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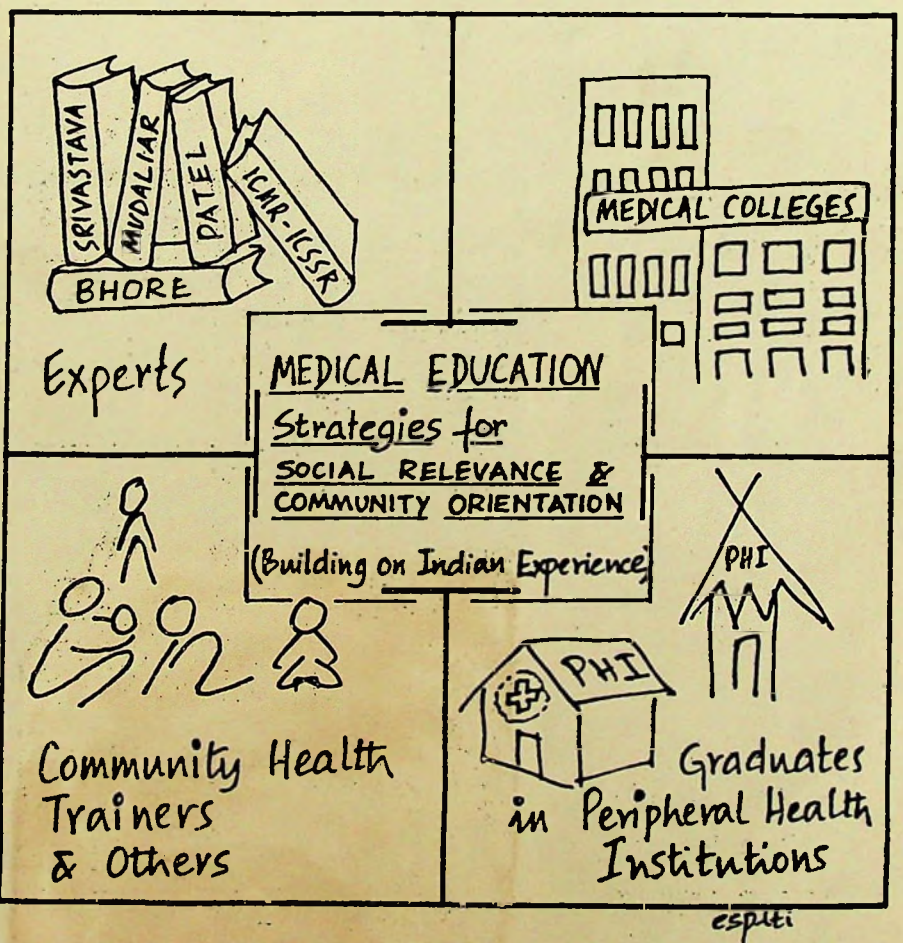
A PROCESS REPORT



(A C.H.C. - C.M.A.I. - C.H.A.I. PROJECT 1990-92)

Research Project : Strategies for Social Relevance and Community Orientation in Medical Education : Building on the Indian Experience

A PROCESS REPORT

Community Health Cell, Bangalore *

JUNE 1992

Sponsored by : Christian Medical Association of India (CMAI), Catholic Hospital Association of India (CHAI), Christian Medical College, Ludhiana (CMC-L).

*Society for Community Health Awareness, Research and Action, No. 326, V Main, I Block, Koramangala, Bangalore - 560 034.

MEDICAL EDUCATION PROJECT 1990-92 June 1992

A PROCESS REPORT

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A. PREAMBLE

a) Medical Education Reform

Medical Education and its social and community orientation have been a subject for discussion and dialogue in India especially since the Bhore Committee Report of 1946. During the last four decades there has been much rhetoric and many exhortations; a few concerted attempts by keen medical educators and institutions; some progressive recommendations by the Medical Council of India (1) and other professional bodies, but little overall change.

The Srivastava report in 1974 (2) sums up the problem and the challenge very effectively when it states :

"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 communities

and the attractions of the export market for medical manpower

are some of the factors which can be identified as being responsible for the present day aloofness of medicine from the basic health needs of the people....

"The Challenge Ahead"

The greatest challenge to medical education in our country is to design a system that is deeply rooted to 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 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".

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The last fifteen years, since the Srivastava Report have however witnessed a growing spirit of introspection and an increasing commitment towards serious reorientation of the curriculum, to suit our own 'needs' and 'socio-cultural realities'.

The period since 1975 has been marked by significant developments, of relevance to Medical Education.

At the national level, there have been the National Health Policy and National Education Policy statements, the operationalization of the Reorientation of Medical Education (R.O.M.E.) Scheme, the 1982 Recommendations of the Medical Council of India, and the development of the Health University concept (3).

Within the medical colleges, there have been serious efforts by a few to evolve community oriented training strategies based on the MCI guidelines and sometimes going beyond it, but within the overall stipulated 'structure' and framework of orthodox medical education that has been historically evolved and is well entrenched. Their efforts have been interesting but of limited impact due to many factors including inadequate faculty response and the changing social/value ethos of the medical college entrants. The absence of the concept of 'autonomy' in the medical education sector in the country, preventing the development of experimental alternative curricula is also an important factor.

Some medical colleges have been involved in networking around various new directions including 'epidemiological orientation', the 'alternative track' concept, and the 'decision based approaches to evaluation/innovation' (3). Many have been participating in the annual deliberations of the Indian Association for the Advancement of Medical Education. The efforts of the National Teacher Training Centres for medical college teachers in Pondicherry and PGI-Chandigarh have also been significant (9).

Outside the medical college sector, there has been experimentation and reflections on alternatives. Key among these are, the 'Kottayam experiment' (6), the medico friend circle's 'Anthology of ideas' for an alternative (5), the JNU plea for a 'New Public Health' (7), the Miraj Manifesto (8) and others (9).

A number of innovative community health oriented training programmes for health personnel especially within the voluntary sector have also developed and are of significance to Medical and Nursing Education, even though they have evolved in a separate 'universe'. Similarly outside the health sector, in the development and informal education sectors there have emerged a number of 'alternative training' experiments that have pedagogical innovations relevant to medical education (10).

b) <u>Some Lacunae in the Process</u>

While there is much evidence therefore of the new spirit of

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introspection and 'innovation', which could stimulate change in the 1990s there are some features of these developments that are not so healthy and could be considered lacunae and even going counter to the emerging process. (11)

Firstly, there is not much interaction or dialogue between the compartmentalised universe of government health services and training centres, medical colleges - government and private and voluntary agencies and other groups interested in alternative medical education. Even within these compartments there are divisions and inadequate networking. Groups are therefore unaware of each others' efforts.

Secondly, there has been inadequate publication of the strengths and weaknesses of these different initiatives. Even though there is a growing mass of 'grey literature' - reports and handouts and circulated papers, these are not accessible to the 'serious' medical educators in India, who are therefore not aware of the wealth of experience in the country itself.

Thirdly, the innovators within and without the system have not subjected their own 'innovations' or 'reflections' to any type of 'objective evaluation' or 'peer group assessment'. In some instances, where this has been attempted, the results are not available, for others to learn and reflect upon.

Fourthly, in the absence of this awareness of the diversity and multifaceted experience in the country, there is a tendency among medical educators to be carried away by 'ideas' and 'expert advice' that have originated in other countries - in situations of different socio-economic-cultural conditions and different educational systems. Some of the recommendations and suggestions are therefore not adequately grounded in local realities and experience.

Fifthly, there has been inadequate attention given to the traditional systems of medicine and healing as well as the prevalent health culture and folk health practices.

Finally, whatever the focus and orientation of existing medical education - there are a growing number of young graduates who have opted for work experience and work commitment to peripheral health care institutions including those in remote rural and tribal areas. This is most often without adequate preparation in their education. Notwithstanding all the rhetoric in recent years about Primary Health Care little or no effort has been made to elicit feedback from these pioneers on what could be the framework of a more relevant education geared to the professional and emotional challenges.

c) <u>Disturbing Trends</u>

Simultaneously, the 1980s have also seen the emergence of a large number of disturbing trends in medical education and health services development in the country which may have far reaching

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consequences on the concept of social/community orientation of medical education (9).

These include :

i) the growth of capitation fees colleges,

ii) the mushrooming of institutions based on caste and communal affiliations,

iii) the privatization of health care,

iv) the mushrooming of private high technology diagnostic centres and the concurrent glorification of high technology through high pressure advertising in the media,

v) the unresolved and probably increasing problem of private practice among full time teachers of medical colleges,

vi) the increasing 'doctor-drug producer axis' with 'vested interest in the abundance of ill health',

vii) the rampant corruption that seems to be accepted as routine practice and the erosion of norms of medical ethics without any debate,

viii) the preoccupation of medical educators with illness care and the disregard for 'medical education for health".

Taken together they are beginning to have 'an insiduous but definitive effect on the focus and orientation of health service development in the country as well as the nature of the manpower education' investment of the state'. **(See Diagram A)**

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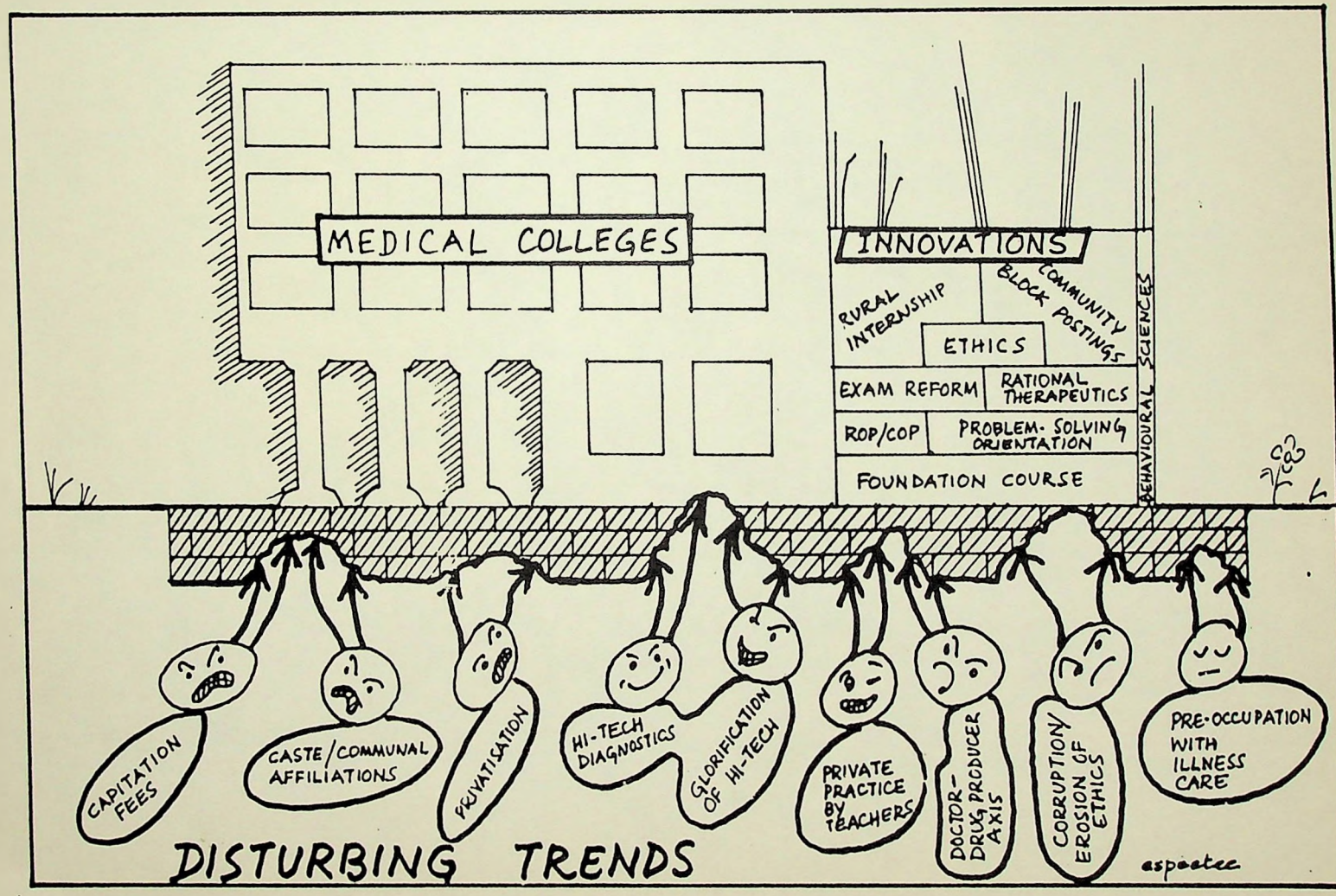
MEDICAL COLLEGES
INNOVATIONS
RURAL INTERNSHIP
COMMUNITY BLOCK POSTINGS
ETHICS
EXAM REFORM
RATIONAL THERAPEUTICS
ROP/COP
PROBLEM-SOLVING ORIENTATION
FOUNDATION COURSE
BEHAVIOURAL SCIENCES
CAPITATION FEES
CASTE/COMMUNAL AFFILIATIONS
PRIVATISATION
HI-TECH DIAGNOSTICS
GLORIFICATION OF HI-TECH
PRIVATE PRACTICE BY TEACHERS
DOCTOR-DRUG PRODUCER AXIS
CORRUPTION/ EROSION OF ETHICS
PRE-OCCUPATION WITH ILLNESS CARE
DISTURBING TRENDS
aspectec

