi - 110 029.

MEDICAL EDUCATION RESOURCE PERSONS

25. Dr. C.M. Francis,
Director,
St. Martha's Hospital,
Nrupathunga Road,
Bangalore - 560 009.

26. Dr. V. Benjamin,
17, Cline Road,
B.L. Rice Nagar,
Bangalore - 560 005.

27. Dr. P. Zachariah,
Editor,
Christian Medical Journal of
India,
2/A, Chitteri Road,
Thorapadi P.O.
Vellore - 632 002.

28. Dr. George Joseph,
Executive Director,
Church of South India,
222, Cathedral Road,
Madras - 600 086.

29. Dr. Alfred Mascarenhas,
Principal,
St. John's Medical College,
John Nagar,
Bangalore - 560 034.

30. Prof. S.V. Rama Rao,
72/4, "Prayag",
5th Main, 7th Cross,
Chamarajpet,
Bangalore - 560 018.

HEALTH CARE/HEALTH POLICY COORDINATING AGENCIES/OTHER INSTITUTIONS.

A. Voluntary Health Association of India

31. Dr. Mira Shiva,
Head - Public Policy Division
Voluntary Health Association
of India,
Tong Swasthya Bhavan,
40 Institutional Area,
New Delhi - 110 016.

32. Dr. Pramesh Bhatnagar,
Senior Programme Officer,
Voluntary Health Association
of India,
Tong Swasthya Bhavan,
40 Institutional Area,
New Delhi - 110 016.

B. Catholic Hospital Association of India

33. Dr. Mani Kalliath,
Medical Officer-Urban,
Catholic Hospital Association of India,
P.B. No.2126,
Gunrock Enclave,
Secunderabad - 500 003.

C. Christian Medical Association of India

34. Dr. Daleep S. Mukarji,
General Secretary,
Christian Medical Association of India,
Plot No.3, A-3 Local Shopping Centre,
Janakpuri,
New Delhi - 110 058.

D. NIMHANS - Bangalore

35. Dr. Mohan Isaac,
Additional Professor,
Department of Psychiatry,
NIMHANS, Hosur Road,
Bangalore - 560 029.

E. K.S.S.P. Thiruvananthapuram

*36. Dr. V. Raman Kutty,
Kerala Sastra Sahitya Parishad,
Parishad Bhavan,
Thiruvananthapuram,
Kerala - 695 035.

HEALTH/EDUCATION POLICY RESOURCE PERSONS

37. Dr. N.H. Antia,
Director,
The Foundation for Research in Community Health,
84-A, R.G.Thadani Marg,
Worli,
Bombay - 400 018.

38. Mr. Desmond D'Abreo,
St.Joseph's Highlands,
Lower Bendur,
Mangalore - 575 002.

39. Dr. Zafarullah Choudhury,
Project Coordinator,
Gonoshasthya Kendra,
Nayarhat, Dhaka - 1350,
Bangladesh.

*40. Dr. Palitha Abeykoon,
Incharge-Medical Education Unit,
WHO-SEARO,
Indraprastha Estate,
Ring Road,
New Delhi - 110 002.

COMMUNITY HEALTH CELL-BANGALORE

41. Dr. Thelma Narayan,
Member Incharge-Research and Evaluation,
Community Health Cell,
326, 5th Main,
1st Block, Koramangala,
Bangalore - 560 034.

42. Dr. Shirdi Prasad Tekur,
Member Incharge-Training and Advisory Services,
Community Health Cell,
326, 5th Main,
1st Block, Koramangala,
Bangalore - 560 034.

43. Dr. Ravi Narayan,
Coordinator,
Community Health Cell,
326, 5th Main,
1st Block, Koramangala,
Bangalore - 560 034.

NOTE: 10 potential participants shown with asterisk could not attend the meeting eventhough many of them participated in the interactive process preceding it.

..8

TOWARDS A COLLECTIVE COMMITMENT:

5. TASKS AND CHALLENGES

The main purpose of the Medical Educators Review Meeting was to promote a collective commitment to a process of change in Medical Education. The group discussions and the plenary sessions were all geared to identifying possibilities for action at three different levels:

i. Individual level tasks

ii. Institutional level tasks

iii. Collective tasks i.e., through networking.

From the group discussions on the second day and the final plenary session, the following key ideas, perspectives and suggestions for action emerged.

A. At Individual Level

(While change in education requires commitment at institutional (management) level and at collective (professional) level, all the participants felt that much could be done at individual level to help initiate the process of building a 'critical mass' of medical education enthusiasts, committed to change, beginning with oneself. A study, reflection, renewal, experimental and learning process begin at an individual faculty member level could itself become the fore-runner of change at the larger level. For this purpose a diverse range of guidelines emerged. This list is significant because many of the participants had already been 'change agents' in their own institutions).

i. Start with small creative changes rather than trying to modify the whole system.

ii. Identify specific tasks within department and among various departments that can be undertaken by staff and students.

iii. Recognise the dichotomy in our own stated ideas/objectives and the actual field/classroom realities in training and set up a system of values and role models for ourselves as a stimulus.

iv. Reflect and introspect into your own small innovations-building it further step by step rather than waiting for external correction or evaluation stimulus.

v. Identify and keep track of current realities and the increasing recognition of the need for change.

..9

vi. Learn from all institutions who have tried changes and not focus just on the innovators. Even institutions that do not introduce change have their own expectations and understanding of the realities that could be significant. We should interact, learn and share with them as well.

vii. Study the relevance of the content of current education to the actual morbidity pattern at community levels and also in the context of other health needs and available resources.

viii. Overcome our own fears and diffidence to initiate change and think anew and gain self confidence realising that it is ultimately individuals who initiate all larger movements.

ix. Identify and promote ideas from individuals/colleagues who are from mainstream colleges which are not necessarily pacesetters.

x. Become members of professional organisations and networks and attend meetings/workshops to broaden our knowledge and skills.

xi. Strategies of medical education should include exposure and involvement to non medical initiatives and efforts as well. Take interest and get involved in them.

xii. Identify motivating factors that cause a 'change' or switch in individuals decision making to broaden out.

xiii. Promote interaction with other groups and institutions who are committed to change.

xiv. Recognise that every opportunity has to be used creatively to push for change and there are ways of getting around obstacles.

xv. Develop a 'questioning attitude' among students and colleagues so as to raise new issues and insights and promote originality. This prevents frustration from setting in the process.

xvi. Get started with what you know rather than waiting for ever to get the best suggestions.

xvii. Sensitise ourselves to national priorities through analysis and then explore how each of us can be involved with the promotion of national priorities within our teaching and work - i.e., locate our efforts in a social/national context.

..10

xviii. Explore and undertake research projects focussed on national needs.

xix. Accompany students to the community to enhance own teaching skills at community level.

xx. Focus teaching on essential/core curriculum and mention challenges at all levels of health care - primary, secondary and tertiary.

xxi. Understand Health economics and be sensitive to costs of health care so that one can balance professional excellence with social relevance.

xxii. Delegate responsibilities and promote skill transfer within the departmental team. At the community level respect affirm and support health workers at different levels in your day to day dealings.

xxiii. In the context of social relevance, some changes in our lifestyles, and monetary and material expectations are called for and have to be seen as challenges.

xxiv. We should try and set examination papers that are more representative of peoples' needs.

xxv. Encourage feedback from staff and students and create structures to deal with this feedback.

xxvi. Share the 'new understanding' and ideas about innovations with other colleagues who were unable to participate in the workshop.

xxvii. Personally discuss and motivate students to the challenges of changing educational system towards greater social relevance.

xxviii. Promote staff-student relationship on the guru-shishya model and promote dialogue at all levels.

xxix. We should strive to become 'role models' to enhance this change effort and improve our communication skills as well.

xxx. Must involve more deans and principals and government medical college staff and health decision makers and planners in all our meetings.

A1. Some individual participants made some personal commencements to undertake tasks to support the emerging collective commitment.

i. To promote importance of 'ethics' and 'value system' at all levels (Dr. C.M. Francis).

ii. To incorporate the concept of social relevance into all our training programmes (Dr. Mohan Isaac).

iii. To equip students better in obstetric skills keeping the new understanding and orientation in mind (Dr. Ranade).

iv. To develop a measurement instrument for monitoring attitude change (Dr. Dara S. Amar)

v. Promote communications between individuals and change agents (Dr. N.H. Antia).

B. At Institutional Level

i. Start Medical Education Cell (ME Cell) in each institution having representatives of various departments and organise regular informal meetings.

ii. Initiate teachers training programmes in conjunation with National Teachers Training Centres at Pondicherry, Chandigarh, Varanasi, etc. Identify enthusiastic staff who can be sent for training to such centres. When a core group of trained staff are available, then initiate institutional based training for all staff of the institution at all levels.

iii. Study the innovations and recommendations that have arisen out of the CHC project and try to apply/ introduce it into the institution after discussions in the ME Cell.

iv. Organise similar workshops and medical educators dialogue for regional groupings of medical college including government institutions to enhance the dialogue and sharing of experiences.

v. Teachers should be encouraged to apply 'learnings of workshop' in day to day teaching efforts i.e., setting up institutional/departmentalinstructional objectives, new evaluation procedures etc. Every department should be gradually involved in these efforts.

..12

vi. Find ways of enhancing student participation and feedback in all institutional efforts.

vii. Constantly sensitise staff and students to the institutional goals. Discuss the objectives of the institution with students atleast once a year.

viii. The institutions must build up a good collection of audio-visual aids and other aids to teaching based on the newer concepts of education.

ix. Students should be exposed more and more to the community/ field realities of health care in the training programmes.

x. The graduate feedback study undertaken by CHC should be compared with similar studies which could be undertaken by institution on relevant samples of their own graduates and feedback for further action generated.

xi. Evolve ways of dealing with political interference in institutions and get around obstacles.

xii. Analyse the situation and streamline the process of change using every opportunity to encourage staff towards innovation.

xiii. Develop a health information system that can support change and a monitoring system that can keep track of the process.

xiv. Create greater awareness of the 'medical education situation' and the urgent need for change.

xv. Look into the problem of gender discrimination within medical education and institutional effort.

xvi. Evaluate institutional effort in a more detailed and rigorous matter.

xvii. Explore further the possibility of a premedical orientation course of 6 months - 1 year which could be a preselection course to look for aptitude of students. Explore the 'practical' and 'legal' difficulties that may be encountered and try to overcome them through creative planning efforts. This course would help to enhance the selection process and minimise the wastage of efforts.

xviii. Identify institutions and projects involved in community services with whom the pre-selection course could be organised. The same projects could also be involved in community phases of curricular training programme and staff and students could be given opportunities for exposure.Such programmes could also be given greater weightage.

..13

xix. To encourage all graduates to work for 2-4 years as a compulsory posting in peripheral health care institutions. To learn from the experience of other institutions who already have such rural bond/placement schemes.

C. At the Collective Level

i. Promote and actively participate in alternate Networks of Medical Educators.

ii. Formalise these groups and networks to enhance the voluntary but collective monitoring of change in medical education.

iii. Promote further interaction and dialogue among members of the network - enhancing the sharing of experimentation and innovation.

iv. Create awareness and involvement of network members in larger health related issues other than merely medical education as at present.

v. Identify guest faculty from the network institutions for training programmes in other member institutions.

vi. Organise meeting with senior opinion makers and key decision makers in the region/national level and promote our objectives and perspectives among them.

vii. Promote 'public debate' and explore mass media publicity of our efforts, initiatives and emerging objectives.

viii. Create a system of honouring health workers who have promoted these objectives at appropriate times rather than posthomously or after retirement.

ix. Work with Medical Council of India and other policy making bodies and asscciations to promote these perspectives and shared commitment.

x. A network of medical education cells should be initiated so that institutions can learn from each others experience.

*****

..14

6. INTRODUCTORY SESSION

The Introductory session of the meeting consisted of four subunits:

A. WELCOME

The participants were welcomed by Dr. Ravi Narayan, Coordinator of the Society for Community Health Awareness, Research and Action (Community Health Cell, Bangalore) on behalf of CHC (the host); CMAI-New Delhi and CHAI-Secunderabad (the sponsors); and the CMC-Network, which were the supportive peer group for the project.

The participants represented an interesting network of medical education enthusiasts who had been identified and brought together by the process of the CHC Project. These included:

i. Some Deans/Principals (current/retired) of Medical Colleges;

ii. Some faculty of medical colleges;

iii. Representatives from coordinating agencies in health- including VHAI (New Delhi), CMAI (New Delhi), CHAI (Secunderabad), CSI, Ministry of Healing (Madras). (Some members were also part of training network/fora like CMC Network; the newly evolving consortium of medical colleges; and IAAME.

Special Invitees

Three special invitees and resource persons were also welcomed and introduced to the participants. These were:

i. Dr. N.H. Antia - plastic surgeon and leprologist who was a participant of the ICSSR/ISMR study group on Health for All - an Alternative strategy and a key policy promoter of alternatives in health care and training.

ii. Dr. Zafarullah Choudhry - the charismatic leader of the Gono Shasthya Project in Bangladesh - which had innovated a health workers training strategy; facilitated the well known Rational Drug Policy of Bangladesh and was presently involved in considering the evolution of a relevant community based medical college for that country.

iii. Mr. Desmond Abreo - Development theologian and well know social activist - involved in the evolution of

..15

alternative strategies for training for the development sector in the country.

The presence and participation of these three people was a source of much inspiration to the group.

The participants were welcomed to the Garden City, to this two day dialogue-to get to know each other and share each others hopes and plans.

B. REFLECTION ON THE GANDHIAN TALISMAN

To set the mood for the meeting and to bring in the peoples perspective a two minute silent reflection was suggested on a quotation by Mahatma Gandhi:

> "Whenever you are in doubt recall the face of the poorest and most helpless man who you may have seen and ask yourself if the step you contemplate is going to be of any use to him... will it restore to him a control over his own destiny?".

C. Then using slides, an introduction was given to the meeting, the background of CHC's interests and efforts in medical education; the linkage with CHAI and CMAI and the newly evolving CMC Network; the evolution of objectives of the Project; and the linking of the project objectives as a preparatory step towards the facilitation of a medical education cell and a faculty development programme for a potential alternative track experiment evolving at Miraj, Maharashtra.

D. To give the opportunity for all participants to get to know each other, a self introduction session then followed.

This short session helped to bring out the diversity and multi faceted experience of the group that had been gathered for the review meeting by CHC. Apart from the organisations mentioned earlier. The disciplines included:

Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Preventive & Social Medicine/Community Medicine, Psychiatry, Plastic Surgery, Cardiothoracic Surgery, Microbiology, Anatomy, Pharmacology, Physiology, Health Planning, Social Work.

..16

The participants brought many concerns and expectations to the meeting. These included:

- 'Concern about what was going wrong with the orientation of medical students from prestigious medical colleges especially Christian.'

- 'Interest to dialogue with health trainers from the background of intense involvement in development training.'

- 'Doctors know so little about mental health in primary health care. What can we do about it? How do we get over this lacunae?'

- 'Involvement of medical college faculty and social conscious doctors in wider issues. Also support the prevention of 'Zombification' of medical education, by moving with the 'enthusiasts' and by passing the 'resisters'.'

- 'Get ideas from those who have tried earlier to help get ideas for a formative project of an alternative track.'

- 'Came to learn how to get students more interested in community medicine issues, which are often low priority among students.'

- 'Grabbed opportunity of attending meeting to learn from experience of others and share the experience of own institution.'

- 'Concern about the medical education system and what is happening to it with an interest to share this understanding with policy makers to lobby for change.'

- 'Keen to learn how to implement changes and how to change examination system which is the key to change.'

- 'Concerned about lack of dialogue between health services and medical education with medical college faculty being ignorant of needs of doctors in the health services.'

- 'Plan to start a community based medical college hence keen to share ideas and listen to the experience of others.'

- 'Concerned about the erosiam of ethics and values among students and the growing phenomena of education and health services not being need based.'

- 'Involved in the training of a range of medical and non-medical groups and apart from sharing this experience, wish to explore what and how can be taught in (i) behavioural sciences and (ii) Ethics.'

- 'Represent CMAI the oldest network with 2 medical college and 80 schools of Nursing - what are the new directions and challenges?'

..17

-'Concerned about where our medical graduates go after all our efforts at reorientation.'

-'Having been responsible for the original stimulus to the study, wish to be a spectator to see what others say and feel about the needs and the process.'

-'Torn between the requirements of academic excellence and exam regulations vs. what our country needs and concerned about how do we step down from the Ivory tower to reach the community.'

-'have long been involved in medical education and having made lots of mistakes keen to hear about the exciting alternatives that are being suggested.'

-'Want to be exposed to new strategies and also be open to unlearn some of the irrelevant ideas that orthodox medical education has promoted.'

-'Studied the concept of community orientation in medical education as topic for post graduate thesis and interested to meet and learn from other enthusiasts.'

At the end of this sharing session what became very obvious to the group was that'round the table' - there was a collection of highly motivated medical education enthusiasts- bringing together much concern - much experience - much reflected wisdom and a lot of openness to reflect on mistakes and uncomfortable realities - All in all a very good ethos for serious dialogue.

E. After the self introduction session the two day programme and some of the organisational dynamics was shared with the participants by the organisers.

F. After tea - the first session was devoted to a presentation of the background, objective, methodology, findings and outputs of the CHC Medical Education Project by the CHC Team -(Dr. Ravi Narayan, Dr. Thelma Narayan, and Dr. Shirdi Prasad Tekur) using summarised datas, visuals and cartoons on OHP sheets. A summary of this presentation follows.

..18

7-A. SESSION-I

THE CHC PROJECT: Strategies for social relevance and community orientation - Building on the Indian experience.

An Overview *

An interactive Research Project with the above title was conducted by us from April, 1990 till June, 1992, sponsored by the Christian Medical Association of India (CMAI)-New Delhi, and Catholic Hospital Association of India (CHAI)-Secunderabad, and supported by a newly emerging Network of Christian Medical Colleges in India (CMC Network).

The Society is a secular, professional resource group which has 'evolving educational strategies for promoting community health action in the voluntary and governmental sector as among its many objectives.

The researchers had a long history of interest in appropriate medical and health humenpower education, which included a decade in community orientation of medical education at St.John's Medical College - Bangalore (1973-83) and many initiatives towards evolving an appropriate training strategies through the Community Health Cell, a grassroots technical resource centre, which they coinitiated and facilitated since 1984. All these initiatives and reports (1973 to 1991) were brought together in a mimeographed report entitled 'Step by Step' as the first output of the Project.

Premises of Study

The first premise of our interactive study was that there are atleast four sectors of innovation from which stimulus for reforms in medical education can and have emerged.

i) The Expert Sector - Starting from the Bhore Committee Report of 1946 till the recently circulated draft outline of the National Education Policy for Health Sciences (Bajaj Report), there have been a series of expert committees in India offering ideas and recommendations of great relevance to the Indian situation.

ii) The Medical College Sector - Some medical colleges have made serious efforts to operationalise some of the expert 'ideas' and recommendations and some have gone further to evolve community oriented training strategies. Much of this reform is within the framework of 'structure' and 'function' stipulated by MCI.

The 'medical college' sector includes ideas and recommendations put forward by professional associations at their annual meetings and also covers much of the

..19

* Presented by the CHC Team.

materials that has been regularly presented and discussed at the annual meetings of the IAAME.

The 'Expert Sector' and the'Medical college Sector' would together constitute what we would like to term as 'traditional/ orthodox expertise'.

iii) 'Voluntary' Training Sector

Since the 1970's a large number of innovative community health oriented training programmes for health humanpower has developed especially within the so called voluntary/non-governmental sector. Many are geared to training or reorienting doctors and nurses (produced by the orthodox system) towards community health oriented work. Many others train 'lay people' (non-doctor, non-nurse) in community health work. A large number of 'alternative training experiments' supplementing these efforts have also emerged in the development and informal education sector. While these may appear to have developed in a 'separate universe' there is growing recognition that their pedagogical innovation, approaches and focus have great significance for professional humanpower education in the country.

iv) The 'PHC graduate' sector

There are a large number of young graduates of the existing orthodox medical education system who have worked in small peripheral rural hospitals, primary health centres and community health projects and have had to creatively adapt their own inadequate education to the 'professional challenges' and 'emotional demands' of community oriented health care. Most of these 'creative tensions' and 'appropriate responses' and ideas are waiting to be systematically tapped and explored.

The 'Voluntary training sector'and the 'PHC graduate sector' would together constitute, what we would like to term as the 'alternative' expertise.

B. The second premise of our 'interactive study' was that while the above sectors of 'innovation' have, separately and taken together, a lot of interesting ideas to offer to all of us who seek to reform medical education, there is inadequate documentation and reporting and inadequate networking and hence this expertise lies relatively unknown within sectors and between sectors. Medical College based innovaters know tlittle of what each other are doing; the voluntary sector trainers have little dialogue even amongthemselves; the graduates in the periphery are seldom contacted for feedback; and therefore there is a 'gross' lack of awareness of the wealth of experience available in the country itself. This is further accentuated by the fact that medical education experts and policy makers, being unaware of the

..20

diversity and multifaceted experience in the country, tend to get carried away by ideas and 'expert advise' that have originated in other countries - in situations of different socio-economic cultural conditions and rather different educational systems. Many policy recommendations and reforms are therefore not adequately grounded in local realities and local experience.

C. The third premise of our study is that there is not only little knowledge in the country of local experience in all the sectors identified earlier but there is also the additional problem that innovaters within and without the system have not subjected their own 'innovations' or 'reflections' to any type of objective evaluation and or peer group assessment. In some instances, where this may have been attempted, the results are not available to others to learn and reflect upon.

The objectives of the Project were:

1. To document descriptively / analytically - key recommendations/ experiments / innovation/ experience in medical education.

2. To review key alternative training experiments to identify issues, perspectives, ideas, pedagogy relevant to medical education.

3. To build an Anthology of Ideas from a sample of recent medical graduates with primary / peripheral health care experience.

The methodology of the study was multipronged and multi-dimensional including classical approaches such as literature review; survey of medical colleges; a survey of graduate feedback, based on experience in peripheral health care institutions; an overview of training programmes in the alternative 'voluntary' training sector. It also used interactive approaches such as peer group correspondence and meetings, and field visits to colleges and group discussion with faculty and interns, and others.

The medical college survey and literature review lead to the identification of 32 colleges out of a sample of 125 colleges, who has tried out some ideas or innovations in this area. Totally 50 initiatives were identified which could broadly be classified into six broad thrusts:

a) Improving pedagogy and educational technology.
b) Widening horizons.
c) Improving skill development.
d) Moving beyond the teaching hospital.
e) Transcending existing compartmentalization, and
f) Promoting self learning.

These initiatives were also divided into five sub-groups:

a) General objectives and curriculum contents;
b) Preclinical phase;
c) Paraclinical phase including community medicine teaching;
d) Clinical phase; and
e) internship.

The initiatives in each category included:

a) General objectives and curriculum structure

1. Defining Institutional Objectives
2. Defining Intermediate (Departmental) and Instructional objectives
3. Development of Medical Education Cell with adjunct faculty
4. Faculty Training Programmes in medical education skills
5. Selection Procedures other than academic merit (Psychological/ Social skills/leadership/value orientation)
6. Curriculum development including
   - i. integration
   - ii. identification of core abilities
   - iii. prioritization (curriculum planning committees)
   - iv. identifying skills
7. Examination Reforms
   - i. objective examinations
   - ii. restructuring assessment towards HFA/PHC priorities
8. Faculty/student involvement in Medical Education feedback/ research.
9. Tutorial system
10. Student electives
11. Students involvement in Research
12. Regular faculty meeting/faculty-student meetings
    - i. curriculum issues
    - ii. Social-Societal issues
13. Student nurture programmes - curricular/extracurricular
14. Rural Bond (Placement) Scheme
15. Continuing Medical Education for alumnus/others

b) Preclinical phase

16. Foundation Course for entrants
17. Community-based orientation programmes
18. Introduction of New Subjects
    - i. Behavioural Sciences
    - ii. Ethics
    - iii. First Aid
    - iv. Nursing
    - v. Integrated Growth & Development

..22

19. Clinical Orientation in pre-clinical phase
20. Humanisation of pre-clinical practicals
21. Samaritan Medicine - interpersonal skills
22. Urban-slum based-multi-disciplinary student programmes

C. Paraclinical phase including community medicine teaching

23. Reorienting Pharmacology Training
    i. Rational Therapeutics
    ii. Essential Drugs Concept
    iii. Clinical Orientation
24. Synchronisation of para-clinical subject lectures with clinical teaching
25. Involvement in Integrated teaching
    i. Para-clinical and clinical subjects
    ii. Clinico-Pathological-Social Case Conference
26. Community Based Family Care Programme/Family Health Advisory Service
27. Community Block Posting (First Clinical Year)
28. Junior Clinical Clerkship
29. Special Training Programmes
    i. Epidemiology
    ii. Biostatistics
    iii. Health Education
    iv. Clinical Epidemiology
    v. Management
    vi. Health Economics
30. Rural/Urban Slum health visits/camps
31. Community Block Posting (2nd Clinical Year)
32. Senior Clinical Clerkship (2nd Clinical Year)
33. Epidemiological / Public Health Projects.

D. Clinical phase

34. Integrated Teaching (interdepartmental)
35. General Outpatient Department (GOPD)
36. Curative/Preventive General Practice Unit (CPGP)
36. Clinical Clerkship in Primary Clinical Departments
37. Training in
    i. Emergency Medicine
    ii. Social Paediatrics
    iii. Social Obstetrics
    iv. Clinical Pharmacology
38. Community visits by Clinical Departments - Camps and regular clinics in Rural/Urban field practice areas
39. ROME Scheme
40. Interdepartmental Coordinated Clinics in Hospital Programmes
41. Peripheral Hospital Postings
    i. TB
    ii. Leprosy

iii. Eye Hospital
iv. Rehabilitation Centres
v. Isolation Hospital / infectious diseases
vi. District / Peripheral Hospitals

E. Internship

42. Interns orientation programme
43. Community Health postings in Rural/Urban field Practice areas
44. Community based camps/clinics by clinical departments
45. Posting to Government PHCs and sub-centres
46. Involvement of interns in special situations

i. Epidemic control
ii. Disaster relief
iii. Plantations
iv. NGOs Health Projects
v. Immunization programmes
vi. FP motivation

47. Involvement of Interns in Primary Health Care Training of Health Workers, Dais, Auxiliaries
48. Internship training in specific additional skills

i. Rational Drug Use
ii. Management
iii. Ethics
iv. Health Education
v. Epidemiological Projects
vi. Clinical Research

49. Internship training in special clinics in Hospital situation- Curative General Practice Unit/GCPD etc.
50. Internship Assessment / Evaluation.

6 pacesetter colleges were identified and some general features as well as key innovative strategies were outlined. The common features of pacesetter institutions were:

a) Established with specific / focussed mandates.
b) Smaller number of admissions (50-70).
c) Autonomous or private management.
d) Own entrance examinations and selection procedures.
e) Adequate teaching hospital beds.
f) Well organised rural and urban field practice areas.

10 key factors that promote change in a medical college curriculum were identified which included:

a) institutional mandate;
b) institutional objectives;

..24

c) instructional objectives;
d) medical education cell; a faculty development process;
e) field practice areas;institutional policy supporting community
f) health;
f) cultural transformation and value orientation;
g) networking and dialogue; and
h) reflective evaluation.

12 obstacles or barriers to change were also identified by the interactive approach in the study and described as twelve 'pathologies'. These were:

1. Mental Disorientation

A confusion in medical college leadership objectives about the change process is the first important barrier. This manifests as a confusion - primarily between the pursuit of technical excellence for the sake of professional satisfaction versus the pursuit of technical excellence for the sake of social relevance.

2. Nystagmus

The second important barrier, which is complementary to the first is the absence of clearly defined institutional and instructional objectives leading to a continuous shift in focus between primary health care orientation and tertiary health care orientation in all the efforts.

3. Optic Atrophy

Continuing 'cultural colonialism' manifesting in the belief system that 'what is west is best', results in the pursuit of some ill defined International MBBS standard. In practice it means that community needs, socially relevant issues, local health culture and tradition and local grassroots innovation are outside the field of vision of medical college faculty. This reduced field of vision, limits the stimulus for change.

4. Anemia

Promotion of individual professionalism, or at best departmentalism, in career advancement rather than collective institutional team work, results in weak individual responses to reform. Sometimes the change process is unidepartmental making little dent on the system and causing the efforts to become rather anaemic.

5. Cancer

Inadequate management planning including improper financial resource management, lead to an initially insidious, and later rapidly growing, entry of the cancer of market economy in medical practice, cost of services, prescribing and

..25

technology policies in the institution. This defeats the purpose of reform by bringing in double standards.

6. Manic-Depressive Psychosis

When planning for change far outweigh implementation of change, there is increasing rhetoric and simultaneous growth in faculty cynicism or dissatisfaction. The institution then passes through, manic phases of planning followed by depression, caused by limited funds, flagging institutional leadership and inadequate follow-up.

7. Atopia - Allergy

Absence of viable and effective linkages, between colleges and the 'teaching community' and the health care delivery system beyond the teaching hospital, results in adhoc, irregular, ill planned community exposure programmes that cause 'allergy rather than enthusiasm in the students. This atopic response severely affects the reorientation process, with community based experiences becoming couter-productive.

8. Atherosclerosis

Bureaucratization and routinization of effort leads to changes becoming statutory and imposed - promoting an atherosclerosis of creativity. This is also symbolised by the absence of active feedback from students, faculty and community, to modify programmes and keep them responsive to change. This leads to a resistance, to new ideas and decreased circulation of enthusiasm towards community orientation.

9. Schizophrenia

The growing dichotomy between community medicine and clinical medicine is a serious obstacle, caused atleast partially, by the creation of separate preventive and social medicine departments and forcing a rural orientation mandate on their faculty. This has meant, that while one department pushes towards the health care challenges of 'Interior India', the rest of the departments feel psychologically free, to push towards the 'East Coast of USA'. This growing dichotomy, produces schizophrenic responses in students and faculty, alike.

If PSM Departments also show these schizophrenic responses, then it can be disastrous for change.

10. Graft Rejection

Caution is required in the planning and evolution of community oriented experiments and innovations. Care must be taken to ensure that, the problems caused by transplanting western high technology hospital models are not repeated

..26

when we accept 'community oriented education models' that have been developed in different cultures, health care systems and educational systems.

While we need to learn from different experiments all over the world, we should critically evaluate ideas, in the context of our own, rather different, socio-economic-political-cultural realities, as well as different educational environment and aspirations. This will prevent costly and painful graft rejections, at a later date.

11. Autism

The danger of too much rhetoric and too little active promotion of change by management; or of discontinuous experiments, waxing and waning in intensity leads to autistic response in the faculty and more and more of them insulate themselves and withdraw from involvement in change. This is not an uncommon feature of many institutions including those with histories of pioneering efforts in the past.

12. Senile Dementia

Finally, the most important barrier to change is a combination of commitment to status quo; a defensive response to critical reflection and evaluation; a rationalisation of inadequacies; and a lack of openness to criticism and new ideas.

These lead to the setting in of a senile dementia in the institution. Management and leadership controlled by the 'orthodoxies' of Secondary and Tertiary Health Care professionals sustain this response greatly.

The challenges for the 1990s identified by the Project were:

1. Urgent Need for change

There is a growing disatisfaction with all aspects of medical education - the content, the focus, the methodology, the process and therefore there is urgent need for action.

2. Multi pronged effort

This action has to be part of a multipronged effort at different levels of the system

* At policy making;
* At human resources planning;
* At administration, governance and organisation of medical education;
* At social control of medical education;
* At health care service delivery linkages and a host of other levels as well.

..27

3. Curriculum change

A change in the curriculum - in objectives, content, focus, methodology and training base has to be an integral part of this effort and within the context of the broader framework of change.

4. Emergino new Framework

The emerging alternative framework could include the 50 strategies that have been identified by the survey, building creatively on the diversity of experiences of atleast 25 or more colleges, that have attempted 'change' and constitute the Indian orthodox experience.

5. Experimental Curriculum

There is urgent need, to evolve the concept of an experimental parallel track or curriculum and allow a few selected colleges, to integrate these 50 strategies and go beyond, the constraints of the existing compartmentalisation of phases and examinations in medical education. Colleges selected for this purpose, must have demonstrated their competence to evolve, sustain and evaluate the process of change.

6. Graduate Feedback

Our survey of graduates, with experience of work in peripheral health care institutions, has demonstrated, that this sort of feedback is an essential component of the planning of medical education and curriculum change. It helps us, to move from 'empiricism', to change, derived from experiential feedback and inquiry.

7. Positive Factors for change

10 factors described in this study have been identified as those that promote and sustain change. Medical College leadership must promote these positive factors, actively in the 1990s.

8. Negative Factors affecting change

12 factors described in this study have been identified as those that act as blocks or barriers to change. Medical College leadership must counter these negative factors actively during the 1990s.

9. Inspiration from Alternatives

Many emerging alternative formulations, prescriptions and training experiences have been identified. These should be taken seriously and must inspire the efforts at moving medical education from the tertiary care situation to the

..28

primary health care situation - from the 'teaching hospital' to the 'teaching community'.

An active interactive dialogue between the 'orthodox' and the 'alternative' sectors of Indian experience identified by the study must be encouraged and further facilitated.

10. Faculty Development Key to Change

Finally, all these efforts would be unsuccessful if the medical education process cannot provide faculty role models, who are inspiring and enthusiastic about, the challenges of social relevance and community orientation in Medical Education. Faculty development and their continuing orientation and education is the ultimate Key to Change.

Publications

The literature review lead to the evolution of a 'ready reckoner' of expert committee recommendations in India from Bhore Committee (1946) to the draft National Educational Policy for Health Sciences (1989); an annotated biliography of 50 key titles primarily from Indian experience but supplemented also by key WHO and other resource materials; and a bibliography of over 700 references on the theme of study focussing primarily on Indian experience.

All the study findings and process are being published between June-December, 1993 as a set of 5 complementary publication:

1. Strategies for Social Relevance and Community Orientation in Medical Education - Building on the Indian experience (The Project Report);

2. Evolving medical curriculum through graduate feedback - a Survey Report;

3. Stimulus for Change (an annotated bibliography and directory of resources;

4. The Key to Change - A booklet for lobbying;

5. The Faculty Resource Book - bringing together details of all the ideas, initiatives, experiments identified by the study.

In Conclusion

The study was primarily designed to collate materials and evolve materials for a process of faculty development for a 'alternative experiment' which was being planned in Miraj(Maharashtra State)

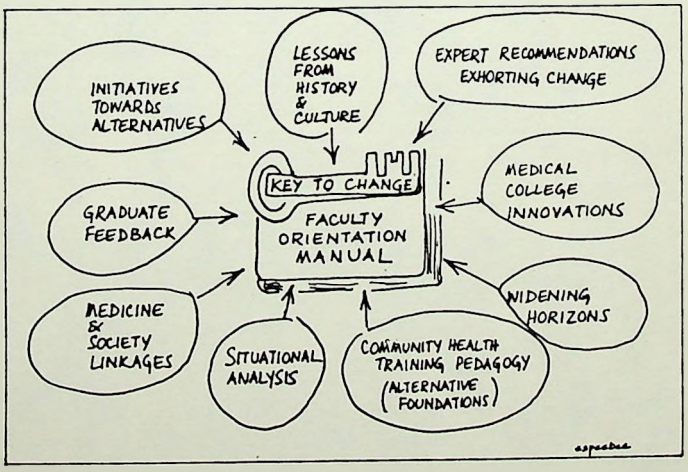
..29

from 1992. Unfortunately due to change in government regulations, this experiment could not start up. It is however hoped that the publications will continue to be a stimulus for all those who seek to experiment with alternatives even within the somewhat compartmentalised existing structure of medical education in India.

* * *
* *
*

For further details and information, refer to the published report entitled "Strategies for Social Relevance and Community Orientation - Building on the Indian Experience", (1993), now available on request from CHC, Bangalore (price Rs. 40-00).

-Ed



7-B. DISCUSSION - SESSION - I

The presentation of the CHC project overview was followed by an animated discussion among the participants, who offered interesting comments and raised many significant issues in the light of the findings of the Project.

The salient issues and questions raised were:

i. The study has shown that there are things being done in India within the constraints and many of us do not know about it. It is heartening to note that it is happening not only in private relatively autonomous colleges but also in some of the government colleges. There are resources, experience, and expertise available. How do we use them to promote the positive factors and avoid the pathologies. In many of the innovations, individuals have played the crucial role as 'a committed believer'. This must be emphasised. How can such individual be identified? and supported?

ii. There was need to look for ideas and answers within each institution, each region rather than always looking out for answers from an external agent.

iii. Students and interns were obsessed with postgraduate examination system and this affected their openness to change / reform initiatives.

iv. While rural placement scheme after internship was a good idea many students were scared to loose two years in seniority if they opt for the two year rural experience.

v. Students nowadays are motivated towards superspecialities and specialities rather than general practice. How can this be countered?

vi. Students are often pressurised for time especially in preclinical course which have rather detailed syllabus. They and the staff are concerned how to finish Anatomy and Physiology portions in existing curricula. Hence any additions would mean extending the course (!)

vii. The image of preventive and social medicine department has to change to a more facilitatory role so that each department can begin to identify what they can do in the context of these alternative visions and objectives.

viii. For efforts to be successful, the innovaters must be linked with administration. This is an important pre-requisite.

..31

ix. Reduce gap between what is often professed and what is the reality at the training/field level.

x. There is need for a spirit of innovation and change suited to particular local situation. It is not enough to just repeat the 50 ideas that have been identified by the project though they may have innovative elements. All innovations must be critically examined and experimented with.

xi. For implementation to be successful groups of staff and networks of enthusiastic colleges need to be involved in the process of change.

xii. The selection procedures tried out by St. John's Medical College was very interesting. Has any follow up on the impact of these ideas been tried out?

xiii. Faculty development should be priority. There is also need for prioritization in efforts as well as need to get a peoples perspective as well.

xiv. There is need to break walls and get further autonomy. There is need to get out of the shackles of an affiliating system which prevents experimentation. An all India movement for autonomy in medical education is required.

xv. Is a Health University a good idea or will it promote a monoculture? We need to address this question seriously in the Indian situation.

xvi. We need to share experiences more and more. We also need to share our failures.

xvii. There is need to publicise the findings of this study and also to follow up with more studies as well.

xviii. Medical education is ultimately a sub-set of the health service which is a sub set of the larger society with its social-economic-political dimension. Change in one must go hand in hand with change in the broader system and vice versa.

xix. There is need to look at other systems of medicine eg., role of Ayurveda to help develop a more integrated, technically, economically and culturally sound system.

xx. There is need to move from illness orientation which is still so prevalent to a health orientation. What role can medical education play in this transformation?

xxi. While talking about attitudinal changes and career options are we underplaying the increasing materialist ethos of our Society? Doctors still see lucrative practice as an important goal of medical education? Most of the sabatticals from medical colleges are nowadays to Middle East to make money? Can Medical students be expected to have different values?

xxii. Finally, it was again reiterated by many that the most heartening fact from the study is that so many efforts are being made to change even within the existing system. Many of us do not realise how much freedom we have and how much leeway for innovation, exists even within the so called MCI regulation constrained curriculum? In this context the proposed MCI Meeting on Need based medical education planned for 1992 August was welcomed and it was hoped that some further changes would be considered to increase the possibility of reform and pursuing innovative ideas.

* * *
* *
*

MEDICAL COLLEGES AND COMMUNITY HEALTH TRAINERS INCLUDED IN STUDY
- a regional distribution

⌂ - Medical Colleges (total - 32)
○ - Community Health / Development Trainers (total - 22)

SESSION II/III

8. INNOVATIONS IN MEDICAL EDUCATION

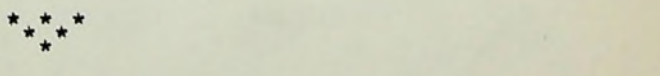
Since many of the participants represented institutions that had been involved in changing medical education and developing alternative ideas and innovations (which had been the focus of the CHC Medical Education Project), this session was organised to give all the participants an opportunity to listen at first hand from some of the innovaters and pace-setters themselves so that some details as well as the feeling for the process of change could be shared as well. Two sessions were held.

The first one focussed on Medical College initiatives at institutional level and some experiences were shared from CMC (Vellore), Smt. NHL Municipal Medical College (Ahmedabad), St.John's Medical College (Bangalore), JLN Medical College (Ajmer), CMC (Ludhiana) and Government Medical College (Bangalore).

In the second session the focus was on other groups involved in initiating alternatives or providing complementary/supplementary efforts to the process of change. In this session, presentations were made by Voluntary Health Association of India on Rational Drug use Education in Medical Colleges; the consortium of medical college initiatives facilitated by CED Illinois; the Miraj manifesto and alternative project; the alternative medical school project of Gonoshasthya Kendra, Bangladesh; the Christian Medical College Network facilitated by CMAI; and the efforts in Community Mental Health teaching by NIMHANS, Bangalore.

The two sessions chaired by Dr. Alfred Mascarenhas (Principal, St.John's Medical College, Bangalore) was very interesting and all the participants got a feel for the exciting challenges and problems of initiating change in medical education. There was optimism tempered with realism in all the efforts and it was a very effective session.

(Some of the participants gave us summaries of their presentations, some left us copies of their OHP sheets and some left us to make summaries of their presentations from the notes of the rapporteurs. The articles that follow represent this diversity).



8A. CHRISTIAN MEDICAL COLLEGE, VELLORE*

Introduction

We recognize that the present-day medical education is not responsive to the needs of our population. To bridge the gap between the training imparted to the medical graduate, and the expertise expected of them, we must make many changes in the overall direction and content in the medical curriculum. As part of the consortium deliberations we have had discussions with our own colleagues to see how change can be effected.

Our presentation will include:

1. Review of the data collected to assess the present scenario. This includes:
   a. a survey of outpatient morbidity statistics in a tertiary, secondary and primary set-up;
   b. a survey of the perceptions of interns and recent graduates working in small hospitals as primary care physicians, about the medical training they received;
   c. a survey of the perceptions of the medical faculty were also asked to give their perceptions of the training imparted by them;
   d. Medical Superintendents of Mission Hospitals where our graduates have worked.
2. The second aspect of the presentation will describe some innovations we have introduced and further innovations we have envisaged, on the basis of the data obtained by the above inquiry.

Assessment of Medical Curriculum

Clinical bedside teaching has changed very little over the decades; its content and emphasis have not been balanced; there is undue stress on:

1. "Diseases" rather than symptom oriented approach.
2. Elicitation of physical findings rather than expertise in elicitation of history.
3. Use almost solely of in-patients with little emphasis on out-patients diseases either in thesecondary or peripheral areas.
4. Emphasis on how to face the final University examination.

This poorly balanced approach results in graduates who have good knowledge of advanced stages of diseases and its management at the tertiary level. However, they are ill equipped as a Primary Care Physician because of their inability to recognize and treat disease early. In addition, the major draw-back is that there is very little exposure to the common diseases encountered on an ambulatory basis.

In order to gain some idea about the common diseases seen in ambulatory care, we collected out-patient morbidity statistics at the three levels:

a. From the peripheral village clinics (Primary).

b. From the secondary care centre.

c. From the tertiary care centre.

TABLE I

OUT-PATIENT MORBIDITY DATA RANKING OF DISEASES IN ORDER OF PREVALENCE

TERTIARY (C.M.C.H.)	SECONDARY (CHAD-Base Hospital)*	PRIMARY (Mobile Clinics)
1. Ill-defined	Ill-defined	URI
2. Ante-natal	Skin	Ill-defined
3. Skin	URI	Skin
4. Upper Respiratory Infection (URI)	Trauma	Musculo-Skeletal
5. Musculo-Skeletal	Tuberculosis	Anaemia
6. Fungal	Musculo-Skeletal	Epilepsy
7. Otitis-Media	Antenatal	Helminthiasis
8. Tuberculosis	Acid-Peptic disease	Trauma
9. Trauma	Anaemia	Hypertension
10. Leprosy	Helminthiasis	Fungal

* The CHAD - base hospital is the 60 bedded - Secondary health centre of the Community Health Department.

It is clear from table I that several common problems appear uniformly at all levels. Some diseases such as leprosy and tuberculosis are not shown at the primary and secondary levels as these cases are dealt within special clinics and therefore not represented in this survey. The same is true for antenatal and immunization clinics.

Against this scenario, we then surveyed faculty and students to see which topics were commonly discussed, and which were usually excluded. Table 2 gives this information regarding clinical teaching in the department of Medicine.

TABLE 2

SURVEY OF FACULTY AND STUDENTS ON CLINICAL TOPICS TAUGHT(MEDICINE)

FACULTY AND STUDENTS	STUDENTS
1. Ischemic Heart Disease	Asthma
2. Diabetes	Malaria
3. Hypertension	Typhoid
4. Urinary Tract Infection	Tetanus
5. Upper respiratory tract infection	Anaemia
6. Convulsions	Renal failure
7. Low back pain	Pericardial disease
8. Vertigo	

Comparison of Tables I and II shows clearly that clinical teaching in Medicine rarely includes topics which would be encountered very commonly in the daily life of a Primary Care Physician. No doubt, these are common diseases which are taught in didactic lectures, but practical exposure to them and therefore expertise, is inadequate.

An Evaluation

The second part of the study was to get an assessment of the undergraduate education programme conducted in our institution by students, recent alumni, and faculty members and Medical Superintendents of the hospitals where our graduates are working. For this purpose a pre-tested questionnaire was given to the interns of 1989 who were about to complete their internship and also to those who graduated before 1987. The third group was the faculty members involved in teaching undergraduates in subjects which had an university examinations.

The questionnaire was sent to 60 interns, 109 recent graduates and 55 faculty members and 60 Medical Superintendents. The response rate was 87%, 42%, 69% and 35% respectively.

The findings were not presented in detail but are available on request.

The third part of the paper focusses on all the innovations in medical education in CMC-Vellore that have been introduced over the years and some which evolved in response to the study.

8-A Contd.

INNOVATIONS IN MEDICAL EDUCATION AT CMC-VELLORE

1. FOUNDATION COURSE FOR ALL NEW COLLEGE ENTRANTS

It has been felt that students coming out of schools at plus Two level find it difficult to handle new subjects and different methods of learning. To make the transition between school and medical college education smoother and more meaningful, we had introduced a mini foundation course for all new entrants to the medical school.

The course was spread over five days with the students working in groups of ten guided by a tutor. The tutors were selected from the teaching departments of Anatomy, Physiology, Biochemistry and Community Health where the students would be spending the next 2 years. The tutors had a briefing session on Problem Based Learning and on the course. Reading materials and other necessary references were provided. The students were also taken to the Library and were given instruction in looking up references.

The course was programmed in such a way that by the end of the first day the students get an opportunity to get to know each other well. The Communication Workshop really helped in this. This was followed by un-structured and structured group discussions, which helped them to understand the mechanism of group dynamics. The group discussion topics were chosen carefully to introduce certain value systems in the young minds. They were also introduced to the concept of problem based learning. The following days were spent in groups applying this method of learning to a clinical problem. The course content and the programme were evaluated on the last day.

Objectives :

1. Help transition from school to college smoother and meaningful
2. To introduce mechanism of group dynamics and team concept
3. Demonstrate linkages between basic sciences and health care through problem based approach
4. Demonstrate self directed learning
5. Develop communication skills
6. To introduce value based education

2. FOUNDATION COURSE FOR THE FIRST CLINICAL YEARS : (USING PROBLEM BASED APPROACH)

The medical students who complete their pre-clinical subjects are usually taught pre-clinical subjects under very close supervision by their teachers. That is not the case in clinical years. More over they start to interact with patients

and their relatives. They also may not have enough experience in interviewing skills. Then they learn new subjects like medicine, surgery, pathology, microbiology and pharmacology. Therefore, we introduced a clinical foundation course with the following objectives to be learned through a problem based approach.

The objectives of the course are:

A. To provide

1. skills in self directed learning using problem based learning

2. skills in problem solving

3. communication skills

4. awareness of ethical issues.

B. To demonstrate

1. Horizontal integration of para and clinical subjects.

3. PERIPHERAL HOSPITAL POSTINGS

Our morbidity survey shows that there is no difference in the pattern of disease in inpatients between the peripheral hospital and teaching hospitals. However most of the teaching is not based on these diseases. Even when common problems are seen their management in the two centres varies greatly. The health priority problems seen in the tertiary hospitals hospitals are in an advanced stage requiring sophisticated investigations and high technology in treatment, whereas the same diseases are seen at the peripheral hospital in their early stage needing simple treatment.

To put the things in their proper perspective we offered one week peripheral hospital posting as an option for the past two years. Based on the feed back from the students, we plan to give all students two weeks of posting in a peripheral hospital of 50-100 bed strength with atleast one postgraduate qualified doctor. Certain criteria have been laid down for the selection of these hospitals. This posting would give the students ample opportunity to learn of the prevalence and pattern of diseases in a peripheral area; clinical decision making and management with the available minimal resources. They would be able to observe and take active part in the management of patients, particularly emergency surgical, medical and obstetrical cases. It would help them to realize the value of team approach, the cost of medical treatment and socio-economic aspects of the diseases.

The following suggestions were given by the students to improve the programmes.

1. Only small hospitals should be selected
2. Postings should not be close to the University Examinations
3. Hospitals in cities and large towns should not be selected
4. The programme in the hospital should be well organised
5. The hospital staff should be informed of the programme in advance and they should be aware of the objectives of the programme.

The students listed the following skills which they gained during the posting.

1. Assisting in surgeries and minor procedures
2. Assisting in deliveries and caesarian
3. Improving the interaction between the doctors and community and management of emergencies such as snake bite, fractures etc.

4. STUDENT CLERKSHIP

Our study had brought out that our students do not possess adequate skills in management of patients. An earlier study showed that obstetrics residential posting was very useful in acquiring management skills. Therefore we plan to give residential posting for 1 month each in Medicine, Surgery and Paediatrics. They would work along with the interns, managing patients in the hospital. We envisage that by the end of this posting they would be able to manage common clinical problems and would be able to do simple essential lab tests and integrate other investigations into clinical management.

They would be able to do simple procedures like venesection, catheterization of bladder, setting up of I.V. infusions, giving blood transfusions and lumbar puncture. Problem oriented learning method will be used and would be supplemented by small group discussions.

5. EMERGENCY MEDICINE / CASUALTY POSTING

Our study had also brought out that our students are not exposed to emergency care medicine. Firstly they do not get an opportunity to see these problems as soon as they reach the hospital. These clinical problems are not discussed by teachers during routine clinics. Yet another reason for the lack of emphasis on emergency medicine may be that they are not assessed on it during the examinations. To overcome this lacuna we plan to give our students a posting in the casualty department. This will be given in small groups of 2-3 students from 6.00 p.m. to 6.00 a.m. They would observe and take part in the diagnosis and immediate management of

..40

emergency cases. The students will be supervised by a faculty member and their performance would be included in the internal assessment.

We hope this posting will give ample opportunity to familiarize the student to the common life threatening clinical situations. The other objectives would be knowledge of differential diagnosis of these various situations, to optimize the clinical decision making skills and therapy in emergency situations, to learn to plan for cost effective therapy, to learn to counsel patients relatives about nature and severity of illness, to assist in minor procedures whenever required.

6. BLOCK POSTING FOR COMMUNITY MEDICINE TEACHING

From 1975 the teaching of community medicine has been made self directed, problem oriented and community based. This was possible by having a block of time of 2 or 3 weeks for community medicine. This enabled the students to spend the whole day from 6.00 a.m. to 8.00 p.m. or longer when necessary in the village. The block postings are in the 1st year, 3rd year, 4th year and during internship. In the first year the students have a live in experience. The details of the various programmes are presented in the paper "Block Posting" - An Effective Method for Community Based, Community Oriented Training Programme" are given in Appendix D.

7. INTERNS ORIENTATION PROGRAMME

It is generally assumed that medical students learn only skills of clinical examinations, to diagnose diseases and the theory of management of certain diseases of patients admitted to the teaching institution. They rarely learn to take part in the management of various diseases they see, some of the management issues related to proper medical record keeping, ethical issues related to management of patients, counselling of patients, their relatives, rational use of drugs and how to order and collect samples for various investigations. Therefore, the orientation programme was given for 5 days at the beginning of internship. The objectives of the Internship Orientation Programmes are:

1. Introduce new interns to various procedures and investigations done in hospitals
2. Introduce ethical concepts in patient management
3. Introduce problem oriented medical record keeping
4. Learn Cardio Pulmonary resuscitation
5. Rational use of drugs
6. Counselling
7. Principles of Hospital Administration and Management.

***

NOTE: A larger more detailed paper - providing details of student evaluation of all these innovations is available on request from Principal, CMC-Vellore or CHC-Bangalore.

..41

8-B. SMT. N.H.L. MUNICIPAL MEDICAL COLLEGE, AHMEDABAD

A Report of innovations/experiments in undergraduate Medical Education at Smt. N.H.L. Municipal Medical College, Ahmedabad, was presented by Dr. Shubha S. Desai. She focussed on the four main thrusts of the changes (see also Appendix 'E').

a) Introduction of Educational Technology

These included the NTTC workshop followed by a satellite workshop organised in the institution by NTTC faculty. Later a mini-workshop for faculty was conducted by local resource persons in the institution.

b) Formulation of objectives at institutional level

After the workshop - the institution formulated its objectives by:

i. reviewing institutional objectives of different medical colleges;
ii. discussion with institutional teaching staff;
iii. discussion with general practitioners;
iv. discussion with students and patients.

An evaluation committee was also set up which worked on the development of a bank of multiple choice questions.

c) Internship Reorientation Programme

A 3 day workshop was introduced for all interns as a reorientation programme. It included group dynamics, rational therapeutics and a project on drug prescription apart from some videos.

d) Comprehensive clinical postings

This consists of two types of posting

i. During the preclinical course - first MBBS students are posted to Medicine, Surgery and Obstetric/Gynaecology during evening hours.

ii. During 8th semester (clinical year) students get a weeks posting each to the path lab, the casualty department and a peripheral dispensary.

A summary from the O.H.P. sheets shown at the meeting

...42

8-C. ST. JOHN'S MEDICAL COLLEGE, BANGALORE

An overview of Medical Education initiatives at St. John's Medical College, Bangalore, was presented by Dr. Dara S. Amar, Professor of Community Health. These included the following:

1. Institutional objectives had been enunciated by the college and departmental/institutional objectives had been evolved by different departments.

2. At the Institutional level there were many formal and informal groups of faculty who worked together on issues related to medical education:

   i. Medical Education Cell;
   ii. Core group of faculty of the college who represent it in the Medical College consortium;
   iii. Ethical cell;
   iv. Epidemiological cell;
   v. Regular clinical conferences.

3. Pedagogy Training for all staff was provided by core group of NTTC trained faculty.

4. Promotion of Health Team training - Doctors, Nurses, lab technician, health workers, etc., were all trained in the same institution.

5. All training was multidisciplinary and enhanced interaction across departments.

6. There were many programmes and inputs beyond university curriculum requirements. These included:

   i. Teaching of Psychology and Behavioural sciences;
   ii. Teaching of Medical ethics including clinical ethics;
   iii. Communication skills;
   iv. Rural Orientation Programme (ROP) at preclinical level and Community Health Awareness Programme(CHAP) at clinical level;
   v. Many timetables in training were problem oriented;
   vi. Retreats for medical students;
   vii. Issue based seminars;
   viii. Clinical postings at night to get experience of emergencies;
   ix. Summer vacation assignments

7. Curriculum content was being determined/modified by local morbidity survey.

8. Promoting Health and Development interaction at the Mugalur Health and Development Training Centre including the Mahila Vikas Project (womens development programme).

9. Tutorship scheme for students.

10. Orientation to alternative/indigenous systems of medicine.

11. Rural placement/bond scheme after internship.

12. Regular colloquia for alumni doctors and community health workers.

13. An Internship orientation programme.

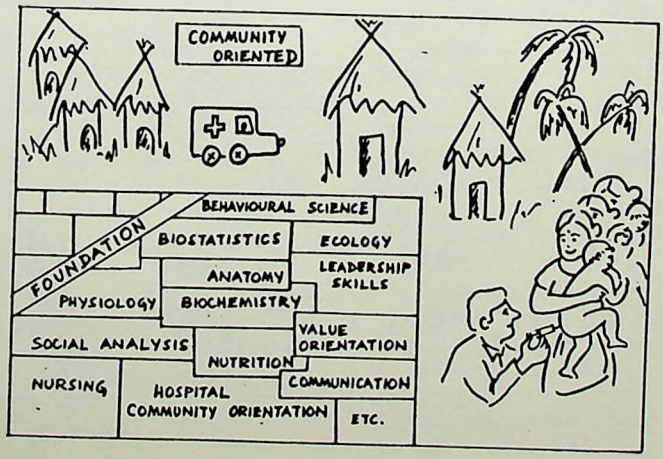
14. Internship postings to plantation health services.

15. Internship posting to other voluntary agency/NGO projects.

16. Evaluation of effort including attitude assessment.

(From O.H.P. sheet presented at workshop. For further details, write directly to Medical Education Cell, St. John's Medical College, Bangalore-560 034. For some of them also refer to Faculty Resource Book evolving out of CHC Project).
-Ed.

* * * * *



8-D. INNOVATIONS AND EXPERIMENTS IN THE MEDICAL COLLEGES OF RAJASTHAN* (1975 - 1992)

I. Project / Group Exercises

In late seventies project exercises were started at Medical College, Jodhpur and Jaipur. Students from VII semester onwards were clustered in group of four each. Each group was given a study topic to be conducted in the field practice area attached to the Preventive and Social Medicine Department. This exercise was to be completed in the six months period and was to be presented by one of the member of group of four. The project report was prepared on set lines i.e., introduction, objectives, review of literature, methods, observation, discussion, summary and references if any. These reports were usually typewritten and submitted in the Department. Most of these studies included a sample of 25-50 families.

Some examples of topics of study:

1. Determination of prevalence of malnutrition in the community.

2. Dietary survey in 50 urban families.

3. Prevalence of Anemia in pregnancy (SMS MC, Jaipur / SNMC, Jodhpur).

II. Integrated Teaching of Maternal and Child Health/Family Welfare (MCH/FW) to undergraduates

It was again in the late seventies that Government of India in collaboration with WHO took up a project on integrated teaching of MCH/FW to medical undergraduates. To begin with heads of Obstetric/Gynaecology, Paediatrics and Preventive and Social Medicine were trained at WHO recognised training centre for this Project - Ahemadabad/ Trivandrum. Group of these three senior teachers were to initiate the integrated teaching of MCH/FW, fitting into the existing curricula. Because of being busy in various assignments by virtue of their senior positions, these trained Professors could not do much except trying to motivate their subordinates through informal discussions. Almost 12-18 months later when a questionnaire arrived from Ministry of Health and Family Welfare, there was a stir. To complete the formalities an ad-hoc integrated teaching programme was formulated in which junior faculty members were to sit together and teach students on various MCH/FW issues. Since most of these junior teachers were neither properly briefed by the trained

*Dr. Shiv Chandra, Associate Professor, PSM Department, Medical College, Ajmer.

professors on the concept of integrations nor were they mentally prepared to share their teaching competance/skill, this project eventually fizzled out (JLN MCA).

III. **Family Care Exercises for undergraduates and its liberalization**

In all the Medical Colleges of Rajasthan, it became a convention to allot a family to medical undergraduates. Students are using many predesigned protocols in the shape of 'Family Health Advisory Notebook' to conduct such a study. Families for this study were allotted to the students in the field practice area of PSM Departments. Supportive help to the students was given through paramedical workers posted in the Field Practice Area, as these workers were always in good laison with the community. Over the years this exercise started losing its importance at Field Training Centres for two reasons:

i. Repeated visits by novice medical undergraduates to a limited number of families always in afternoon became a source of annoyance for family members.

ii. A limited number of paramedical workers who were helping students became tried of these repeated exercise. Subsequently at Medical College, Ajmer, students were given the liberty to chose the families at their own. Most of the time students selected the family of their domestic servants or a known acquaintance amongst the poor persons who usually have a medico-social problem. Hostellers usually select a family living in college/Hospital campus, often of a wardboy or class IV of the college. This system is so far, working well (JLNMCA).

IV. NTTC Collaboration

Medical college, Ajmer, is regularly receiving a circular from PGI-Chandigarh (twice a year) for the course on Educational techniques for Health Professionals. Over last eight years only four teachers had gone and attended this course. First teacher who has gone to NTTC managed to call the NTTC faculty to hold a workshop on Evaluation. This was attended by about 25 teachers. Since the course of NTTC lasts for 10 days, most of the teachers express their inability to leave the town for such a long duration. Eventually one more workshop was organised in collaboration with NTTC, Varanasi. This led to lot of stimulation in the faculty about giving a facelift to the teaching programme (JLN Medical College, Ajmer).

..46

V. ASSORTED EXERCISES

i. A seminar for freshers entering in Medical College was conducted on the subject of expectations from Doctors by Society vis a vis why a new entrant wishes to become a Doctor. This seminar had two parts - first part being lectures by people representing various section of the society. This included a professor from academic college, an administrator, a paramedical worker, a trade union leader and an ordinary member of society like a rickshaw puller. Second part of the seminar was expression by the newly entering medical students on their perceptions on Medical/Health organisations and why have they opted Medicine as a career. This exercise proved a tremendous exercise and was replicated subsequently at another Medical College within the State (SMS MC, Jaipur/JLNMCA, Ajmer).

ii. In 1991, a debate was organised on the subject of "Private Practice amongst Medical Teachers: Promotor or Inhibitor in Medical Education" involving a wide range of medicos starting from undergraduate to senior professors. An equal number of entries were received for and against the matter. This debate was chaired by a very senior (retired) professor of the faculty. About 14 speakers placed numerous episodes and experiences to prove their contention. It was brought out through this debate that a combination of a good teacher and good practitioner is not so common but this was a fact that many teachers in Medical Colleges are not good teachers and it often happens that many times Teachers indulging into practice gain a reputation as good teachers. Therefore all that is required from a medical teacher is a teaching aptitude (JLN MCA, Ajmer).

This presentation of Dr.Shiv Chandra is marked by great realism and frankness and it highlights some of the obstacles to change highlighted earlier by the Study. However inspite of the constraints, the fact that even in government colleges (mainstream) some changes are being tried out is very heartening.

- Ed

8-E. CHRISTIAN MEDICAL COLLEGE, LUDHIANA

Dr. Mohan Verghese, Vice Principal presented a few highlights of Christian Medical College, Ludhiana's attempts at innovation. These included:

i. The college has set the goal of making its graduates - socially relevant, professionally competent and spiritually alive.

ii. In the selection procedures at undergraduate level, sponsorship from or commitment to go to a mission hospital is given preference in addition to academic qualifications.

iii. In the postgraduate selection - 75% of the weightage is given for rural work.

iv. Workshops for college faculty have been held in skills like problem-based learning. Inter collegiate workshops involving Dayanand Medical College, have also been held. While preclinical departments were initially resistant to PBL and other ideas, they have now changed.

v. Recently a WHO sponsored workshop on PBL for colleges of North India (north of Delhi) was organised.

vi. The college has been wanting to move to a new curriculum - not just a parallel track.

vii. During 1st MBBS, a months rural / hospital posting has been introduced to give students an opportunity to feel and solve problems of the community.

viii. Samaritan Medicine - an initiative to improve the listening, communication and inter personal skills of the students has been experimented with.

ix. The college has adopted a slum on the ash heap in the city for a new multidisciplinary community orientation and action programme. Medical, nursing and para medical students are posted together in batches to undertake several studies of the community and plan and initiative responsive action.

A more detailed report entitled "An educational experiment in Community Oriented Medical Education (COME) through Issue-based Learning Activities", is available on request from Principal, Christian Medical College, Ludhiana-1.

..48

8-F. THE CONSORTIUM OF MEDICAL COLLEGES (INDIA)

The consortium of Medical Colleges in India is a process facilitated by Centre for Education Development, Illinois, since June, 1985. It follows the principle of evolving strategies through research enquiry.

(Since two participating colleges in the meeting (CMC-Vellore and SJMC-Bangalore) were members of the consortium, the dialogue participants were given some orientation to the history, objectives and process of the Indian Consortium and the evolving role and initiatives of some of the participating colleges. This note is based on the OHP sheets presented by Dr. C. Kirubhakaran of CMC-Vellore, and Dr. Ragini Macaden of St. John's, Bangalore.)

The Indian Consortium of Medical Colleges facilitated by CED Illinois (Chicago) was the outcome of a request and linkage established by Prof. V. Ramalingaswami with CED Illinois in June, 1985, to help initiate curriculum innovations directed towards the new goals of Primary Health Care and 'Health for All by 2000 A.D.'. Dr. Mohan Garg of CED Illinois visited four institutions in India. In November, 1986, the consortium was formed with AIIMS-New Delhi, CMC-Vellore, JIPMER-Pondicherry and BHU-Varanasi as participants. A symposium was organised in March 1987 and 'Medical Education and PHC Need' - successes and failures.

The symposium recommendations outlined four major steps:

i. Initiate health service research;
ii. Identify health care needs to reform curriculum planning;
iii. Identify innovations based on inquiry;
iv. Develop strategies for implementation.

Phase - I

A consortium strategy was evolved which included the following logical steps:

i. Each institution will identify core faculty;
ii. This core will be enlarged within the institution;
iii. Some innovations will be identified, planned and introduced;
iv. These innovations will be evaluated.

In the first phase the four founding institutions developed certain instruments for Health Services Research:

i. AIIMS-New Delhi, studied the perceptions of patients and GPs role of doctor;

ii. BHU-Varanasi, identified core abilities perceived by students, postgraduates and faculty;

iii. CMC-Vellore, studied the morbidity and mortality patterns at PHC, Secondary and Tertiary care levels and also studied the perceptions of students, recent graduates, faculty and medical superintendents of peripheral hospitals;

iv. JIPMER-Pondicherry, studied the perception of faculty about Health For All and Primary Health Care.

Based on the above enquiry, certain innovations were planned by each institution.

The innovations introduced by CMC-Vellore have been mentioned earlier. (Please refer 8-A).

After the first phase the consortium of four would grow by the addition of four more institutions. Each founder member would identify and work closely with another medical institution. This linkage will be operationalised through regular site visits. This will form the Phase II of the process.

PHASE II

After the successful completion of Phase I, the next phase was initiated by the four founding members identifying their twins. These are St.John's Medical College-Bangalore (by JIPMER); Siddartha Medical College (by CMC-Vellore); Cuttack Medical College (by AIIMS-New Delhi); and Gwalior Medical College (BHU).

The next process will involve the four new institutions in studying their present department wise curriculum and then planning, implementing and evaluating innovations which will be scrutinized and supported by the core-twin throughout the process. This will be done by site visits and meetings and the comments on reports submitted on a regular basis.

In May, 1992, at Delhi, a meeting was to be held when each of the four new members were to present:

i. Morbidity/mortality data of region to determine Health needs;
ii. List of skills expected of a medical graduate;
iii. List of topics considered redundant in each discipline; and
iv. a innovation each eg., SJMC-Bangalore, has selected the introduction of Clinical Ethics as its innovation.

The survey of skills in St. John's Medical College included

i. the skills learnt/taught presently;
ii. the skills required to pass the examinations;
iii. skills required in a primary health care situation.

From these lists the mismatch of what is taught and what is needed was determined.

List of lectures, practicals, tutorials and bedside teaching topics from each department including redundant topics provided insights into how we could integrate.

The topics and curriculum on clinical ethics was to be developed by the results of a questionnaire.

Outcome: Based on these enquiries each institution was requested to:

i. prepare a core curriculum;
ii. list of skills as decided at consortium to be used for training;
iii. study graduates and teachers perceptions of skills and how to implement it;
iv. to prepare a modular approach to the teaching of Jaundice.