DIAGRAM - A

B. ORIGINS AND SCOPE OF THE STUDY AND ITS LINKAGES

ORIGINS

The study arose out of an interaction between different groups, each one with its own particular interest in health human power education in general and 'medical education' in particular.

a) The Researchers

The project coordinators had a long history of interest in 'appropriate medical education' arising out of internship experiences in a Bangladesh refugee camp (1971) and Andhra Cyclone Disaster relief camp (1977). The experiences of 'medical care in conditions of acute mass poverty' and 'disaster linked environmental realities' led to a process of reflection on the relevance of large, high technology, teaching hospital oriented medical education in preparing doctors for the challenges of Primary Health Care. This interest led to a decade of involvement with the community orientation of medical education in a socially relevant medical college (St. John's, Bangalore) in South India followed by the development of a 'grassroots' technical resources centre (CHC) to promote community health action through voluntary effort in South India. During these years there were many opportunities and initiatives to reflect on 'appropriate medical education' as outlined in Table I. It was these varied experiences, that led to the evolution of the project so that the researchers could build on all the past efforts.

b) The Sponsors

The sponsors of the study - The Christian Medical Association of India (CMAI) and The Catholic Hospital Association of India (CHAI) are membership associations in the voluntary sector which together network over 2,500 institutions in the country. By virtue of their commitment to health care particularly focussed on the 'marginalised and underprivileged' they are interested greatly in all efforts to produce more 'socially relevant' and 'community oriented' health professionals in the country. They were therefore eager to associate and support the project as soon as it evolved and they were contacted for support. The detailed background to the evolution of this linkage is outlined in Appendix A_1 and A_2.

c) Other Linkages

The facilitation of the first network meeting of the four Christian Medical Colleges by the CMAI and the invitation to CHC to provide the 'keynote stimulus' led to an establishment of an informal linkage between the researchers, the sponsors and the four medical colleges of the CMC Network, who were all interested in community oriented and community based education and therefore agreed to participate as an 'interactive peer group' in the evolving study (See Appendix A_1). These colleges, who

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TABLE I

INITIATIVES OF THE RESEARCHER'S WHICH FORMED THE BACKGROUND TO THE STUDY (12)

YEAR	INITIATIVE	PUBLICATION/REPORT
1972	Refugee Camp Experience	Making Medical Education Relevant to the needs of Society - Interns reflections
1973	DTPH Dissertation	Training Doctors for Community Health Service (Trends in Undergraduate Medical Education in India)
1973-83	Community Orientation of Medical Education - SJMC, Bangalore (various experiments)	Moving beyond the Teaching Hospital
1977	MD - Term Project (Interactive Evaluation)	The Kottayam Experiment : Training Programme for Community Nurses / Health Supervisers
1982	Year of Travel and Reflection with Community Health Action initiators at the Grassroots	Notes on a year of Travel and Reflection in the context of Social Orientation of Medical College Educational Experimentation
1984	mfc Annual Meeting on Medical Education - Calcutta	Background paper (150 years of Medical Education : Rhetoric and Relevance)
	Workshop for Rural Bond Scheme Pioneers (SJMC/CHAI/CHC)	Report of a Workshop for Rural Bond Scheme Pioneers
1988	CHC Network - Sub Committee on Medical Education	Memorandum to the Health University Committee of the Karnataka Government
1989	Supportive stimulus to Network of Christian Medical Colleges	Keynote Address : Towards Greater Social Relevance
	Facilitation of first dialogue of Community Health Trainers in India (VHAI)	Report on Proceedings of the Trainers Dialogue
1990-91	mfc Anthology - Medical Education Re-Examined (Planning Collective Process)	3 Articles in Anthology including Anthology of Ideas - Alternative Framework of a Curriculum (Compilation)

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were, already involved in innovations/experiments of various types were interested to hear of the wide ranging efforts in the 'keynote address' and evinced further interest in the compilation of Indian experience.

d) Scope

The present study emerged through an interaction between the three groups mentioned above, and the scope of the study evolved as an attempt to explore and document all the 'innovations' and relevant reflections in India so that a Researched Review Document would be compiled, which would be practical, relevant, and use to all those, who wish to explore medical education reform in the 1990's, building on the wealth of Indian experience.

Focussed primarily on the Indian experience and basing itself on an interactive process which would be multipronged - including literature review, individual and group discussions, field visits, questionnaire surveys and other orthodox and alternative approaches the project study sought to put together

"a handy reference manual of local innovation,

an anthology of ideas emerging from local experience,

and a resource directory of local Indian expertise"

in community oriented and socially relevant medical education and health training in India. (11)

After much deliberation the project researchers decided that the key target group of the project would be "**faculty of medical colleges**' who in 'groups' wish to reflect and experiment with alternative/relevant ideas.

Other target groups were also identified during the process and it was decided that as a 'lobbying for change' process a summary document of the key findings and conclusions of the study would also be sent to them as a complementary process in the follow up of the project.

The researchers and the CHC team had already good contact and linkages with the 'alternative training sector' and the 'young graduates in rural centres' due to the nature of CHC work in past years and this 'network' of linkages was used with great advantage, for the evolving project.

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C. BASIC PREMISE OF THE STUDY

The basic premises of this interactive study were that

Recognising Sectors of Innovation

a) There are atleast four sectors of innovation from which stimulus for reforms in medical education can and have emerged (13).

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 - 1989) 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**

A few medical colleges have made serious efforts to operationalise some of the expert 'ideas' and recommendations and some have gone further to evolve their own 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 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'**. (Diagram B_1)

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 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 approaches and methods have great significance for professional humanpower education in the country (10).

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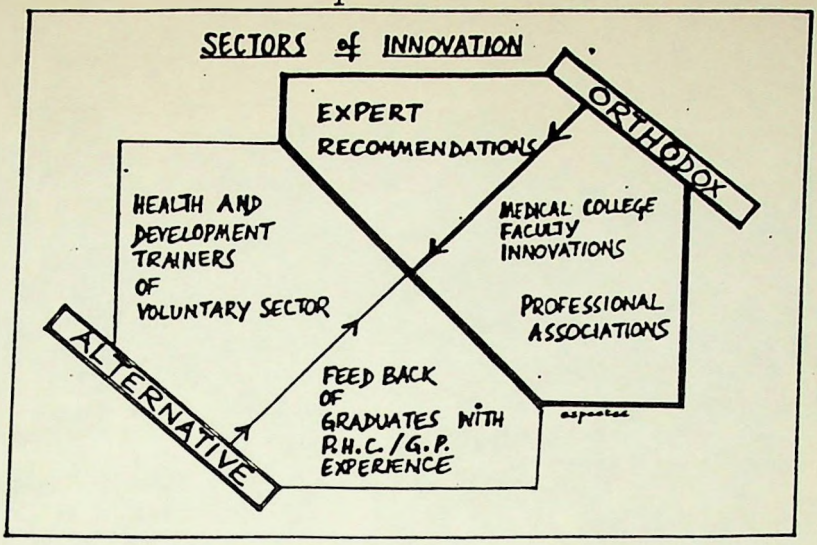
DIAGRAM B_1



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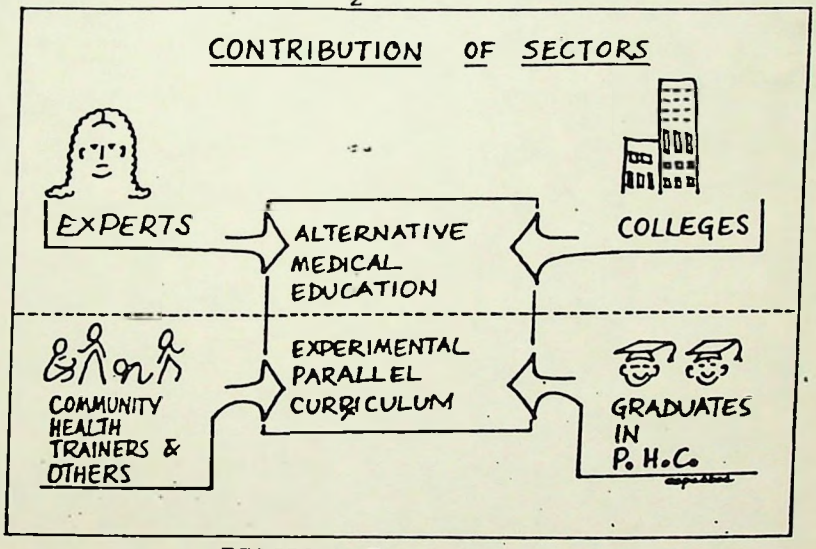

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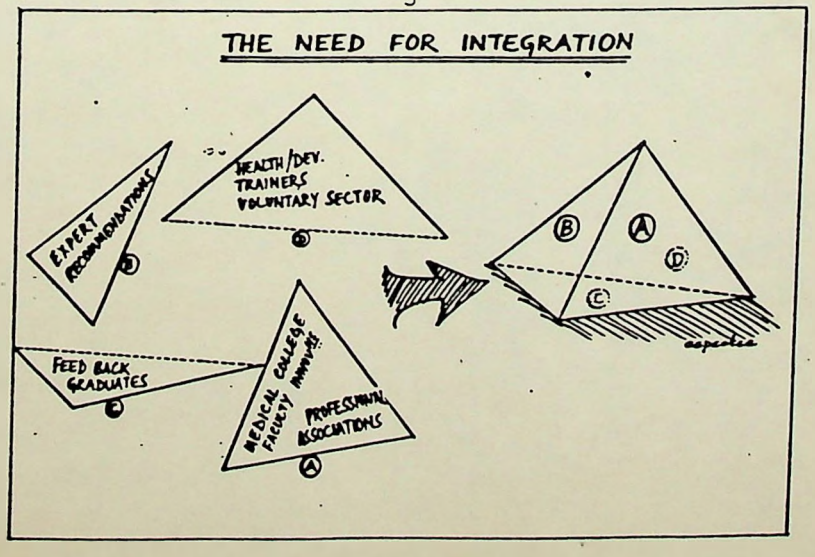

iv) **The 'PHC graduate' Sector**

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.** (Diagram B_2)

b) **Need for Dialogue Among Sectors**

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 innovators know little of what each other aredoing; the voluntary sector trainers have little dialogue even among themselves; 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. Unless all these ideas, suggestions, experiments and innovations are available together in some sort of compilation/ publication there is little chance of a cross fertilization of ideas and for dialogue between the innovators and the enthusiasts of all the sectors. It is now more than clear that any form of alternative medical education or experimental parallel curriculum can emerge only if attempts are made to bring the traditional orthodox expertise to dialogue with alternative expertise and evolve an integrated strategy and response to the challenges of **Appropriate Medical Education.** (Diagram B_3)

c) **Faculty Development - A Neglected Issue**

The third premise of our study, which has therefore greatly determined its focus and scope, particularly in the context of the 'end products' is that the 'Faculty' of a medical college are **'the Key to Change'** and that faculty development has been the single biggest casualty in the Indian Medical Education Scene. There has been a lot of rhetoric and some lip service to faculty development but faculty development and training is at the bottom of the priority list of medical college leadership. Teaching in a medical college is still not considered an independent and important enough 'vocation' and tends to be still relegated to a sort of 'appendage' skill or at best an unavoidable task.

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If reform in the 1990's has to have relevance, rigour and collective commitment, then **developing a core group of faculty in every medical college committed professionally to medical education** is an urgent necessity and this study is primarily oriented to that task.

We have tried to build some 'structure' and a framework towards this 'faculty development process'. The availability of faculty role models in the institution are crucial for inspiring students towards more community oriented and socially relevant vocations in medicine. This task can no longer be ignored.