Progress

At SJMC-Bangalore, the progress of this effort will be:

i. Meetings with preclinical/paraclinical and surgeons/physicians on the faculty to sensitise all faculty to National Health Policy, MCI Regulations and the Draft National Policy for Health Sciences Education (Bajaj Report);

ii. Preparation of core curriculum based on National Health Policy;

iii. Preparing a module on jaundice and implementing the teaching of it and evaluating the use of the module.

The findings will be submitted at the meeting in December, 1993.

*****

A meeting in February, 1994 at CMC-Vellore is scheduled. Core curriculla develcped by the 'North group' and the 'South group' will be integrated and presented for consideration. For further information, write to Centre for Medical Education Technology, All India Institute of Medical Sciences, Ansari Nagar, New Delhi - 110 029.

8-G. VHAI'S ROLE IN RATIONAL DRUG USE EDUCATION IN MEDICAL COLLEGES*

VHAI's (Voluntary Health Association of India) involvement with Medical Colleges, their students and faculty has been mainly in relation to Rational Drug use as part of the activities of the Department for Peoples Education for Health Action and the larger Rational Drug campaign.

For long we had attempted to draw in faculty members and medical students into some of the major debates related to drugs and health policies, as these were being formulated.

It has become evident over time that medical colleges kept aloof from all these issues resulting in the pharmaceutical industry, trade etc., influencing drug policies to safeguard their own vested interests.

1. The initial interactions had been with certain medical colleges faculty concerned about Rational Drug use and we worked closely with them:

   i. AIIMS-New Delhi: Dr. O.P. Ghei, (Paediatrics Department) organised a National workshop on the Rational use of Drugs in paediatrics. The issue of Rational Drug Policy was discussed with the Drug Controller etc., and drug activists to highlight the complexities, the priorities and areas requiring urgent intervention.

   ii. Gorakhpur Medical College: With Dr. G.P.Mathur (Department of Paediatrics) a workshop on 'Protecting the Child consumer'was organised in Gorakhpur Medical College to focus on Baby foods and pharmaceuticals and the need for policy intervention and the linking up of medical colleges with health and consumer groups.

2. Role of Medical Colleges in EP campaign & EP Hearings

   In the campaign against high dose Oestrogen-Progesterone combinations (being used for pregnancy testing for inducing as well as preventing abortion, bringing on delays and regularising periods) it was basically the health consumer and women's groups that had played the leading role.

   Except for the involvement of a few medical faculty members to support the consumer stand during the EP hearings in Calcutta, in most other places the Obstetrics and Gynaecology faculty members besides academic bodies, members of FOGSI (Federation of Obstetrics and Gynaecological Societies of India) were brought by the pharmaceutical industry to support the industry stand.

..52

*Dr.Mira Shiva, Peoples Education for Health Action, VHAI, New Delhi.

The drug was ultimately banned but the process of getting it banned clearly showed the relationship of medical colleges and faculty with the pharmaceutical industry, who often sponsor the conferences. VHAI has attempted to get these institutions to look at their relationship with the pharmaceutical industry, which can undo what is taught by way of pharmacology and therapeutics.

3. Involvement with issue of Iodine Defficiency Diseases

We have been focussing on the IDD problem in the endemic areas of East Uttar Pradesh, Bihar, Garwhal area. An attempt was made to link the community medicine department of AIIMS with the peripheral institutions for iodised salt testing and for helping out in training and field study.

4. Rational Drug Use Workshops in Medical Colleges

These were organised in the past 3-4 years. The objectives were:

i. To involve medical colleges in societal issues related to Rational Drug use and Rational Health Care;

ii. To link up socially conscious medical college faculty with consumer and health activists, NGOs in health, socially conscious journalists and lawyers to form a local core group of concerned individuals to provide support to such efforts;

iii. To encourage medical colleges in being involved with policy intervention activities and communicate their views, and stand on issues related to Rational Health Care;

iv. To recognise the major problems related to so called 'scientific medicine' so as to seriously consider alternatives;

v. Strengthen state VHAs by linkages with medical colleges to help build resource centres/pool - by way of information clearing house in different regions and in regional languages.

Experience has shown that rather than dealing with medical colleges in different parts of the country, it was better to focus on different regions where linking up with other support groups was possible - eg., where the State VHAs were willing to be involved in follow up work and where linkages with drug activists, health activists and consumer activists was possible. We therefore decided to focus on Andhra Pradesh and Karnataka.

In Andhra Pradesh, Rational Drug use workshops were conducted

along with Community Medicine Departments, Pharmacology Departments and in one place with the Students Union as well.

The colleges were:

i. Osmania Medical College-Hyderabad;
ii. Gandhi Medical College -Secunderabad;
iii. Kakatiya Medical College-Warangal;
iv. Tirupathi Medical College-Tirupati;
v. Siddartha Medical College-Vijayawada.

In Karnataka meetings were held in Government Medical College, Bangalore and Al Ameen Medical College, Bijapur.

The learning experiences from these meetings/workshop were many:

1. Most institutions and faculty themselves had never been exposed to issues related to Rational Drug Use and Rational Drug Policy and hence expecting them to incorporate the issues in Medical Education did not arise.

2. A few socially conscious individuals existed in every institution who felt intellectually isolated and wanted to do something socially relevant. They needed to be linked up with like minded people outside the medical college, to build a critical mass for collective action.

3. Interaction with field personnel is very important to inject a dose of social reality and issues such as Rational Drug Use opens up the very rigid medical structure to recognise the existence of some of these broader concerns.

4. It was very important to involve medical students in some of these issues as some of them were quite idealistic eg., Public Health Activist Group from Coimbatore Ayurvedic Medical College.

5. It also became clear that some of the health related concerns must be dealt formally or informally by medical colleges - so that some of the distortions must be handled by the institutions themselves.

6. Increasing dissatisfaction by the public of the medical professionals was becoming abundantly clear and in view of the failure of MCI etc., to look into these issues, consumer concerns would have to be dealt with in consumer forums and consumer courts. The medical college faculty must be challenged to address this lacunae.

7. The resistance from colleagues from clinical departments

whose prescription practices are questioned can be extremely demotivating and therefore these individuals must be linked up not just with alternate drug and health but other networks as well.

8. Whenever medical students were involved in prescription analysis, promotional material analysis, they were much more receptive to the analysis results.

9. Use of video films, slides, samples of drugs rather than writing materials was appreciated. eg., use of Newstrack documentaries on Kalazar, Japanese E enceptialities, IV fluid tragedy in Delhi, Sura tragedy in Delhi, Blood banks and professional donors, loperamide issue, etc.

10. Involvement with institutions such as JIPMER-Pondicherry and CMC-Vellore as part of the campaign for Rational Drug Use has been very useful and we welcome more, such meaningful institutional linkages.

*****

"Eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug-producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health"

- - ICMR/ICSSR (1981)
Health for All - An alternative Strategy

8-H. THE MIRAJ MANIFESTO *

I. PREAMBLE

Many of the causes of the glaring deficiencies in the health care system in India lie outside of the traditional domain of doctors. Yet, one of the factors that could promote a change for the better is a purposeful training of the medical graduate for the provision of health care appropriate to the needs and socio-economic realities of the Indian situation.

Previous attempts to evolve such an alternate pattern of medical education have had limited success and some of the limiting factors can be identified. Well-established medical colleges have a formidable inherent resistance to radical reorientation. Most of the Indian medical colleges are funded and administered by the government. In such an interlocked system, it is difficult for even new colleges to acquire sufficient autonomy in the selection of suitable students and in the selection, training and retention of faculty, guided only by the objectives of the new programme.

In the light of these considerations, the management of the Miraj Medical Centre has now committed itself to develop a new, self-funded medical college with the necessary independence in the selection of students and staff, with the objective of training "appropriate" doctors especially for service in the network of Christian hospitals.

This Manifesto is a preliminary working document summarising the present perceptions of the small faculty currently available in Miraj. It is prepared as a basis for further discussions among the staff and the management at Miraj and for eliciting the suggestions and support of others interested in the development of "appropriate" medical education in India.

II. OBJECTIVES

A. The primary objective of the training programme will be to produce a doctor able and willing to play his role in appropriate health care in the disadvantaged rural and urban communities of India. This orientation should not exclude the graduate from any of the other avenues currently open to Indian medical graduates, including specialisation and research. The major desired change is a commitment to the promotion of health and the

---

* Dr. P.Zachariah, Co-ordinator, Medical Project, Miraj-416 410.

..56

prevention of illnesses in the community, while also being proficient in curative care thoughtfully adapted to the limitations of resources and facilities. At least 50% of our graduates must be inclined to serve in this way, for a major part of their professional lives. They should:

1. be able to:

   a. identify the health problems of the community they are connected with;

   b. resolve them through planning, implementation and resource mobilization; and

   c. evaluate their progress.

   This will include effective health education, motivation and managerial or team leadership skills.

2. be familiar with, and reasonably competent in, medical care at the secondary level outside the teaching hospital, in rural and disadvantaged urban situations.

3. be competent and proficient in delivering sound scientific medical care, their knowledge and skills being prioritised by considerations such as prevalence and harmfulness of diseases, and availability, affordability and cost effectiveness of the therapeutic measures.

4. be used to incorporating socio-cultural and behavioural aspects in analysing the causation, and in deciding the management, of illnesses.

5. be skillful in problem based, self-directed learning, able to identify the knowledge base necessary for solving unfamiliar health/medical problems and to acquire it on their own.

B. In addition, the new curriculum should also aim to reinforce the following capabilities which are inadequately emphasised at present:

   1. Recognition of the proper place of prevention, referral and rehabilitation in clinical management.

   2. Awareness and utilization of the whole work team as the effective instrument, the doctor himself assuming leadership where appropriate. Inclusion of the patients/family/community as active participants, rather than passive beneficiaries.

3. Skill and sympathy in both listening to, and communicating with, patients and others.

4. Personal and professional integrity; concern and respect for patients and colleagues.

5. Aptitude for recognizing, and seeking solutions for, unidentified or unresolved problems in patient care, community work or in the health care delivery system.

III. METHODOLOGY

The following methods are considered necessary for achieving these objectives, especially the ones under [A] above:

A. Student Selection

Selection of candidates has to be entirely by the Institute based on criteria most likely to fulfil our objectives; one criterion could be performance in a pre-selection training programme.*

B. Staff

1. Orientation of staff to the objectives by initial and ongoing training will be important. In the selection and promotion of staff, suitable weightage should be given to proficiency in, and commitment to, their "teaching" responsibilities.

2. Medical and non-medical staff in the periphery will also be "faculty". But faculty from the tertiary centre will also give not less than 25% of their time to teaching and service at the periphery.

3. Development of source material for "problem presentation" and for learner-centred study will be an important initial and ongoing responsibility of the faculty.

C. Duration of the course

*If necessary, the duration of the course may be increased by upto twelve more months, perhaps also as a pre-selection training/orientation programme.

D. Curriculum and training

1. From the beginning of the course, the students will be exposed to and involved in medical/health care situations at all levels, but specially at the periphery.

2. The students will be introduced, as early as possible

to self-directed and learner-centred education with progressive reduction of teacher-centred transfer of knowledge.

3. Learning will be organised increasingly around problems and situations, rather than disciplines.

4. Fifty per cent of the "practical" work of students will be outside the teaching hospital, in health facilities at the primary (25%) and secondary (25%) levels. Development of this peripheral network should be the first task in starting the Institute.

5. A major emphasis in all the learning situations will be the development of competence and proficiency rather than mere acquisition of information. For this, the curriculum will provide for increasing participation of the student in professional activities at all levels of health/ medical care.

E. Evaluation

1. Every module or type of learning experience should be evaluated by the students and faculty against the objectives. Also, the participation and progress of the students should be continuously monitored with adequate feedback to them.

2. There should be periodic evaluations of the progress and effectiveness of the whole programme by an external agency.

*The Preselection Sandwich Programme

The present position of the Medical Council of India is that even innovative programmes should conform to the pattern of the subject-based I? II and Final MBBS examinations. So the group favoured a one year preselection training/orientation course preceeding the 4½ years MBBS programme. Only students who fulfil the minimum requirements for admission to the MBBS course should be selected for this sandwich course. During this selection course:

1. The students should receive a good exposure to what community oriented Medicine really means and what the role of the doctor is in such an approach. They can then decide with greater understanding whether they wish to be trained for such a career.

2. The college can also assess the candidates for their suitability for such a programme in terms of their maturity, motivation and commitment.

3. The candidates should also acquire the following knowledge and skills to prepare them for the proposed "innovative" MBBS programme:

   a. Working knowledge of local language

   b. Knowledge of English sufficient for acquiring necessary information from standard sources.

   c. Basics of the following three Bs:

      i. Behavioural Sciences;
      ii. Biostatistics;
      iii. Biology (human) - This is to facilitate problem-based, student-centred learning from the first year of MBBS.

***
***
*

The CHC Project was a preliminary step to identify and collate researched resource material for a faculty development process at the proposed new Medical College at Miraj which got the green signal in June, 1992. However due to the capitation fees medical college related crisis, the Supreme Court cases and the aftermath including the new Central Ordinance, this Project could not start up. We however hope that the 'Miraj Manifesto' and all the publications of the CHC Project will be resource materials for all those who are keen to initiate an alternative track (experimental parallel curriculum) - sometime in the future when the climate for such an experiment evolves.

-Ed

8-I. THE NIMHANS INITIATIVES IN MENTAL HEALTH TRAINING

Dr. Mohan Isaac shared that though NIMHANS* was not a medical college but an autonomous National Institute of excellence, it had been concerned about the problems of mental health at the community level for a long time and equally concerned about the inadequacy of Mental health / psychiatry teaching in present day medical education.

There was adequate evidence that Mental Health related problems was an important unmet challenge in Primary Health Care. 20-25% of attenders of a PHC clinic were somatizers with psychosomatic - emotions - psychosocial problems. Epilepsy was as common as 15-20 / 1000 and psychotics about 2-3 / 1000. This implied that doctors, nurses and health workers involved in Primary Health Care should have some preparation and skills to deal with these problems.

Many medical colleges did not have a Department of Psychiatry as yet and some who had them - had a one person department.

Most students got 15 days posting at a Mental Hospital. Examinations in psychiatry were most often just a short note in the Medicine paper.

NIMHANS had over the years systematically launched a pilot community mental health project; then extended it to a district; then evolved the National Mental Health programme; then evolved various training programmes for health professionals and workers at various levels; and prepared manuals for different grades of workers. In addition it had facilitated some meetings on the content of psychiatry in Medical Education and made recommendations.

NIMHANS welcomed requests by institutions and organisations for reorientation and skill training in Community Mental Health.

*****

Manuals on Mental Health Orientation and Training for all levels of Health Care/ types of health workers are available from: The Director, NIMHANS, Hosur Road, Bangalore - 560 029, on request.

* NIMHANS - National Institute of Mental Health and Neuro Science, Hosur Road, Bangalore - 560 029.

8-J. AN ALTERNATIVE MEDICAL SCHOOL

THE GONOSHASTHYA MEDICAL COLLEGE PROJECT

Dr. Zafarullah Choudhury of Gonoshasthya Kendra Project, Bangladesh, shared the background in Bangladesh in the context of which the idea of alternative medical college had been evolved and also shared some of the salient features of the suggested framework of the strategy.

* The poor were getting poorer. The state was preoccupied with the political instability and the frequent breakdown of law and order. Health care services had deteriorated due to bad planning, growth of commercial sector and in the bargain even a small sickness was becoming a major crisis in the lives of a person or a family. Due to human greed, malpractice and corruption had increased and some 'unthinkable' forms of private practice had become common. The World Bank and IMF pressures to privatise and globalise the economy was worsening the situation further.

* Against this background GK Project had initiated a action to evolve a scheme to train students selected from already existing nurses and paramedics cadre for the role and function of doctors.

* The students would live in the community and be responsible for some aspects of health work.

* Collecting learning would be stressed.

* The students would work as nurses for 3 months in 1 year.

* Preventive medicine would not be taught in isolation but integrated with all other aspects.

* Communication skills will be developed.

* The political role of the doctor would be emphasised.

The Project had been on the anvil for a long time but due to various local problems and some resistance from the medical professional lobby - it could not take off as yet. He expressed his enthusiasm for all the ideas and resource materials generated by the CHC Project and looked forward to utilizing them as a complementary support to their ongoing planning.

*****

8-K. THE CHRISTIAN MEDICAL COLLEGE NETWORK

Prof. V. Benjamin presented a short review of the evolving CMC Network giving some background and the key issues discussed at the meetings of the Network.

* The Christian Medical Association of India (CMAI) is the oldest network of health institutions and hospitals in the country. It has two medical colleges as members and numerous training centres for nurses and the allied health professionals. More recently the Miraj Medical Centre (Wanless Hospital) has been initiating a process to develop the third Medical College in the Network (see 8-H).

* The Catholic Hospital Association of India is the second oldest network of health institutions established in 1943. One of its earliest objectives was to set up a medical college to propogate christian values is health care. St. John's Medical College was established in 1963.

* In 1986-87, the CMAI initiated a process to explore the possibility of CMAI and CHAI and the four medical colleges under 'Mission' auspices to come together in a spirit of dialogue and to reflect on the past, present and future together in the context of the health situation in India, the emerging needs and the increasing challenges to be socially relevant and community oriented.

* The first meeting of this informal network was in August, 1989. Dr. Ravi Narayan gave the keynote address in which he presented a birdseye view of Medical Education in India and the attempts at reform and initiatives towards an alternative. He also presented some key issues and challenges for the consideration of the Network.

* The first meeting also had presentations of reflective and interpretative histories of each of the 4 CMCs and their own initiatives, directions and experiments,to help the participating colleges to get a deeper understanding of their goals.

* The second meeting in March, 1990, was devoted to exploring together what was 'christian' about a Christian Medical College (in other words what was the mission of a college under church auspices). The meeting also explored the concepts of Health, healing and wholeness.

..63

* The third meeting in March 1991, explored Ethical issues in Health care including in clinical practice and more recent dilemmas such as organ transplantation.

* The fourth meeting in March, 1992 explored the ethical responsibility of medical colleges especially in the ethos of unequitable distribution of resource including health care in the community. A collective statement on Health Care-ethics was prepared called the whitefield document. At this meeting St. John's Medical College also presented its experience of teaching Ethics to medical students.

* This Network has initiated a process of questioning of the roles and goals of medical education in the Christian Medical Colleges all of which are among the top medical colleges in the country known for excellence and quality of medical education. While the ethical dimensions have been adequately focussed upon, the social justice dimension has not yet been adequately considered.

* The Network offered peer support to the CHC Project which incidentally arose as an offshoot of the first meeting since many CMC Network members discovered, they knew so little about the Indian experience, which the keynote address had described. The Miraj Medical Centre was particularly interested since it wanted to build its alternative experiment strongly on Indian experience and on ideas that had been tested out in reality. The CHC Project therefore emerged as the preparatory and preliminary step for a Faculty Development Process for such an alternative/experiment.

***

For further information regarding Network meeting minutes and background papers, write to:

Christian Medical Association of India,
Plot No. 2, A-3 Local Shopping Centre,
Janakpuri, New Delhi - 110 058;

or any of the Christian Medical Colleges.

..64

SESSION IV

9. REPORT OF DAY ONE - JUNE 20, 1992

- By a participant

Medical Educators Review Meeting organised by Community Health Cell started at 9.30 A.M. At the very outset Dr. Ravi Narayan requested each participant to concentrate on the talisman by Mahatma Gandhi - "Whenever you are in doubt recall the face of the poorest and most helpless man whom you may have seen and ask yourself if the step you contemplate is going to be of any use to him ..... will it restore to him a control over his own destiny?".

This way of opening a meeting sensitised every participant on the seriousness of the subject they were going to discover and explore together.

Then in a self introductory session, participants expressed their feelings and expectations of the workshop. It appeared that Medical Education was a cause of concern for each and every individual and everybody in his own or her own way was comitted to bring a change for good in Medical Education. The other heartening thing about the group was that there was a representation from most of the disciplines of faculty of Medicine starting from basic science like physio and Micro to superspecialities like Cardiothoracic and Plastic Surgery, Feathers in the cap of this CHC meeting was added by the presence of senior Professors who had been involved in Medical Education for 3-4 decades and also by persons from related health organisations working for the Development of Health Care and Human Power Training Strategies in the voluntary sector in India.

The group of 29 participants was joined by three more participants who arrived after the first session.

Dr. Ravi Narayan then introduced the subject of the meeting briefing the participants on the medical education scene in India. He emphasised the need and relevance of a ballonistic research which helps to build an overview of the problem and the situation. Also the need to identify responses and solutions to turn off the tap of diseases and bring a community health orientation in the transplanted Western model of Medical Education in this country. He outlined the process to study the situation and explore the responses by medical educators in India.

Dr. Thelma Narayan highlighted, through transparencies, the sectors of innovation in medical education, their

..65

contribution to orthodox Medical Education and the emergence of alternatives. She stressed that organisation engaged in the advancement of medical education need to be re-energised mentioning IAAME in particular. This was possible by greater focus on Indian experiments and promoting greater networking in the efforts.

In succession Dr. Shirdi Prasad Tekur placed his lucid and comic illustrations on the subject through caricatures/cartoons depicting the ills and challenges of Medical Education. It reminded me of the book of dialogue by David Morley, entitled 'MY NAME IS TODAY' - an interesting document often utilised in the training of health professionals. Many of these drawings of Dr. Shirdi Prasad were going to be used to animate the CHC publications arising out of the Medical Education Project.

Then Ravi Narayan reviewed the finding collected from 25 Medical College who responded to the letter of CHC. He outlined the examples of pace setters, the obstacles to change and set out some challenges before all of us. This was followed by a discussion.

In the post lunch session different participants shared the experience of different institutions/organisations.

i. Dr. Kirubhakaran from CMC-Vellore, presented the innovations proposed through consortium of inquiry driven strategies in Medical Education focussing on CMC-Vellore's efforts.

ii. Dr. Shubha Desai from Smt.NHL Municipal Medical College-Ahmedabad, highlighted how a small group of trained teachers from NTTC formed a cell to renovate curricular and academic programme in that college.

Dr. Mohan from Christian Medical College-Ludhiana, Dr. Shiv Chandra from Jawaharlal Nehru Medical College-Ajmer and Dr. Dara S. Amar,(St. John's Medical College-Bangalore and Dr. Vasundhra from Government Medical College-Bangalore, then presented the experiments performed or being conducted in their institutions. The Chair person Dr. Alfred Mascarenhas summarised the session at the end by stressing

i. that experiments are more possible where one has relative autonomy, but it is heartening to note how much has been attempted even in the absence of it;

ii. that unless we share our failures and not only our success we cannot learn from each others experiments and initiatives.

In the last session of the day,presentations were made by

people who were not in medical colleges, but were representing the organisations who were highly concerned about broader health and social issues including the production and utilisation of Doctors. They included:

1. Dr. Mira Shiva, VHAI-New Delhi, who outlined the efforts to promote Rational Drug Therapeutics education in Medical Colleges.

2. Dr. Zafarullah Chowdhry, Gonoshasthya Kendra Project, Bangladesh, who shared about Gonoshasthya Kendra's efforts to evolve a more relevant doctor/medical education course for Bangladesh.

3. Dr. P. Zachariah (MMC-Miraj), who shared the key process of evolving the Miraj Manifesto - which was the blue print for a alternative medical education project initiated by Miraj Medical Centre (A request was still pending with Maharashtra Government).

4. Dr. Mohan Isaac (NIMHANS-Bangalore) shared about their efforts to improve the community mental health knowledge and skills of existing health human power at all levels.

5. Some reflections on the Consortium of Medical Colleges evolving curricular change by research inquiry (by Dr. Ragini Macaden on St. John's Medical College).

6. Some reflections on the CMC Network that has been meeting annually since 1989 (by Prof.V. Benjamin, Ex. CMC-Vellore).

The sessions on the first day provided all the participants with a rich stimulus of inspiration and information.

--- Dr. Shiv Chandra, Ajmer.

* * *
*

"THE GREATEST CHALLENGE TO MEDICAL EDUCATION IN OUR COUNTRY IS TO DESIGN A SYSTEM THAT IS DEEPLY ROOTED IN THE SCIENTIFIC METHOD AND YET IS PROFOUNDLY INFLUENCED BY THE LOCAL HEALTH PROBLEMS AND BY THE SOCIAL, CULTURAL AND ECONOMIC SETTINGS IN WHICH THEY ARISE".

- SHRIVASTAVA REPORT, 1975.

"THE ENTIRE BASIS AND APPROACH TOWARDS MEDICAL AND HEALTH EDUCATION AT ALL LEVELS SHOULD BE REVIEWED IN TERMS OF NATIONAL NEEDS AND PRIORITIES AND THE CURRICULAR AND TRAINING PROGRAMMES RESTRUCTURED TO PRODUCE PERSONNEL OF VARIOUS GRADES OF SKILL AND COMPETENCE, WHO ARE PROFESSIONALLY EQUIPPED AND SOCIALLY MOTIVATED TO EFFECTIVELY DEAL WITH DAY TO DAY PROBLEMS WITHIN THE EXISTING CONSTRAINTS".

- NATIONAL HEALTH POLICY, 1982

SESSION - V

10-A. GRADUATE FEEDBACK ON MEDICAL EDUCATION - AN EXPLORATORY STUDY

Preamble

Eversince the freedom movement in India and the attainment of national Independence in 1947, it has been the stated intention of national level professional bodies, expert committees and several medical colleges to mould medical education to suit the specific needs and circumstances of the majority of the population in India.

A study undertaken by the Community Health Cell of Bangalore in 1990-92, reviewed the past four decades of Indian experience in evolving and implementing strategies to make Medical Education socially relevant and community oriented. As an integral part of this exercise, feedback from medical graduates who had work experience in peripheral health institutions (PHIs) in the country was obtained. This was to elicit their opinion regarding the adequacy of the undergraduate medical curriculum, as preparation for the professional work that they had to carry out at the PHIs.

This aspect was undertaken as an exploratory study the therefore used an open-ended approach. The goal was to identify broad areas that could be studies later in greater detail, possibly by each of the different disciplines as part of a process of evolving relevant curricular change based on a method of enquiry and on data collection. Thus it was done with the hope that medical educators would take note of the findings and develop them further. It is an effort to link up experience in the health services and feedback arising from involvement in health/ medical care, with the system of medical education, so that in the natural process of growth and evolution they could be mutually supportive in the common search to be relevant to the health needs of people.

The following is some key aspects of the Study as presented by Dr.Thelma Narayan on OHP sheets at the Meeting.

For further details and findings, you can refer to the Report entitled: 'Evolving Medical Curriculum through Graduate Doctor Feedback' by T.Narayan and R.Narayan, published in March, 1993 (Now available from CHC).

-Ed

..69

Objectives

The objectives of the exploratory study were as follows:

a. To elicit feedback on all the major aspects of the undergraduate medical course;

b. To identify in the undergraduate medical curriculum,

i. areas that were useful, relevant and adequate;
ii. areas that needed further strengthening;
iii. areas of lacunae;
iv. areas that could be reduced or deleted.

Methodology

a. Questionnaire

As an instrument of study a questionnaire was developed. The different aspects of medical education on which it elicited feedback were:

i. all the preclinical, paraclinical and clinical subjects, including medical ethics;

ii. additional skills in patient care and hospital work like nursing, management, communication and training;

iii. other related aspects like selection or admission procedures, teaching methodology or pedagogy, curriculum structure, examination system, base of teaching,etc.

A total of thirty seven (37) different aspects were covered through open ended questions.

Information was also collected about the respondents work experience viz., location of the peripheral health institution, nature of medical/health activities, type of facilities available, distance from nearest referral centre, etc. This was to build up a profile of the background of work experience based on which the feedback was being given.

The design of the questionnaire, including choice of aspects to be studied, was based on previous experience of a workshop on Medical Education held in 1984 for medical graduates working in PHIs. We also held a group discussion at the onset of the study for this purpose with a group of ten medical college teachers who had all worked in PHIs earlier. Several other personal interactions and experiences were also useful.

..70

The questionnaire was pilot tested on 10 respondents. Modifications were made based on this, as well as on comments by the advisory committee.

b. Sample

The criteria for the respondents were as follows:

i. That they had graduated from any Indian medical college during the decade of the 1980s. This was to ensure that feedback received related to contemporary medical education. This was considered important, as over the decades several modifications have been made.

ii. That they should have completed a minimum of two years working experience as a doctor in any peripheral health institution in India. This included work in Government Primary Health Centres or in community health programmes/small peripheral hospitals run by Voluntary Organisations. This was to ensure that they had first hand experience of understanding and responding to the health needs of people in rural areas and urban slums and had worked for a sufficiently long time to put their knowledge and skills to use in these circumstances.

The sample was not statistically chosen to represent any particular region or college. Finding respondents who fitted into the criteria given above was not easy and building a sampling framework was much less so. This was also at this stage only an exploratory qualitative subunit of a larger study. However we did try and get a mix of graduates from several different colleges. Eligible respondents were identified from applicants to postgraduate medical entrance exams where rural service was given special recognition, and from a meeting of a national group called the Medico Friend Circle (mfc).

Anonymity of the individual respondent as well as the medical college was maintained as we were wanting to study issues in the different disciplines along with other aspects of the undergraduate medical curriculum, and were not studying or evaluating any particular college.

The questionnaire was given/sent out to 120 eligible respondents. Of these, 78 were given out by the researchers and the remaining through contact people. The latter attempt was not very successful. One reminder was sent after a period of a month to the 78.

A profile of the respondents work experience in PHIs in India

1. Year of graduation

1980 - 84	- 40%
1985 - 88	- 57%

2. Geographical distribution

South India	- 73.5%
Rural	- More than 90%

3. Years of experience

Average	- 2 years, 10 months
Total	- 152.4 person years

4. Bed strength

Less than 50 beds	- 65%
51 - 100 beds	- 20%
More than 100 beds	- 15%

5. No. of Departments

1 (mainly general)	- 51%	
2 departments	- 14%	combinations of
3 departments	- 14%	obstetrics and
4 departments	- 7.5%	gunaecology, medical surgery, paediatrics.

6. Total No. of Doctors in PHI

1 Doctors	- 29%
2 doctors	- 20%
3 doctors	- 19%
4-6 doctors	- 11%
More than seven doctors	- 19%

7. Diagnostic facilities

Simple lab	- 30%
Simple lab + X-Ray	- 44%
Simple lab + X-ray+ECG	- 12.5%

8. Nearest referral facility

Less than 12 k.m.	- 30%
13-25 k.m.	- 19%
26-50 k.m.	- 26%
51-100 k.m.	- 14%
More than 100 k.m.	- 5%

..72

9. Average workload

A. Average outpatients/day

i. Less than 30 beds	- 49 per day
ii. 31-50 beds	- 85 per day
iii. 51-100 beds	- 115 per day
iv. More than 100 beds	- 207 per day.

B. Average inpatients admissions per day

3,12, 17, 25.

C. Community level programmes

i. community health	- 60%
ii. TB control	- 30%
iii. Leprosy control	- 24%
iv. Disability	- 11%

Overall Impressions

1. Need for skill development

in emergency medicine
basic nursing procedures
minor surgical procedures
obstetrics
local anaesthesia
running a simple lab and pharmacy
management
communication
assessing community health needs and evolving simple strategies to meet them.

2. Suggestions regarding curriculum strategies teaching methodology, etc.

- Integrated teaching with focus on clinical application, and common problems;
- Reduce details in theory - preclinical phase (anatomy, physiology, biochemistry) to 1 year;
- Introduce/strengthen psychology and sociology;
- Need to develop experience in basic nursing procedures;
- Responsibility and decision making capacity during ward work;
- Remove concept of 'short postings' as being relatively unimportant;
- Posting during final MB/internship to pathology lab, blood bank, pharmacy, MRD, accounts;
- Involvement during final MB/internship in training of health workers.

..73

3. Comments on examination system

"We are getting more and more exam oriented, while exams are getting less and less patient oriented".

Several felt that the sytem was subjective, unreliable, outdated, irrelevant to actual medical practice, and even unethical.

Suggested

- continuous assessment focus on common problems focus,on approach to diagnosis, MCQs for theory.
- several short cases with discussion.
- assess basic, necessary knowledge and skill

Feedback on Pre-clinical disciplines

1. Need for strong clinical orientation
   - to compare normal to the abnormal.
2. To integrate teaching
   - between preclinical subjects
   - and with clinical subjects.
3. To reduce time period from 1½ to 1 year
   - by deleting unnecessary detail
   - reducing time in Anatomy.
4. Intrcduce/strengthen teaching of sociology.
5. Introduce/strengthen teaching of psychology.
6. Intrcduce students to patient care in wards
   - learn basic nursing procedures.
7. Learn practical skills even at this stage
   - as above
   - first aid
8. Biostatistics - considered not very necessary.
9. Need to reinforce pre-clinical subjects during clinical years.
10. Need to develop healthy attitudes, life styles and values at this stage.

..74

Feedback on Para-clinical disciplines

1. Need to stress clinical and practical application.

2. Need ability to carry out/interpret routine investigations in pathology/microbiology.

3. To be skilled in blood banking procedures.

4. Need ability to support and supervise technical staff in laboratories.

5. In pharmacology - focus on
   - commonly and currently used drugs;
   - drug use in pregnancy, lactation, children;
   - drug interactions;
   - rational therapeutics;
   - cost effectiveness;
   - need for frequent continuing education.

6. Teach these subjects in the ward/community.

7. Reduce unnecessary detail eg., histopath, of uncommon diseases, drugs not in use, making of mixtures, experimental pharmacology.

8. Introduce postings in hospital pathology, laboratory, participate in blood donation camps/blood bank, discuss/ analyse prescriptions.

9. How to organize/run a small laboratory/pharmacy?

10. Enhance teaching of Forensic Medicine
    - poisons, snakebites, accidents, injuries;
    - certification of wounds, death, cause of death;
    - this aspect is becoming increasingly important.