*****

> Call it by whatever name, the need is for a new breed of physician, who has a broad understanding of human biology, who is imbued with the ingredients of rural and peri-urban societies and their way of life, who can communicate effectively with the patient's family regarding the nature of the ailment, who can address himself to preventive aspects in the homes, who will be an effective leader of health workers, and who will use his knowledge to stimulate other community building programmes. We need in effect, a social biologist. Mass public health and hospital patient care, however well developed, cannot fill this gap.
>
> Ramalingaswami, 1968

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D. EVOLVING THE OBJECTIVES

a) The Steps in the Process

The objectives of the study based on the premises described in (C) evolved through an interactive process which consisted of 4 steps.

Step I

A project proposal was drafted in January 1990 and circulated to the Advisory Committee, Peer group and a group of key resource persons in the country. **(Appendix B)**

Step II

Many ideas, reactions, modifications were suggested by some of these resource persons and were considered by the researchers.

Step III

At the first meeting of the Advisory Committee in May 1990 all these suggestions were considered and discussed. A modified set of objectives, keeping in mind the existing limitations and constraints available, especially of time framework were evolved.

Step IV

As the project evolved and the field visits and interactions took place and feedback from respondents and peers came in some of these objectives got further modified in terms of focus, priority and significance. This symbolised the interactive aspect of the action-research.

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b) The Original Objectives

The following were the objectives listed out in the first project proposal circulated in January 1990 :

I. General Objectives

1. To Document and Review

   a. Innovative and alternative experiments in medical education in India since the 1950s.

   b. Alternative Community Health training programmes in the voluntary health sector.

   c. Relevant alternative educational strategies in the non-health sector.

   in the context of social relevance and community orientation of medical education.

2. To evolve a handy 'resource' book

and some tentative guidelines for social relevance and community orientation in Medical Education, out of this cumulative experience, the focus being primarily on medical educators.

II. Specific Objectives

1. To document descriptively/analytically the recommendations/ key experiments / innovations and 'experiences' in appropriate medical education in India since the 1950's **(Appendix A).**

2. To review the key alternative 'training experiments' in the 'Health and Non-Health' sectors in India, to determine issues, perspectives, ideas and 'pedagogical innovation' relevant to 'appropriate medical education' in India.

3. To build an 'Anthology of Ideas' from suggested changes/ reforms/reorientation in Medical Education from

   a. a sample of medical graduates who have worked in peripheral rural hospitals and community health projects since the 1980's.

   b. a sample of Community health project innovators and community health trainers.

   c. innovative medical educators.

4. To evolve a set of exploratory guidelines for curriculum reorientation within the existing MCI recommendations based on the above 'reviews' and discussions.

5. To formulate a curriculum outline for a year's pre-selection foundation course for potential medical students which is being contemplated by some medica colleges basing the community health orientation and sensitization strategies primarily on educational experiments in the health and non-health sectors. (The main goals of such a course as envisaged at present is intensive community health orientation and foundation as well as language and learning skills, necessary for successful medical education through a reoriented curriculum).

6. To prepare an annotated bibliography/resources inventory of key books/papers/reports/manuals/studies/pedagogical innovation and educational aids evolved from the Indian experience and relevant to 'Appropriate Medical Education'.

7. To supplement the above objectives by the following additional sub-objectives (if time permits)

   a. A short review of Medical Education in Ancient and Medieval India (Ayurvedic and Unani traditions) to explore our own cultural roots and identify some lessons from history.

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b. A pilot survey of student 'ideals' and 'expectations' in medical education.

c. A pilot survey of 'key policy makers' and 'medical college administrators' for determining needs, requirements and organisational dynamics for pursuing appropriate Medical Education.

d. A brief overview of 'ideas' and innovative programmes emerging the world over in order to locate the Indian experience in a global context.

III. The 'interactive response'

The interactive process was quite fruitful. The key ideas/ questions and suggestions that were offered by many peers who received the first draft proposal were :

a. Whether such an exhaustive review would produce the results commensurate with the efforts?

b. For whom will the resource book be? Medical Educators? or policy makers? A focus may be useful.

c. In objective three, the curriculum outline should be for a one year pre-selection/foundation course for medical students focussing on

i) community orientation and social relevance

ii) adequate preparation of school leavers for a community based medical education.

iii) necessary language, terminology and learning skills.

d. The review of community health training experience should be in order to formulate the sensitization strategy in the foundation course and in the medical curriculum itself.

e. Data collection by personal visits to places and (meeting) people identified through the first three methods of review is unavoidable, since one can actually get a full idea of the experiment only by visiting their sites.

f. To involve the CMC's, a suitable mechanism needs to be evolved.

g. Meetings no doubt would be needed. They can serve two purposes

i) Data collection and clarification of issues and ideas

ii) to facilitate a ferment in the direction taken by the study.

Meetings aimed at the latter can be thought of as following the study rather than being part of it.

h. It's too ambitious for one year. Make it two years.

i) Review of 'ancient medical education' is useful only if you have 'tentatively discovered something relevant for today's scenario.

j) A specific review of the kinds of question papers set, the kinds of questions asked in the viva should be done. Examinations rule teaching and the problems of reforming examination system is a must for any review of any education in India.

k) Some process must be started to critically review the textbooks. Even Indian textbooks are lopsided, many times the rationale of a particular approach is not explained. This is especially true in surgery. The PSM textbook also needs critical review.

l) The questionnaire survey should provide a lot of grassroot relevant critical information on relevance of medical education. Irrelevance is being talked about but not documented. This survey should be done very systematically.

m) An opinion survey of practicing physicians and surgeons etc., in the cities may also yield important information in documented form.

n) A survey of the knowledge and skill base of fresh graduates should also be done.

o) Unless there is a specific bearing on medical education how worthwhile would it be to review non-health development sector of training in the project review?

p) The goals and objectives are so broad based and comprehensive that, one wonders whether all these can realistically be attempted within a year?

q) Different medical colleges may be considering different strategies in regard to the proposed foundation course. It may be good to consider the possibility of working on two or more possible formulations in this regard. For instance, one medical college may like to devote two or three months at the beginning of the first M.B.B.S., course after the students have been selected. Another may prefer a shorter or longer duration still as a part of the pre-clinical course. A third group may be considering a pre registration course of the type that we are thinking about in Miraj. A fourth group may like to put all their prospective candidates through such a course for orientation to all the health professionals. Can different scenarios be evolved indicating the potential and limitations of each?

r) The pilot survey of key policy makers and medical college administrators is a good idea but they are so evanescent and so short lived in their official roles that one may not gain much. Perhaps those figures who did play such a

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role in the past, who had thought a great deal about the problems under search and who have the time to reflect might be more useful.

IV. Final Objectives

The first project advisory committee meeting was held on 12th of May 1990. The committee explored the various dimensions of the project outline and considered all the important suggestions and ideas listed earlier and then decided that the **Final objectives** of the study would be

1. Document descriptively/analytically - Key recommendations/experiments/innovation/experience in Medical Education (within Medical College Sector).

2. Review Key Alternative Training Experiments to Identify issues, Perspectives, Ideas, Pedagogy relevant to Professional Education.

3. To build Anthology of Ideas from sample of recent Medical Graduates with Primary/Peripheral Health Care experience.

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> Health services and systems of education must be organised for the good of the people and not to meet the personal needs of a certain cadre of doctors for material gain or scientific satisfaction.
>
> Carl Taylor, 1970

E. METHODOLOGY

The final objectives, were then realised by using a multi-pronged data collection methodology that included both 'orthodox' and 'interactive' approaches.

1. Literature Review

Identification of key experiments/innovations, experiences and ideas was done through an extensive literature search which included the following components.

a) Library Reference

While reference to several professional journals were made, the key focus was on a detailed search through the Indian Journal of Medical Education from the late 1960's to date.

Access to the St. John's Medical College Library was very useful. In addition, a temporary loan of back issues of the Indian Journal of Medical Education from the Dept. of Community Medicine at St. John's Medical College was a major time saving development and is gratefully acknowledged.

b) Project Announcements in Bulletins and Journals

i) Several professional bulletins and journals published by the 'voluntary' sector, as well as a few daily newspapers were contacted for announcements about the project.

ii) Announcements and or letters to the editor were carried by the following **(See Appendix C)**

The Hindu; The Indian Express; Health Action; mfc bulletin; Health For the Millions; Economic and Political Weekly; BMJ (Indian Edition).

iii) Letters to the following received nil response :

Indian Journal of Paediatrics; Indian Journal of Community Medicine; Indian Journal of Medical Education; Journal of the Association of Physicians in India; Journal of the American Medical Association (Indian Edition); Indian Journal of Public Health.

The announcements in bulletins, journals and newspapers did not get much response. Three announcements got 1 response each, 2 of which were not from medical colleges. Some of the professional journals requested for advertisement charges and correspondence to waive this took time.

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c) 'Online' Search with the National Medical Library was planned, but not carried out.

d) Literature Search

Some of the other methods especially library search, field visits and 'peer' correspondence provided a large number of references and materials that was beyond our expectations and to a large extent was the primary reason for the evolution of Phase II of the project.

e) From Peers

Some 'peers' provided substantial information and we would like to particularly record the lists and materials from Dr. P. Zachariah (CMC-Vellore), Mr. B.V. Adkoli (NTTC, JIPMER), FRCH (Bombay), Dr. Abraham Joseph (CMC - Vellore), Dr. M.J. Thomas, Consultant Psychiatrist, Bangalore and Dr. Philip Abraham, Dept. of Forensic Medicine (SJMC, Bangalore).

2. **Letters to Medical Colleges**

i) Letters were sent to the Deans/Principals and Professors of Community Medicine of 125 Medical Colleges in the country in June - July 1990. **(See Appendix D_1 & E).**

ii) A reminder was sent to those who did not respond to the first letter in January 1991. **(See Appendix D_2).**

In some cases such as the colleges in Madras and Delhi, the reminders were hand delivered and personally followed up by a research assistant and a colleague-researcher.

iii) In addition a letter was distributed to all the participants of the IAAME annual conference in Hyderabad in January 1991.**(Appendix F).**

iv) A second reminder was sent to all the colleges that had not responded by March 1991.

v) Depending on the replies received from medical college principals/professors further correspondence was carried out to determine finer details of ideas and programmes which were considered relevant for the project.

vi) The letters to medical colleges with two reminders elicited response from 25 colleges (a 20% response). Some colleges sent reports and other materials apart from the letters of reply. **(Appendix E)**

vii) The overall response to the methodology of sending out letters to colleges has been rather poor in terms of quantity and also in terms of quality i.e., relevance of materials received to the overall project objectives.

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While some colleges wrote brief paragraphs on the experiments, three just provided annual reports, three sent 'nil' responses. Useful material was received and or collected from 8 colleges. These probably also represent the key innovators in the country who have done substantial work. **(Appendix M).**

3. Letters to Community Health/Development Trainers

i) Letters were sent to a select group of Community Health and Development Trainers in October 1990. **(Appendix G and H).**

ii) Reminders were sent in January 1991 to all those did not respond to the first letter.

iii) Many trainers sent annual reports and training reports and further details wherever required was elicited through ongoing correspondence.

iv) Informal discussions were also held with some of the trainers with whom the CHC team had contact due to ongoing CHC linkages.

v) The CHC documentation unit already had substantial material on

a) VHAI Courses,

b) CHAI Courses,

c) SJMC, Bangalore - CHW Courses,

d) SEARCH, Bangalore Courses,

e) INSA, Bangalore, Training Programmes and

f) CHDP, KSSS Programmes.

vi) Substantial material was received from JNU - Centre for Social Medicine and Community Health; Deenabandhu - ACHAN Training Centre; RUHSA, CMC-Vellore; CINI, Calcutta; Behavioural Science Centre, Ahmedabad and additionally from SEARCH, Bangalore and VHAI, New Delhi.

Communications and some materials were also received from individual free lance trainers like Dr. Uma Sricharan (Bangalore).

vii) In general one could say that the material collected earlier by CHC and also received from this sector during the project was very detailed and qualitatively more relevant, for community oriented medical education than some of the materials received from the medical colleges, strengthening one of our earlier mentioned basic premises that dialogue with the alternative sector would be extremely beneficial to the progress of Medical Education in the country.

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4. Survey of Medical Graduates with work experience in Peripheral Rural Hospital and Health Care Projects (14)

i) A preliminary proforma was developed by the researchers after a group discussion with a few (10) doctors who had worked in peripheral rural hospitals and were presently faculty of St. John's Medical College, Bangalore, that had a rural placement scheme as well as gave preference in PG and staff selection, to those with rural experience.

ii) The proforma was circulated to the same group and further developed incorporating their feedback. **(Appendix I).**

iii) This was pilot tested on 10 postgraduate students who had peripheral health care institutional experience and then finalised.

iv) The pre tested questionnaire was distributed at the post-graduate entrance examination of one college that gives specific preference to candidates with rural experience (Examinees were requested to stay back if they qualified to be in the sample).

v) The questionnaire was distributed to eligible respondents in another college by one of our advisory committee member and also at the medico friend circle annual meeting in Sevagram in September 1990.

vi) We explored the possibility of identifying eligible respondents from three other medical colleges who have a rural bond scheme and two colleges who have contacts with rural medical officers. Due to some delays in the receiving the lists, the survey was ended in June 1991 and responses received by then only were included in the final report as a pilot study. **(See separate report - 14)**

vii) The questionnaire was fairly extensive with 38 different sub-sections. **Table II** lists out these components of medical education on which feedback was elicited.

5. Institutional Visits

i) Visits were made to seven institutions who were identified in the process of the ongoing project as having programmes of significance. The field visit opportunities were utilised for interactions with staff and wherever possible with a group of interns who had experienced most of the innovative programmes being studied.

ii) The objectives of the field visits were to observe innovative programmes wherever feasible and to have informal discussions with faculty and interns regarding various programmes and initiatives of the respective institution. This onsite visit and informal discussion helped us to identify the strengths and

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TABLE II

GRADUATE SURVEY COMPONENTS (14)

Pre-Clinical

1. Anatomy
2. Physiology
3. Biochemistry/ Biophysics
4. Biostatistics
5. Sociology
6. Psychology
7. Others

Para-Clinical

8. Pathology
9. Microbiology
10. Pharmacology
11. Forensic Medicine

Clinical

12. Medicine
13. Surgery
14. Obs. & Gynae
15. Paediatrics
16. PSM/Community Medicine
17. Psychiatry
18. Dermatology
19. Ophthalmology
20. ENT
21. Radiology
22. Anaesthesiology
23. Dentistry
24. Orthopaedics
25. Medical Ethics
26. Others

Other Skills

27. Basic Nursing Procedures
28. Communication
29. Management
30. Training of Health Workers / Other Personnel
31. Any other skills
32. Internship Training
33. Selection Process
34. Teaching Methodologies
35. Curriculum Structure
36. Examination System
37. Any aspects of content/ process environment or base of teaching
38. Measures to enhance social/emotional preparedness for C.H. Work.

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weaknesses of various programmes, as they emerge in the field operation with trainees - a dimension seldom explored adequately in college annual reports or published reports.

iii) The institutions were :

a) Christian Medical College, Ludhiana;

b) Christian Medical College, Vellore;

c) Mahatma Gandhi Institute of Medical Sciences, Wardha;

d) St. John's Medical College, Bangalore;

e) King George Medical College, Lucknow;

f) All India Institute of Medical Sciences, New Delhi; and

g) JIPMER, Pondicherry

iv) The visits were linked to other meetings (incidental opportunity!) and or specially planned in the context of the project. In two cases it was in response to the institutional need.

v) **Appendix 1a** lists out the salient features of the institutional visits.

vi) Due to a certain degree of inadequate planning, lack of initial standardization and some logistic, communication and time schedule problems the field visits though very meaningful and productive were not of an adequate 'standardised methodology' to allow for inter college comparisons among the innovators.

vii) However since the research team who visited the college and observed programmes and interacted with faculty, interns or students were the same in all colleges and the method of informal individual and modified focus group discussion was used, some observations and conclusions could be drawn from the field visits about the overall process of medical education reform and many of the problems and obstacles to change as well as the diversity of experiences.

viii) All the colleges in the original protocol could not be visited but the '<u>seven college field visit</u>' was a very relevant experience and definitely gave additional perspectives that was not possible to get from reports and correspondence.

6. <u>Meetings and Interactive Dialogue</u>

i) To increase the interactive nature of the project, links with peers were maintained not only through correspondence but also through meetings. Some of these were complementary to the project and some organised in the context

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of the project. Other meetings to which CHC researchers were invited as participants or resource persons listed were also utilized to explore ideas and innovations towards an appropriate medical education.

ii) Some of the meetings helped to clarify issues and ideas and others just to stimulate further on different aspects of the challenge.

iii) The key meetings are listed in **Appendix 1_b** .

iv) From the very beginning it had been decided that the study would have a strong interactive component and the researchers would use every available opportunity for discussion with peers interested in medical education alternatives. These would be discussions at individual level as well as in groups during meetings and dialogues specially called for the purpose or opportunities utilised at ongoing meetings/visits related to other topics and occasions.

v) This interactive dimension of the project was emphasised and operationalised as follows :

a) Many discussions with the Advisory Committee were not just organisational but interactive in the context of them being senior peers. Several issues were raised and explored.

b) Discussions with peers with relevant experience during visits to CHC and/or Bangalore or elsewhere were held whenever possible.

c) Correspondence with peers and contacts throughout the study.

d) Three reports were sent out to all our contacts in November 1990, May 1991 and January 1992. Some peers responded to ideas and project developments mentioned in these reports.

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7. Approaches - Orthodox and Interactive

As a general policy of the project, and keeping in mind CHC's own approach and commitment to networking, the approach to research was a combination of 'orthodox' as well as interactive. **(See Table** III).

While 'Orthodox' approaches helped to standardise procedures and bring in the required rigour the interactive approaches helped to increase the sense of participation and involvement among respondents as well as often helped to tap the 'affective domain' as much as the cognitive in the data collection process.

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Very often we could find out what people felt about things not only what they thought. Many negative impressions and often more reflective responses were picked up by this method. Also different perspectives on the same programme especially from 'organisers' as well as 'participants' were explored. All this would not easily be possible through an objectivised standardised questionnaire. Since our study was not 'quantitative' in its assessment of the situation (not how much?) but was trying to find out the range of 'what/where/why of medical education reform'. This combination of methods helped to get a wider qualitative impression of the diversity of innovations.

Table III

Research approaches in the Study

Orthodox / Classical / Established	Interactive
* Literature Review	* Peer Group correspondence and meetings.
* Letters to Colleges (with reminders)	* Field visits to colleges and Group discussions with faculty/interns
* Letters to Trainers (with reminders)	
* Questionnaire Survey (Graduates)	* Correspondence with College respondents and Community Health Trainers.

"The purpose of medical education is not to produce Nobel Prize Winners but to provide doctors for health services, who will meet the health needs of the country in which and for which they are needed."

WHO Regional Committee for South East Asia.

F. ORGANISATIONAL DYNAMICS

To operationalise the methodology, five components of the Organisational dynamics of the project are outlined. These include :

a. The Research Team

b. The Advisory Group

c. Peer Group Support

d. Project time and process schedule

e. Financial support

The related organisational dynamics were evolved, step by step as the project took concrete shape. Modifications and changes were made in response to various constraints and contingencies.

The following are the salient features of each of these organisational components as they evolved during the two year project, a second year phase II being added to the initial one year phase I time framework, due to the response and ongoing dynamics.

a) The Research Team

There were two primary researchers whose background experience has been outlined earlier.

During the second year Dr. Thelma had to coordinate another Evaluation Study and Dr. Shirdi Prasad Tekur of CHC provided additional support as a research associate.

Right through the project we tried to identify suitable research assistants to join the team on a full-time basis. Out attempts were unsuccessful because there were very few research-oriented people interested in medical education per se, or adequately experienced for this 'interactive' sort of project.

The research team therefore tried to involve other members of the CHC team for specific tasks and various other contacts were enlisted for short-term assignments (See Acknowledgements).

Another problem was that much of the material collected or compiled was such that it was not possible to delegate its analysis or assimilation to research assistants. Most of this had to be done by the primary researchers themselves.

During the second year a request was made for a middle level staff member from the participating medical colleges (who would be willing to support the project on a sabattical), to join the research team. Inspite of some scouting around

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such a possibility could not be operationalised. Thus the entire project had to be completed by the primary team.

The Research team were based in CHC utilising all its facilities but much of the compilation/analysis was done from a home based office by the researchers.

b) The Advisory Group

A small advisory group with 4 resource persons was formed. These included :

1) Dr. C.M. Francis - Previously Dean of St. John's Medical College and Kottayam and Calicut government medical Colleges and presently Director, St. Martha's Hospital, Bangalore.

2) Dr. P. Zachariah - Professor of Physiology of CMC-Vellore and Coordinator of the MMC - Miraj Medical College Project (when on Sabbatical).

3) Dr. V. Benjamin - Previously Professor, Community Health and Development Department of CMC-Vellore and presently Training Consultant to CMAI, New Delhi.

4) Dr. George Joseph - Previously Professor, Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi and presently Executive Director, CSI Ministry of Healing in Madras.

The resource persons were selected for their consistent interest in the challenges of reorientation of medical education and for their previous track record in supporting and being part of medical college innovations. They also represented perspectives in medical education from the different types of experience, viz., pre-clinical teaching, community medicine teaching, administration and research. This greatly enhanced the overall planning of the study.

The advisory committee met formally approximately every quarter **(refer Appendix-L).** In addition, since two of the members were Bangalore based and the two others visited Bangalore fairly frequently, there were many opportunities for informal interaction with the researchers. Some support was also available through correspondence and in the final phase many of the initial outputs/reports of the project were intensively reviewed in a special review meeting in October 1991 and thereafter individually as the occasion arose.

c) Peer Group Support

Institutional Linkages - Formal and Informal

The project proposal had envisaged that collaboration and support from other institutions and associations to widen its scope, as well as to ensure that it would be of significance and relevance

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to a larger number of people and initiatives in the 1990's. It had also been decided to request every collaborating institution to nominate one of their faculty/staff members to participate as a peer group member of the study.

This linkage was explored with CMAI, CHAI and VHAI; the three CMC's - Vellore, Ludhiana and Miraj; St. John's Medical College, Bangalore and the National Teacher Training Centre, JIPMER, Pondicherry.

Ultimately as the two year project evolved the following linkages were established :

1) Formal

i) CMAI (New Delhi) and CHAI (Secunderabad) co-sponsored and provided financial support for both Phase I and Phase II of the project, with CMAI providing the major share of Phase I support.

ii) CMC-Ludhiana provided some financial support for Phase I of the project and offered peer group support through their Principal, Dr. Alex Zachariah.

iii) CMC-Vellore, St. John's - Bangalore and Miraj Medical Centre offered peer group support through their nominees Dr. Abraham Joseph, Vice Principal and Head of Department of Community Health, Dr. Prem Pais, Associate Professor of Medicine and Asst. Medical Superintendent and Dr. Kalindi Thomas of the Department of Community Health respectively.

2) Informal

While these formal linkages were established, the 'interactive methodologies' of the ongoing project led to the development of informal links and contacts with some of the faculty/members of a larger number of institutions and initiatives. Some previous links already established by CHC were strengthened including

a) Voluntary Health Association of India, New Delhi

b) Informal evolving network of Community Health Trainers in India

c) Foundation for Research in Community Health, Bombay

d) medico friend circle (Bombay - Pune)

e) Centre for Social Medicine and Community Health, (Jawaharlal Nehru University), New Delhi.

f) National Institute of Advanced Studies, Bangalore

Some new ones also emerged including

i) Network of Christian Medical Colleges

ii) NTTC, JIPMER, Pondicherry

iii) Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha.

iv) King George Medical College, Lucknow.

v) Centre for Medical Educational Technology, AIIMS, New Delhi.

vi) NHL Municipal Medical College, Ahmedabad

vii) Indian Association for Advancement of Medical Education

viii) A.P. Health University

ix) Osmania Medical College and Social Paediatric Unit, Nilufer Hospital.

3) Individual Peer Support

Informal peer group support was also sought from a large number of people often in their individual capacity as well. **(Appendix-P).** A wide circle of contacts was established through this process.