Feedback on Clinical disciplines

1. Emergency Medicine.

2. Skill in procedures.

3. Clinical acumen, not high tech diagnostics.

4. Focus on common problems in India and how to manage them in PHI.

5. Student involvement and responsibility in patient care.

6. Integrate preventive and curative aspects.

..75

7. Use periferal institutions for teaching - OPDs/mobile clinics.

8. Enhance study of paediatrics.

9. Concept of "short postings" to be removed.

10. Importance of psychiatry, dermatology, orthopaedics, ophthalmology, ENT, radiology, dentistry.

11. All four primary clinical departments are very important, especially obstetrics, which is also the most tension producing.

Feedback on Community Medicine

1. Very important to work in PHIs.

2. Need better training.

3. More community based teaching, more field work.

4. Integrate curative aspects with PSM/CM.

5. Enhance practical training in Health Education, School Health, Nutrition, Occupational Health, Management, Epidemiology, Statistics.

6. Learn to assess local health problems and evolve strategies of intervention.

7. Need to experience the functioning of feasible programmes in the field.

8. Establish special cells to maintain links with doctors in PHIs.

9. Need committed staff with field experience.

10. Involvement in training health workers.

General Suggestions

1. Career guidance cell and preparation/orientation of graduates opting for rural service .

2. Sharing of experiences with undergraduates by those who have worked/are working in PHIs.

3. Visits of specialists to PHIs.

4. Internship postings to PHIs.

5. Introductory lectures on Ayurveda, Homeopathy, traditional health practices.

6. Sessions on different religious scriptures and their positive features regarding health.

..76

SESSION - VI

11-A. MEDICAL EDUCATION IN THE CONTEXT OF BHARATH (THE REAL INDIA)*

The trend of instability, unevenness and fragmentation of political development in India has shaped up with a vengeance at this point of time. A very conscious ideological and political strategy is at work, deliberately shut out from our people. We need a realistic understanding of what has gone wrong with our polity. There is a grim consensus that India is passing through a period of major crises : economic, political, social,cultural and religious The system has become inequitable and incapable of serving the people of India. Millions are unemployed and unchecked population growth continues to increase the number of hungry, desperate Indians.

India is a Developing Country

Whatever be the promises and the rosy picture painted of our country's growth and progress by our politicians and those in positions of power, we have to accept that India is still a developing country. Though it has good potential prospects for using more capital, labour and other available resources to support its present population at a high level of living, yet there exists in it an exploitation so oppressive that the vast majority of its people live at a sub-human level. It is very clear that more than 40 per cent of Indians, numbering more than 350 million, are living below the poverty line. Many are tumbling every year below this line, and one of the major reasons is the constantly rising prices of essential commodities.

What is the "poverty Line" which is the yardstick used to measure poverty? The Central Pay Commission has defined it has the "minimum required diet for a moderate activity". According to 1978 prices, the Boothalingam Commission had determined it to be Rs.53 per head per month. Today, in 1992, it will definitely come to at least about Rs. 200 per head per month. This is what would provide the minimum amount of calories, proteins and other nutrients that one needs in India to work normally.

Looked at from the perspective of economics, the people in India constitute a pyramid. At the top of this pyramid are the "rulers of India" made up of about 1 per cent of the households in our country. These are the financial kings of the country who decide or influence every decision made by those in political power so that their own vested interests can be served. These are served and sustained in their position by the technological and managerial elite who constitute 4 per cent of the population. The organised sector of the Indian economy, comprising the blue collar and white collar workers organised in powerful trade unions constitute 5 per cent. According to the Central Statistics Organisation estimates, this sector appropriates 33 per cent of

* Mr. Desmond A. D'Abreo, St.Joseph's Highlands,
Lower Bendur, Mangalore - 575 002.

the national income. Adding to the black income as well as open and hidden perquisites, the share of this total top ten percent of the Indian population may come to about 40 per cent of India's national income.

In the middle of this pyramid are 40 per cent of Indians who live around the poverty line. Each of these people can afford to have only 2,500 calories of food intake per day and the barest requirements of clothing and shelter, if at all. Down below at the base of this pyramid are 50 per cent of the Indian people, who cannot even afford to have a single square meal per day. They are the least articulate in the political, economic and social fields. All the Five-Year Plans, and scores of special programmes, like the Twenty Point Programmes, are framed for them, but they do not benefit from them, because whatever gains they may have made in terms of monetary earnings have been more than neutralised by the constant rising prices and by the exploitation practiced on them by politicians, traders, government officials, etc.

We really seem to be living in two Indias : One is the India of the 10 to 15 % per cent, the "ones who have made it", basking in luxury-oriented growth in advanced and privileged regions, comprising the caste, class and ethnic elites. The other is the poor, backwards, marginalised, people on or below the poverty line, living in the backward and consciously neglected areas, the Dalits, tribals and the landless labourers.

Erosion of Values

The onslaught of Capitalism and Modernisation have brought in a new set of values from the West which are in total opposition the human values that our Indian culture has inculcated for centuries. Founded on a communitarian culture, our values were those of sharing, cooperation and personal relationship. Even though caste differences were strictly maintained, there was an arrangement of harmony and collaboration among the people of a community. There was respect for nature and for living beings. But the new values that have invaded our society are competition, individualism, excessive profit motive, disregard for nature and environment and regard for prestige. This value system has pushed the Indian psyche towards hypocrisy which is one of the major roots of the corruption prevalent in our country. The tragedy is that these alien values are making rapid inroads into our villages and have created a whole culture of selfishness, consumerism, competition and rivalry which are intensifying the problems of underdevelopment and exploitation of our masses.

The Health Situation of our Poor

When we come to the health care of the people at the lower part of the pyramid, constituting about ninety per cent of the Indian population, we find a very grave vacuum. While we accept that we have a large number of doctors, nurses, midwives,

auxiliary nurses, health inspectors, hospital beds and PHCs, these persons and institutions are not really serving the poorest sector of society. Our health standards are still extremely low and the great majority of our people are vulnerable to disease. Communicable diseases are still rampant and the mortality rate is still 15.1 per thousand!

To be born poor in India means to be born unhealthy or to become unhealthy. One out of every four persons unnecessarily suffers from disease; this could have been prevented by improving the environment and by timely immunisation. The miserable health standards of the masses are a reflection of the overall conditions of life. Those who are living below the poverty line, ill-clad, undernourished, homeless, without sufficient drinking water and no sanitation at all, cannot avoid diseases ranging from T.B., leprosy, mental retardation due to malnourishment.

The medical personnel in India are not trained to cater to the masses, as one doctor recently confessed, "We are trained to practise abroad!" At the time of Independence, the Government of India decided to subsidise the training of medical graduates to the extent of 90 per cent so that there could be sufficient doctors to attend to our poor and unhealthy population. However, very many doctors migrate after obtaining their degree so that they can feather their financial nests beyond possibilities open in our country.

Medical aid is not within the reach of our poor, especially those who live in villages. The poor man has to walk miles before he can see a doctor or a poorly equipped or rarely manned health centre. 80 per cent of the doctors and 97 per cent of the hospital beds of our country are in the urban areas which have only 20 per cent of the total Indian population. The remaining 80 per cent are left to manage without any medical personnel or medical aid.

Very little attention is given to providing the rural people with facilities of drinking water. Till recently, out of 5.76 lakh villages, 4.55 lakh villages had some kind of water supply like hand pumps, conserved wells and springs. But in 1.16 lakh villages, water is still not available within a depth of fifty feet or a distance of a mile.

On the other hand, 83 per cent of the total urban population is provided with drinking water. A concrete example of the shocking disproportion of concern for city over village is a recent scheme for the renewal of the water supply in one of our major cities, which cost over thirty crores of rupees, while in that same time, absolutely very little is spent for providing water for Indian villages, in which the majority of our people are living!

To talk of sanitation would be still more meaningless, for while 38 per cent of the urban population are provided with a sewage system, there is practically no sanitation system for the

rural population.

To add to the extreme situation of the poor majority of our country, the new economic policy of the Government already has made the situation of the poor worse, and promises to intensify their sufferings. The Government has taken a loan from the IMF which has attached to it a number of conditions. Because of the pressure from this international organisation, the Government is definitely giving top priority to repaying the loan, or at least, trying to keep up with the servicing of this loan through the paying of interest This is a stupendous sum to be given away every year. This has automatically led to the tightening of belts and to increasing austerity - OF THE POOR!

One of the first results of this urgency to repay the loan will be the reduction of Government spending on the free services of health and education. We say this, because there is undeniable evidence in other countries that have taken this loan, that these are the areas in which spending is cut. As in these other countries, the free service or subsidy in health, education housing and other services will disappear in India. In fact, the last budget has already shown several cuts in this direction. The worst victims are the poor, who are unable to avail themselves of the services of privatised health, education, etc.

1. With the reduction of free health service for the poor, their health will definitely deteriorate. Malnutrition, sickness and death will be their constant companions. Tragically, it seems that we are soon reaching the point of no return in this area. To add to that, the communal demon is dividing the poor, so that they are unable to get together in an organised movement and fight or struggle for their rights with regard to health and other basic human necessities.

2. Rising prices have primarily hurt the poor. This has made food and other necessary amenities very difficult to obtain. The result is a greater malnutrition.

3. Financial resources are less available for proper housing for the poor. Hence the number of the homeless Indians will be on the rise.

4. Consequent on homelessness, is a mushrooming of slums. But with the Government's lack of concern in providing water, and other essential amenities to the slum dwellers, insanitary conditions is rampant, leading to a proliferation of diseases, especially of the stomach and skin, to which children will be the most susceptible victims.

5. Unemployment is reaching staggering heights leading to greater poverty, sickness, death...

Unless this policy is reversed, the nineties are going to become for us a lost decade for development. The tragedy of this is that in addition there will be a lost generation. Millions of

the poor children of our country will bear the scars of the crisis in the social sectors. They will suffer from the cutbacks of the nineties in their bodies and in their minds well into the 21st century.

If the majority of our children are to exist in a childhood that is not worthy of that name, but rather is a period with inadequate education, if they must go through a period of severe malnutrition, not have effective health services to go to, then, I am afraid, they will grow up as a people less prepared to be fully affected adults. Even more important, mothers, who grew up as girls through a period of malnutrition are more likely to suffer higher rates of maternal mortality and themselves pass on these problems to their children.

There is a lot of tragedy in store for the future because we in the majority world (I refuse anymore, after having seen the machinations of the elite world in the World summit of Rio, to give our part of the world the obscene title of Third World. Rather would I it what it really is: the majority world) - we have bowed down to the elite world and created for our country an economic policy that is utterly neglectful of the poor majority. Our rulers may call this an economic policy with a human face. But it seems to be a mere mask offering only lip service, even as we have observed in the last few months since the economic policy was promulgated.

Medical Education for the Real India!

In this bleak scenario, we ask ourselves, "What is the role of Medical Education?" We cannot deny that it is responsible to a very extent for the elitism in the medical profession. The subjects that are emphasised are more oriented to the medical care of the well-to-do than towards the majority of our people, and certainly in contradiction to the intention of the Indian Government at the time of Independence when it decided to subsidise medical education so that the poor can be primarily helped.

There is no real education conducted in our Medical colleges that is built on the actual situation and needs of our country. The education purveyed in these institutions is what Paul Freire calls a "banking system of education". In it the teachers decide and the students follow. The syllabus is constructed by the teachers, rather, we may say, by the pharmaceutical multinationals with a view to popularising and selling their products, and in no way is related to the actual needs of the students or the majority of the people of our country whom they should serve. The teachers plan, the students follow. The teachers do, the students see and accept. Even where the students are enjoined to involve themselves in actual work in laboratory or field, there is not much scope allowed them for initiative and creativity, but they are bound to follow the textbook and professor rather blindly.

The list of deficiencies in medical education can be expanded, but this is not the place to make this inventory of shortcomings. Rather we would insist on the new orientations that are essential in view of the picture we have painted of the situation of the majority of our people who are struggling below the poverty line and have no scope or opportunity to have their health needs taken care of.

If any change is envisaged in medical education, it is absolutely vital that first attention be given to the creating of an ambiance, an environment in which a spirit of service and commitment is engendered and sustained. The primary responsibility of this belongs to the management and the teaching staff. Their example is of vital importance in sustaining this spirit and environment.

The education proferred in these medical institutions must be related to the actual needs of the people of the area. Hence, we believe that there has to be a continual analysis made of the socio-economic, political and even the cultural situation of the people, since all of these have their impact on the health care which is a very important sector of the total system.

It has been remarked that many people who are on the staff of medical colleges are rather burnt out cases. They have been working for more than a decade and have now wilted after their long spurt of enthusiasm. Their contributions have waned, they seem to have turned a shadow of their former robust selves. After years of fruitful work educating generations of doctors, they have suddenly found teaching a chore rather than a pleasure.

They are burnt out because, essentially, they do not get the sustenance they need to replenish the energy they have been using up. Doctors cannot remain good doctors if they have no further access to medical knowledge that is relevant to the situation in which they are teaching medicine. Their prior knowledge starts blurring because of lack of renewed contact with actual health situations. This has caused a sense of being exhausted from the labour of teaching. But worse, it leads to a depersonalisation, a deliberate distancing from other people involved in the same profession of teaching.

To rise up from this situation of being burnt out, it is important that the staff of medical colleges revitalise themselves through contact with the poor who have an abundance of sicknesses and sufferings, so that they can get back the personal dimension into their medical horizons.

A deeper analysis of this phenomenon of being burnt out indicates that there has not been a refurbishing of the spirit while the medical college teachers have been spending themselves in their work. Every human being requires a spiritual aspect to motivate and given dynamism to her or his actions, especially in the mission of communicating to others the knowledge and the spirit needed for health care. We are not

speaking here of a spirituality that is linked with any religious sentiment or practice. We are referring to a spirituality which involves a faith in one's fellow human beings, however suppressed they may be, a hope built on their potential to discover their own health care practices and orientations and a love for those who eke out their living in subhuman conditions but are equal to us in everything that is authentically human. It is essential that one recognises these people as worthy of equal dignity as oneself. It is only when one is able to discern the divinity in the other, be he or she poor, neglected, less knowledgeable than oneself that one's spirituality will provide the elan and vitality to keep on working in this noble profession of leading others to take care of the health of those who need it.

Consequent on this is the realisation that institutionalising of the health education is a dangerous trend that causes the depersonalisation we have been referring to above. It is urgent that we give primary importance to persons, whether they be our co-professors, our students or even the rural poor who frequent our hospitals. This importance will lead us to a deep humility, which will enable us to be ready to learn even from the poorest with whom we come in contact.

These poorest must be awakened to the deficiency, nay, the exploitative nature of the health system prevailing in our country. They must be helped to rediscover the health system that is indigenous and very effective, because related to the very life situation, culture and ambiance in which our people live. We would not be exaggerating if we say that the members of the teaching staff of medical colleges should realise that the people can find their own health system.They must be given the enthusiasm to build up their own health system, in which they are the primary planners, the real implementers and the authentic result of their health care, founded on their innate sense of community, their traditions, their simplicity of life style, and their self-reliance.

This seems to be asking for much. But it is an ideal that cannot be denied. And ideals are meant to be striven for, even though in our life-time we may not achieve them!

SESSION - V/VI

10-B/11-B. DISCUSSION

The presentation by Dr. Thelma Narayan on the feedback from graduates on various aspects of Medical Education in the context of their experience of the needs and challenges in Health Care in small rural hospitals and health care institutions (see section 10-A) was well received and stimulated much discussion and comment. However due to shortage of time, the reflections by Mr. Desmond Abreo on the challenges of Medical Education for the 'Real India' (i.e., the large majority of poor and under-privileged and marginalised) was introduced as a supplementary input in the discussions (See 11-A) and then the discussion on both these presentations was taken together. Though this was not part of the original plan, the complementarity of the two presentations - one based on rigorous study of actual feedback of young doctors from the field and the other based on 'inspirational reflection' from years of grassroots development training experience helped to make the session a very enthusiastic and spirited event.

The participants made many interesting observations and relevant comments while at the same time raising significant questions. These included:

i. The polarisation of the 'haves' and 'have nots' in the country and the polarisation of the health care to these two groups was a significant perception ranging from overmedication of the rich to near total neglect of the very poor.

ii. The commercialization of medicine and the phenomenal impact on market forces in the development of medical malpractice should not be underplayed. Infact this has had a major impact on staff and student values who are part of the larger social system and internalise and reflect those values. Therefore professional prestige, maximisation of profits and competition become very dominant values.

iii. For those who opt to work in underserved and marginalised areas there is need to have structures for support and nurture. We need to recognise their need for facilities, recognition, companionship and remuneration.

iv. Inspite of the growing awareness of the dichotomy between medical professional goals and goals of medical education vs the primary health care needs of the people, changes and responses have not emerged adequately. This is due to the professional stranglehold on the medical system and also reflects our social structure.

v. If what is needed and what is given is so different why dont we close down some medical colleges instead of starting more?

vi. There should be an increasing awareness that changes will not come about just by attitudinal change but also by political change. Hence while training can make some contribution tc skill development and attitudinal change, the political economy of health and the politics behind expansion of medical education in the country must be seriously analysed and countered.

vii. We need to reflect seriously, have we failed as teachers? The situation around us is known to us. Why is it we feel more and more unable to change things? Are we willing to confront our students with the realities? Do we ask ourselves whether what we are offering them makes any sense to the realities in the field?

viii. While welcoming the contributior of pacesetter colleges, we must recognise that change must come in the government sector that is the larger and quantitatively the greater challenge. This means that we must involve this sector more - and have more representation from this sector in our meetings and dialogue. We must also be sensitive to the increasing demoralization that is taking place among the students and staff of this sector while at the same time support the innovations that are also being attempted, within government institution by some motivated staff, as has been presented at this meeting.

ix. The growing political interference in Medical Education is also a serious problem, affecting fall in standards and the morale of staff and students. What can we do about this?

x. There is good evidence that what is really needed are good role models for the students to emulate in their career aspirations. Are our faculty such role models? Are we providing the environment in which they can become role models?

During the discussion, a group of young interns from one of the local participating medical college were present and they were invited tc share their reactions and responses to the ideas on challenges and feedback from peers, that they had heard about during the session.

The very frank sharing by these young interns, many of whom had completed their rural internship was a good indication of the changing values in our social ethos and the dilemmas that young doctor face when they are faced with career options in

.....85

the changing ethos. This was particularly significant since these were interns from a highly motivated and community oriented medical college. Two dilemmas that were very thought provoking were:

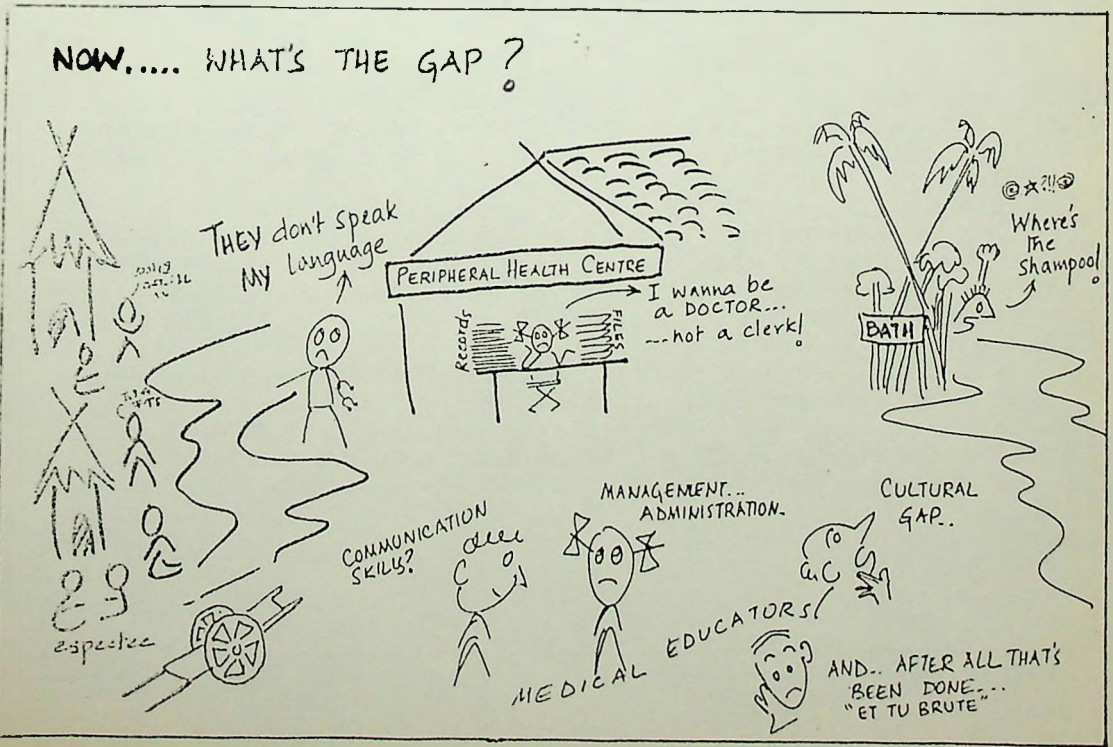
1. Are highly trained people like us really required for the type of village work that is required? Or that we have experienced during internship?

2. How do we handle the stresses created by the life style changes that such work calls for? We do not get what we are used to in our daily life? Are we prepared for these challenges?

The dilemmas were presented by graphic personal anecdotes but the message was clear to the group of teachers after the initial shock. Are we doing enough to prepare them emotionally as well as professionally to meet the challenges of community work? Have we been too preoccupied with knowledge transfer and skill development but neglected value development?

The sharing by the interns and students also helped the group to understand the phenomenal challenges and commitment that are required to move against the growing materialist and commercial ethos of our society.

The session left us all with the nagging doubt that while initiatives towards changing the content, the base and the process of learning in the curriculum would be supportive of the overall goal much more broader changes in the socio-political-economic-cultural system as well as in the wider goals of the broader educational system are required, if REAL CONCRETE CHANGE has to be sustained. As enthusiastic medical educators what will be our role in this change process?



COMMUNITY ORIENTATION - THE MEDICAL STUDENTS DILEMMAS — IS ANYONE LISTENING?

12. IN CONCLUSION

One of the key goals of the CHC Medical Education Project was to stimulate and support the formation of a critical mass of medical educators to commit themselves individually, institutionally and collectively to reform medical education to make it more socially relevant and community oriented.

The Medical Educators Review Meeting was a culmination of this effort. However, as mentioned in the section on Background, at the beginning of the proceedings, while the meeting marked the end of the formal project, it also symbolised the beginning of a new phase leading hopefully to action at various levels.

While the CHC had facilitated and played the key role during the two year study phase, it was now upto the collective of 'medical education enthusiasts' representing various medical colleges and other organisations to play a more active role in lobbying for change and in experimenting with further action.

At the concluding session of the meeting, the following suggestions were put to the participants as component actions of the next phase and as a stimulus for follow up.

The participants were requested to:

1. Read the background materials, articles, circulated and send comments and suggestions, that would help the evolution of the project publications especially the Faculty Resource Book.

2. Share materials and ideas picked up at the meeting with other colleagues in each participant's parent organisation. Continue to share the enthusiasm and experiences with each other and with CHC as well.

3. With atleast two possibilities of alternative experiments being shared at the meeting, all participants who were keen to join the new ventures as volunteers/participant faculty, were requested to keep in touch with those organisations:

   a) Dr. Cherian Thomas, Director, Wanless Hospital, Miraj Medical Centre, Miraj, Maharashtra-416 410;

   b) Dr. Zafarullah Choudhury, Project Coordinator, Goncshasthya Kendra, Nayarhat, Dhaka-1350, Bangladesh.

   CHC was keen to support either or both of these initiatives and had already volunteered to be an available resource to the process.

4. If any group are serious about organising a pre-selection course which brings together as much of the wealth of experience in the formal and informal Health training sector- they could get in touch with CHC about the interest/initiative since we were keen to help this process in particular.

5. The publications of the reports of the Project and the proceedings of the Meeting will be completed in the coming year and CHC welcomed ideas, responses, suggestions on them. CHC would also be interested in their use for lobbying for change within a institution, in a region or at national level and would request participants to keep us informed about such developments.

6. The participants were also requested to keep all the others whom they had meet at the meeting informed about ideas, and experiments that any of them or their institution would initiate in the future. This informal communication could lead to many forms of linkages between institutions and between project initiatives, developing a healthy peer support and peer review process. Those, who had experimented longer, may have much to offer those who had just begun. Those who had just begun may stimulate through their inquisitiveness, the more experienced ones to evaluate their own experiments with greater rigour and openness thus producing mutually beneficial effects.

7. If any individual or group was organising a meeting/ workshop/dialogue to spread this enthusiasm for change and required support, encouragement, help or a dose of enthusiasm, it was hoped that the Medical Educators Review Meeting had put people in touch with adequate number of enthusiastic and infectious resource persons for such a task.

8. Finally, since the interaction was too packed, there was not enough time to seriously discuss whether there was need to develop this informal group (who had gathered at CHCs invitation to discuss the project findings and share their own enthusiasm and experiences) further into a more formal alternative medical educators network. It was noted that already we have atleast three fora where such sharing and joint action could take place:

    i. The Indian Association for Advancement of Medical Education was such a forum though in recent years it had lost some of its original inspiration and collective style;

..88

ii. The Network of Medical Colleges - called the Consortium was another development which could be stimulated to widen its membership and perhaps even allow for associate members who could be observers at the meeting; (See Section 8-F).

iii. The Christian Medical College Network which had been facilitated by CMAI since 1989 was another forum which could also cater to a large and more secular group of colleges and individual enthusiasts by widening its circle of linkages. (See Section 8-F).

Many of the participants were already members of one or more of these fora. However many felt that all of them focussed on the orthodox medical college sector and were not open adequately to inspiration and interaction with other sectors such as Community Health Trainers of the Voluntary sector, Development trainers, students and health workers and so on, so a more broad based open ended informal network was necessary.

However it was felt that it may be good idea to keep the CHC initiated process an informal association and linkage and allow the collective enthusiasm of the group to build up gradually.

*****

See Post Script

13. PARTICIPANT FEEDBACK ON MEETING

At the end of the workshop all participants were given a participant feed back form to get a frank feedback on the meeting. They were requested to assess the strengths and weaknesses of various aspects of the programmes including the preparatory phase, the technical sessions and the facilities. 6 forms were received. Though the number of replies were a bit disappointing, those who handed the forms gave a lot of interesting and thought provoking comments and suggestions.

The following is a collation of the feedback from Dr. Shiv Chandra-Ajmer, Dr. P. Zachariah-Vellore, Dr. Mira Shiva -New Delhi , Dr. Prem Pais-Bangalore, Dr. Deepak M. Kamle-Miraj, Dr.C.N.Francis-Bangalore.

Dr. Shiv Chandra - Ajmer

1. The preparation was satisfactory.

2. Duration: Two days have proved shorter since it appeared that many more ideas/feelings remained unexpressed.

3. Expectation: A copy of Faculty Resource Manual.

4. Facilities: I wish arrangements for transport/mobility would have been provided.

Dr. P. Zachariah - Vellore

1. The preparatory communications and facilities were appropriate.

2. Composition: It might have been good to involve more government colleges. Some not directly related to medical education could have been omitted, if necessary.

3. Programme: A certain amount of meandering was inevitable though I felt uncomfortable with it.

4. The technical quality of the presentations by the Cell could have been improved.

Dr. Mira Shiva - New Delhi

1. What I liked best was the kind of people that had been invited - it was such a joy to be with people one admires and respects in this day and age.

..90

2. The CHC team was very helpful and kind and the conscious selection of a simple place was really a very good thing to do.

3. The schedule and content were very well organised. I learnt a lot.

4. I did not like the way the students intervention was handled. I felt we were all becoming defensive and pacifying. It would have been good to have these views exchanged in a student debate at a national level inviting participation from all colleges about 'personal rights'vs'social responsibility'of medical doctors?

5. Since there was no central room to meet after formal sessions, everyone tended to return to their rooms, missing an opportunity for interaction.

6. The Community Health Cell team has put in a lot of efforts and the labour of love really shows. Would you all be willing (off and on) to travel a bit, if needed, to introduce some of the new concepts. All of us will help in the exercise.

7. If we try to get the different medical college people together on Rational Drug Policy theme, then Rational Health Care and Rational Medical Education can also be introduced in those sessions.

8. At a time when there is so much burn out an paralysis and dystonia - your constructive efforts - really mean a lot and are more relevant today than even before.

9. Thanks a lot and my dream is that all the forces of good will join together forming a critical mass and work together. The issues are secondary bethey drugs, medical education or eccnomic policy related; be they in India or across the border in Bangladesh.

10. Thanks once more. I felt very very happy being with all of you.

<u>Dr. Prem Pais, Bangalore</u>

1. On the whole the meeting was useful.

2. I felt the majority of participants were no longer involved in teaching medical students and had no concepts of how medical students feel and react.

3. How can all that was discussed, begin to be implemented?

..91

Dr. Deepak M. Kamle - Miraj

1. The medical educators review meeting was arranged and organised to the full satisfaction. The accommodation and food was excellent.

2. The participants should have been hospital heads or administrative/authorative staff preferably. The Directors of CMC - Ludhiana, Vellore, Miraj etc., should have been the ideal choice.

3. I strongly agree with Dr. Thelma Narayan's study regarding feedback from graduates.

4. The meeting should have included a bit more concrete assurance and discussion from voluntary association/agencies regarding innovations.

5. The twelve pathological obstacles in growth of institutions highlighted in the study were very good. I would appreciate if you give remedies/solutions to them as well.

6. We have not touched the subject of unemployment of doctors! Consumers malpractice Act should also have been discussed and we should have asked CMAI and other voluntary agencies their role, in this issue. Why are only doctors included in it? Advocates, Judges, Solicitors also should be include under this Act.

7. The facilities for the meeting were good, and the schedule was completed within the time.

8. The technical sessions were good but should have had a stricter time limit.

9. Organisers should have kept free time in the evening and included visits to St. John's and other institutions to see their work and take inspiration.

10. Congratulations to the CHC team for their sincere, hard working, team effort in patiently preparing and well documenting this project. They have done a very good and difficult job.

11. Transportation facilities would have been welcomed and should have been arranged.

12. The address list of participants and the proceedings should be circulated.

..92

Dr. C.M. Francis, Bangalore

1. The Medical Educators Review Meeting was very useful.

2. The preparation was really good, with the background information being given to the participants.

3. The facilities were ideal for a meeting like this:

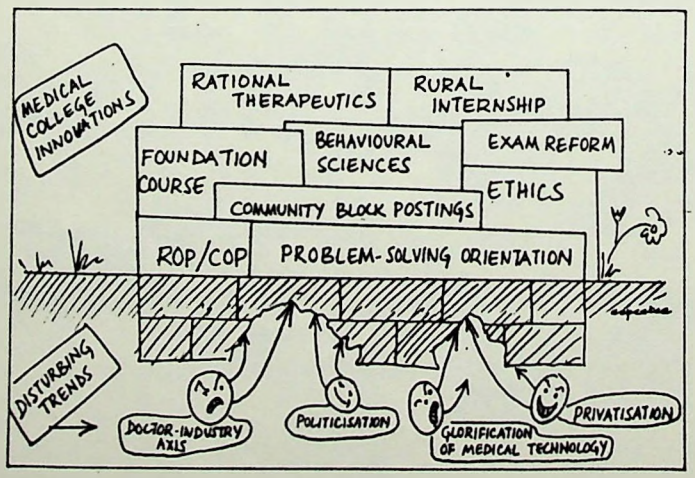
   i. it was a quiet atmosphere;
   ii. the style was simple with respect to meeting room and the food;
   iii. the atmosphere was informal and friendly.

4. The sessions were good. The presentations were appreciated.

5. There was not enough time for discussions. As all the participants are knowledgeable in one way or other, more time should have been made available.

6. The final sessions of action plan is important. If people begin leaving in the middle, it detracts from achieving the objectives fully.

* * *
*



POST SCRIPT

It is over 18 months since the Medical Educators Review Meeting was organised by CHC as a final event of the CHC/CMAI/CHAI project on "Strategies for Social Relevance and Community Orientation in Medical Education - building on the Indian experience". Many developments have taken place in the wider context of Medical Education in India as well as in the context of ideas and initiatives shared by participants at the review meeting. While apologising for the unavoidable delay, in editing and collating the proceedings, these developments and events are presented as a process of continued information and interaction since June, 1992.

1. The Project reports of the study and the report on Graduate Feedback was completed and sent in draft format to the following for comments before finalisation

   i. Project Advisory Committee and CMAI, CHAI (July, 1992);

   ii. Prof. V. Ramalingaswami (Prof. Emeritus-AIIMS) and Prof. D.K. Srinivasa (NTTC-Jipmer) as independent reviewers (August, 1992);

   iii. ICMR, IAAME, IMA and MCI (September, 1992);

   iv. The four CMCs and medico friend circle (November, 1992)

   Some comments received were incorporated into the final manuscripts before publication.

2. The outline of the Faculty Resource Book (see Appendix H) was circulated to all the respondents of the Medical Education Project and a large list of peer and medical education enthusiasts for comments and further suggestions. Various responses received are being added to the faculty resource book.

3. a) Miraj Medical Centre (Wanless Hospital) had been given an indication in June, 1992 that the Maharashtra Government was keen to approve its long pending request for a (Alternative Track) Community Oriented Medical College. The initial project proposal had been outlined by some groundwork done by Dr. C.M. Francis and Prof. P. Zachariah in 1989-90. In August 1992, Drs. Ravi and Thelma Narayan of CHC visited Miraj to explore the option of giving full time to a Medical Education Cell for faculty development from January, 1993 (if the final permission was granted). The Society had agreed to release them for this assignment for a period of two years. However during the visit, the implication of the newly proclaimed Central ordinance on new Medical Colleges was discussed and Miraj project has now been temporarily postponed due to this new development.

..94

b) During Dr. Ravi and Dr. Thelma Narayan's visit to Miraj in August, 1992 the Staff Research Society of Government Medical College, Miraj and the local chapter of the Maharashtra Medical teachers association organised a special meeting on the Medical Education giving an opportunity to present the study findings to an enthusiastic audience of staff of a government medical college.

4. The Supreme Court Judgment on the capitation fees Medical College problem and the subsequent writ petitions and stay and the newly promulgated Central ordinance regarding the need for Central Government permission for all new Medical Colleges, led to an interesting and effective break on the growing commercialization and mushrooming of private medical colleges in the country. This has led to an intense public debate on privatization/commercialization and the role of the state in Higher Education. While the capitation fees lobby is very very strong, partly because of its linkages with big business and 'political party funding' it has not been able to stall the court cases and the judgments about allotment of seats and related procedures for payment and non-payment seats which has put the state governments, particularly of Karnataka, Andhra Pradesh and Maharashtra in a quandry. This is a good example of legal measures that are required to make some aspects of Medical Education development more relevant to out needs and realities.

5. August 1992 : The Medical Council of India circulated a draft report of a special committee set up by it in October, 1991 to draft recommendations for the evolution of a revised curriculum (The Kacker Committee Report). One of the highlights was an Alternate Track after preclinical, paraclinical training. It was stated that, "the focus of the training in these courses will be on general practice, in community setting, with capabilities of providing primary and secondary care. There will be a significant component for training in Mother and Child Health Care and family welfare programmes. Input will be provided to work with a health care team to achieve fulfillment of national health programmes and to participate in health education activities in the community. The opportunities for those who elect this track will be equivalent to those who continue as physicians to be specialists or to take postgraduate courses.".

   A workshop on Need based curriculum for undergraduate medical education was also organised 28-29th August, 1992.

6. An extract from the Graduate Feedback Survey raw data on basic skill requirements for Doctors working in peripheral health care institutions was sent to St. John's Medical College for a survey they were carrying out in the context of a consortium initiative.

7. The final recommendations of the MCI Workshop on Need Based Curriculum in August, 1992 was circulated a few months later. With reference to the Alternate Track, the recommendation noted: "Having debated at length the suggestions for providing an alternate track for the MBBS course, the workshop recommends that the proposed changes in the MBBS curriculum would take care of the kind of competency suggested in the alternate pathway, as such there is no need for the same. However the MCI may permit and encourage innovative educational reforms for providing inputs for introducing curricular changes". A disappointment no doubt for all of us who believe in the alternative track concept!
Significantly the only relatively new recommendations were (i) 'the establishment of a medical education unit in every college for faculty development'. (ii) 'the senior faculty may also be enthused in participating in the educational activities in the district, taluka and rural health centres to ensure their exposure to the realities of community health care'. (iii) One month of the primary care training during internship may be in the form of preceptorship with a practising family physicians or voluntary agency or other primary health care provider approved by the faculty. All these three do provide new opportunities as well to all of us!

8. Dr. Mohan Garg, Consultant-Medical Education from CED-Illinois who has been one of the key facilitators of the Consortium of Medical Colleges (see section 8) was in Bangalore in December, 1992 in connection with a consortium related visit to St. John's Medical College. During this visit, the CHC Project coordinators (RK & TK) were able to meet him and apprise him of the study and the related process as well as the Medical Educators Review Meeting in June, 1992. He was particularly interested in the Graduate Feedback Survey, since there was a renewed interest in reaffirming the role of General Practice/Family Medicine in the USA and various projects/discussions were underway to operationalise their shift of emphasis. The Graduate Feedback survey greatly emphasised the content and nature of this shift. The need for the consortium initiative to tap other sectors was also emphasised.

9. An unsuccessful attempt was made by the CHC project coordinators to get IAAME to provide sometime for the presentation of the study findings at the annual conference held in Madras, in January 1993, on the theme"physician for the Twenty First Century". Inspite of being IAAME members, having sent full manuscripts of the pre publication reports; and being in touch since February, 1992 after the preliminary papers from the Project were presented at the Bombay Conference (IAAME annual meeting - January, 1992) an opportunity could not materialise,which was a disappointment!

10. Prof. V. Ramalingaswami, Chairman, Task Force on Health Research for Development, Geneva, sent a very interesting

..96

foreword for the first publication of CHC Project in February 93 which he endorsed that "there is a message of hope in this monograph even as the obstacles to change are identified clearly and the many disturbing trends in medical education and practice are outlined. The monograph makes a positive contribution to reform in medical education and the author deserve praise and gratitude". (See rest of foreword in Medical Education Project Report, March, 1993 available at CHC).

11. Prof. D.V. Srinivasa of NTTC-JIPMER sent the foreword for the second publication mentioning "this report, part of the whole project focusses on the feedback from medical graduates and covers a wide range of topics in medical education. This study is intended for medical education. It is hoped that they take note of the findings and mould their thinking to the specific needs, expectations and innovations".

12. The first two publications of the CHC/CMAI/CHAI Project on Medical Education was published in March, 1992 and available for lobbying and sale. These were:

    i. Strategies for Social Relevance and Community Orientation - Building on the Indian Experience (A Project Report); (Cost: Rs.40-00, U.S.$ 5)

    ii. Evolving Medical Curriculum through Graduate Doctor Feedback. (Cost: Rs. 40-00, U.S. $ 5)

    A pre publication offer was circulated to all project contacts offering a 20% reduction in the cost of the total set. Many contacts availed of this offer and we also received bulk orders from some groups. A post publication handout has also been distributed and announcements of the publication have been caried in some health bulletins and journals.

13. Dr. Madhav Ram, Lecturer, Department of Community Medicine, PSG Medical College, Coimbatore, was a short term research associate of the CHC Medical Education Project and helped to compile the chapter on Innovations in Medical Colleges for the evolving Faculty Resource Book. This was the largest section of the book and contributions and papers of varying quality had been received,which needed both, systematic and creative editing and collation.

14. Dr. Arvind Kasturi, who completed his postgraduation in Community Medicine from CMC-Vellore, joined the CHC Medical Education Project as a short term research associate to undertake an overview - compilation of 14-15 Training

programmes in Community Health in the voluntary Health sector in India. This first stage compilation was circulated as a background paper for a planning meeting organised by Dr. R.S. Arole of CRHP, Jamkhed, for a special three month course in Primary Health Care being organised by him (which is being sponsored by Pune University and Institute of Child Health, London). This draft report will form part of a larger interactive process that will help in evolution of a CHC Monograph entitle 'Laying the New Foundation' (expected completion in 1995).

15. Dr. Thelma Narayan of CHC attended the Silver Jubilee Celebrations of The Faculty of Health Sciences, McMaster University, which had pioneered the concept of 'problem based learning' in the world. The three day meeting included small group work to interact with faculty and thus get acquainted with the learning methods used at McMaster. The workshops covered areas of small group process, evolution of community experiences using journal method, faculty development for problem based learning, selecting priority problems and designing curricula, adapting problem based learning to different learning situations and community based experiences. Useful discussions were held with the team working on "Educating Physicians for Ontario".

16. The third report of the CHC Medical Education Project was published in August, 1993. This was an annotated bibliography of 60 key publications in Medical Education entitled 'Stimulus' for Change'. It was hoped that it will prove to be a useful stimulus particularly to medical education enthusiasts in medical colleges in the country. (Cost Rs.8-00, US $ 2).

17. Dr. Thelma Narayan of CHC attended the 8th Biennial meeting of the International Network of Community Oriented Health Sciences Institutions at Sherbrooke in Canada in August, 1993. She also attended the International Conference on "Student Centred Learning" which was linked to the meeting. Two papers from the Project (summaries of the first two publications) were presented at the meeting, which will now be featured in their 'Annals'. She also participated in a special interest group meeting on "Community Orientation in Medical Education" and presented some reflections and data from the study.

18. The Consortium of Medical Colleges have been undertaking Phase II of their process (see Section 8). St. John's Medical College was selected as one of the four newer entrants to the Network and a twin of JIPMER-Pondicherry. After the surveys on skills and also on relevant and redundant portions of the curriculum, the meetings have

..98

progressed towards the development of core curriculum by a North group and a South group within the Consortium, which are scheduled to be integrated at the next meeting of the group in February, 1994.

19. The fourth publication of the CHC Project (Key to Change) and the fifth publication (Faculty Resource Book) are in the final stages of being edited and published. There were unavoidable delays in the work. In response to many of our communications and circular letter more material was received and our attempts to integrate them caused further delays. They are now scheduled to be out of the press by March 199 and the delay is regretted.

20. Finally,Dr. Tamas Fulop, one of the originators of the International Network of Community Oriented Educational Institutions for Health Sciences and the author of the recent report "Crossing Frontiers" - Reflections on the Networks post and future, wrote a very interesting letter sharing his assessment and comments on the first two publication of the CHC Project which was a real morale booster "As to your two brochures, I first certainly would like to congratulate you and your colleagues, for a job well done: they both reflect a highly intelligent, timely and most relevant peice of work. They provide a lucid and daring analysis of what is the Indian reality in Medical Education in the 90s based on data obtained by well chosen, valid methodology. The results are most interesting and revealing. They certainly are worth publication in a widely read journal as their international validity should be in no doubt, and this in addition to your planned book/s whose readership will unavoidably, be rather small. The recommendations are all well-based, important and feasible... After sending detailed critical comments to sharpen our analysis and future initiatives he also mentioned that "Finally, a good solution to the problems, listed in the two brochures, could be, what you also propose, to organize just in a very few, volunteering schools (may be in some of the so called "pace-setters") "parallel tracks" with all the characteristics of CCME/CBE and PBL, properly adapted to the Indian reality, and with appropriate monitoring and evaluation. May be that would be more feasible than trying to propagate large-scale, institution-wide innovation/change".

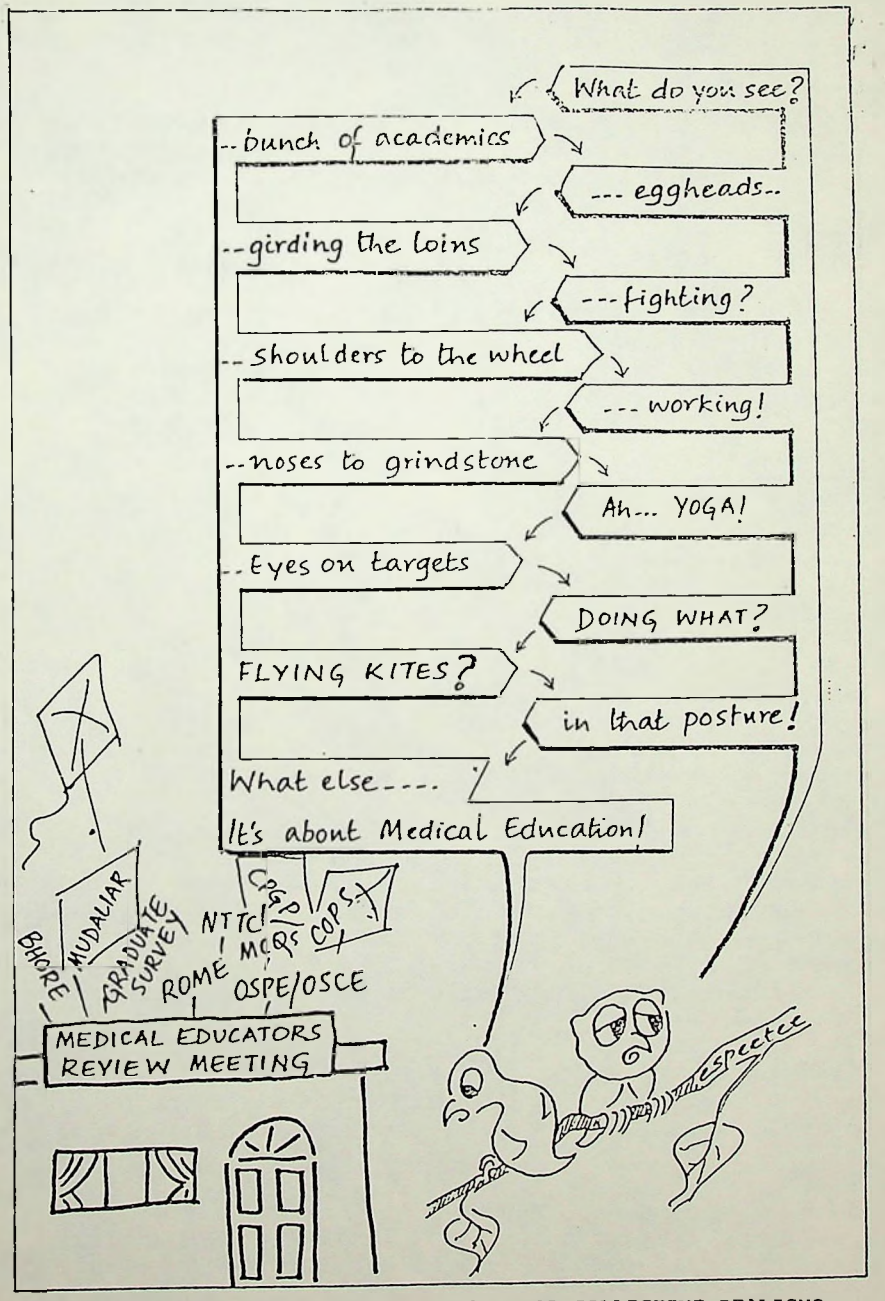
Among his suggestions for future complementary studies are:

i. "Examination of content of medical education against the Indian demographic and epidemiologic situation;

ii. Examination of the same against the Indian health system reality (structure, function, etc.);

iii. Examination of the same against the opinion of other, may be the real, consumer groups: the public (patients as well as healthy people) and the health system managers."

A very thought provoking suggestion from someone who has done similar overview studies on alternatives at the global level and we hope that all of us in this informal network will take up these ideas seriously in the years ahead.



JUNE 1992 - WAS IT INDIVIDUAL RHETORIC OR COLLECTIVE REALISM?
A CHALLENGE TO ALL PARTICIPANTS OF THE MERM.

..100

A Note

These appendices include some of the key resource materials that were distributed before and during the Medical Educators Review Meeting.

Appendix A

This is a compilation of an opinion survey conducted among the potential participants which identified 56 changes needed in medical education and 40 innovations that were ongoing in the country.

Appendix B and C

These are two articles circulated as background stimulus for the dialogue. (i) Dr. N.H. Antia, Founder of The Foundation for Research in Community Health, Bombay, makes an urgent plea to prevent 'Health Care' and medical education, from remaining a chimera and a mirage for the vast majority of our people. (ii) Dr. Thelma Narayan presents an overview of the Medical Education situation in India - highlighting the problems and the new initiatives.

Appendix D and E

Represent two key examples of serious reforms in medical colleges (i) The primary health care oriented, four-phase, training module of CMC-Vellore representing the NGO sector (ii) The evolving process in NHL Municipal Medical College, Ahmedabad, symbolising the 'optimistic' possibilities within the government sector as well.

Appendix F

A chart from David Werner and Bill Bower's book 'Helping Health Workers learn' was circulated to stimulate participants to consider how 'conventional medical education' can move towards more progressive and liberating directions.

Appendix G

A self assessment guide was prepared and circulated to all participants to help them assess the level of their knowledge on the Indian experience of Medical Education. The guide was based on the premise that after all the project outputs were available, participants would be able to mark 'yes' for every item and have access to enough detail to be able to write some notes on each.

Appendix H

This note was circulated to all participants to seek their response to the evolving manual which would be the culminating effort of the two year project and was available in its pre final format for perusal.

Appendix I

Is a list of the key documents and publications identified by the project as important resource materials for medical educators in India. An annotated bibliography of all these 40 items was distributed at the meeting (see publication 'Stimulus for Change' - third output of the Project).

-x-x-x-

APPENDIX - "A"

BUILDING COLLECTIVITY

- A Preworkshop opinion poll

As part of the preparatory process for the Medical Educators Review Meeting to be held on June 20th and 21st (1992) an opinion survey was conducted to explore the views of the participants on

i. The key changes which should be introduced into the present medical education system to make it more relevant to our social/community needs.

ii. The key innovations/experiments currently in practice which will help this reorientation process.

As of 1st June, 1992, 12 participants had sent in their opinions which has been collated for circulation. These two lists of issues enclosed in this first collation give a very interesting picture of the key issues of concern of the participants and the salient experiences that they bring to the review meeting.

It also gives a birdseye view of the key challenges that face medical education in India as well as the wide range of experiences that are a cause for optimism, in the midst of the increasingly disturbing situation of medical education in the country.

This compilation includes responses from Dr. Ulhas Jajoo(MGIMS-Sevagram), Dr. Varsha Patel (NHLMC-Ahmedabad), Prof.S.V.Rama Rao (formerly SJMC-Bangalore), Dr. Asha Oumachigui (JIPMER-Pondicherry), Dr. Ragini Macaden (SJMC-Bangalore), Dr.M.J.Thomas (formerly SJMC-Bangalore), Dr. Shirdi Prasad Tekur (CHC-Bangalore), Dr. Deepak Kamle (MMC-Miraj), Dr. Mani Kalliath (CHAI-Secunderabad), Dr. S.K. Das (KGMC-Lucknow), Dr. Shiv Chandra (JLNMC-Ajmer), Dr. P. Zachariah (formerly CMC-Vellore).

NOTE - 1

This compilation may be used as an instrument of self assessment and preparation for the meeting. You can tick off all those that you agree with. Reflect why? You can tick off all those that you do not agree with. Reflect why?

NOTE - 2

It can also be used to initiate an exploratory discussion with a group of faculty in your own institution.

..102

A. Key changes that should be introduced into the present medical education system to make it more relevant to our social/ community needs. (I)

Preparatory

01. Reeducation of policy and decision makers to see medical education in the present context.

02. Reeducation of Medical Teachers to wean them away from the traditional and conventional miseducation.

03. Must develop a consensus on objectives and priorities.

04. Mechanism or opportunity for providing 'recognition' or 'affirmation' to the product of an alternative track. (As this person would be working against prevailing culture and values).

05. Medical education should be taken away from elitist grip by doing away the admission on donation/privatisation basis.

06. Education must become a more conscious goal of medical faculty.

07. Reorganisation of MCI.

Objectives

08. a. Define clear objectives at all three levels i.e., primary, secondary and tertiary health care - accordingly change the methodology and evaluation strategy.

b. The objectives should include:

i. - able to understand social reality and processes;
ii. - able to use clinical skills and preventive methods to meet the needs of the people;
iii. - have technical and managerial skills and ability to integrate various programmes;
iv. - be able to identify areas of relevant research and carry out such research programmes.

Selection

09. Selection should be based on aptitude to take up medicine.

10. Selection criteria to be more broad based and opening up to health personnel at various levels of the health care system.

11. Candidate sponsored by a group committed to primary health care.

..103

Teachers (Selection / Preparation)

12. All the teachers should be oriented to the need for relevance in education through workshops and meetings.
13. The reforms in medical education should begin from teachers so that they can become role models for the trainees.
14. Reorientation of the 'key' teaching faculty to innovative approaches to teaching. This will facilitate the programme.
15. Training medical teachers on teaching techniques.
16. 'Rolemodels' among teachers or guides who can inspire and who hold different values.
17. Selection of teaching staff who would be role-models, and providing facilities for them to fulfil their needs.
18. Private practice amongst Medical Teachers should be curbed.
19. Selection of students at the undergraduate level for taking up teaching as a career and offering them special courses e.g., pedagogy.
20. Incentives / rewards for teachers contributing to these changes.

Curriculum (General)

21. Teaching should be integrated, not compartmentalised.
22. Introduce the concept of 'holistic' approach through integrated teaching and learning programmes.
23. Eliminating compartmentalisation in teaching by various departments and integrating teaching with a built in system of evaluation to eliminate competition and studying for examination.
24. Curricular content (syllabus) to be made more relevant.
25. A periodic update on the morbidity - mortality data of diseases prevalent in our country. This becomes the reference point.
26. Teaching priorities/methodologies to be modified to be more relevant to present situation.
27. Curriculum to be relevant to the community needs.
28. Altering the curriculum to suit the need of the recipient population (student centred).
29. Teaching process should increase the student's learning capacities.

Curriculum (Detail)

30. For each discipline in pre, para and clinical section to make a conscious effort to present topics in
    i) INTEGRATED;
    ii) PROBLEM BASED MANNER.

..104

31. Reduction in courses and the period spent in Basic/Non clinical sciences, eg., Anatomy/physiology/pharmacology/bio-chemistry/ pathology etc. Applied aspects should not be taught during core training in these subjects but may be taught later on during clinical classes as revision/reinforcement.

32. Deletion of superspeciality training eg., Cardiology or Cardiothoracic surgery from MBBS curriculum. These subjects should be taught as part of Medicine/Surgery by Department of Medicine and Surgery and not by Cardiologists/Cardiothoracic surgeons.

33. Public health engineering should be deleted from PSM subject of Medical Curriculum and should be taught as a speciality subject in Engineering colleges.

Exposure / Experience

34. Actual exposure to the exploitative (economically, socially, politically) social structure, with special focus on exposure to poverty, as it operates at the grassroots.

35. Exposure of students to patients, hospital and community right from their entry.

36. Training the students in an ideal Primary Health Care Hospital where he is taught to put his knowledge and skills to maximum use.

37. Venue of practical training must shift to general hospitals and peripheral settings.

Skill Training

38. To develop in the student sufficient laboratory and clinical skills to enable him to function effectively in a Primary Health Care situation.

39. Spend more time on helping students to acquire clinical skills/practical skills.

40. Need to stress on communication skills and managerial skills.

41. To aim at behavioural modification, development of communicating skills and perfection in delivery of peripheral health care.

42. Improvement in practical training and stress on 'hands on' experience.

Additional Subjects

43. The curriculum to include study of ethics, behavioural sciences, social sciences, management, economics and ecology as related to health.

44. Ethics of professional work to be emphasised.

45. Make students aware of ethical issues in medicine and health care.

..105

46. Inclusion of alternatives/indigeneous systems of health care prevalent in the community as a major subject of study.

47. Adequate emphasis on value education such as team work, social responsibility, etc.

Examination

48. Critical evaluation and change in examination.

49. Examination / Evaluation system to be more 'self-evaluatory' and with practical slant.

Internship

50. In view of emphasis on pre PG-senior housemanship, internship should be done away(!).

51. It should be mandatory to get full registration as a practitioner to serve in rural area for minimum three years.

Evaluation of Innovations

52. Evaluate the results of these changes from time to time by teacher-teacher and teacher-student interactions.

Certification and Continuing Education

53. To lay down, minimum qualifying criteria before getting certification of practice which must be reviewed on regular basis by appearing in programmes of continuing education.

Postgraduation

54. Postgraduate Medical Education (specialist) should be de-emphasised.

55. Greater emphasis and postgraduate training in general practice.

56. Career guidance should be introduced at different levels.

It is interesting to note that though the overall changes seem to be moving towards a consensus in direction, there was a diversity in the opinion survey which led to a rather comprehensive list of ideas.

B. Innovations / Experiments currently in practice which will help this reorientation process. (I)

01. Formulating Educational Objectives - Institutional, Departmental and instructional.

02. Identifying core curriculum.

03. Formation of a core group of faculty to reappraise modify and enthuse the reorientation programme (frequent meetings which are alive, vibrant, determined).

..106

04. Sponsorship of students by groups to whom the candidate has a commitment after graduation.

05. Exposure to existing health care delivery system - beyond the teaching hospital.

06. Selection of students to include methods to assess values, motivation, team work, social orientation etc.

07. First hand experience of living with village households.

08. Rural/community orientation camps for medical students and nurses in preclinical year.

09. First MBBS examination after 15 months and three months for preclinical orientation for community medicine, nursing and support facilities and orientation to hospital.

10. Paraclinical teaching;

    i. integrated teaching;
    ii. reduce didactics to 30 minutes and leave 30 minutes for discussion and learning;
    iii. involve relevant pre/para/clinical faculty to reduce danger of compartmentalization.

11. Train students in simple lab tests and give confidence in verify/investigating clinical problems on own.

12. Community health care should become a compulsory ingredient of all clinical department teaching.

13. General practice clinics in outpatients for undergraduate and interns teaching.

14. Integrated Teaching/learning sessions in OBG with surgery and medicine.

15. Competency based curriculum for labour room posting of Final MBBS.

16. Making student record book more comprehensive.

17. Community block postings in clinical years with specific objectives and tasks.

18. Project allotments to undergraduates.

19. Involving medical students in evaluation surveys in immunization and family planning.

20. Extra rural postings of students to peripheral hospitals in prefinal year.

21. Educational trips to good primary health care projects.

22. Involvement of community in their own health care system.

23. Teaching/orienting medical students to alternative systems of health care.

24. Involvement of students in running a primary medical care hospital.

..107

25. Used modified essay questions and other evaluation approaches for internal assessment and examinations.
26. Conducting an internship orientation programme covering areas like aims of internship, rational therapeutics, essential drug concept, etc.
27. Effective peripheral community health postings for 3 months.
28. Placement of interns at peripheral rural clinics in independent charge under Community Medicine Department faculty supervision.
29. Social-epidemiological problems and their study by interns at village level and presenting a scientific report.
30. Two months optional subjects for training during internship including - dermatology, clinical pathology, radiology, ENT, ophthalmology, anaesthesia, etc.
31. Conducting regular educational technology workshops-How to teach?
32. Developing well developed, critical faculty among the teachers to assess and analyse social and technical problems and dimensions of health.
33. Regular academic meetings on medical education for faculty.
34. Inquiry driven strategies of consortium of medical institutions-their findings and experience should be studied and adopted.
35. Development Training groups like SEARCH-Bangalore emphasise value education, self-learning, group tasks, periods of field placement and periods of reflection. These should be reviewed and adapted to medical education.
36. Community Health training programmes and voluntary agency role models should be studied.
37. Many innovative experiments in other countries have been tried out and these should be studied and adapted.
38. Balance attitudes, values, technical and social orientation to evolve relevant competence.
39. Reorientation should be a continuous and concurrent process.
40. Continuous participatory group evaluation by staff and students of innovations and experimental changes in curriculum.

Many responses mentioned specific institutions where the experiments are operational and many did not. To standardise the compilation we left out the names of institutions so that the focus is on 'what is being done' and not 'who is doing it'. For details refer publications of Medical Education Project:

i. Project Report;
ii. Stimulus for change;
iii. Faculty Resource Book. -Ed

..108

APPENDIX 'B'

Medical Education: In Need of Cure

N H Antia **

While the medical profession has played an important role in determining the health status of the country, it has also been responsible for the distortions in the health care system. What can be done to change the situation?

THE aim of professional education in the field of health must be the production of a cadre of professionals who would have both the competence as well as the motivation to serve the health needs of the country and its people as a whole. The number and type of health professionals, their recruitment and training for the various functions at various levels and locations must be determined primarily by the actual problems of health in both the rural and urban situation, the prevailing pattern of diseases, the available health technology, all this in keeping with the human and financial resources available to the country.

Unfortunately the production of the number and various categories of personnel as well as their training is entirely disproportionate to the actual needs and has to a great degree been dictated by the perceptions and needs of the medical profession whose values and aspirations are more in consonance with those of the prevailing western model rather than the entirely different needs of the vast majority of our own people. Hence the larger number of doctors than nurses and paramedicals, the emphasis on expensive specialised curative medicine in large urban hospitals for non-communicable diseases rather than the far more effective yet lower low cost preventive, promotive and basic curative services for the rural population and urban slums.

The crucial role played by the medical profession (and especially of the private sector which now commands two-thirds of the country's medical manpower as well as the health expenditure) in reversing the health priorities can no longer be ignored. Their influence in determining the type and quality of the country's health services, either directly, or indirectly as physicians to the rich and influential, far outweighs that of those who seek to develop the health policy and services along rational lines for the good of our society as a whole. The medical profession has equated health with illness, doctors, hospitals, drugs and westernised medical technology and converted illness into a lucrative business and industry.

Medical education plays a key role in perpetuating this system. The vast increase in the number and size of medical colleges from 25 to 125 in four decades has resulted in an increase in the annual production of doctors from about a thousand to over 13,000 during this period. The majority are still government colleges funded by the public exchequer but lately there has been a rapid increase in the private colleges. The struggle to secure a seat in a government medical college is demonstrated by the mark list of the candidates and by the high capitation fees paid in the private colleges by those who fail to get entry into the government ones. In both cases the advantage is for the children of the affluent. Those few who are admitted in the seats reserved for the backward castes are at a considerable disadvantage due to their different cultural and educational background. Despite this after qualifying they too have the same aspiration as the rest. Bar exceptions the reason for the choice of medicine as a career is the assured high level income with a high social status.

The values of the medical profession are, therefore, determined even before the student enters the portals of the medical college. These values are reinforced throughout the five and a half year course and later during post-graduate specialised training. While the honorary system attracts the elite of the profession, the training they impart is biased by the specialised expensive medical technology they practise. Even worse are the values of lucrative private medicine that they subconsciously inculcate into the receptive young mind. With the increasing disparity between the earnings of the private and public sector, where a surgeon in a single operation in private practice can earn the equivalent of one or two months salary of his full-time counterpart, it is difficult to retain good motivated teachers and doctors especially in the clinical subjects. This has led to a further deterioration in both the technical aspects of medical education as well as in the values that are imparted to the student.

The values of the vast majority of students is reflected in the importance they assign to the various subjects and even more so in the choice for post-graduate training. The glamorous high tech and lucrative fields like medicine and surgery and their subspecialities like cardiology and plastic surgery are the first choice while preventive and social medicine and community health are at the bottom of the ladder; a choice inversely proportionate to their usefulness in determining the health of the nation. These important subjects in medical education also suffer from a vicious circle for they by and large also fail to attract the best teachers. The fossilised methods and nature of basic science teaching combined with glamorised teaching of technology in the specialised clinical subjects has resulted in the failure to produce medical scientists and basic doctors. While the vast majority will perforce have to eventually gravitate to general family practise it is anachronistic that there is not a single general practitioner as a teacher in the medical college especially when the majority of outpatients are flooded with simple common ailments from the local vicinity which are then referred to specialists for lack of a family physician. The reorientation of medical education (the ROME scheme) is a farcical exercise in a vain attempt to sensitise the student trained for five years in high tech clinical medicine to the entirely different rural health problems of our people in a period of three months. The Lentin Commission has also demonstrated the chaotic administrative and bureaucratic management of these hospitals and their specialised units, revealing that even the so-called best medical colleges and hospitals are mere caricatures of the western model they choose to emulate.

The aim of the medical student after qualifying is to specialise and get theoretical if not much practical knowledge with the hope that this may help him/her to secure a job abroad or in a five star private institution in a city. Since these avenues are limited, the majority perforce gravitate to small private nursing homes or general practice for which they neither have the training nor even basic facilities. Over-production has now driven them to seek government posts which were difficult to fill a decade ago. Unless posted in a city or district hospital they perforce have to serve in a rural primary health centre where the requirement is chiefly of a managerial physician to cater to the health of a population varying from 30,000 to over 1 lakh with about 30 to 60 paramedical staff under their guidance and supervision. Besides management even the medical functions are chiefly of preventive, promotive and of a social medicine nature, the lowest in the hierarchy of medical education. There is little time and even lesser facilities for clinical medicine for which alone he/she is trained. The most important aspect of our health system, the primary health centre which has to cater for the needs of the 70 per cent of our rural population

** Director, The Foundation for Research in Community Health, 84-A, R.G.Thadani Marg, Worli, Bombay - 400 018.

is therefore encumbered with a leader whose training and values are almost diametrically opposed to the health needs of the majority of our people and the functions to be performed.

Under the circumstances the prevailing system of medical education is almost entirely divorced from the health needs of the majority of our people, both in the public as well as in the private sector. The over-production of doctors and of drugs because of their lucrative nature has invariably resulted in a form and extent of malpractice which now poses a new threat to the health of our nation, both the poor as well as the rich.

The question arises that if the vast majority of both the non-medical as well as the medical functions of health can be best managed by the people themselves with the help and support of the para-medical workers then why not concentrate on this aspect of health and ignore the medical profession which has gone so awry. This unfortunate attitude continues to prevail not because of the failure to appreciate the needs for the increased level of skills and facilities which are essential for certain aspects of technical medical care, however small it may be of the totality of health, but because of a feeling of helplessness when confronting the entrenched and extremely powerful bastion of the medical profession which it has built for itself through various means. These vary from offering the lure of an extremely lucrative professional career to the children of the rich and influential at public expense, high level of monetary gains to both the promoters and the politicians who run private medical colleges under the guise of producing doctors for the rural poor, a good prospect of emigration so attractive to the elite, by offering the 'latest' western type medical care to the politicians, bureaucrats and the rich who believe that 'West is Best' and that too often free of cost in major government and five star private hospitals, by glamourising expensive technology and mystifying health into an illness business which the people are told is too dangerous to be left to anyone but the allopathic trained medical profession and preferably those who are specialised.

Unfortunately health is too important a commodity to be left to the tender mercies of a profession whose chief interest, like most other professions in capitalist market economy, lies in the maximising of monetary gain regardless of other scruples. The nation's health, both of the rich as well as of the poor is now threatened by the burgeoning health industry with its insatiable appetite based on self-created demand and consequent rising costs without concomitant benefit. The effect of this on the poor masses in a country with limited resources is far worse. The health debate even in the affluent countries is now centred in the containment of cost, with control of the medical profession as the key factor.

Since the profession as it exists today has failed to shoulder their responsibility the inevitable result is that society has perforce to undertake most of these functions by itself and define the role of the medical profession in serving its needs. This must perforce lead to the control of the profession in the interests of the society at large. Since self-regulation is not a part of this new order in India and since the people must be provided with adequate basic health care, alternative means have to be devised to regulate the medical profession and define their role in the health care system of the country.

The regulation of the profession must start even before the stage of medical education by determining the human power required at each level in a graded decentralised system based within the community. The gross distortions in the present set up where there are more doctors than nurses, more nurses than ANMs and more ANMs than community health workers will have to be corrected for any meaningful health system. This will invariably result in limiting the number of medical schools and the annual production of doctors. It is clearly unacceptable that the two-thirds who enter the private sector be trained at the cost of Rs 3 lakh per head at public expense in government hospitals.