While the 'individual approach' was probably more fruitful than the 'institutional approach', at the end of the project one cannot but feel that the overall interactive process was not as productive or active as we had initially hoped.

d) Project time and Process Schedule

The project time framework can be divided into three phases, as it evolved since the idea was first conceived in February 1989 by CHC.

i) A Pre-project phase from February 1989 till March 1990 when the idea evolved into a project proposal and the sponsors and linkages were identified **(See Appendix - L).**

ii) Phase I from April 1990 till June 1991 when the objectives were clarified by an interactive process, and then operationalised through a multidimensional methodology. Data collection was initiated and completed by June 1991 **(See Appendix - L).**

iii) Phase II from July 1991 till June 1992 when the data was analysed and compiled into a range of definitive outputs. This phase was also marked by the beginning of a collective dialogue and lobbying process which will end in the Medical Educators Review Meeting in June, 1992, the finale of the Project **(See Appendix - L).**

iv) Phase III has not been thought of since CHC, CMAI and CHAI, the project partners are convinced that any further commitment to the 'evolution' of an appropriate medical education must be based in a specific medical college or a group of medical colleges and cannot continue to be a pre occupation or thrust of any of these three organisations any longer. The attempt to bring together Indian experiences and provide some stimulus for medical educators fits in with the catalyst role of all three organisations, (to stimulate/support a process towards more relevant health professional education'). Now the initiative has to be carried further by a medical college group or a collective/network of colleges. It is hoped that the June 1992 dialogue will explore this aspect among other issues discussed in the meeting.

e) Financial Support

The pre-project phase and the first 3 month's of Phase I were supported from the resources of the CHC, CMAI, CHAI and CMC-Ludhiana were partners and co-funded Phase I. Phase II was co-funded by CMAI and CHAI.

The overall budget of the project was Rs. 4,52,400/-, for the 2 year phase. The detailed break-up of the project grant and related details is shown in **Appendix-N.**

Some of the other CMC's were invited to consider the possibility of co-funding the project but there were organisational/policy issues that came in the way of a broader consortium of funding putting a heavier burden on CMAI and CHAI than initially planned. Their gesture in taking joint responsibility of seeing the project through was most welcome and is appreciated.

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The best way to avoid large scale migration is to train doctors to work in the conditions that prevail in their own country. For most developing countries this means a curriculum overwhelmingly geared towards Primary Health Care in the rural areas.

Earthscan (1978)

G. RESPONSES - RESULTS - FINDINGS

The outcome of the study in terms of responses, results and findings may be discussed under the following subheadings

a) Literature Review
b) Medical College Survey
c) Alternative Training Sector Survey
d) Graduates Survey
e) Some overall general observations/findings

a) LITERATURE REVIEW

i) The literature review lead to the identification and compilation of over 750 references on key Indianexperience in Medical Education which has been arranged into a bibliography (arranged alphabetically). While the main source was the Indian Journal of Medical Education, articles from other Indian Journals and articles on Indian experience in WHO/foreign journals were also identified. All the personal communications and unpublished reports and papers received by the researchers during the phase of study have also been included.

ii) Some WHO sources as well as a large number of references on more recent community/primary health care oriented innovative experiments in other countries was also collected. We also identified some key papers on issues and directions from foreign sources. Just a few key foreign papers have been included in the bibliography, though the main focus is on Indian experience.

iii) 40 key titles were also identified and an annotated bibliography (**stimulus for change**) was prepared as a basic collection for a medical education cell of a medical college.

iv) A key aspect of the literature review was a thorough study of what the 'experts' committees have said about Medical Education and a detailed compilation of recommendations from Bhore (1946) till Draft National Education Policy for Health Sciences (1989) under different sub headings/aspects of medical education. This 'ready reckoner' would help medical colleges to locate their own organisation and structure and curriculum framework against the key recommendations of the expert committee all of whom were focussed on both social relevance as well as community orientation.

v) The literature review also identified a large number of ideas/innovation within medical colleges and within

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other sectors of innovation mentioned in Chapter C which were not identified by surveys and interactive methods.

All this forms parts of Volume I of the Faculty Resource Manual which is expected to be a concrete definitive output of the two year project (See later Chapter H (e)(v).

b) **MEDICAL COLLEGE SURVEY**

i) 25 colleges responded to our project related letter (which included two reminders). Out of the 125 colleges in our sample this meant a 20% response.

ii) While we cannot conclude that the non-respondents are necessarily non-innovaters, we could identify only 7 more colleges from the literature review, who had reported innovative programmes in 'literature' but had not responded to our letter. This brings the total upto 32 (25.6%).

iii) Table IV shows a statewise distribution of the 'respondent' colleges including the sources of identification. 7 colleges, one each from seven states visited by researchers is also shown.

iv) Recent 'guestimates' of the health ministry and planning commission are that the number of medical colleges as of 1992 are between 160-170. Most of these are of recent origin, mostly 'capitation fees' colleges in the states of Karnataka, Maharashtra and Tamilnadu. Since most are not recognised by MCI they have not begun to appear in official statistics. For our survey we restricted ourselves to the 125 which were listed in a guide-publication on medical colleges for entrants in 1990. ( )

We did not try to get details of these newer colleges partly because they were difficult to get through other sources and partly because of our assumption that they were too new, and too preoccupied getting established to initiate experiments or initiatives in social/community orientation.

v) Tables V-IX list out key ideas/and innovations that were identified through the materials sent by medical colleges; collected during field visits; received from peers; identified through literature search; or already available with CHC in its pre-project collection.

The ideas are divided into five groups

- General Objectives and Curriculum contents
- Pre-clinical Phase
- Para-clinical Phase including Community Medicine (PSM) Teaching
- Clinical Phase
- Internship

TABLE IV

Medical College Survey (Sample : 125)

Respondents - Statewise Distribution and Source

State	No. in Sample (A)	Responded to Survey (B)	From Literature Review (C)	Visited (D)		Total (E) (B + C)
1. Andhra	9	2	1		(1)*	3
2. Assam & North East	4	-	-	-		-
3. Bihar	9	-	-	-		-
4. Gujarat	6	1	1	-		2
5. Haryana	1	-	1	-		1
6. Himachal Pradesh	1	-	-	-		-
7. Jammu/Kashmir	2	-	-	-		-
8. Karnataka	16	2	-	1		2
9. Kerala	6	1	-	-		1
10. Madhya Pradesh	6	-	-	-		-
11. Maharashtra	16	7	2	1	(1)*	9
12. Orissa	3	-	-	-		-
13. Punjab	5	2	-	1		2
14. Rajasthan	5	1	-	-		1
15. Tamilnadu	13	4	-	1		4
16. Uttar Pradesh	9	1	1	1		2
17. West Bengal	7	-	-	-		-
18. New Delhi	4	2	1	1		3
19. Other Union Territories	3	2	-	1		2
	125	25	7	7	(2)*	32

* Osmania Medical College, Hyderabad and LTM Medical College, Sion, Bombay were visited by the researchers incidentally. Not included in formal field visits.

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Totally about 50 strategies/innovations have been identified which taken together, collectively represent an evolving framework of an alternative medical curriculum within the existing MCI determined framework.

It is important to clarify here that since the letter was an openended survey it helped to get a qualitative assessment of the range and diversity of innovative strategies. But what percentage of these respondents

TABLE V

Medical College Strategies

Objectives and Curriculum Structure - General

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. Student involvement in Research
12. Regular faculty meeting/faculty-student meetings
    i) curriculum issues
    ii) Social-Societal issues
13. Student nurture programme/curricular/extracurricular
14. Rural Bond (Placement) Scheme
15. Continuing Medical Education for alumnus/others

(for further details including colleges involved refer Appendix J & K)

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TABLE VI

Medical College Strategies

Pre-Clinical Phase

1. Foundation Course for entrants
2. Community-based orientation programmes
3. Introduction of New Subjects
   i) Behavioural Sciences ii) Ethics
   iii) First Aid iv) Nursing
   v) Integrated Growth and Development
4. Clinical Orientation in pre-clinical phase
5. Humanisation of pre-clinical practicals
6. Samaritan Medicine
7. Urban-slum based-multi-disciplinary student programmes

(for further details including colleges involved refer Appendix J & K)

TABLE VII

Medical College Strategies

Para-Clinical including Community Medicine Teaching

1. Reorienting Pharmacology Training
   i) Rational Therapeutics
   ii) Essential Drugs Concept
   iii) Clinical Orientation
2. Synchronization of Para-clinical subject lectures with clinical teaching
3. Involvement in Integrated teaching
   i) Para-clinical and clinical subjects
   ii) Clinico-Pathological-Social Case Conferences
4. Community based Family Care Programme/Family Health Advisory Service
5. Community Block Posting (First Clinical Year)
6. Junior Clinical Clerkship
7. Special Training Programmes -
   i) Epidemiology ii) Biostatistics
   iii) Health Education iv) Clinical Epidemiology
   v) Management vi) Health Economics

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8. Rural/Urban Slum health visits/camps
9. Community Block Posting (2nd Clinical Year)
10. Senior Clinical Clerkship (2nd Clinical Year)
11. Epidemiological / Public Health Projects

(for further details including colleges involved refer Appendix J & K)

TABLE VIII

Medical College Strategies

Clinical Phase

1. Integrated Teaching (interdepartmental)
2. General Outpatient Department - GP Training
3. Clinical Clerkship in Primary Clinical Departments
4. Training in
   i) Emergency Medicine
   ii) Social Paediatrics
   iii) Social Obstetrics
   iv) Clinical Pharmacology
5. Community visits by Clinical Departments - Camps and regular clinics in Rural/urban field practice areas
6. ROME Scheme
7. Interdepartmental Coordinated Clinics in Hospital Programmes
8. Peripheral Hospital Postings
   i) TB
   ii) Leprosy
   iii) Eye Hospital
   iv) Rehabilitation Centres
   v) Isolation Hospital/infectious diseases
   vi) District / Peripheral Hospitals

(for further details including colleges involved refer Appendix J & K)

TABLE IX

Medical College Strategies

Internship Phase

1. Interns orientation programme
2. Community Health postings in Rural/Urban field practice areas
3. Community based camps/clinics by clinical departments
4. Posting to Government PHC's and sub-centres
5. Involvement of interns in special situations
   a) Epidemic control
   b) Disaster relief
   c) Plantations
   d) NGOs Health projects
   e) Immunization programmes
   f) FP motivation
6. Involvement of Interns in Primary Health Care Training of Health Workers, Dais, Auxiliaries
7. Internship training in specific additional skills
   i) Rational Drug Use
   ii) Management
   iii) Ethics
   iv) Health Education
   v) Epidemiological Projects
   vi) Clinical Research
8. Internship training in special clinics in Hospital situation - Curative General Practice Unit/GOPD etc.
9. Internship Assessment / Evaluation.

(for further details including colleges involved refer Appendix J & K)

have actually included these strategies in their present process could not be estimated since this would need a check-list survey.

vi) From the survey and literature review we did identify 6 colleges that may be considered fore-runners or pace-setters in terms of community oriented strategies. They had large enough number of innovations and a relatively sustained process of reorientation in their programmes to qualify for this label.

Table X outlines some of the key characteristics of these

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colleges. It is evident from this table that the reasons for their sustained commitment to both 'quality' and 'change' include a combination of predisposing factors which are :

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) Rural and urban field practice areas.

vii) Table XI outlines the key innovations that we identified in each of these pace-setter colleges. These show some similar thrusts as well as a certain degree of diversity. None of the colleges, including all the pace-setters had internalised all the innovations, though CMC-Vellore would probably be the one college with the maximum number of operational strategies. From our study determined list St. John's, JIPMER and AIIMS also had introduced multiple innovations.

viii) Among the larger mainstreamers - i.e., colleges with large number of admissions and run by government without autonomy or minority status, a few colleges showed an increasing openness and involvement in reorientation. From our study the Municipal Medical College in Ahmedabad (NHLMC); BJ Medical College, Pune; KMC, Manipal; SVC, Tirupathi; Rangaraya, Kakinada; TN Medical College, Bombay and Kottayam Medical College were on the move towards a strategy of change with NHLMC, Ahmedabad demonstrating a very sustained and planned commitment to change.

However a word of caution is necessary. With an open-ended survey it is not completely valid to make intercollege comparisons and hence these statements reflect a qualitative judgement - pacesetters being most interested and some of the mainstreamers mentioned above being increasingly more interested.

ix) An interesting finding was that a significant association like the Indian Association for the Advancement of Medical Education was not actively involved in keeping track of these innovations or initiating processes to document or research the evolving strategies. Though some of these ideas and innovations were presented by the colleges at IAAME annual conference and some even found a place in the recent issues of their somewhat irregular journal, our overall conclusion was that IAAME and its journal - the Indian Journal of Medical Education was not fully in touch with evolving Indian experience.

x) What was however both an interesting but in a way disconcerting finding was that most of these pacesetter and mainstreamer colleges were not aware of each others initiatives. There was little formal or informal dialogue or networking on medical education matters, inspite of the presence of an association like IAAME,

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TABLE - X

Pacesetter Colleges

Some Features

Sl. No.	Feature	CMC (Vellore)	AIIMS (New Delhi)	SJMC (Bangalore)	JIPMER (Pondicherry)	MGIMS (Sevagram)	CMC (Ludhiana)
1.	Established	1918(LMC) 1942(MBBS)	1956	1963	1956	1969	1894
2.	Recognised by MCI	1950	1956	1969	1956	1976	1953
3.	Reason for establishment = Mandate	For Training of women doctors in India.	For Training Medical College teachers for India.	For Training doctors for peripheral rural hospitals.	By Central Government for Quality education.	Gandhi Centenary project to promote Gandhian idealism.	For Training of women doctors and nurses and women health professional
4.	Type of Management	Private Society (Minority)	Central Govt. (Autonomous)	Private Society (Minority)	Central Govt.	Private (Registered Society)	Private Trust (Minority)
5.	University	Madras	AIIMS	Bangalore	Madras	Nagpur	Punjab
6.	Seats	60	50	60	70	65	50
7.	Methods of Selection	Own entrance test+ interviews	Own entrance test.	Own entrance test+Interview +Psychological tests+social/ group observation tests.	Entrance Test + interview	Entrance Test+Test on Gandhian thought.	Written Test Aptitude and General awareness test.
8.	Hospitals	1492 beds	1053 beds	680 beds	770 beds	501 beds	697 beds
9.	Field Practice Areas	Rural & Urban +Mobile Clinics (ROME) + Rural base Hospital	Rural and Urban + Rural base Hospital	Rural & Urban + Mobile Clinics (ROME)	Rural & Urban	Rural	Rural and Urban

SOURCE: CBHI - Directory of Medical Education, 1986.

TABLE - X

Pacesetter Colleges

Some Features

Sl. No.	Feature	CMC (Vellore)	AIIMS (New Delhi)	SJMC (Bangalore)	JIPMER (Pondicherry)	MGIMS (Sevagram)	CMC (Ludhiana)
1.	Established	1913(LMC) 1942(MBBS)	1956	1963	1956	1969	1894
2.	Recognised by MCI	1950	1956	1969	1956	1976	1953
3.	Reason for establishment = Mandate	For Training of women doctors in India.	For Training Medical College teachers for India.	For Training doctors for peripheral rural hospitals.	By Central Government for Quality education.	Gandhi Centenary project to promote Gandhian idealism.	For Training of women doctors and nurses and women health professional
4.	Type of Management	Private Society (Minority)	Central Govt. (Autonomous)	Private Society (Minority)	Central Govt.	Private (Registered Society)	Private Trust (Minority)
5.	University	Madras	AIIMS	Bangalore	Madras	Nagpur	Punjab
6.	Seats	60	50	60	70	65	50
7.	Methods of Selection	Own entrance test+ interviews	Own entrance test.	Own entrance test+Interview +Psychological tests+social/ group observation tests.	Entrance Test + interview	Entrance Test+Test on Gandhian thought.	Written Test Aptitude and General awareness test.
8.	Hospitals	1492 beds	1053 beds	630 beds	770 beds	501 beds	697 beds
9.	Field Practice Areas	Rural & Urban +Mobile Clinics (ROME) + Rural base Hospital	Rural and Urban + Rural base Hospital	Rural & Urban + Mobile Clinics (ROME)	Rural & Urban	Rural	Rural and Urban

SOURCE: CBHI - Directory of Medical Education, 1986.

TABLE - XI

KEY INNOVATIVE STRATEGIES IN PACE-SETTER INSTITUTIONS

Sl. No.	Common Features	CMC (Vellore)	AIIMS (New Delhi)	SJMC (Bangalore)	JIPMER (Pondicherry)	MGIMS (Sevagram)	CMC (Ludhiana)
1.	Institutional Objectives	Defined	Defined	Defined	+	Defined	Defined
2.	Faculty Training (Pedagogy and other skills)	+	+	+	+	+	+
3.	Selection Procedures	-Psychological Tests -Interview	-	-Psychological Test; -Group Observations on social skills, values/ motivation.	—	Knowledge of Gandhian ideology.	-
4.	Examination	—	Objectivised Exams(OSCE/ OSPE)	-	Restructuring towards HFA/PHC	-	-
5.	Community/PSM Medicine Dept.	Well organised CHAD	Centre for Community Medicine.	Community Health Department.	Community Medicine Department.	PSM Department.	PSM Department
6.	Student-nurture i)Programmes ii)Tutorial system	+	—	+	—	—	—
7.	Rural Bond Scheme	+	—	+	—	+	+
8.	Foundation Course entrants	+	—	—	—	+	—
9.	COP/ROP(Preclinical)	+	—	+	—	+	+
10.	Block Postings (Community)	CHP I & II	Community clerkship	CHP - I	+	+	+

(*) Those who have +

Those who do not have —

Sl. No.	Common Features	CMC (Vellore)	AIIMS (New Delhi)	SJMC (Bangalore)	JIPMER (Pondicherry)	MGIMS (Sevagram)	CMC (Ludhiana
11.	Internship Rural/Community posting	CHAD Hospital +Sub centres	Graded i.e., Base Hospital PHC-Sub Centre	Village based centres in batches of 2	Rural/Urban posting	PHC/Rural Centres	Urban Slum/ corporation centres/ Rural centres.
12.	Other programmes	*Clinical Epidemiology; *Extra rural-peripheral hospital postings; *Community specialist camps; *Internship Assessment.	*Family Care exercises (Urban); *Instructional Objectives; *Clinical clerkship.	*Medical Ethics; *Plantation internship; *Community Specialist Camps; *Internship Assessment; *Epidemiological Projects.	*Interns Orientation Programme; *Rational Drug Training; *Emergency Medicine Training; *Community Specialist Camps.	G.O.P.D.	*Samaritan Medicine; *Problem Based Learning.

a forerunner of its kind when it was first established. However the recent establishment of the formal consortium network and the informal CMC network have both been positive steps in the direction of interactive dialogue for the 1990's.

An equally surprising finding was that while many of them were aware of the details of experiments in McMaster, Maastricht, Albuqurque, Dundee, Bersheva, Israel and Suez Canal Egypt and other community oriented experiments abroad they knew little about each others initiatives - reinforcing one of the basic premises of our study that most medical educators were unaware of the limited but significant Indian experience.

xi) Our field visits to seven of the respondent colleges and informal interactive discussions with faculty and interns led to an identification of key factors stimulating and sustaining change as well as major obstacles and problems in evolving experiments particularly towards social relevance community orientation but these will be listed out later in the chapter (**See Section e**).

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C. ALTERNATIVE TRAINING SECTOR - REVIEW

i) Building on a sizable collection of community health training materials from different training groups in India already available with the CHC at the beginning of the project, the letter to health and development trainers led to the identification of many more courses, 'ideas' and methodologies, that are being listed out in a separate report, entitled 'Laying the Foundations'.

ii) **Table XII** lists out the key programmes included in the survey or studied through literature survey.

iii) The major contributions of this group of trainers to appropriate medical education as listed in **Table XIII** are:

* Experimentation with an alternative philosophy of education which is more participatory, experiential, learner centred and action oriented.

* Introduction of a large number of 'small group' techniques and methodologies in the learning process.

* Strong community orientation in the methods since most of the training is community based and non-hospital oriented.

* Strong social analysis and exploration of community/ societal responses and initiatives to problem solution. This is very different from the preoccupation with

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TABLE - XII

ALTERNATE TRAINING SECTOR - HEALTH

(Profile)

Sl. No.	Project A	Name/Type of course* B	Duration C	Target Group D
1.	CINI - Calcutta	i) MCH/ICDS/Health/ Development orientation course	6 Days- 3 Months	i) Middle level functionaries in Health & Development
		ii) Orientation course in Community Health.	6 Months	ii) Fresh medical graduates.
2.	RUHSA, CMC - Vellore	i) Diploma in Community Health Management.	15 Months	i) Personnel working in Health and Development agencies at middle and senior level.
3.	Institute of Health Management - Pachod (Maharashtra)	i) Rural Health Management	6 Weeks	i) NGO-sector Nurses-Doctors, social workers, nutritionists etc.
4.	CMAI - New Delhi	i) Community based Primary Health Care.	15 Days	i) Project managers training.
5.	Christian Fellowship Community Health Centre - Ambilikkai.	i) Diploma course in Health and Development.	2 Years	i) Young men and women.
6.	NIMHANS - Bangalore	i) Training in Mental Health Care	1-4 Weeks	i) Doctors and Health Workers

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Sl. No.	Project A	Name/Type of Course* B	Duration C	Target Group D
7.	St.John's Medical College, - Bangalore	i) Basic course in Community Health.	3 Months	i) Health Workers (NGO Sector)
8.	INSA - Bangalore	i) Rural Health and Development Training Programme.	10 Weeks + 1 year supervision/ follow up	i) Health and Development Workers at supervisory levels.
9.	VHAI - New Delhi	i) Health Management (CHPOM)	1 year	i) Persons in Development Projects wanting to start a CH Programme
10.	JNU (University) - New Delhi	i) Masters in Community Health/ M.Phil / Ph.D	2 Years	i) Medical/Nursing Behavioural Science, Social work professionals.
11.	Deenabandhu Training Centre, -Madras	i) Leadership Course in Community Health. ii) Participatory Training in Community Based Health Action.	6 Weeks 10 Days	Sponsored candidates from NGOs.
12.	Thread - Orissa	i) Community Health and Development	6 Months	i) Sponsored NGO candidates.

(* All these groups also organise short courses and reports of these were also studied)

**The Christian Academy of Medical Sciences has introduced in 1990 a 3year postgraduate fellowship course for doctors working in rural hospitals. This is multidisciplinary and committed to multicompetent skill development.

individual/medical/professional problem solution which is the current orientation of orthodox medical education.

* Focus on skill development especially those important for community based work viz., planning, organisation, communication, health education, training of health workers, community diagnosis, participatory management, evaluation etc.,

* Greater learner centredness with participants of training programmes involved in planning and giving shape to learning experiences through feedback,much more actively than medicos in present day Medical Education.

TABLE XIII

Alternative Training Sector

(Key ideas)

Alternative Philosophy/Pedagogy of Education

Participatory/Experiential

Learner Centred/Action Oriented

Small group techniques / methods

Strong Community Orientation

Social Analysis

Problem solving - Societal/Community level as well

Focus on skill development

Learning by doing

Participatory Planning/Evaluation

Training in affective aspects as well (values/motivation/team skills/self analysis)

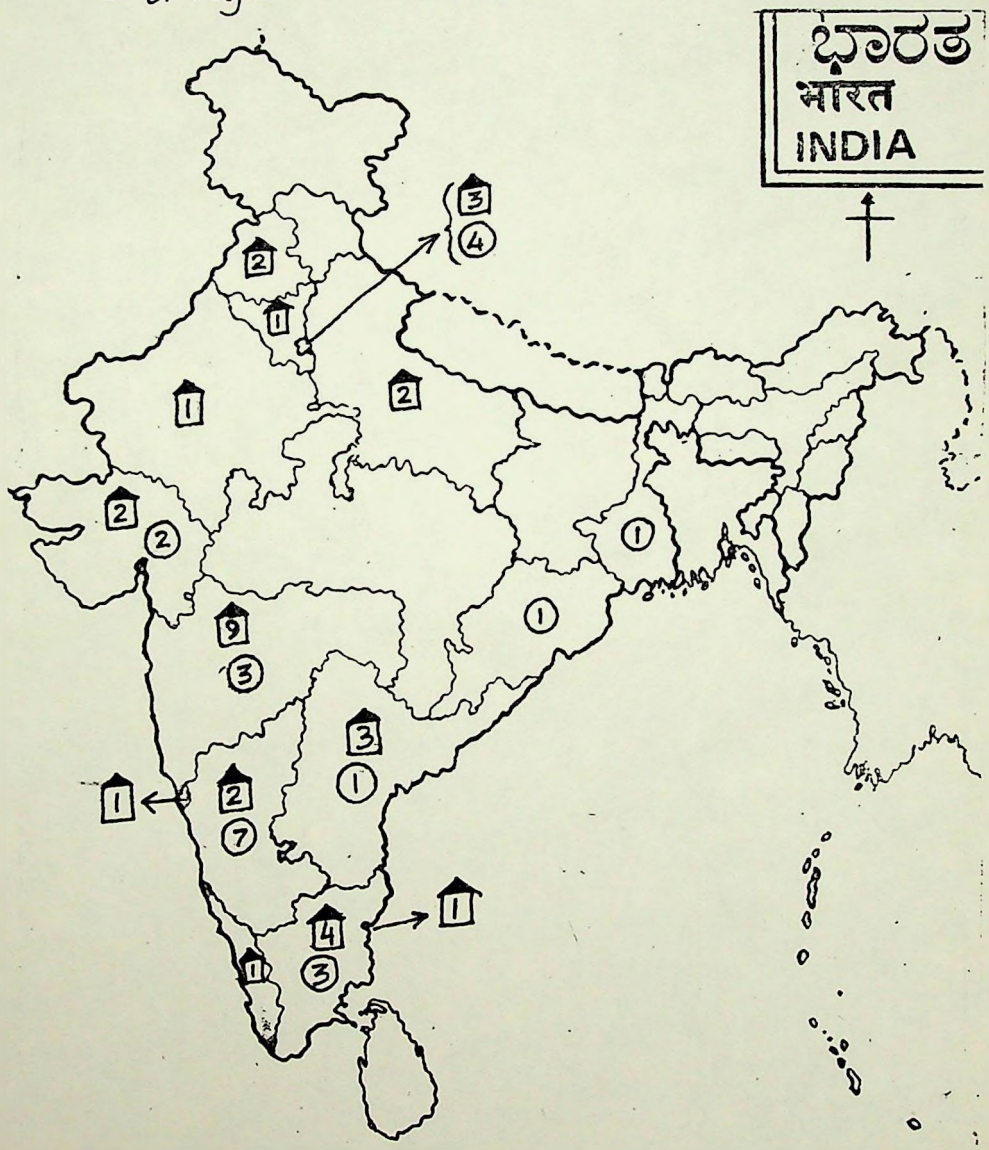
Case Studies / Simulation Games

Role models / Learning Exercises

* Exploration of training beyond 'cognitive aspects' to include training in 'affective aspects' of work/skills e.g. value orientation, motivation, self analysis, group dynamic skills, team work etc.,