Since over-production invariably leads to malpractice, especially in a field where consumer resistance is at its lowest, the opening of private medical colleges cannot be justified on the basis that this does not involve public funds and that over-production will automatically provide services to the rural poor. The majority of graduates even of these colleges choose to practice in urban areas and even if under economic duress are driven to rural areas they practice a form of curative medicine without even minimal facilities and which is highly dangerous, like the widespread practice of giving of unnecessary and even harmful injections. This has diverted the meagre income of the poorest from nutrition to such necessary and unethical medical expenses with little benefit even for the actual care of their illnesses.

The present form of medical education which is based on an *ad hoc* importation of western medicine also needs a radical reorientation to meet the entirely different needs of our people. The teaching of basic sciences like anatomy, physiology, biochemistry and pathology are outdated even by the western standards they imitate.

As a result of the vast increase and rapidly changing nature of knowledge the need is for the teaching of broad principles, stimulating curiosity and teaching the intelligent retrieval of information and utilisation of the libraries and other documentation facilities; to inculcate a habit of continuous self-education not merely to pass exams but as a lifelong pleasurable exercise; a process which is almost entirely neglected in the present curriculum.

Since public needs demand that the vast majority of the graduates must undertake general practice whether in private or at the primary health centre the emphasis of under-graduate medical education must be for this rather than specialised services. The present clinical training is undertaken entirely in specialised departments, for strange as it may sound, there is not a single general teacher of family medicine in our entire medical educational system. As a consequence the young MBBS doctor sees the patient as a series of disjointed specialist problems rather than a whole human being in relation with his family, job and society which is the essence of family practice. This has consciously or unconsciously led to over-investigation, over-medication and over-reference to specialists and excessive hospitalised care. The majority of undergraduate clinical medicine should hence ideally be undertaken within the community at the primary health centre and community hospital. Since this is a distant goal there is no reason why the out-patients of medical colleges, which are mainly crowded with thousands of patients from the adjacent locality with common family ailments should not have a number of family physicians with simple pathology and diagnostic facilities to attend to these problems who are at present referred by out-patient clerks to whichever specialist they feel is the correct one. This simple practical device would not only screen the majority of patients and save much time and expense of both patients and specialists but also enable instruction of the students in the most essential and relevant part of their undergraduate training namely, general practice. It would at the same time reduce the cost of these expensive hospitals where some of the beds can be allotted to these teachers of general practice.

The subject of decentralisation of such large and inappropriate urban hospitals into community health care institutions where 95 per cent of all preventive, promotive and curative services will be catered to within the 1,00,000 population level as recommended by the ICMR/ICSSR report will need to be dealt with elsewhere.

Far more important than a reorientation of the technical aspect of the medical education are the values that are inculcated during the entire period of training in the young and receptive mind. As stated previously the influence of the dominant values of the society at large will prevail. The most that one can hope to achieve within this social system is to inculcate a desire to combine monetary with job satisfaction, which has somehow got lost on the way and has led to much frustration.

The present method of inducting immature youth at the age of 16 or 17 years directly after SSC into medical college cannot be condemned adequately; for medicine is a subject which deals ultimately with people and the most intimate aspects of their life. Many if not most of the problems that modern medicine suffers from is the conversion of a science dealing with life into an exercise in mere technology. This has resulted in the commercialisation of health into an 'illness business', from 'caring' to 'cure', frustration from loss of job satisfaction and alienation from the people.

Some corrective measures need to be taken. Five years of training is unnecessarily long for the technical training of a basic doctor for the needs of our society. Specialists will in any case receive appropriate additional training in their own field. Much more important would be to provide the first one-and-a-half to two years of training in the general as well as health related humanities and basic sciences both which stand out by their absence in the present medical curriculum. This should include subjects like the sociology, anthropology, economics, statistics, demography, psychology, ethics, documentation and communication. This may either be undertaken in the medical college with a suitably inducted faculty or in the departments of the university. This would help to produce a more mature and sensitised individual for a three-year course of which one year should be in basic medical sciences and two in appropriate basic medical technology and practice.

Even in the field of specialisation the largest needs will be for the general surgeon, general physician, paediatrician and obstetrician/gynaecologist who can be trained to carry out the common procedures which comprise the vast majority of specialised care which have now been appropriated by the ever increasing superspecialities today. This would leave only a few problems for the superspecialities located in independent institutions, preferably isolated from the medical colleges, and acting as pure referral centres for the most difficult problems. This will ensure that in the medical colleges the students will be exposed to the general practice type of medicine and only to the four above mentioned basic specialities and not distracted and diverted by the glamorous but far less important superspecialities with which they need only nodding acquaintance. This will also permit the rejuvenation of the four basic specialities whose realm has been eroded by the superspecialities in the present medical colleges and hospitals.

The present system of medical education dominated by the superspecialities has played a crucial role in distorting the values of medicine not only among the medical students who will be the future doctors, but also of the public as seen by the false demand created by these specialities. One of the results of this distortion is the devaluation of most important subject of preventive and social medicine which, bar exceptions, fails to attract the best teachers or students. This vicious circle has to be broken by raising the prestige of its teachers and by compulsory devotion of more time and examination questions to this subject. There are several examples where a good teacher has been able to create interest in what is basically an interesting subject which is generally taught drably and perfunctorily. The most important aspect of medicine, namely, epidemiology and communicable disease control, is a part of this discipline.

The importance of the medical profession in determining the health care of the nation cannot be underestimated. They can be the leaders in orchestrating the health services if not in health care if they so choose. On the other hand they can and have played a crucial role in distorting the whole system. Motives and values are far more important and must precede and not be subordinated to technology which used appropriately can transform the health of our people. Used inappropriately it can be a powerful tool for their exploitation.

The Medical Council of India as the apex body responsible for medical education has failed to fulfil its task. Leave aside setting an example of high moral and ethical values it has utterly failed even in devising a curriculum in keeping with the needs of our country. Nor has it been able to resist the political pressures in the opening of new colleges which fail to meet even the elementary needs of medical education. A radical change in this outmoded body with the induction of dynamic young teachers is an essential prerequisite for the improvement of medical education in this country.

All this will undoubtedly require a powerful 'peoples' outcry and through them the development of political will to bring about the necessary changes. Without this health care will remain a chimera and a mirage for the vast majority of our people.

"However it is from the perspective of the poor and underprivileged — the 350 million and more people in India — for whom health and wellbeing still remain a distant dream, that the training of doctors and Health For All (HFA) need to be reviewed."

Training of Doctors for India

Thelma Narayan*
Community Health Cell,
Bangalore

Promise of a New Dawn

When one thinks of medical care or of health services, among the images that come to mind, the doctor always seems to play a major role. Medical professionals, particularly doctors, have held the centre stage in the health care scenario. This is so particularly from the points of view of planners, administrators and doctors themselves.

Other points of view, based on field experiences, have been gaining ground during the past few decades. In 1978, the world wide acceptance of the goal of Health for All (HFA) by 2000 A.D., with its concern for equity and social justice, seemed to promise a new dawn. It initiated fresh thinking on several issues including that of the role of a doctor. It has developed multidimensional strategies of which Reorientation of Medical Education is one. Its terminology has now become part of the consciousness and statements of Governments, NGO's, medical educators, health professionals, development workers and social activists. Even the private sector uses it to its own benefit !

However it is from the perspective of the poor and underprivileged — the 350 million and more people in India — for whom health and wellbeing still remain a distant dream, that the training of doctors and HFA need to be reviewed.

This article attempts to focus on a few questions concerning medical education : What is the image of the new doctor ? What has been the Indian experience ? What are the challenges we face? What are the positive initiatives that have been developed ? and, What are the negative trends ?

The need for a "new" doctor

The health status of people and populations is determined largely by socio-economic-political-cultural-ecological factors. At the family and individual level these translate into income, occupation, residence, education and a host of cultural factors. While curative medicine plays an important healing and supportive role in times of disease, the other roles that a doctor can play need strengthening. For example, *they could be pacesetters in making available knowledge concerning the promotion of health and the causative factors for ill health, using the people's idiom and culture. Thus they could "teach", "educate" and "liberate" from unnecessary illness and suffering, in the truest sense.*

Several groups play a role in shaping health and more specifically health care services.

People themselves are crucially important — in making decisions, in being capable of looking after themselves and others, in living healthy lifestyles if circumstances permit, and in participating actively in and shaping their own health. This calls for different styles of functioning, different

* This article was written with the support of the Community Health Cell Team

perspectives, and different attitudes especially of the health professionals. *Doctors probably require a change of self image from being centre-stage to moving to the periphery, to playing catalyst, to learning from people and building on their existing knowledge and skills.*

The contribution and role of the silent majority of health workers is also gaining increasing recognition. We have a virtual army of different levels of health "workers" — nurses, pharmacists, laboratory technicians, health supervisors, multipurpose workers, health educators, ANM's trained "dais" or birth attendants, community health guides etc. For every medical officer of a Government Primary Health Centre there are over twenty workers. The GOI statistics say that about 53,000 of all these grades of workers are trained annually in the country. *Doctors need to be trained to work with all health personnel as democratic team leaders, outside the hospital setting as well as in it, and also to be able themselves to provide relevant training to others.*

We have a rich tradition of indigenous systems of medicine viz., Ayurveda, Siddha, Unani and also other systems of medicine, e.g., Homeopathy, Acupuncture etc. Besides these, there is also a wealth of local folk health practices. *Doctors need to move away from the present condescending, superior and largely ignorant position to a more open-minded and scientific approach involving these systems and their practitioners in Health Care.* This can only occur if serious efforts are made towards integration during the training phase in medical college itself.

As a result of far-reaching changes that are taking place in the philosophy and practice of medicine and health care services, *there seems to be a need for a redefinition and rediscovery of the role of a doctor in this more complex and decentralized scenario.* Their formation needs to prepare them more adequately for the new challenging roles they care called upon to play.

Prescriptions For Change

In India, reflections regarding the type of health care services and medical education we need, predated the HFA declaration at Alma Ata. They go back to the freedom movement.

The Nationalist Inspiration

The *Sokhey Committee on National Health* was set up by the National Planning Committee in 1940. It included many medical professionals who were active in the Independence Struggle. A demand was made for the provision of comprehensive health care by the state to all the people. They suggested the training of one health worker per thousand people within 5 years. A longer term target was to have one doctor per thousand people. This has not been achieved fifty years later. They also recommended that the Ayurvedic and Unani systems should be part of our national health system. This too has not moved much beyond apologetic rhetoric.

The landmark report by the *Health Survey and Development Committee* (Bhore Committee, 1946), recommended the training of a "basic doctor" to provide comprehensive health care to the vast rural population of the country. The earlier licentiate course was closed down. Several important recommendations were made which formed the blue print for change in Health Care and Medical Education (See Box 1).

(Box 1)

The Bhore Committee, 1946

- Expand medical education — more colleges
- Social and Preventive Medicine departments in medical college
- A year's "internship" after graduation
- Reduce didactic instruction and increase self-learning skills
- Set up All India Institute of Medical Sciences to train "teachers"
- Reserve 25 — 30% seats for women
- Provide subsidy and freeships for 30%
- Stress research for full-time teachers
- Refresher course for GPs
- Increase training of Nurses

The Fifties and Sixties were witness to a tremendous effort in infrastructural development and expansion of training capacity. *The Mudaliar Committee (1959)* recommended the need for consolidation and the *Patel report (1968)* spelt out in greater detail the qualities of a "basic doctor". Numerous conferences and meetings to discuss reorientation also took place.

Rethinking Change In 1974 the Government of India set up an expert committee to review the Indian medical education scene.

The report of the *Group on Medical Education and Support Manpower (Shrivastava Report, 1975)*, made a very strong indictment of the system and identified the challenges ahead (See box 2).

(Box 2)

Diagnosis of the Problem

"the stranglehold of the inherited system of medical education,

the exclusive orientation towards the teaching hospital,

the irrelevance of the training to the health needs of the community,

the increasing trend towards specialization and acquisition of postgraduate degrees,

the lack of incentives and adequate recognition for work within rural community,

the attraction of the export market for medical manpower,

are some of the factors ..... responsbile for the present day aloofness of medicine from the basic health needs of our people"

Srivastava report 1975

The Committee went on to offer its own prescription for change which reinforced and went beyond the "Bhore" blue print (See box 3).

(Box 3)

Srivastava Committee 1975

- "Humanities and social sciences in premedical education to be introduced.
- Principles of "Educational Science" to be utilized,
- Skills of "Basic Doctor" to be defined,
- Community orientation — as overriding objective of change,
- Community medicine teaching to be joint endeavour of entire faculty,
- GP's to be involved in teaching,
- Internship in District and Taluk hospitals,
- Continuing education for all health professionals / workers".

The Group considered it important to create a structure — a Medical and Health Education Commission — charged with the responsibility of bringing in the change process.

Unfortunately the major part of the recommendations of the Shrivastava report were not implemented. In fact presently, 15 years later, the majority of "medical educators" (teachers) are not even aware of the report or its contents.

The *1982 Statement on National Health Policy of the G.O.I.*, recognised that effective health care services depend largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel. It also stressed the need for a National Medical and Health Education Policy which would

- chart out changes in curricular content,
- assess requirement of health personnel according to regional needs,
- ensure social motivation of all personnel towards health services, and
- establish inter-relations between health personnel of various grades.

The first attempt to have a national level policy has been the *Educational Policy for Health Sciences*, 1989, (Bajaj report) which is still in the form of a draft report. The absence of a national policy or commission on Medical Education/education of health personnel leads, to adhocism and anarchy at the ground level, with market and political forces playing the major role, resulting in adverse effects on the quality of medical education and medical care. *The Medical Council of India*, MCI, provides guidelines and recognition, but lacks adequate statutory powers to be a regulatory body. Health being a State subject, medical colleges can start and function, having received affiliation by a local university and sanction from the State Government.

There is a Bill in Parliament to provide the MCI with more powers. It raises issues like providing autonomous colleges and institutions to allow them to innovate more freely. However, with all political instability of the past 2 years, it has not yet seen the light of day. During the 1980's a few States (Andhra Pradesh, Tamil Nadu and Karnataka) have started or initiated the process of forming a *State Level Health University* to which all medical colleges are affiliated. This helps in providing some standardization of curriculum, examinations, etc. It is hoped that they will aso be able to move ahead with new directions, and innovations.

At the national level therefore we have very clear and unambiguous statements regarding future directions. This is reinforced at the South East Asia Regional level by the WHO-SEARO reflections on Reorientation, and at the international level (See box 4), by the Edinburgh Declaration of the World Federation of Medical Education (reprinted elsewhere in this issue). However the most important aspect of policy is its implementation. What has been the experience of translating polices to programmes of change ? Are the prescriptions still rhetoric or reality?

(Box 4)

TRAINING THE NEW DOCTOR .... THE SEARO REFLECTIONS

"The new doctor will be the leader of a health team comprising various disciplines and professionals, working in partnership with the community it serves. Training would prepare the doctor for the application of a limited technology to preventive as well as curative interventions for patients predominantly from lower economic and rural groups. The leadership role would not be symbolic but rather based upon managing, coordinating and training skills.

Medical education to support this development would have to become community-oriented, which would mean students learning about care in, of and for the community. Curricula would change to stress content relevant to Health for All and Primary Health Care. Teaching methods would become more flexible, integrated, and problem oriented. Students would work in teams and in communities. Their goal would be life-long, self-educative skills. Standards would be competency-based and linked to local priority problems. Students would be selected to represent more closely the

socio-cultural circumstances in which their skills would be needed, and would be strongly encouraged to take career directions consistent with HFA/PHC. The overall emphasis would be upon appropriate technology and comprehensive health care management.

New demands would be made upon administrative structures for better coordination between faculties, professional bodies and communities because community — oriented medical education is like a three-legged stool which cannot do without any of these".

SOURCE: Reorientation of Medical Education, WHO-SEARO Regional Publications No. 18 (1988).

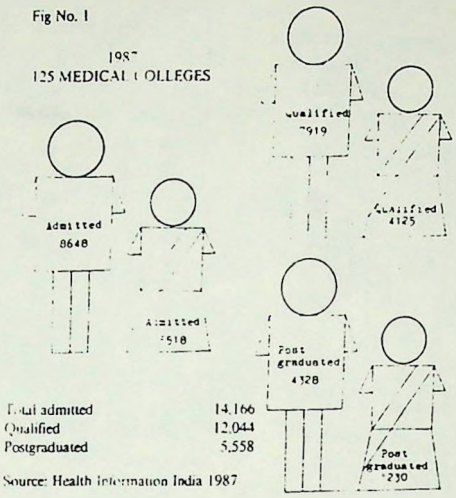
From Rhetoric To Reality

Over 40 years of experience are over. Where are we today ?

How many Doctors?

There has been a quantum growth in medical education and in the training of health personnel of different levels, since 1947. From 15 medical colleges admitting 1,200 students (other than medical schools) before 1946, we today have around 140 medical colleges(of the allopathic system) in the country. These form one tenth of allopathic medical colleges world-wide! Unfortunately, we do not know the exact number of colleges as of now. With rapid growth of capitation fee colleges and other new colleges in the 80's, many of which are not recognised by the Medical Council of India, we have only an approximation — viz., 140. The summary picture given in the figure below pertains to 125 colleges only. The actual numbers will therefore be higher.

Fig No. 1

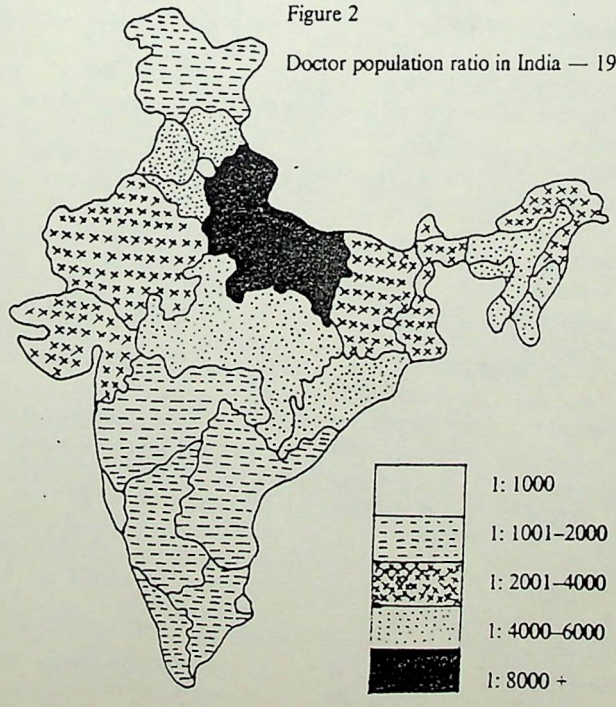


Where are the Doctors?

Mere numbers do not imply equitable distribution. Medical colleges are clustered in and around the large cities like Bombay, Calcutta, Madras, Delhi, Bangalore, etc. It is useful to take a look at the G.O.I. statistics on the doctor — population ratio in different States and Union Territories. The figures for 1988 show a wide variation in different regions.

Figure 2

Doctor population ratio in India — 1987



Source: Health Information India 1989

Doctors are not evenly distributed in a State according to the population, but are clustered in the urban areas with the rural areas being underserved. Even so, a clear pattern emerges, showing that the Northern States, including those holding the bulk of India's population, fall into the fourth group.

Who are the Doctors?

We are doing fairly well in terms of the number of seats for women students, with 36.4% of seats in 1987 going to girls. This trend has in fact been increasing over the years.

A compilation has been done regarding seats reserved for students from the Scheduled Castes, Scheduled Tribes and Other Backward Castes for the year 1984 — 85, covering 106 medical colleges recognised by M.C.I. It revealed that 30.6% of seats were reserved for these three categories.

As an approximation, one can also say from Figure — that about 45% of undergraduates complete their post graduation.

How good are the Doctors ?

It is the area of quality of medical education, and its relevance to the health needs of the large majority of our population, that presents the greatest problem and also the greatest challenge to medical educators.

It has been the experience of people and NGO's, Volags involved in health work in the periphery, that doctors fresh from medical colleges are ill-equipped to cope with even the medical problems in a rural area. Much less when it comes to issues like being the manager of a health centre, handling accounts, running a small pharmacy and laboratory handling X-ray equipment, training health workers, coping with rivalries and conflicts in the villages, and working in differing cultural situations. Understanding and intervening sensitively along with multidisciplinary groups in the broader societal factors that impinge on health is most often considered as "none of our business" or impossible.

The young graduates who are trained to believe that they are the cream of Indian society, having entered medical college in the face of stiff competition and having laboured for 5 1/2 years before graduation, are aghast when they come face to face with the realities. They are neither professionally competent nor emotionally prepared to face such a situation. Trained in a very structured, hierarchical, compartmentalised environment, with a surplus of medical personnel and a specialist for every organ, they feel incompetent to make important decisions concerning life and death independently. There is a long list of jobs for which they have never been trained.

Being used more to "Chart Care" than "Patient Care", even the so called "good students" often find themselves handicapped when it comes to carrying out basic nursing procedures, calculating drug dosages for children, handling normal and complicated deliveries, setting fractures, treating snake bites and a host of similar every day medical problems.

Where lies the problem ?

Feedback from medical graduates who have worked in peripheral health institutions in the late 70's, 80's and early 90's reveals *the urgent need for skill development during their undergrduate years.* However, unless medical teachers themselves get exposed to the realities of medical practice in the periphery and are themselves skilled to handle such situations it would be wishful thinking to expect them to train young students adequately.

It is important to shift the base for clinical training from being 100% in the exceptional environment of a large teaching hospital, to smaller hospitals, dispensaries and health centres. This should not be confused with the community based training under the Department of Community Medicine which is essentially to equip students with skills in epidemiology, sociology, health education and communication, understanding the life situation of people in rural areas and urban slums etc.

The present system of medical education in India was built on the British model. The curricular content, text books, college and hospital structure and environment, examination system etc., are all patterned and firmly set on the Western System as it prevailed 50-100 years ago.

A universal culture seems to prevail among medical students. Whatever may be the background of the student, a certain process of westernized socialization occurs. While certain aspects may be positive, it produces an alienation from our poor and a yearning to work in the familiar, comfortable surrounding of a hospital with all its infrastructure and back-up services of personnel and technology.

The Challenge before us

The Shrivastava report sums up this paradox and dilemma succinctly by stating that —

"The greatest challenge to medical education in our country, is therefore, is *to design a system that is deeply rooted in the scientific method and yet is profoundly influenced by the local health problems and by the social, cultural and economic settings in which they arise. We need to develop methods and tools of instruction which have relevance to the resources and cultural patterns of each area. We need to train physicians in whom an interest is generated to work in the community and who have the qualities for functioning in the community in an effective manner.* In addition to medical skills, they should be trained in managerial skills and be able to improvise and innovate".

Innovations/ Initiatives Within The System

During the past 44 years, there have been several attempts to introduce changes within the medical curriculum

to make it more meaningful to our situation. Some of these have been at an All-India level, through guidelines provided by the MCT, expert committee reports, and meetings of Deans and Principals of Medical Colleges. Some have been lobbied for by professional bodies eg., the Indian Academy of Paediatrics (IAP), the Indian Association for the Advancement of Medical Education (IAAME), and The Indian Medical Association (IMA.)

Some have been introduced at the State level eg., through the Health Universites of Tamil Nadu and Andhra Pradesh. Others have been developed at an institutional level. Yet others have grown around particular departments and individuals. The MCI guidelines (the latest was published in 1982) provide the overall framework for curriculum and examination system and also the minimum requirements in terms of staff and facilities. The guidelines are of a general nature and flexible enough to allow for innovations and modifications.

Some of the key initiatives have been :

Teaching Preventive and Social Medicine

Department of Preventive and Social Medicine (later called Community Medicine) were introduced during the early fifties. Field practice areas in urban slums and rural areas were developed for the purpose. Programmes such as the Family Health Advisory Service, where each student followed up 3-5 families for periods of 1-2 years, clinico-social case conferences, and field visits to different institutions were introduced. However, in general, these efforts have not made a dent in the situation for various reasons. In fact medical students and doctors always rate PSM about the lowest among all disciplines. Much worse has been the sometime counterproductive effect it results in, creating long-lasting negative impressions and a decision never to get involved with this sort of work or situation. Another adverse effect has been that community orientation has got compartmentalised into a departmental responsibility, while the rest of the 22 or so departments of a medical college continue their individual patient or system/organ oriented work.

However the PSM departments in a few colleges have done creative work and have been more inspiring. Foremost among them are CMC-Vellore, MGIMS-Sevagram, SJMC-Bangalore, AIIMS-New Delhi, JIPMER-Pondicherry, CMC-Ludhiana and BHU-Varanasi. They have introduced rural or community orientation camps where students live and learn in villages for a period of 2-3 weeks, block postings, health education and child to child programmes, socio-epidemiological projects, actually organizing health programmes of various types in rural situations, collaboration with other departments etc.

The ROME Scheme

The Reorientation Of Medical Education (ROME) Scheme was launched by the Janata Government in 1977, based on earlier expert committee recommendations. Three Government Primary Health Centres (PHC's) were attached to each medical college. It was hoped that the entire faculty would be involved in the training of students in the periphery. They would thus develop a community orientation and also upgrade skills at the PHC level. Over time, each college could take responsibility for an entire District. Unfortunately, the programme remained more at the level of mobile clinic services provided by interns and junior doctors, utilising the 3 large white mobile vans procured from the U.K. by Raj Narain.

These "White Elephants" cannot manoeuvre the smaller roads leading to the more remote villages; they are confined to the highways. The implementation of the scheme in its entirety also has not moved ahead and has not brought about changes that were hoped for.

Training the "Teacher"

Action was also initiated to introduce the principles of educational sciences into medical education. The *National Teacher Training Centre* (NTTC) was set up at JIPMER-Pondicherry during the 70's by the Government of India in collaboration with WHO. It did commendable work in organizing workshops and training programmes for medical teachers from colleges across the country. Subsequently a NTTC was also started at PGI, Chandigarh and later at B.H.U-Varanasi. Some colleges now have medical education cells with core groups of trained teachers who organise programmes at their own institutional level. AIIMS-New Delhi more recently has developed a Centre for Medical Education Technology (CMET) with a fairly large number of teachers trained at the professor and Assistant Professor level,who form its adjunct faculty. CMET has all the equipment necessary for the development of teaching aids. All these centres are also working on making assessment/examination methods more objective and rational.

Socialising 'Mother and Child' Care

The development of the concept and practice of *social or community Paediatrics* (child health) was also initiated during the Seventies. Osmania Medical College, Hyderabad was a pace setter; so also have been the colleges in Ahmedabad, Trivandrum, and Madras. The Indian Academy of Paediatrics has recently published recommendations for the teaching of paediatrics relevant to our social situation.

Attempts have also been made towards the development of social obstetrics with the support of WHO. Integrated teaching of Mother and Child Health (MCH) by the depart-

ments of Obstetrics and Gynaecology, Paediatrics and PSM was introduced in some colleges.

Expanding medical horizons

More recently some colleges eg., MGIMS-Sevagram, PGI-Chandigarh, JIPMER-Pondicherry, CMC-Vellore and others have been spearheading the introduction of *Rational Therapeutics* through the Departments of Pharmacology, Medicine etc. The need for a greater emphasis in the undergraduate medical curriculum to *Psychology, Behavioural Sciences and Psychiatry* is also gaining ground. The development of *epidemiological skills* is also being strengthened by initiatives and networks linked to CMC-Vellore and AIIMS-New Delhi. A few colleges are also concerned about a more planned approach to training in *Medical Ethics*. Some ground work has also been done to work out a curriculum for the teaching of *Management* to medical undergraduates.

Selecting and Motivating

CMC-Vellore and SJMC-Bangalore have introduced *selection* methods, which strive to understand attitudes and motivation rather than only intellectual ability. They also have a scheme through which young graduates *work in peripheral health institutions* of the voluntary health sector for 2 years after graduation. Having completed this, doctors get a preference for entrance into postgraduate courses. Over the years some of these postgraduates have become staff members. It is hoped that their experiences in the periphery will influence their teaching.

Most of the experiments and innovations have been confined to a relatively small number of institutions — the "Top Ten" medical colleges. These colleges also attract "good" students who tend to go in for superspecialization. It would probably not be a surprise to find that most doctors going abroad come from these colleges. The mainstream colleges should therefore be the focus for major efforts in reorientation. Another phenomenon is that creative and committed work usually continues as long as the key person who initiated it, is around. After they move on, the work gradually reaches a different level of routinized, meaningless functioning or gets lost to history. We need to develop a commitment to the cause and a process rather than individualized functioning and kingdom building.

Networking for Change

In addition to changes attempted by individual colleges and small groups of faculty there is an emerging trend in the 1980's for networking and exploring the problems and the solutions together.

Asking the right questions

In 1987 a symposium on "Medical Education for Primary Health Care Needs — experiences in successes and failures" was held at AIIMS-New Delhi. One of the key resource groups was the Centre for Educational Development, University of Illinois (USA), which has been spearheading changes worldwide. Four participating medical colleges — AIIMS (New Delhi), BHU (Varanasi), CMC (Vellore) and JIPMER (Pondicherry) formed a working consortium on "Inquiry Driven strategies for Innovations in Medical Education in India, Health Services Research and Context Evaluation". Each took on an area of study concerning medical education. There was sharing of information and views at different workshops. It is now hoped to enlarge the consortium, and spread its scope with each of the 4 colleges taking on 4 more colleges. The idea is to build the "case" and substance of change step by step asking the right questions and initiating studies to find answers and approaches.

Exploring Community approaches

The Miraj Medical Centre has put up a proposal for the development of a Christian Institute for Health Sciences. The group decided to be much more community oriented and community based. The manifesto articulates an alternative vision in objectives, methodology, student/staff selection, curriculum development, evaluation, development of peripheral health facilities etc.

Recognising the Social Paradigm

The *Medico Friend Circle* (mfc) is an all India group of people interested and involved in health issues within a broader social perspective. In a recent publication entitled *"Medical Education Reexamined"* (1991) they explore various dimensions of medical education, building on the perceptions of their members who come from diverse medical, social activist and developmental backgrounds. Using the framework of the 1982 MCI curriculum they have formulated an innovative alternative *anthology of ideas* which stresses the "societal causes of ill health and the community orientation" of the medical solutions.

The Alternative Track

In 1988, the MCI and WHO initiated homework with a few medical colleges on the possibility of an experimental parallel curriculum which would be "community oriented" and "problem solving" in its approach. Inspite of running into "bad weather", one member of the group, CMC-Ludhiana has gone ahead with preparation for change, having received the Punjab University's green signal to lay the new track. As faculty and students prepare of change CMC-Ludhiana has discovered the trials ahead with status quo forces. The process in its initial teething troubles has discovered the need for a "voluntary incrementalism".

Searching for a value orientation

1989 saw the Christian Medical Association of India (CMAI) facilitating a network of Medical College viz., CMC-Vellore, CMC-Ludhiana, SJMC-Bangalore and Miraj Medical Centre. Their objective was to learn from one another pioneering expe-

rience and strengthen each other. At the same time they have been exploring the need for greater social relevance and a new orientation in medical education upholding ethical values in medical practice, research and health care delivery.

EXPLORING NEW LINKAGES

Learning from the Grassroots

The voluntary health sector, working primarily with the more underprivileged sectors of society, has been growing during the past 3 decades. Non-formal training programmes in health related subjected were begun by different groups, independent of each other, in different parts of the country. Some of these date back about 25 years, while others are more recent. *The motivating factor was to train people to intervene sensibly and sensitively in the situation that prevails in each local region.* There is a tremendous variety in the types of training that evolved from the training of dais and community health workers, health educators, community organizers, multipurpose workers, development workers with a health training as well, to community health training and reorientation for doctors and nurses. From a six weeks' course the range of courses and alternative courses go right up to an M.phil and Ph.D programme in Community Health offered by JNU University.

These programmes *have developed their own curricular content and alternative training methodologies.* Since they were unfettered by regulations and accreditations, they were rather creative in their approach. These programmes are a very rich Indian resource and important lessons could be drawn from their experience and internalised into the medical education system, particularly for the community orientation and community health aspects. The Kottayam experiment a forgotten experience is given elsewhere in this issue.

Some newer areas developed are social analysis at a macro-level and also methods of understanding and analysing local situations. Simulation games have been developed to enable this. Another important area is the understanding and acceptance of oneself, one's needs, motivations and aspirations.

Identifying and utilising local health traditions, resources and medicinal plants has been done by several groups in different parts of the country.

Methodologies have been developed to enable and empower women who any way are the main providers of health care in the family and community.

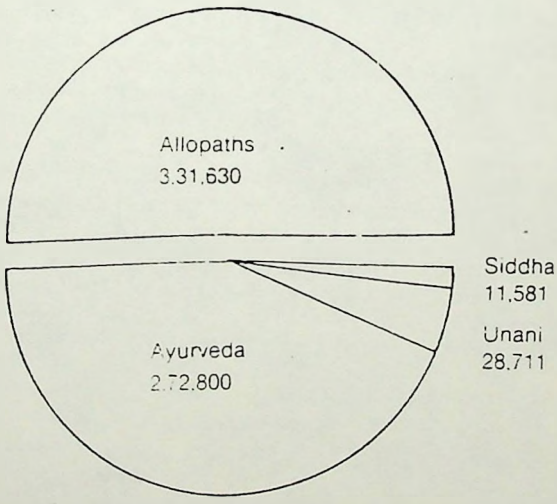
Medical skills have been demystified and health workers have been found very capable even in performing minor surgery and tubectomies. There is therefore an urgent need for interaction between the classical medical educators and this very alive and dynamic process at the grassroots which will be to their mutual benefit.

Recognising fellow physicians

The wealth of resources available in the Indian and other systems of traditional medicine which are culturally acceptable, closer to the people and more holistic in approach is gradually being recognised by health planners. Given below is a picture of the manpower available and training capacity.

Fig 3 a

Total number of registered practitioners of the different systems of medicine in India — 1987

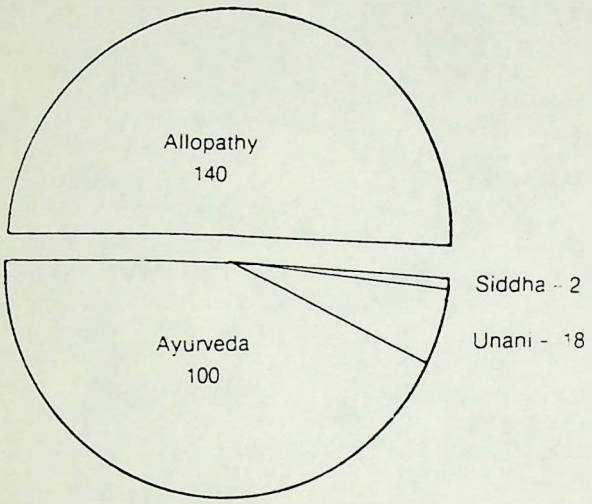


Source Health Information India 1988

Allopathy	3,31,630	51.43%
Ayurveda	2,72,800	42.31%
Unani	28,711	4.45%
Siddha	11,581	1.80%
Total	6,44,722	

Fig 3 b

Number of Training Institutions for medical practitioners of the differnt systems of medicines in India — 1987



Source: Health Information India 1988

Allopathy	140	53.85%
Ayurveda	100	38.46%
Unani	18	6.92%
Siddha	2	0.77%
	260	

Source: Health Information India 1988.

Medical educators can no longer ignore the other systems of medicine. Western medicine trained doctors in the community cannot ignore or their fellow physicians from the other systems. This calls for a courageously new commitment to integration in a medically plural situation, a task which the people have already begun. Notwithstanding the lofty exhortations of G.O.I. reports and the newly converted rhetoric of WHO—this continues to be a sadly neglected aspect of health care policy exposing the deeply embedded "cultural colonialism" of the allopathic tradition and the lack of an open ended rationalism. How long can we continue to ignore this plural partnership ?

Medical Education And Society In India

The training of doctors does not take place in isolation, but is moulded by powerful forces that operate in Indian Society.

Doctors at what cost

Medical education in India is highly subsidised. Doctors are educated at a tremendous cost to the public exchequer. This was done with the hope that they would provide medical care to "the vast rural population" (Bhore Committee). However, most of the graduates remain in urban areas and a large number — presently about 5000 a year i.e., 40% of graduates — migrate (R. Duggal). Even today, large proportions of our rural population have to make do with substandard medical care or no care at all from the state sector.

Private or Public ?

There is an increasing trend particularly in the 1980's towards the privatisation of medical education. Private colleges today account for about 25% of all medical colleges. "Capitation Fee' Colleges have sprung up as business enterprises. Upto Rs. 5 lakhs are collected as "capitation fees" per student on entrance. The facilities and staff requirements are more often than not inadequate and hence the colleges are not recognised by the MCI.

Thus a profession, that was once a vocation, is being commercialised and made into a business where medical care is bought and sold like any commodity. This is becoming increasingly evident in the type of doctor-patient relationships that prevail, in prescribing practices and in the mushrooming of high-tech diagnostic services and five star curative centres.

Unemployment in the midst of need

The total number of qualified medical doctors (allopathic) registered with the various State Medicl Councils in India, in 1987, was 3,31,630. In 1988, the total number of doctors working at the Primary Health Centre/Community Health Centre level was 26,230 i.e., about 7% of the total number of doctors. The Taluk and District Hospitals and hospitals/dispensaries/health centres of the NGO/voluntary sector also employ doctors. Private practitioners also sometimes work in villages. However even an optimistic estimate would not be more than 20-25% of doctors working in rural areas.

Paradoxically, we also have unemployment and underemployment of doctors. The number of medical graduates on the live register of the employment exchanges are as follows:

1986 — 25, 613
1987 — 31, 029
1988 — 27, 599

This is more than the number of doctors working at the PHC level! The actual numbers are much higher !

In Conclusion

There have been several changes for better and for worse in the field of medical education in India. There has been tremendous increase in the total number of trained personnel. Clinical competence is on the whole good. Over the years the varying needs at the grassroot, secondary and tertiary level have become more and more clear. Opinion and pressure have gradually been growing at the local, national, regional and international level regarding the need for a new type of physician viz., one

— *who can* understand health problems in a community context,
— *who can* build on the strengths of the community, working with them, facilitating growth, learning,
— *who shares* information and knowledge with the patient and the public,
— *who can* function democratically within a health team, and
— *who is* open to different systems of medicine and healing and health practices.

Never before have we been so close to embarking on this challenging path. We already have before us pioneers and trail blazers. At a wider level we have also with us competence in various fields, knowledge about local reality and a self-confidence to intervene creatively. Perhaps what is needed is a coming together of various elements who are committed to the training of the new doctor. A critical mass of these "live elements" could spearhead change in the years ahead.

References

1. Central Bureau of Health Intelligence, G.O.I., Health Information India — 1988 and 1989
2. Medico Friend Circle, Medical Education Reexamined, 1991
3. Narayan Ravi, mfc bulletin 97-98, 150 years of medical education
4. Duggal Ravi, Radical Journal of Health, Vol. III, No. 4 Medical Education in India : Who pays ?
5. Ministry of Health and Family Welfare, G.O.I., Report of the Group on Medical Education and support manpower, 1975
6. Government of India, Report of the Health Survey and Development Committee, 1944.

Dear Reader

Medico Friend circle is conducting a survey of patients' experiences and opinions of their doctors. Reproduced below is their letter and questionnaire. Your answers will help you and everyone else. (Ed)

Dear friend,

Medical care is an essential service we all need at sometime or the other. Almost 80% of it is in the private sector in our country. Of late, inspite of paying for private medical care, people have been raising doubts about the quality and the cost of medical care. But are these doubts really justified ? Unfortunately our research institutions have paid scant attention to the medical care of consumers and adequate information is not available.

Medico Friend Circle is a group of socially conscious doctors and other health activists, interested in knowing consumer's (patient's) experiences and opinions. We will gratefully appreciate if the readers respond to the following questions for the last visit they or any of their family members made to a doctor. We feel that dissemination of the findings of such a survey may begin a process of new thinking and perhaps, a process of change in medical care.

1. Date of visit to doctor. 2. Doctor's Qualification (degree) 3. Describe nature of illness for which doctor's help sought. 4. Number of days this illness lasted. 5. How long did you wait in the clinic before the doctor examined you? 6. How much time did the doctor spend in examining and advising you ? 7. Cost of the visit: Doctor's fees, cost of drugs, transport cost and any other. 8. Without having to demand it, did the doctor give you a receipt for the money you paid him ? 9. Did the doctor tell you the diagnosis, and give you information about the side effects/ bad effects of the medicines given or tests recommended? 10. Do you think that the fees paid by you to the doctor was low/reasonable/high/very high ? 11. Do you think the doctors' fees should be standardised throughout the country ? Why ? 12. Were you satisfied with the behaviour of and the treatment given by the doctor ? Why ? 13. What, according to your experience are the good and bad practices of the medical profession today ? 14. What according to you, should be done (including tightening regulations) to encourage good medical practice ?

While responding to the above questionnaire you need only put the respective Question Numbers.

We thank you for your response and promise to communicate the results to you. Kindly send your responses to:

Medico Friend Circle (Bombay Group) 310, Prabhu Darshan, 31 SS Nagar Amboli, Andheri (W), Bombay 400 058

Please write your name and address along with the response. All information given will be kept in strict confidence.

Thanking you,

Annie George
Coordinator

APPENDIX "D"

BLOCK POSTING - AN EFFECTIVE METHOD FOR COMMUNITY-BASED, COMMUNITY-ORIENTED TRAINING PROGRAMME *

The teaching of Community Medicine to undergraduate students in Christian Medical College takes place in a phased manner in four "Block Postings": during the first year of medical school, the first and second clinical years, and internship. Each phase has specific objectives, and is designed to build on the experience gained in the previous phases.

A block posting is when students are relieved from attending other classes and concentrate only on Community Medicine. This concept of teaching was introduced in 1975 by the Community Health Department when they realized that the previous programme known as Family Health Advisory Service had some serious limitations.

The Block Posting has the following advantages:

1. It helps to get the students full attention as well as have more time in the community. The students are not distracted by other classes, exams and extra curricular activities.

2. They are able to spend the entire day at the village, from early morning to late evening.

3. Living in the village or being present for the greater part of the day enables the student to observe the life style of the villages: their day to day activities, health practices, work schedules etc.

4. Besides, the students are able to contact, interact and organize programmes according to the convenience of the community.

5. The community is more receptive as students mingle with them freely, become involved in their daily lives and develop friendships with some of the families.

6. The close contact with the people is an enriching experience for the students as they discover the warmth and hospitality of the community. They are also able to identify and meet some of the felt needs, using the potentials and local resources of the community.

There are some disadvantages to this system of teaching:

1. It has the tendency to compartmentalize the subject.

* Dr. Abraham Joseph, Christian Medical College, Vellore-632002.

..122

2. The faculty are unable to attend to their other duties and clinical responsibilities during this period.

3. The other departments in the medical college are also inconvenienced as they have to reorganize their schedules for this programme.

However, cooperation and understanding between the faculty of the various departments has helped to organize these teaching programmes successfully.

METHODOLOGY

PHASE - I

Upon entry into medical school, the students are introduced through didactic lectures, case studies and simulation games to sociology, psychology, and biostatistics. The main part of the primary health care training, however, takes the form of a block posting of three weeks in what is known as the community orientation programme. This experience aims to familiarize students with the demographic, socio-economic, and environmental aspects of rural community health; with beliefs about diseases; with the role of various members of the health team; with government and voluntary organizations in rural health; and with the principles of health education. The students, in groups of two or three (depending on how many Tamil speaking students there are), live for two weeks in a rural community typical of those in the area. They use local sources of water, which they have to draw and purify; they plan the meals in thatched huts and use toilet facilities constructed at the camp site.

Each group is assigned 12-15 households and asked to study them in detail, using a form, designed by the college's department of Community Health and Biostatistics. Interviews and observations, help to uncover information on various aspects of village life. In addition, special studies are made of particular problems, such as the nutritional status of children (through anthropometric measurements), prevalence of diseases such as filariasis and scabies, the role of traditional practitioners, and the social problems of old age. With the help of the staff, the students analyse the data they have collected, which gives them practice in using and interpreting statistics and applying theories and methods they have learnt in the classroom. Groups of students then present their results to the rest of the class, using various methods of presenting the data. The ensuing discussion is often heated and educative and forms an important part of the learning experience.

During the camp, the students present special case studies of individuals suffering from common illnesses which they have identified themselves. Senior faculty members from CMC are invited to be present at these presentations, and to help students understand both the socio-economic roots and implications of the problems and the practical aspects of finding solutions in the village context. The presence of specialists from Physiology, Pathology, Surgery, Child Health, Medicine, Obstetrics and Gynaecology departments underlines the importance of Community Health.

To interact more effectively with the Community, the students organize and participate in various other activities: games and competitions for the village children and young people, health education activities (particularly in Nutrition), immunization programmes, construction of soakage pits to improve environmental sanitation, and the conduct of medical clinic each evening. In all such activities they work both with community leaders and with other members of the health team. In order to help the students understand the existing programmes in the rural areas, officials from various government departments and agencies and personnel from relevant private industries give talks about their role in community welfare. At the end of the posting period, the students organize a social gathering for the village at which they thank its eresidents and entertain them with songs and dances.

The students, on their return to the college, spend three days presenting and discussing the data they have collected, with the help of staff members and the use of audiovisual aids. Their learning experience includes an evaluation of what they have accomplished.

The CCP has been organized with the following objectives:

1. To bring about an awareness of the:

   a. social and economic status of the rural community
   b. demographic structure of the community
   c. environmental status of the community
   d. influence of social, economic and environmental factors on health and diseases
   e. existing health practices and beliefs about disease, its causes and prevention
   f. role of Government and Voluntary Organization and their programmes in improving the welfare of the rural community
   g. role of various members of a health team
   h. principles of health education.

2. To provide the student with skill in:

   A. Making a Community diagnosis by:

      i. interviewing individuals and families

..124

ii. carrying out a field survey
iii. using appropriate sampling techniques
iv. analysis of data
v. interpretation of data.

B. Organizing a Community Programme by:

i. identifying leaders and enlisting their cooperation
ii. enlisting community participation especially by working through leaders, youth and women group.

C. Carrying out health education for individuals andgroups using appropriate health education methods such as flash cards, flip charts, villupattu, skit, drama and songs.

D. Identifying the role of, and working with other members of a health team in organizing community programmes.

3. To inculcate an attitude of concern and compassion for the individual and the community.

PHASE - II

The second phase, which takes place during the first clinical year and lasts two weeks, focusses on the principles of epidemiology, health administration, and health planning. It includes lectures, classroom exercises, and field exercises.

The students, working in groups of 10-12 have 2-3 villages as the subject of field investigations. They conduct a cross-sectional survey of morbidity and mortality and, from the data collected, estimate the morbidity rate, susceptible ages, and sex-specific prevalence of certain diseases; the birth rate, crude death rate, infant mortality rate, and maternal mortality rate; and the utilization of health services, the distances that must be travelled to reach the services, and the cost of treatment. The students study the various types of health services available at the different administrative levels, from primary health care center, through tahsil hospital and district hospital (or community health and development hospital), the referral hospital. Through interviews with patients they obtain information on the distances patients have travelled, the types of disease that are common, and the length of time patients were ill before they sought medical aid. Information on each of the health services is compared in relation to types of illness, duration of illness, and distance travelled.

A time and motion study of the hospital organization is done to determine the waiting time and actual service time at various points the doctor's consultation, pharmacy, laboratory and injection room.

On the basis of lectures and the data they collect, the students plan a programme for a defined problem for a specified population. Their knowledge of community health principles is, in turn evaluated at the end of this phase.

The objectives of the CHP-1 are:

A. To make the students aware of the:

i. Principles of epidemiology
ii. principles of health planning
iii. Principles of health administration
iv. National health programmes with special emphasis on the organisation of Primary Health Care
v. Common health problems of a community
vi. Utilisation pattern of health services
vii. Role of the various members of the health team.

B. To provide them with skills in:

i. Formulating a questionnaire
ii. Carrying out community surveys - cross sectional morbidity and mortality surveys
iii. Analyzing and interpreting data
iv. Estimating vital statistics such as birth rate, death rate, infant mortality rate
v. Carrying out observation and time motion studies and interpreting the data
vi. Health Planning
vii. Use of various audio visuals aids, overhead projector, slide projector, movie projector etc.

PHASE - III

The third phase comes during the second clinical year and is of two to three weeks duration. It aims to give the students an opportunity to apply in practice, the knowledge and skills they have acquired in the previous two postings to implement a programme in a given community. This is primarily a community based, problem-solving problem. The students form their own groups of 5 or 6 students. A defined population is given to them. Within two weeks they are asked to make a community diagnosis by carrying out a survey or using existing data, plan a programme, implement and evaluate it. Each group of students chooses a particular problem to work with. Usually these will be common national health problems, or problems more specific to the area under study, such as nutrition, maternal and child health, leprosy, tuberculosis, family welfare, environmental pollution etc. The study questions are formulated in such a way that a variety of study designs will also be employed by the various groups eg., descriptive study or case control study.

..126

During the implementation of their programmes, the students make their own time schedules and use the services of various members of the health team as required. Two staff members from the college are assigned to each group as resource persons, but provide only guidance. The last few days of this programme are set apart for presentation. Each group presents the projects' goal, objectives, methods, results and limitations of the programme. They highlight their success and failure and analyze the reasons for the failure. The students also give a feedback of their data analysis to the community based on which they conduct a health education for the community. The students have reported that this phase of their training is the most useful, because of the experience it gives them in actually organizing a programme on their own and doing something for a community. But its effectiveness depends on the knowledge and skills the students have acquired in previous phases.

The objectives of the CHP-II are to provide skills in:

i. Making a community diagnosis prioritization and manpower planning
ii. Working with the members of the health team
iii. Organizing a health programme in the community
iv. Carrying out a health education programme
v. Evaluation of the health programme carried out
vi. Analysis of the data collected
vii. Presenting the findings of the study
viii. Using various audio-visual aids.

PHASE - IV

The one year compulsory internship is a continuation of undergraduate medical education. It includes a three month community posting that aims to prepare the intern as a "basic doctor" and to give him or her elementary knowledge of community health practice. As part of the health team the interns participate in the organization and implementation of primary health care in the area where they are posted; they also do short evaluation studies of programmes conducted by the department of Community Health of the college.

The "basic doctor" should be able to diagnose and treat common illnesses without the use of sophisticated laboratory aids and should know when to refer patients to specialists or to larger hospitals or other facilities. He should also be able to perform simple laboratory tests and common minor surgical procedures, such as tubectomy and vasectomy.

The interns training in community health practice focuses on: organizing preventive services for vulnerable population groups, such as mothers and children; conducting surveys and using their findings as a means of evaluation the health status of the community; applying the basic principles of

health education and the use of relevant techniques; promoting family planning; functioning as a general practitioner (or medical officer) in a health center, hospital, or national health programme; identifying the various political and socio-economic factors that influence a community's health and learning ways of improving it by working with people in other disciplines (eg., agriculture, education, and animal husbandary); understanding and working with other members of the health team; and becoming familiar with other community agencies and the help that they have to offer.

During their community health posting, the interns are an integral part of the health team. They make regular visits to the villages to take part in leprosy outreach work; supervise the work of part-time community health workers, health aides, andnurses at mobile clinic sessions; give health education talks at community gatherings; conduct maternal and child health clinics; and treat common conditions and make the necessary referrals. They also participate in all the activities at the Community Health and Development Hospital, Bagayam, for 3-4 weeks, treating inpatients, working in the clinical laboratory, seeing patients in the outpatient clinic, and performing simple surgical procedures under the supervision of a senior doctor.

Faculty attempt to use each patient encounter as an opportunity for teaching. Patients are told the causes of their maladies and how to prevent such disorders in the future. The intern learns to view patients not simply as isolated individuals with particular clinical disorders but also as signs of an unhealthy physical, biological, or social environment. An environmental problem, for example, can be viewed as a "community disease" and the patient as a "sign" of that disease. Treatment of the "community disease" often requires the use of non-medical approaches - hence the doctor's need to work with people in other disciplines. The necessity for involving the whole community in the solution of certain types of problem is demonstrated to the interns.

Working in pairs, the interns conduct a special study (an epidemiological) during their community posting. Often these studies serve as pilot projects that subsequently evolve into larger-scale endeavours.

The training of the interns aims to impart the following with regard to Community Health practice:

a. Ability to organize preventive services for vulnerable groups in the population eg., mothers and children.

b. Ability to conduct surveys and use its findings as a means towards arriving at a community diagnosis.

..128

c. Ability to understand and work with other members of the health team.

d. Knowledge of the basic principles of health education and ability to use health education techniques.

e. Ability to promote family planning.

f. Ability to function as a general physician (or medical officer) in a health center, a hospital or National Health Programme.

g. Ability to identify the various factors, social, political and economic, which influence the health of a community; and gain knowledge of ways by which this could be improved by working with other disciplines eg., agriculture, animal husbandary, cottage industries, etc.

h. Appreciation of the need to know government and private agencies in the community and acquiring knowledge of how to utilize their assistance.

An important aspect of the training model is evaluating it at various stages. Students submit pre and post evaluation questionnaires to assess their change in attitude toward rural medical care, knowledge acquired as a result of the programme, and the students own assessment of the programme. Department staff members give serious consideration to the students' evaluations, make relevant comments themselves, and try to alter subsequent programmes accordingly.

* * *
* *
*

For further information regarding each phase including reports, proformas, methods of evaluation, please contact Dr. Abraham Joseph, Professor and Head, Community Health Department, Christian Medical College, Vellore - 632 002.

..129

APPENDIX "E"

RECENT CHANGES IN UNDERGRADUATE MEDICAL EDUCATION AT SMT.N.H.L. MUNICIPAL MEDICAL COLLEGE, AHMEDABAD

A REPORT ON INNOVATIONS/EXPERIMENTS*

1. INITIATING THE CHANGE

In 1989-90 during the meetings of departmental heads arranged by the Additional Dean, Dr. K.J. Nanavati, various problems regarding undergraduate training programme and their possible solutions were discussed. Some changes were suggested like:

a. Need for frequent meetings and interactions between departmental heads, teachers from different departments and between teachers and students.

b. Strict review of attendance of students.

c. Synchronisation of theory lectures programme between various departments for example, between pathology, pharmacology and medicine, also synchronisation between theory and practicals/clinics for the same subject.

d. Formation of a Teaching Programme Review Committee(TPRC) to supervise these changes and give necessary suggestions.

2. THE CATALYST

To bring about changes in education in the right direction scientific approach is necessary and the first step towards developing a scientific approach was to orient the teachers to the concepts of Educational Technology. Thus a workshop on "Principles and Practice of Education, Technology in Medical Education"was organised at the institute and conducted by the faculty of NTTC from PGIMER-Chandigarh (Post Graduate Institute of Medical Education and Research) in March, 1990. The four day workshop covered two areas - Educational objectives and Evaluation. Twenty-eight teachers from the institute participated in this workshop which used real workshop methodology (Group Discussions/Group Work, etc.).

Most of the participants were quite impressed by this newly acquired knowledge and were convinced that for the change in the desired direction proper application of Education Technology would be necessary. It was also realised that a total reorientation and not the isolated, patchwork type changes in education was necessary to achieve relevance and effectiveness.

..130

*Minutes sent by Dr. K.J. Nanavati, Additional Dean Smt. NHL Municipal Medical College, Ahmedabad.

3. FEW STEPS FORWARD (INNOVATIONS AND EXPERIMENTS)

A follow up meeting of all teachers participating in NTTC-workshop was called by the additional Dean (who himself was one of the participants). It was decided to proceed for the change using principle of Educational Technology. The proposed change can be represented as follows:

*DEFINE LEARNING OBJECTIVES (Relevant to society needs);
*CHANGE TRAINING METHODOLOGY;
*CHANGE EVALUATION METHODS;

(The group, now called Educational Technology Group(ETG) was divided in three sub-committees).

i. Sub-committee for conducting Education Technology Group workshop for remaining teachers;

ii. Sub-committee for formulating Educational objectives;

iii. Sub-committee for MCQs, collection and forming MCQ Bank (now changed to sub-committee for Evaluation).

All sub-committees worked under the leadership and guidance of the Additional Dean.

Following is the outcome of the ETG activities over the last two years.

3.1 WORKSHOPS ON EDUCATION TECHNOLOGY

The Sub-committees for workshops conducted a series of workshops on Educational Technology. Main objective was to expose the teachers of the Institute to Education Technology and to enable them to participate effectively in the activities like formulating learning objectives in their department, constructing tests for student's evaluation etc.
Total 217 teachers participated (almost all the teachers of the institute) in 10 workshops conducted between April 1990 and March, 1991.

3.2 FORMULATING EDUCATIONAL (LEARNING) OBJECTIVES

The sub-committee for Educational objectives worked simultaneously with the workshop committee and so far has completed the following tasks.

3.2.1 Formulating Institutional level objectives:

The committee obtained Educational objectives from some premier Medical Institutions in India and reviewed them. At the same time it also defined priorities in education on its own during the course of several meetings. The draft of institutional objectives prepared by the sub-committees was revised, after being discussed in the meeting of the departmental heads.

3.2.2 Formulating Departmental level objectives:

Once the institutional level objectives were ready, the tasks of defining objective of various departments was undertaken. A two step strategy was adopted.

STEP I: Defining priorities - division of the subject into three areas:

a. Core areas absolutely essential areas in which 90-100 per cent efficiency is expected;

b. Good to know - in which 50 per cent efficiency is expected;

c. Nice to know - least important may be dispensed with.

STEP II: Stating the objectives - describing the competence in terms of knowledge and skills and also the attitudes, by referring mainly to the Core Area. While stating departmental level objectives, their relevance to the institutional objectives was also being checked. So far most of the departments have completed this exercise, and a few are in the pipelines.

3.2.3 These objectives will be modified if necessary taking into consideration the views/suggestions of the practitioners, resident doctors, interns and students. A step in this direction - two workshops/meetings recently held with the members of Ahmedabad Medical Associations to discuss these objectives and to get their feedback.

3.3 INTRODUCTION OF CLINICAL TEACHING FROM FIRST MBBS

Clinical posting has been introduced for first MBBS students for the last two years. The objectives is to orient them to the hospital set up, and to make them familiar with history taking, physical examination of patients, bedside manners and simple ward procedures.

3.4 Evaluation Programme for the first year was evaluated by the students by responding to the questionnaire. Similarly during the Orientation Programme for interns (Refer 3.6) feedback was also obtained from them.

3.5 COMPREHENSIVE CLINICAL POSTINGS

A one week experiment of comprehensive posting was conducted for the batch of 8th semester students, attending medicine term. During this period, the students stayed with the department for the whole day (9.00 a.m. to 5.00 p.m.) during which they were exposed to the working of Radiology and Pathology departments in addition to clinics/clinical

..132

lectures in Medicine so as to give an picture of integrated coordinated working of all these departments.

It was felt by the teachers that although this type of posting was possible for all the clinical subjects it required a careful and long term planning.

3.6 ORIENTATION PROGRAMME FOR INTERNS

In February, 1992, the new batch of interns was exposed to a three day orientation programme. The programme covered the following:

a. Short lectures and discussions on objectives of internship and rational therapeutics;

b. Introduction to group dynamics;

c. Project work and project report.

Students worked in groups of ten and gathered information on the different type of formulations available for the given group of drugs (Brand names, contents, potency, cost of a course of therapy).

They presented the report using tables, charts, histograms, etc. The information thus gathered was discussed in relation to rational therapeutics.

d. Projection of a video film covering aspects of rational therapeutics;

e. Group Exercise - three groups were formed and each undertook one of the following three exercises:

i. Essential drugs scoring system;

ii. Evaluation of promotional drug literature;

iii. Discussion on expectations of interns from internship programme.

The programme was perceived as 'useful' to 'very useful' by about 85 per cent of the participants.

4. A LONG WAY TO GO

Above is an acccunt of a few experiments - some planned and some spontaneous. To bring about a perceptible change, these few steps should lead to a long journey - involving not only a few teachers but all concerned - the teachers, the students and the administration.

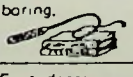
****

..133

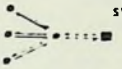
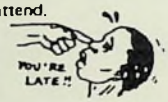
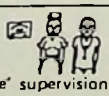
APPENDIX "F"

THREE APPROACHES TO EDUCATION

This chart gives a summary of 3 approaches to teaching. It may help instructors to evaluate their own teaching approach. But we do not recommend that this analysis be given to health workers. Analyzing stories and role plays will work better. So pass by this chart if you want.

	CONVENTIONAL	PROGRESSIVE	LIBERATING
Function	to *CONFORM*	to *REFORM*	to *TRANSFORM*
Aim	Resist change. Keep social order stable.	Change people to meet society's needs.	Change society to meet people's needs.
Strategy	Teach people to accept and 'fit in' to the social situation without changing its unjust aspects.	Work for certain improvements without changing the unjust aspects of society.	Actively oppose social injustice, inequality, and corruption. Work for basic change.
Intention toward people	*CONTROL* them—especially poor working people—farm and city. 	*PACIFY* or *CALM* them—especially those whose hardships drive them to protest or revolt. 	*FREE* them from oppression, exploitation, and corruption. 
General approach	*AUTHORITARIAN* (rigid top-down control)	*PATERNALISTIC* (kindly top-down control)	*HUMANITARIAN* and *DEMOCRATIC* (control by the people)
Effect on people and the community	*OPPRESSIVE*—rigid central authority allows little or no participation by students and community.	*DECEPTIVE*—pretends to be supportive, but resists real change.	*SUPPORTIVE*—helps people find ways to gain more control over their health and their lives.
How students (and people generally) are viewed	Basically passive. Empty containers to be filled with standard knowledge.  Can and must be tamed.	Basically irresponsible. Must be cared for. Need to be watched closely.  Able to participate in specific activities when spoon fed.	Basically active. Able to take charge and become self-reliant.  Responsible when treated with respect and as equals.
What the students feel about the teacher	*FEAR*—Teacher is an absolute, all-knowing boss who stands apart from and above the students.	*GRATITUDE*—Teacher is a friendly, parent-like authority who knows what is best for the students.	*TRUST*—Teacher is a 'facilitator' who helps everyone look for answers together.
Who decides what should be learned	The Ministry of Education (or Health) in the capital.	The Ministry, but with some local decisions.	The students and instructors together with the community.
Teaching method	• Teacher lectures. • Students ask few questions. • Often boring. 	• Teacher educates and entertains students. • Dialogue and group discussions, but the teacher decides which are the 'right' answers.	• Open-ended dialogue, in which many answers come from people's experience. • Everyone educates each other.
Main way of learning	*PASSIVE*—students receive knowledge. Memorization of facts.	More or less active. Memorization still basic.	*ACTIVE*—everyone contributes. Learning through doing and discussing.

..134

	CONVENTIONAL	PROGRESSIVE	LIBERATING
Important subjects or concepts covered	• the strengths and rightness of the present social order • national history (distorted to make 'our side' all heroes) • rules and regulations • obedience • anatomy and physiology • much that is not practical or relevant—it is taught because it always has been • unnecessary learning of big words and boring information	• integrated approach to development • how to make good use of government and professional services • filling out forms • desirable behavior • simple practical skills (often of little use—such as learning 20 bandages and their Latin names). 	• critical analysis • social awareness • communication skills • teaching skills • organization skills • innovation • self-reliance • use of local resources • local customs • confidence building • abilities of women and children • human dignity • methods that help the weak grow stronger
Flow of knowledge and ideas	school or health system → teacher → students  all one way	school or health system → teacher → students  mostly one way	students ⇄ group ⇄ leader ⇄ school or health system  both ways
Area for studying	The classroom.	The classroom and other controlled situations.	Life—the classroom is life itself.
How does the class sit?			
Class size	Often *LARGE*. Emphasis on quantity, not quality, of education.	Often fairly small, to encourage participation.	Often *SMALL*, to encourage communication and apprenticeship learning.
Attendance	Students *have to* attend. 	Students often *want to* attend because classes are entertaining and they will earn more if they graduate. 'Incentives' are given.	Students *want to* attend because the learning relates to their lives and needs, and because they are listened to and respected.
Group interaction	Competitive (cooperation between students on tests is called cheating).	Organized and directed by teacher. Many games and techniques used to bring people together.	Cooperative—students help each other. Those who are quicker assist others.
Purpose of exams	Primarily to 'weed out' slower students; grades emphasized. Some students pass. Others fail. 	Variable, but generally tests are used to pass some and fail others.	Primarily to see if ideas are clearly expressed and if teaching methods work well. No grades. Faster students help slower ones.
Evaluation	Often *superficial*—by education or health system. Students and community are the objects of study.	Often *over-elaborate*—by education or health 'experts'. Community and students participate in limited ways.	*Simple* and *continual*—by community, students, and staff. Students and teachers evaluate each others' work and attitudes.
At end of training, students are given . . .	• diplomas • irregular, police-like supervision 	• diplomas • uniforms • salaries • 'supportive' supervision 	• encouragement to work hard and keep learning • supportive assistance when asked for
After training, a health worker is accountable to . . .	his supervisor, the health authorities, the government	mainly to the health authorities, less so to local authorities and the community	mainly to the community—especially the poor, whose interests he defends

SOURCE : Helping Health Workers Learn
(A book of methods, aids, and ideas for instructors at the village level)
by David Werner and Bill Bower

..135.

CHC/CMAI/CHAI
Medical Education
Project

Please fill this form before you come for the meeting. It will take you 5 minutes only. Your participation is solicited.

MEDICAL EDUCATION / SOCIAL-COMMUNITY RELEVANCE

Indian Experience

SELF ASSESSMENT GUIDE

Are you interested in Medical Education in India Yes/No

If Yes would you like to know what your score in information terms is as of today !

Mark tick for each item that you feel you know something about. Would you be able to write 5 lines on each ?