* Evolution of numerous case studies, simulation games, role models and other interesting problem solving and situation analysis methods that help participants get

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



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

a deeper and more relevant understanding of the realities in which they have to operate in their future work.

iv) While much of this experimentation and innovation is not directly 'translatable' to 'orthodox medical education' when it is hospital/clinical oriented, these innovations can be a good stimulus and greatly enrich any process of shifting focus to community based medical education.

v) Medical educators experimenting with community orientation camps, community block postings, community based adhoc or planned experiential learning and all field based learning activities beyond the teaching hospital and in health settings lower down in the pyramid of health care can and should learn a lot from this experimentation in the alternative sectors.

vi) Very few medical colleges (probably only SJMC-Bangalore and CMC-Vellore) had contact and some idea of the evolving methodologies of this sector. Most others - even the pace-setters were unaware and therefore untouched by this wealth of alternative experience.

As mentioned earlier in this section all the ideas and training strategies identified from the detailed survey and review of the alternative training sector - both community health and community development are being compiled into Volume II of the Faculty Resource Manual under the title of **Laying the Foundation.** Apart from giving a comprehensive overview and listing of resources/ innovations/training methodology from this sector, this volume of the manual will also make various suggestions of how this can be introduced into the existing medical education system as part of foundation courses at different phases which are primarily community based and community oriented.

D. SURVEY OF GRADUATES WITH PRIMARY HEALTH CARE EXPERIENCE

i) The pilot survey of graduates of the 1980's was probably 'qualitatively' the most productive method utilised in the study. Most of the responses from participants in the pilot survey were serious, offering many constructive suggestions for improvement in the existing training programmes and for additional initiatives to make it more socially relevant and community oriented.

ii) The dialectic tensions faced by these young graduates in health care service situations for which they were inadequately prepared by the existing 'medical education' system led to some 'gut level' and very frank suggestions which could prove very useful to medical educators. While

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some institutions like the consortium linked ones are eliciting feedback from students at different levels of the course, interns, junior doctors and faculty, this pilot survey was particularly significant since the graduates had two years field experiences in the realities of Primary Health Care - while all the other groups mentioned above have only experienced the teaching hospital.

iii) For all colleges interested in preparing graduates for community health / primary health care vocations this graduate survey feedback will be very relevant. It is probably the first time that the 'consumers' of medical education are giving feedback after experiencing clinical/ community work in situations of primary care - a supposed goal of all medical education in India from the Bhore report of 1946 to the Bajaj report of 1989.

iv) A detailed summary of the feedback from 53 respondents in this pilot survey has been compiled in a companion publication to this report entitled 'Graduate Feedback from Peripheral Health Care Institutions'.

v) At this juncture we list out a summary of the salient findings of the survey (15). The focus is on general aspects and not what has been suggested for each of the pre-clinical, para-clinical and clinical subjects. **Table XIV and XV** summarise the main points about skill development and curriculum structure and framework.

TABLE XIV

Graduate Survey Summary I

Need for Skill Development/Increased Competence in the following areas

a) Basic Nursing Procedures
b) Emergency Medicine
c) Minor Surgical Procedure
d) Obstetrics
e) Local Anaesthesia
f) Running a simple laboratory and Pharmacy
g) Basic Management Skills
h) Basic Communication Skills
i) Assessing Community Health Needs and evolving simple strategies
j) Training Health Workers

Source(15)

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TABLE XV

Graduate Survey Summary II

Feedback on Curriculum Structure/Framework

(8 Key Issues)

a) Introduce integrated teaching focussing on common problems/clinical applications

b) Reduce unnecessary detail in theory

c) Reduce Pre-Clinical phase to 1 year

d) Teach Sociology/Psychology/Nursing Procedures in 6 months gained from pre-clinical reduction

e) Increase responsibility and decision making capacity in ward work

f) Long and short postings - stress importance of both

g) Final MBBS / Internship postings in hospital pathology laboratory / pharmacy / records department / blood bank / accounts section

h) Final MBBS / Internship - involvement in training of health workers.

vi) The Examination system came under intensive review in the feedback. The Weaknesses of the present examination system were felt to be that it was subjective, unreliable, outdated, irrelevant to actual practice and sometimes unethical and even corrupt. The Challenge was to reorient and restructure examinations to :

- Assess basic knowledge/skills
- Focus on Approach to Diagnosis and Treatment
- Focus on Common Problems
- Evolve continuous assessment process
- Increase use of multiple choice questions
- Increase short case discussions

vii) Many interesting suggestions of a more general nature also came in. These included lectures on principles, advantages, limitations of other systems of medicine / reflection on ethics and health practices of different religions / sharing of experiences with undergraduates by those who have worked in peripheral health institutions (PHI's) / visits of

specialists to PHI's / internship postings to PHI's / career guidance cell and preparation or orientation of graduates opting for rural services.

From the above summary it is evident that such a structured interaction and data collection process from medical graduates who are performing the functions intended in the objective of undergraduate medical education is a useful guide to curriculum development. We found it a particularly useful and satisfying aspect of this study.

However one must mention at this stage that graduates in small peripheral rural hospitals form only part of the Primary Health Care Samples. Other subgroups include Primary Health Centre Doctors, General Practitioners, Community Health Project Based Doctors and so on. A larger sample survey involving all these subgroups would give a more comprehensive feedback for curriculum development.

E. SOME OVERALL GENERAL OBSERVATIONS

In the previous sections we have outlined the main findings derived from three sectors viz., the professional sector (medical colleges), the alternative training sector (health and development trainers) and the feedback from graduates with peripheral health care institution experience. This was apart from the review of expert committee prescriptions and identification of innovations through the literature review.

In a previous chapter, we had mentioned the additional dimension of interactive dialogue, that was added to the methodology. This included dialogue with interns, faculty members and peers on medical education innovation. While this was introduced at every opportunity, the field visits to seven medical colleges provided much scope for this dimension. This interaction was particularly significant, because it gave us a 'real life' feel, about some of the ongoing innovations and also gave us feedback, that was 'affective' in nature, supplementing the 'cognitive' feedback mostly available in published and unpublished reports about innovations and strategies.

Some overall general observations, that can be made about strategies for reorientation of medical education, based on the above process, and particularly among the pacesetters (defined in Section B) since we visited all six of them, are as follows :

i) Reorientation of medical education towards social and community relevance is on the periphery of the agenda of most medical colleges - even the pace-setters and the innovative mainstreamers because of the established traditions and ongoing demands of orthodox medical education.

ii) Where change is taking place the institutions are caught in the horns of a dilemma of being socially relevant as well as being professionally excellent. Since this excellence is most often defined in high technology and specialisation terms, it means in practice that the students are trained in a tertiary care environment of the teaching hospital, with increasing levels of exposure to 'primary health care situations outside the teaching hospitals. The glamour of the former far outweighs the challenging stimulus of the latter.

iii) The value systems of staff and students are changing over the years keeping in line with the materialist and consumerist values of the wider 'class society' of which they are part. Stress on academic merit in competitive entrance examinations of the pace-setter institution ensures that majority of the students are still 'middle class' with elite, urban oriented professional goals. Quality education, a sign of the pacesetters also ensures an advantage in the competition of the market economy; both national and international, affecting career choices.

iv) The culture of 'medical education institutions' is severely 'elite urban middle class' and the observed similarities of dress, cultural aspirations, hostel life, personal needs among students in all the seven colleges we visited was most striking. We will need more than a 'Mandal Commission' if the culture has to change to prepare them for life among the larger masses that form the 'Bharat' of this country. Even if selection procedures change towards a focus on students with disadvantaged caste and class background the dominating culture of medical education is more likely to give them urban aspirations rather than build on and stimulate in them a longing for the rural life.

v) Many interns who spoke very encouragingly about the different innovations in their college, giving both positive and some critical feedback were however quite clear about 'large urban specialist hospital' aspirations in their future vocation. The effect of the reorienting efforts were not going to affect career choices. All one could conclude was that the reorientation had made them sensitive to 'needs' and 'situations' which would modify their attitudes and make them more humane and sensitive to patient needs even in the tertiary care vocations of their choice.

vi) The 'culture' and 'aspirations' of the faculty are even more severely elite urban middle class than the students, and since most of them have never had exposure to the realities of 'Bharat' except through the news and TV media, their ability to pass on this 'sensitivity towards wider social realities' or enthuse the students towards community oriented vocations were limited. While many institutions we visited had increasing faculty exposure (other than community medicine department faculty) to the realities outside the teaching hospital this was still not on a very continuous or sustained basis to make an impact. The

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teaching of other departments.

vii) Faculty enthusiasm for high technology advances in medicine, the super specialist ethos of medical care and keeping up with the 'western model' aspiration were high. Hence the few faculty of community medicine departments and the fewer faculty of other departments involved in strategies towards social/community relevance were marginal to the dominant culture and in terms of attitudinal change were working against a strongly established tradition. Even among the innovaters their knowledge of western community oriented models and the aspirations for WHO assignments also reflected a fallout of the same tradition. Many of the younger faculty of community medicine departments were therefore not so enthusiastic about 'community based health action' and 'community based training initiatives' but were caught up with the 'public health specialization' aspirations towards health management operations research, epidemiology (especially clinical) health planning, health economics and so on.

Demystification of health knowledge, training of health workers and auxiliaries, health education and low cost communication efforts, exploring the peoples local health culture and traditions etc were low priority, again reflecting the dominant culture.

viii) A reassuring finding was that the Medical Council of India regulation was not the 'bogey' it is sometimes made out to be. Most of the innovaters were trying out experiments that seemed to fit in within the wide margins of experimentation that is already available within the existing framework. Where major changes were made, such as block community postings and changes in pattern of internship, there seemed to be little problem with MCI or university regulations. This was even less so if the college faculty were themselves senior in the university faculty heirarchy in their own specializations.

The two major constraints: were the division into pre, para and clinical phases and the consequent phasing of the examinations; and the compartmentalization that this framework caused.

However, it is more than obvious that for the present atleast, if these two components of the framework were accepted as 'basic structure', there was no other major obstacle to innovation other than established tradition and 'resistant attitude' to change within college faculty mostly, and college management sometimes. Infact a careful reading of the 1981 MCI curriculum guideline will indicate a large amount of stimulus and freedom to innovate and operationalise change. Out study of the guideline has convinced us that even the

'pace-setters' are still not utilising the 'stimulus' and the freedom adequately. In a paradoxical sort of way MCI is still ahead of most of us.

ix) Committed deans/principals and professors of community medicine and 'critical masses' of enthusiastic faculty were seeming to be getting over these above mentioned internal college constraints without much difficulty in most cases,proving that there were no structural constraints but only attitudinal ones.