SECTION A

1. Bhore Report (1946) Yes/No
2. Mudaliar Report (1959) Yes/No
3. Srivastava Report (1974) Yes/No
4. ICSSR/ICMR - Health for All Report(1981) Yes/No
5. National Education Policy for Health Sciences (1980) Yes/No
6. MCI Curriculum 1982 Yes/No
7. Indian Association for Advancement of Medical Education Yes/No
8. Indian Journal of Medical Education Yes/No
9. National Teacher Training Centres Yes/No
10. Institutional Objectives Yes/No
11. Rural Internship Yes/No
12. ROME Programme Yes/No
13. Basic Doctor Definition (1970) Yes/No
14. Edinburgh Declaration (1939) Yes/No
15. Problem based learning Yes/No

Total Yes in A=_____

X 2 =_____

..136

SECTION B

16. Patel Report (1970)	Yes/No
17. National Health Policy (1982)	Yes/No
18. National Educational Policy (1986)	Yes/No
19. Perspective Plan for Science & Technology 2001 A.D.	Yes/No
20. Eighth Plan Document - Sector : Health	Yes/No
21. National Medical/Health Commission	Yes/No
22. MCI Bill in Parliament	Yes /No
23. Health University Concept	Yes/No
24. Family Planning Course - MCI Guidelines	Yes/No
25. Clinical orientation in pre-clinical phase - MCI requirements	Yes/No
26. Integrated Teaching	Yes/No
27. Social Paediatrics/Obstetrics	Yes/No
28. Family Health Advisory Service	Yes/No
29. Epidemiology for Undergraduates	Yes/No
30. Leprosy Teaching - MCI Guidelines	Yes/No
31. Mobile Rural Hospital Scheme	Yes/No
32. Objectives of Internship	Yes/No
33. Interns Orientation Programme	Yes/No
34. Internship Assessment	Yes/No
35. Humanization of Preclinical Experiments	Yes/No
36. Synchronised lecture programme	Yes/No
37. Community Orientation Camps	Yes/No
38. Community Block Postings	Yes/No
39. CPGP Units / G O P D	Yes/No
40. Priority listing in Clinical subjects	Yes/No
41. Core abilities	Yes/No
42. Integrated Health Team Concept	Yes/No
43. Clinical clerkship concept	Yes/No
44. Health Education in Medical Education	Yes/No
45. Behavioural Sciences in Medical Education	Yes/No
46. Students Electives	Yes/No

Total Yes in B1 = _____

X 1 = _____

.....3/-

47. Rational Therapeutics Course	Yes/No
48. Ethics course in Medical Education	Yes/No
49. Foundation Courses for Medical College Entrants	Yes/No
50. Management Training in Medical Education	Yes/No
51. Teachers Training	Yes/No
52. Medical Education Technology	Yes/No
53. Instructional objectives	Yes/No
54. Small Group Learning	Yes/No
55. MCQs	Yes/No
56. SAQs	Yes/No
57. Skill Laboratory	Yes/No
58. Self Learning Skills	Yes/No
59. Participatory Training	Yes/No
60. OSPE	Yes/No
61. OSCE	Yes/No
62. Teaching in Emergency Medicine	Yes/No
63. Alternative Systems of Medicine in Medical Education	Yes/No
64. Simulation Games	Yes/No
65. Low Cost Communication skills	Yes/No
66. Kottayam Experiment	Yes/No
67. Doctors for Villages - Study	Yes/No
68. mfc - Anthology of Ideas	Yes/No
69. JNU - Plea for a new Public Health	Yes/No
70. CMC - Vellore model of Community oriented Medical Education	Yes/No
71. Miraj Manifesto	Yes/No
72. Alternative Track	Yes/No
73. Inquiry driven Strategies-Indian Consortium	Yes/No
74. ENCLYN Network	Yes/No
75. EPIDMAN Network	Yes/No
76. National System of Medicine	Yes/No

Total Yes in B2=_____

X 1=_____.

..138

77. Selection Procedures - Psychological tests/ Group Observation Yes/No

78. Extra mural Postings for Undergraduates Yes/No

79. Graduate Feedback Yes/No

80. Alternative Health Trainers Sector Yes/No

81. Alternative Development Trainers Sector Yes/No

82. SEARO booklets on Reorientation of Medical Education Yes/No

83. Alma Ata Declaration Yes/No

84. International Network of Community Oriented Health Sciences Institutions Yes/No

85. Rural Bond/Placement Scheme Yes/No

Total Yes in B3 = _____

X 1 =_____

Total Yes in A + B1 + B2 + B3 =_____

That is the percentage of information you have on Indian experience. If you would like to increase your score you may like to read/use the Faculty Resource Manual which we will be producing as an output of our study 'Strategies for Social Relevance and Community Orientation in Medical Education : Building on the Indian Experience' (Due to be published by end 1993)

Welcome to theMedical Education Review Meeting on 20/21st June 1992 where you will find out more about all these Indian Experiment/experiences.

COMMUNITY HEALTH CELL

10th June 1992

A modified shorter version of this was distributed to IAAME Annual Conference participants in January 1992.

ANNEXURE "H"

STRATEGIES FOR SOCIAL RELEVANCE AND COMMUNITY ORIENTATION IN MEDICAL EDUCATION - Building on the Indian Experience

A FACULTY RESOURCE MANUAL
VOLUME I-III

A Note and the content list of the Faculty Resource Manual for consideration by participants of the Medical Educators Review Meeting organised by Community Health Cell in Bangalore in June 1992.

Dear Reader,

Please review the enclosed note and the content list that follows :

i) Please read the note about the manual which is in its pre-final stage. Do you have any ideas/suggestions about format/presentation at this stage which would make its use more easy, relevant and meaningful to your faculty group work.

ii) Are there any ideas/issues, experiments/innovations that you know of, which have not been mentioned?

If so, can you give/send us further details/references or leads on the same.

iii) You may like to show this to some of your other colleagues in your institution who have an interest in medical education reform. Please do so and send your comments after that if you like.

iv) Please mark the communication to Community Health Cell, Attn.: Faculty Resource Manual, Society for Community Health Awareness, Research and Action, 326, V Main, I Block, Koramangala, Bangalore - 560 034.

v) All communications/suggestions will be acknowledged in the final publication.

vi) All communications to us should be sent in by 31st July, 1992.

A NOTE

* This manual has been put together as a resource book for the faculty of medical colleges who are keen to be involved in reorienting medical education towards greater social and community relevance in the 1990's.

* It brings together a large number of ideas, innovations and experiments that have been part of the Indian experience in the last few decades and especially since the mid 1970's.

* These were identified through a project undertaken by a group of researchers of the Society for Community Health Awareness, Research and Action, Bangalore which was sponsored by C.M.A.I. and C.H.A.I. and supported by the C.M.C. Network.

* The project methodology included a literature survey; a survey of medical colleges; field visits to a few key colleges which included discussion with faculty and interns; a study of the training experiences in the voluntary sector to identify issues and methodologies relevant for professional education; and a survey of graduates who had two years experience in a peripheral health care institution.

* The manual attempts to put the faculty in touch with the wide range of Indian experience so that they can build on ideas and experiences that have arisen from a creative interaction with local realities and not just transplanted from another culture, health service or educational system.

* It also draws inspiration from different sectors of experience which include the experts; the medical college innovaters; the alternative community health and development trainers; academics and activists interested in the topics and young graduates working in primary health care situation.

* This manual is not a recipe book. It <u>does not</u> aim at telling you <u>how to do it</u> but to bring to your notice <u>what was said</u> and <u>what has been done</u> by someone else in a similar situation.

* It is a resource manual - a reference manual to inform, to stimulate, to support.

* The ideas identified by the study have been grouped into sections so that they cover different aspects of reorientation - different issues - different tasks.

* Ideally the resource manual could be an adjunct to the group discussions and group work of a team of the faculty, who form part of a formal or informal medical education cell of a college. Issues and ideas suggested in the manual could be taken up and the materials provided used as background reading and background stimulus.

* Some tasks have been identified in each section or whenever/ wherever it is relevant. Many other tasks could be evolved by the group itself.

* The format of the manual is a file with information and ideas in loose leaves. The faculty team are advised to make their

own notes, include additional reference materials, modify or update the section in any way and as they require.

* The manual will have three volumes. The first is the current volume which will include 5 key areas for reorientation :

  a) Exploring Expert Prescriptions

  b) Lessons from History, Culture and Tradition

  c) Medical College innovations and experiments

  d) Exploring new horizons

  e) Studying the pace-setting innovations that have relevance for the 1990's

* The second volume is a detailed report of the 'graduate survey' which was part of the study and which apart from the scientific report of the study and its findings will provide all the key ideas and suggestions from the graduates for reorienting teaching in each of the subjects taught in the existing course as well as about a wide range of related issues and aspects of the curriculum.

* The third volume which focusses primarily on the contribution of trainers from outside the medical college sector will focus on Laying the New Foundation for an alternative medical education by

  i) Exploring the links between Medical Education and society and hence understanding the social/societal context in which change has to take place.

  ii) Explore the alternative pedagogy, ideas, content and methodology of training in the alternative training sector in India which helps trainees to locate their action and efforts in a broader community/societal framework.

* The final format of the first two volumes is being released at this Medical Educators Review Meeting in Bangalore in June 1992 to get your ideas, views and opinions on the areas/issues covered and to get any suggestions or feedback that will help us to prepare the trial copies.

* We hope that in the months ahead these trial copies will be used by a certain number of faculty teams to undertake certain common group tasks and exercises and provide a feedback on the contents and presentation of the manual.

* This trial phase will lead to many ideas, modifications, alterations and additions to the volumes of the manual and will greatly help to ensure that when it is finally published by early 1993, it will be in a format for easy and more meaningful use by a wider cross section of medical college faculty in the country.

* The Faculty Resource Manual (three volumes) will be complemented by three other publications from the project.

  a) <u>Stimulus for Change</u>

  An annotated bibliography of 40 key titles around the theme of the project.

b) Step by Step

An anthology of all the earlier initiatives towards an appropriate medical education by the researchers before the project was initiated.

c) Evolving a Process

A detailed project report on the two year study.

V O L U M E - I

This volume is divided into four sections.

Section I

This section provides the introduction to the manual and some ideas about how to use it; the areas it covers; short descriptions of the sub-units; approaches and plans; limitations of use; format and arrangement; and other relevant background information.

Section II

Introduces the need for strategies of social relevance and community orientation in medical education by bringing some real life case studies of the challenges of health care in rural, tribal and urban slum situations in the country and then provides a situation analysis and comprehensive overview of the challenges in training of Doctors for India.

Section III

This section brings together all the ideas, issues, innovations, experiments identified by the study organised into 5 broad subsections A to E with multiple subunits in each subsection that focuses on different issues, groups of ideas or themes.

The detailed content list of this section follows

Section IV

This section includes a bibliography of all the key reports, articles, publications reviewed by the researchers and presents them in an alphabetical order with a supplementary subject index as well.

The bibliography covers over 800 references.

..143

S E C T I O N - III

A- An Anthology of Expert Recommendations on Medical Education in India

A-1 Introduction
A-2 Background on expert committees/organisations
A-2.1 Bhore Committee (1946)
A-2.2 Mudaliar Committee (1961)
A-2.3 Patel Committee (1968)
A-2.4 Srivastava Report (1974)
A-2.5 ICSSR/ICMR - Health for All study group (1981)
A-2.6 National Education Policy in Health Sciences (1989)
A-2.7 Medical Council of India (MCI)
A-2.8 The Indian Association for Advancement of Medical Education (IAAME)

A-3 The Expert Prescription

A-3.1 What's wrong with Medical Education
A-3.2 Type of Doctor
A-3.3 Objectives/aims of medical education
A-3.4 Learning objectives for undergraduate medical education
A-3.5 Recognition and control of colleges
A-3.6 Pre-medical education
A-3.7 Admission requirements and selection criteria
A-3.8 Duration of Course
A-3.9 Coeducation
A-3.10 Medium of instruction (Debate)
A-3.11 Medical curriculum : Overall principles
A-3.12 Medical curriculum : The challenge before medical education
A-3.13 Medical curriculum : The new focus of education
A-3.14 Educational strategies
A-3.15 Nature and organisation of Teaching Hospital
A-3.16 Nature and organisations of community centres for teaching
A-3.17 Pre-clinical phase
A-3.18 Additional programmes (Pre-clinical)
A-3.19 Para-clinical phase (Phase II)
A-3.20 Clinical Phase (Phase III)
A-3.21 Preventive and Social Medicine (Community Health)
A-3.22 Integration
A-3.23 Examinations
A-3.24 Internship
A-3.25 Teachers - selection/development
A-3.26 Research - General
A-3.27 Medical College facilities
A-3.28 General Practitioners
A-3.29 Students Health
A-3.30 Electives
A-3.31 Amenities/Incentives for Rural Work
A-3.32 Image of a doctor at the PHC's
A-3.33 Continuing Education
A-3.34 National System of Medicine and integration with ISM

A-4 Some major thrusts and approaches

A-4.1 Training of Basic doctor in Preventive Medicine and Public Health (Bhore Report 1946)
A-4.2 Preventive and Social Medicine - Building the outline and framework (Carl Taylor - 1955)
A-4.3 The Field Internship (Carl Taylor - 1955)
A-4.4 Medical colleges and Health Services (Kartar Singh Report, 1974)

C-5 Selections/Admissions
C-5.1 Criteria for Admissions in Medical Colleges in India - Selection/Reservation - An overview
C-5.2 Interviewing Philosophy and procedures (SJMC-Bangalore)
C-5.3 Interviewing Philosophy and procedures (CMC-Vellore)

C-6 Faculty Development
C-6.1 The National Teacher Training Centres
C-6.2 Faculty Development (JIPMER, IMS-BHU, AIIMS)
C-6.3 Teacher Training Programme (KMC-Manipal)
C-6.4 Education Technology Group (NHLMC, Ahmedabad)
C-6.5 Staff experience in peripheral hospitals (CMC-Vellore)

C-7 Examination Reform
C-7.1 Objectivised Assessment System (AIIMS)
C-7.2 Restructuring assessment towards HFA/PHC (JIPMER)

C-8 Electives and Research by Students
C-8.1 The Role of electives and participation of Students in Research Projects
C-8.2 Exposure of Undergraduate students to research (WHO)
C-8.3 Health and Society - Reflections on a Travel elective

C-9 Pre-clinical phase initiatives
C-9.1 Rebuilding Pre-clinical Foundation (CHC, Bangalore)
C-9.2 Short Study Skill Course for New Entrants (VMMC, Solapur)
C-9.3 Foundation Course (CMC-Vellore)
C-9.4 Clinical Orientation in Pre-clinical Phase (KGMC, Lucknow)
C-9.5 Behavioural Science Teaching - A plea
C-9.6 Behavioural Sciences - suggestions for curriculum content (A compilation)
C-9.7 Samaritan Medicine (CMC-Ludhiana)
C-9.8 Rural Orientation Camps - An outline (SJMC, Bangalore)
C-9.8.1 Go to the People - Learn from them (SJMC, Bangalore)
C-9.9 Community orientation programme (CMC-Vellore)
C-9.9.1 Attitudes - evaluation form (CMC-Vellore)
C-9.9.2 Post Community Orientation Programme - Evaluation (CMC-Vellore)
C-9.10 Community Oriented Training Programme (PSG, Coimbatore)
C-9.10.1 Community Orientation Programme - Evaluation (PSG, Coimbatore)
C-9.11 Integrated teaching of growth and development - AIIMS, New Delhi - a manual

C-10 Para-clinical Phase initiatives
C-10.1 Reorienting Pharmacology Teaching - An overview
C-10.2 Reorienting Teaching of Pharmacology (BJMC, Pune)
C-10.3 Synchronised lecture programme of Pathology, Pharmacology and Medicine (NHLMC, Ahmedabad)

C-11 Preventive and Social Medicine Teaching
C-11.1 Family Health Advisory Service (LHMC, New Delhi)
C-11.2 Integrated teaching of PSM with para-clinical/clinical departments (A suggestion)
C-11.3 Family Health Care Exercises (AIIMS, New Delhi)
C-11.4 Training in Epidemiology (LHMC, New Delhi)
C-11.4.1 Training in Clinical Epidemiology/Health Economics/ Managerial Skills (CMC-Vellore)
C-11.5 Community Block Posting - I Clinical Year (CMC-Vellore)
C-11.5.1 Health Planning Exercises (CMC-Vellore)
C-11.6 Community Block Posting - II Clinical Year (CMC-Vellore)
C-11.7 Beyond PSM - A Community Health Experience (SJMC, Bangalore)

C-12 Integrated Teaching
C-12.1 Objectives of integrated teaching - An overview
C-12.2 Integrated Teaching (Goa Medical College)
C-12.3 Integrated Course of Human reproduction/ Family Planning and Population Dynamics (SVMC, Tirupati)
C-12.4 Integrated Teaching (SVMC, Tirupati)
C-12.5 Human Sexuality Course (MC, Nagpur)
C-12.6 Integrated Training in Leprosy (An approach)
C-12.6.1 Training of UG's in Leprosy (GMLF/MCI Workshop)

C-13 Clinical reform
C-13.1 Priority listing in clinical teaching (NHLMC, Ahmedabad)
C-13.2 G.O.P.D. (MGIMS, Sevagram)
C-13.3 Extra mural postings (CMC-Vellore)
C-13.4 Training in Emergency Care (JIPMER)
C-13.5 Student Clerkship - Medicine, Surgery, Paediatrics (CMC, [illegible] Vellore)
C-13.6 Integrated teaching of MCH (WHO, SEARO)

C-14 Mobile Rural Hospital Scheme
C-14.1 Mobile Rural Hospitals - Rohtak experience

C-15 ROME Scheme - Guidelines
C-15.1 ROME Scheme - Evaluation
C-15.2 Implementing ROME (Kottayam Medical College)
C-15.3 Implementation and Evaluation of ROME (Goa Medical College)

C-16 Internship Programme
C-16.1a Integrated Orientation Programme (JIPMER, Pondicherry)
C-16.1b Interns Orientation Programme Plan (GMC, Bombay)
C-16.2 Community Health Postings (CMC-Vellore)
C-16.3 Rural Community Health Clinics (SJMC-Bangalore)
C-16.4 Training interns in integrated GP Unit (BMC, Baroda)
C-16.5 Interns and epidemics (NHLMC, Ahmedabad)
C-16.6 Interns and Health Education (TNMC, Bombay)
C-16.7 Internship Evaluation (CMC-Vellore)
C-16.7.1 Internees Assessment Proforma (SVMC, Tirupati)
C-16.8 Other aspects

D- Exploring New Horizons

D-1 Introduction
D-2 Management in Health Care
D-2.1 Management Training needs of MO of PHC (NIHFW, New Delhi)
D-2.2 Management concepts in Medical Education (NTTC, JIPMER) - Workshop recommendations
D-2.3 Management Training in Medical Colleges (NIHFW, New Delhi) - Trivandrum Workshop recommendations

D-3 Education for Health
D-3.1 Learning made Easy (TNMC, Bombay)
D-3.2 Health Education in UG Medical Education (CHEB, New Delhi)

D-4 Medical Ethics
D-4.1 Teaching in Medical Ethics (SJMC, Bangalore)
D-4.2 Ethical issues in Medicine - An opinion survey (NIMHANS, Bangalore)
D-4.3 Current problems in Medical Ethics (a listing)
D-4.4 Medical ethics, medical malpractice and Patients rights (mfc, Bombay)

D-5 Mental Health
D-5.1 Teaching methodology of Mental Health to UG Medical Students (AIIMS, New Delhi)
D-5.2 Training undergraduates in Psychiatry (NIMHANS, Bangalore)
D-5.3 Mental Health - Time table for a short course (NIMHANS, Bangalore)

D-6 Rational Therapeutics
D-6.1 Components of an educational programme on Rational Therapeutics - A check list (CHC, Bangalore)
D-6.2 Rational Drug Use (CHC, Bangalore)
D-6.3 A to Z of Drug Policy issues and Problem Drugs (CHC, Bangalore)
D-6.4 Rational Drug use in Medical/Pharmacy Education (IOCU Consultation)
D-6.5 Essential Drugs and Rationalised Drug Use - Objectives of teaching (NTTC, JIPMER)
D-6.6 Improving therapeutics through an ADR Monitoring Centre (CMC-Vellore)

D-7 Alternative Systems of Medicine
D-7.1 Situational Overview (mfc)
D-7.2 Curriculum plan for an input on Alternative Health Care Systems (CHC/SJMC, Bangalore)

E- Setting the Pace for the 1990's

E-1 Introduction

E-2 Pioneering Efforts - Pre 1980
E-2.1 Doctors for the villages - An internship study on 7 colleges
E-2.2 For a new pattern of rural medical education-Some Guidelines
E-2.3 The Kottayam experiment
E-2.3.1 Curriculum development
E-2.3.2 The curriculum
E-2.3.3 Doctors or Health Educators
E-2.3.4 Health Awareness and Health Science
E-2.4 The ROME experiment - an overview
E-2.4.1 A Study of ROME Programme (JNU)

E-3 Recent Policy Statements
E-3.1 The National Health Policy (1982/83)
E-3.2 Health for All by 2000 A.D. - Working Group (1981)
E-3.3 The New Education Policy (1986)
E-3.4 The Revised Education Policy (1989)
E-3.5 A perspective plan for 2001 A.D. on role of Science and Technology (1989)
E-3.6 The Eighth Plan Document - Sector: Health (1990)

E-4 A Plea for a new Public Health (JNU)
E-4.1 Crisis in the Medical Profession in India (D. Banerji)

E-5 The Community Health Trainers of the Voluntary Sector
E-5.1 A Statement of Shared Concern and Evolving Collectivity (C.H. Trainers' Dialogue - October 1991)

E-6 The mfc Anthology of Ideas
E-6.1 The medico friend circle manifesto
E-6.2 The Alternative Curriculum

E-7 The Health University Development
E-7.1 University concept of medical and health education

E-8 Emerging Networks
E-8.1 The Alternative Track (1988)
E-8.2 The Consortium of Colleges (1987) (Inquiry driven strategies)
E-8.2.1 Synopsis of curricular deficiencies
E-8.2.2 Curriculum reforms at consortium institutions
E-8.2.3 Block Posting for Community based training (CMC-Vellore)

E-8.2.4 Core Abilities (IMS-BHU)
E-8.2.5 Introduction of Problem Learning (Consortium)
E-8.2.6 Introduction of Management Concepts (Consortium)
E-8.2.7 Integrated Health Team Concept (Consortium)
E-8.2.8 Clinical Clerkship (Consortium)
E-8.2.9 Introduction of Behavioural Sciences (Consortium)

E-8.3 Strengthening Epidemiological Skills

E-9 The CMC Network
E-9.1 The CMC Network - (1989)
E-9.2.1 The Vellore model of Community Oriented medical education (MGR University Workshop)
E-9.2.2 The Challenges of Continuing Education (CMC-Vellore)
E-9.2.3 Education in CMC - Themes and Strategies in the 90's
E-9.3.1 CMC-Ludhiana - Process of voluntary incrementalism
E-9.3.2 Child survival through a slum health and development project - a multi disciplinary training module (CMC-Ludhiana)
E-9.4.1 The Miraj Proposal (CHC)
E-9.4.2 The Miraj Manifesto (MMC-Miraj)

E-10 Reorientation of Medical Education - SEARO efforts
E-10.1 Towards the New Doctor
E-10.2 Obstacles to Change
E-10.3 Goals Areas and Direction for SE Asia Region
E-10.4 Targets in Educational Programme Reform

E-11 The Network of Community Oriented Health Sciences Institutions (1979)
E-11.1 Lessons from the Network (A report)

E-12 The Edinburgh Conference - An over view
E-12.1 The Edinburgh Declaration
E-12.2 The Edinburgh Declaration - The questions asked

E-13 Education for Decentralised Health Care (CHC, Bangalore)

E-14 References and further reading on recent developments

E-15 A WORD OF CAUTION

> A teacher can never truly teach unless he is still learning himself. A lamp can never light another lamp unless it continues to burn its own flame. The teacher who has come to the end of his subject, who has no living traffic with his own knowledge, but merely repeats his lesson to his students can only load their minds. He cannot quicken them. Truth not only must inform, but also must inspire. If the inspiration dies out, and the information only accumulates, then truth loses its infinity.
>
> -Rabindranath Tagore

- - - - -
- - -

APPENDIX "I"

AN ADDITIONAL READING LIST

AN-01 Srivasteva Report (1974)

AN-02 Health For All - An alternative strategy-ICSSR/ICMR(1981)

AN-03 MCI Recommendation on Graduate Medical Education (1982)

AN-04 National Health Policy (1982)

AN-05 Recommendations of Health and Development Committee 1943-1975, CBHI (1985)

AN-06 Medical Education in India - CBHI Directory (1986)

AN-07 Draft National Education Policy Bajaj J.S. et al (1990)

AN-08 Health Education in Medical Curriculum - CHEB (1979)

AN-09 Primary Health Centre Training Guide - Part I, MHFW (1980)

AN-10 Handbook for the MCH in a Community Development - Dhillon H. et al (1983)

AN-11 Manual of Mental Health for Medical Officers - Isaac, M.K. et.al (1985)

AN-12 Child Health and Manpower 2000 AD - IAP and WHO (1987)

AN-13 Undergraduate Medical Education in Mental Health, NIMHANS (1988)

AN-14 Concepts of Essential Drugs and Rationalised, NTTC (1989)

AN-15 Teaching Community Medicine, CMC Approach, CMC-Vellore (1990)

AN-16 Inquiry Driven Strategies - An Indian Consortium (1991)

AN-17 Health and Family Planning - Multidimensional Analysis - Banerji, D. (1985)

AN-18 Medical Education - Radical Journal of Health, March 1989, No.4.

AN-19 Medical Education Re-examined, Medico Friend Circle (1991)

AN-20 Medical Education:Where does it lead - Health Action, June, 1991.

AN-21 Monsoon: A Simulation Game, SEARCH Publication (1981)

AN-22 People in Development - A SEARCH Trainer's Manual (1982)

AN-23 A Manual of Learning Exercises, VHAI (1983)

AN-24 Taking Sides: The choices before the Health Workers, ANITRA (1986)

AN-25 Trainers Manual for Training Community Level Workers, CHAI (1987)

AN-26 FIONA - A Manual for Managers of Primary Health Projects CMAI (1987)

AN-27 Approaches to learning for health work, VHAI-HFM (1988)

AN-28 Through a Glass, darkly - ACHAN Newsletter, April-May,1988.

AN-29 Training for Social Change - ACHAN Newsletter, December 1991.

AN-30 The Rationale & Vision - A Springboard for change, ROME Booklet 1, WHO-SEARO (1988)

AN-31 Strategies & Targers, ROME Booklet 2, WHO-SEARO (1988)

AN-32 Indicators for Monitoring & Evaluation, ROME Booklet,3, WHO-SEARO (1988)

AN-33 Educational Handbook for Health Personnel, Guilbert, WHO Publication (1977)

AN-34 A Guide for teachers of Primary Health Care staff, WHO (1979)

AN-35 Helping Health Workers Learn - David Werner & Bower Bill, 1982

AN-36 Self Assessment for Teachers of Health Workers, Rotem, et al WHO, (1982)

AN-37 Innovative Schools for Health Personnel, WHC (1987)

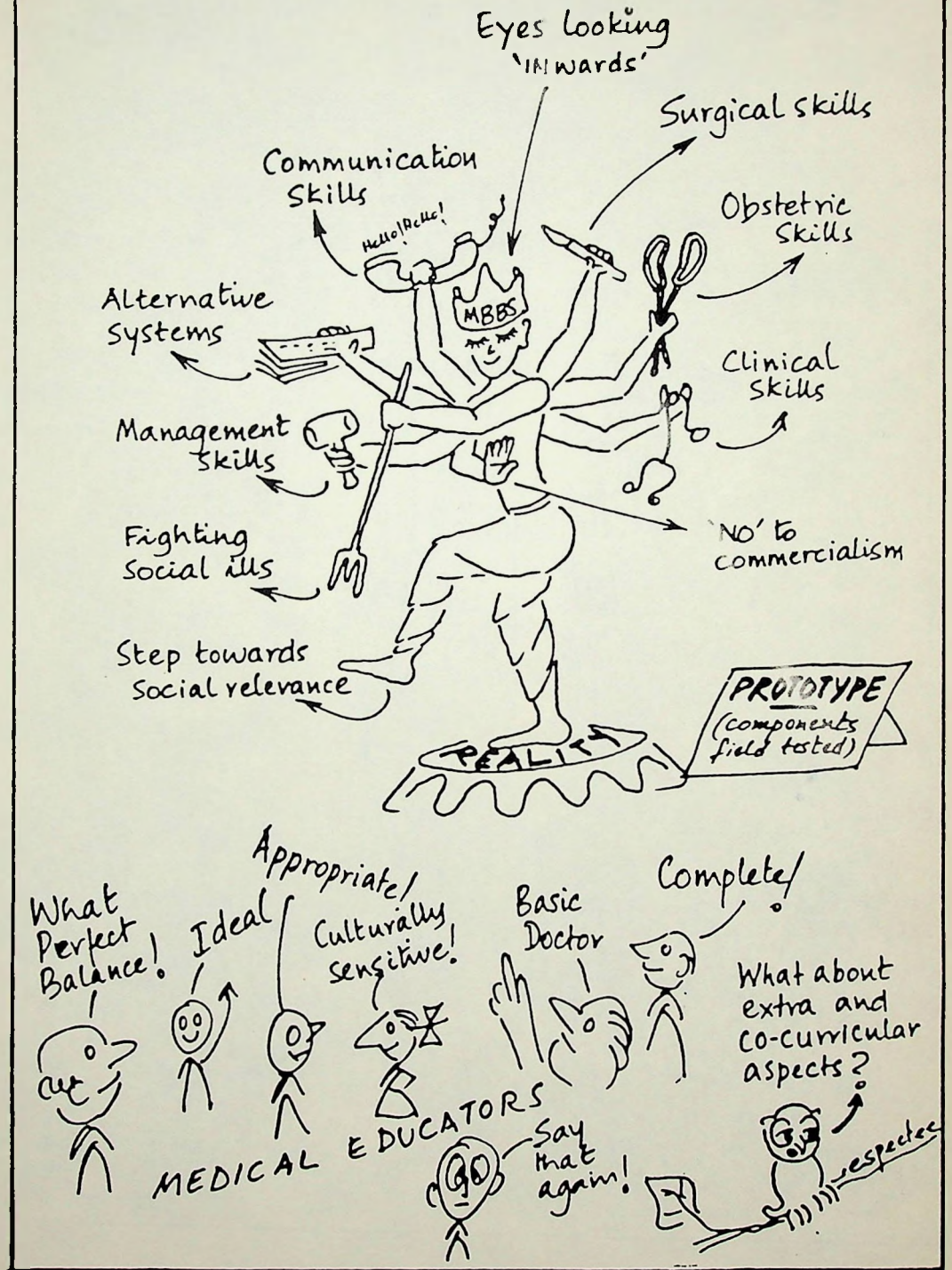
AN-38 Innovative Tracks at established institutions for the Education of health personnel, Kantrowitz & et.al, WHO Publication, (1987)

AN-39 Report on World Conference on Medical Education, World Federation for Medical Education (1988)

AN-40 Doctors for the Villages - Study of rural internships in seven Indian medical colleges, Taylor, Carl, et al (1976).

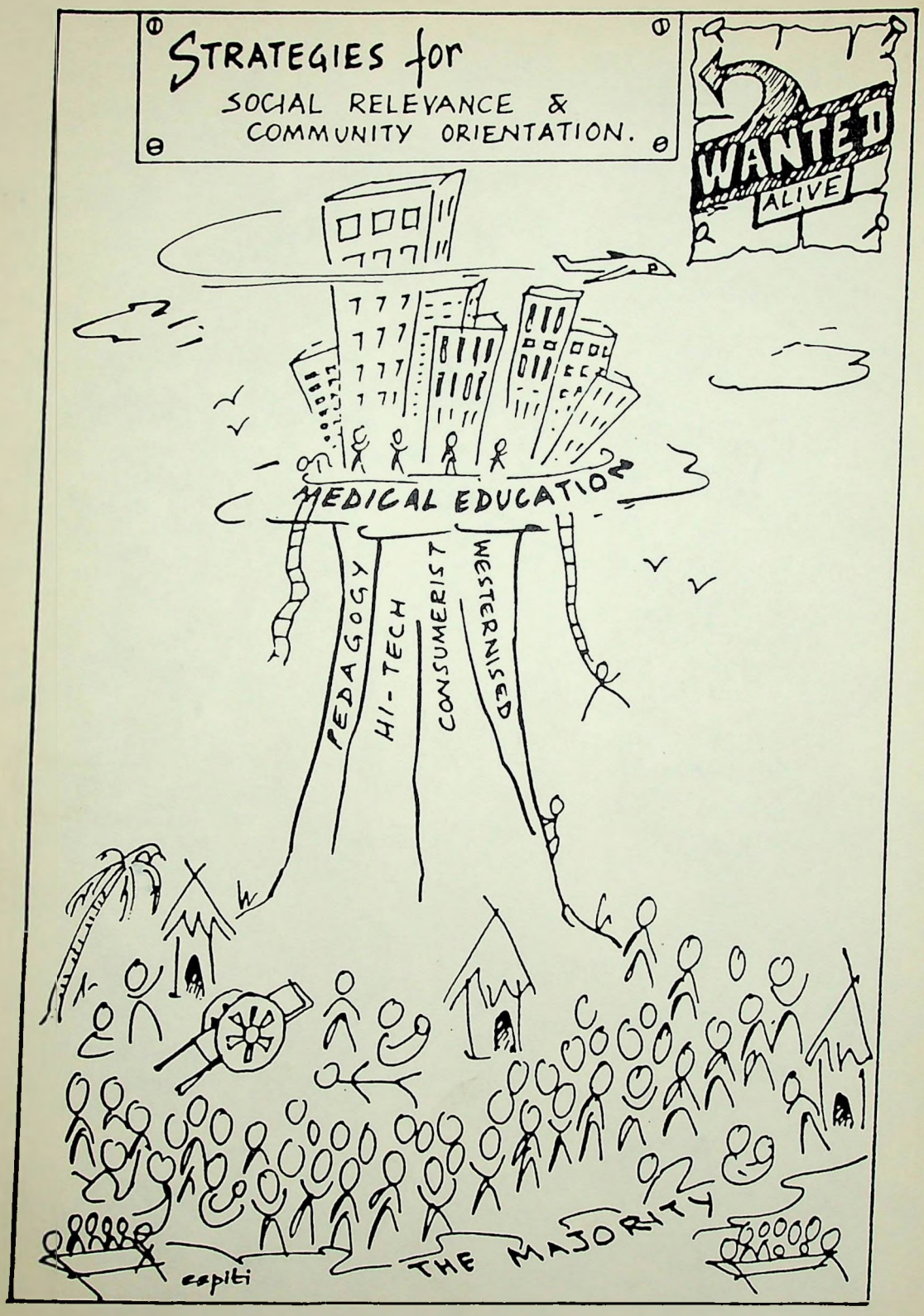
NOTE: All forty publications are included in the Annotated Bibliography entitled Stimulus for Change published by CHC-Bangalore, in August, 1993 and available on request (cost Rs. 08-00).

COMPOSITE MODEL



TOWARDS THE INDIAN DOCTOR MODEL - ARE WE READY FOR THE ALTERNATIVE TRACK?

-CHC


STRATEGIES for
SOCIAL RELEVANCE &
COMMUNITY ORIENTATION.
WANTED
ALIVE
MEDICAL EDUCATION
PEDAGOGY
HI-TECH
CONSUMERIST
WESTERNISED
THE MAJORITY
espiti