In this context,however we also found that varying enthusiasm and commitment of the leadership of institutions,and the leadership of PSM departments,also contributed to phases of growth and phases of 'statusquo' or routinization,affecting the enthusiasm of faculty and the challenging stimulus to students. Some institutions were not aware of innovations in their own institutions during earlier phaseswhich we picked up through literature review.

x) The 'inspirational' and facilitatory role of community medicine departments was well established as a major criteria for change. The morale of the faculty and their development as 'innovaters' and inspirers of change seemed very crucial. It seemed very important therefore to be very selective in faculty selection for this department. The attitudes of the interns,seemed directly proportional to the morale of the faculty. If the faculty were enthusiastic,outgoing,field work oriented and committed the interns were picking up the infection. If they were arm chair community specialists, cynical and not very enthusiastic about community based work,the interns were picking up the 'cynicism' and 'double standards'. The demands on community medicine department faculty,in terms of time, wide range of knowledge and multidisciplinary skills are increasing day by day. Faculty who aspired for the more limited framework and security of a paraclinical, preventive and social medicine department,are increasingly proving to be mismatched with the demands of an active, clinical but community oriented/community based department of community medicine.

Also the increasing challenge of 'converting' colleagues from all the other departments from marginal interest in social/community orientation to co-workers and partners in mutually planned and organised initiatives is a major challenge requiring an 'interactive' and 'communication' skill of a different order. Improper faculty selection, and even worse inadequate staff development and training, can hamper these processes with long term consequences.

xi) Involvement of the faculty of all departments in the process of reorientation was a great stimulus for both success, as well as for maintaining the continuity of change. Where 'critical masses' of faculty enthusiasts (beyond community

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medicine department teams) were available, initiatives, experimentation and reflective dialogue were getting well established. Where most of the reorientation was seen as the primary responsibility of one department, or was being projected as having to support one departments training programme, or being introduced as statutory rules of the institution - the significance of the reorientation attempt or the enthusiasm of the faculty was being negatively affected. Projection of programmes as the colleges' programmes and the collective responsibility of faculty, as socially relevant and community oriented medical educators, was resulting in a more positive image and greater sustained enthusiasm.

xii) The use of faculty and student feedback (pre, para and clinical students, interns and senior house officers) was only gradually gaining ground, even among the pacesetters. However this was still adhoc or research project oriented and not a regular part of the planning cycle. There seemed still a major lacunae in 'consumer involvement' in medical education, notwithstanding the fact that the 'consumer experience' within medical college would include only 'medical college ethos' and 'teaching hospital practices' and not bring in the wider societal/consumer needs or perspectives. Our study to elicit feedback from medical graduates who have actually worked out in peripheral secondary and primary health care (living out as it were the stated objectives of medical education in India) is therefore a first step. While what has been said and collated is very useful, we wish to emphasise that this too should become a regular feature of the curriculum planning cycle, with institutions involving alumni (who specifically live out institutional stated goals) in the planning process.

H. THE PROJECT PROCESS AND OUTPUTS

The project proposal and process initiated by CHC in April 1989 was basically motivated by a desire to initiate a "process seeking collective commitment to appropriate medical education". Phase I was focussed on a data collection, literature review and interactive dialogue. Phase II was utilized for analysis/compilation of findings as well as to initiate various steps for collective reflection, networking, collaboration.

Therefore given the goals and objectives of the project, the output/outcome cannot only be looked at in terms of the final publication/s and reports but must also be understood in the totality of all the complementary and supplementary activities that were undertaken as part of a process of reflection, dialogue and building collective commitment to a socially relevant medical education system during the two years.

In this context we would like to outline four types of 'interactions' that have emerged from the project already as part of the evolving process and then focus on the final publication, reporting and nature of the terminal dialogue planned as endpoint of the project which ends in June 1992.

a) Interactions with Individual Colleges

The project led to the establishment of a credibility for the researchers in the context of their interest and commitment to the evolution of appropriate medical education strategies.

An important interaction of the project, therefore has been the evolving role of the researchers as non-institutional based resource persons for many medical college based initiatives in the project years.

Five colleges - the four CMC's and JIPMER, Pondicherry (especially through the NTTC) have begun to regularly involve the primary researchers in some aspects of their development of medical education innovations/initiatives.

The major events/developments falling into this category of interactions is listed below and give an indication of the nature and diversity of this output.

CMC - VELLORE

* Workshop on Curriculum Planning for a community based training programme for undergraduate Medical Education specifically for Community Medicine (CMC-V / MGR Health University / WHO) (January 1990)**

* Response to syllabus of Hospital Administration Course as well as recent fellowship course (April 1991)

* Visit to COP for pre-clinical medical students and students of allied health courses. (January 1991)

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* Keynote address to DCHM-RUHSA Alumni Meeting and Educational Council Meeting. (July 1991)

* Background materials for 'foundation course' for medical students going into community oriented MBBS Programme, being explored by CMC-V with Madras Christian College.

* Request for feedback/observations on CHAD after visit**.

SJMC - BANGALORE

* Discussion with junior staff who have completed rural bond scheme to appreciate possible nature of feedback and evolve framework of graduate survey proforma. (July 1990)

* Discussion with Medical Education Cell related faculty of St. John's. (January 1991)

* Participation as resource person in Group Observation Tests during college entrance selections procedures in July 1990 and 1991 respectively.

* Late Dr. H.J. Mehta Oration on : Rebuilding Pre-clinical Medical foundations as part of Alumni Association Jubilee Celebrations. (December 1991)

* Interaction and background note to SJMC study on "Basic Skill requirement for doctors working in peripheral health care institutions" for Consortium meeting in May 1992. (March 1991)

CMC - LUDHIANA

* Request from Principal for use of mfc Anthology of ideas and related papers as basis for proposed experimental curriculum and request for CHC team and CHC contacts to support CMC-L faculty in the process (there has been a constant interaction through correspondence since then).

* Feedback and suggestions for proposed MPH type course being considered by CMC-Ludhiana.

* Planning a 3 day Workshop/Consultation for CMC-Ludhiana faculty to clarify their own objectives and evolve an action plan. Due to unavoidable circumstances this could not actually take place. (However the plan drafted for the purpose has been modified in **Appendix Q** to be used as a framework for post project interactions with colleges).

* Feedback on CMC-L Project - on Child Survival through a slum health and development project.

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MMC - MIRAJ

* Response to Miraj Manifesto and related papers and three questions in detail :

  a) What is the need to start a new medical college institution for appropriate medical education?

  b) Why should that be in the voluntary/christian sector?

  c) Should the efforts be to produce

     i) an appropriate medical graduate or

     ii) to take the present medical graduate and give them 'appropriate' PG training.

* Visit to Bombay to orient CMC-M lawyers about community oriented medical education in the context of their writ petition in the Bombay High Court to get state government to give permission to start a community oriented medical college which will emphasise primary health care and problem based learning.

JIPMER - PONDICHERRY

* Participation in formulation of questionnaire for ICMR sponsored research project on "The Place of Primary Health Care in Medical Education in India".

* Suggestions for WHO sponsored national workshop on Medical Ethics in Medical Education.

* Invitation to participate in NTTC Meeting/workshop on Management Training in Medical Education **

* Involvement as resource person in WHO sponsored workshop for Training core faculty in Disaster Preparedness. (August 1991)

This 'output' and involvement has been mutually supportive, providing the researchers with a lot ofopportunities for dialogue, discussion, clarification as well as for learning and growth.

At the same time it was also an opportunity to share ideas and perspectives that would be a 'stimulus' for the medical college initiatives themselves.

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** (We could not respond to some of the requests but these have been included to emphasise the diversity)

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b) The Community Health Trainers Dialogue

CHC had facilitated the first dialogue among Community Health Trainers in India in October 1988 at the request of the Voluntary Health Association of India. Since it was the first 'coming together' of a large number of training groups, with different backgrounds and perspectives, but with a common commitment to Community Health the meeting focussed mainly on sharing training experiences and identifying issues and processes significant to networking. Some of the suggestions at the meeting, including bringing out a directory of trainers and training programmes was followed up by VHAI, New Delhi. However for various reasons no further common action towards sustained networking emerged.

At the suggestion of the Principal of St. John's, Bangalore during the March 1990 meeting of the CMC Network, we in CHC initiated a process to organise another dialogue of Community Health and Development Trainers. This was to collectively reflect and respond to the draft National Education Policy for Health Sciences (Bajaj Report), which had been circulated by the government to medical colleges, prior to approval and announcement. While this was not directly linked to the 'Medical Education Project objectives, it gradually became a 'supplementary initiative' since exploring the relevance of the pedagogical innovations of the alternative health and development training sector to medical education was an objective of the project.

Our evolving links with the trainers through the letter - survey of ideas, one of the methods used in the project, built up a linkage and a common trust. The response to the Trainers Dialogue on the National Education Policy for Health Sciences held in October 1991 was very enthusiastic and encouraging.

The statement of 'shared concern and evolving collectivity' that emerged at the end of this meeting of 28 health and development trainers and the 'Proceedings' have been circulated to all concerned.

This meeting and document, and the five background papers that were prepared in the pre-dialogue participatory planning process provided much support and stimulus to the medical education project itself and provided a certain cross fertilization of ideas and perspectives. While the 'review of training methodologies' relevant to medical education could not be discussed at this dialogue (even though it was part of the initial objectives of the dialogue) the opportunity for informal interaction and building up interest in the idea was immense.

Networking among trainers was discussed and some plans for a third dialogue around the theme of 'Training Methodologies' in October - November 1992 were initiated.

The Medical Education Project did give the researchers adequate

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opportunity to support and promote the networking of trainers in India and just like the mutually supportive and interactive processes with the CMC Network, a similar mutually supportive process can be said to have taken place with the evolving Network of Community Health and Development Trainers - this being another but complementary output of the project.

c) **Participation in the Network of Christian Medical Colleges**

The seriousness and regularity of the meetings of this network is an important development. While the project team would not claim any responsibility in the evolving dynamics of this group, the fact remains that it has been a great opportunity to the project researchers providing a regular forum for sharing and dialogue. There has been a growing complementarity with the network and the project which has links with all partners in the network could also be seen as a common commitment.

Table XII lists out the main areas covered by the Network meeting during the last four years.

The researchers provided a stimulus to the first meeting through a keynote address by providing lessons from history; overview of recent developments and listing out challenges for the network of colleges to consider as they evolve. In subsequent meetings however their role has been catalytic raising ideas and sharing experiences based on grass roots, non institutionalised community experiences as well as emphasising social/societal relevance.

Having moved beyond the medical college base in 1984 as a conscious step towards the development of CHC and its objectives, it has been a very welcome development to come back full circle and relink with institutional efforts in a spirit of partnership and dialogue.

d) **Concurrent Publication - Stimulus for Change**

An additional feature of the project was that rather than the usual focus on the final report or terminal publication, bringing together the process and findings of the research study, the project tried to produce a continuous output of 'stimulus' to the interacting and participating respondents and peer linkages. From the 28 publications listed in **Appendix - O** of the report, 18 appeared and were circulated as part of ongoing/concurrent stimulus from the project.

i) In the pre project phase mentioned earlier three articles contributed to the mfc anthology - Medical Education Re-Examined were circulated to a select group of medical

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TABLE - XVI

CMC NETWORK MEETINGS

Areas Covered in Discussion

July 1989

Lessons from History;

Overview of recent developments and challenges before the Network (part of keynote);

Interpretative histories of each participating institution and their initiatives in Medical Education;

Exploring Roles and Challenges;

Rediscovering original commitments/objectives.

March 1990

What is Christian about Christian Medical Education;

What are the values/principles important to such colleges;

What are the implications for our colleges being 'minority community' educational institutions;

Relationship between training and needs of member churches.

March 1991

Ethics in Health Care;

Ethics in Clinical Practice;

Ethics in Organ Transplantation;

AIDS - implications for Christian health workers;

Formation of teachers.

February 1992

Ethics and the Doctor;

Medical College and their ethical responsibilities;

Ethics in the University teaching hospital;

Clinical ethics;

Brain death and organ transplantation;

Equitable distribution of resources;

Towards a curriculum on Medical ethics;

Decision making in ethics;

Teaching of medical ethics;

A Whitefield document - joint statement on ethics.

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educators to build up interest in the larger project as well as stimulate collective commitment to appropriate medical education. **(Appendix - Q)**

ii) The project proposals for Phase I and II and three mid-term reports of November 1990, July 1991 and December 1992 were circulated to all concerned to keep them informed of the evolving processes and responses.

iii) 4 background papers, a collective statement and a detailed proceedings of the Community Health Trainers Dialogue on 'Education Policy for Health Sciences' was another group of related publications drawing inspiration from the project.

iv) A special issue of Health Action - the monthly magazine of Health Accessories for All Trust (HAFA of CHAI, Secunderabad) on Medical Education was planned and edited by us as part of the concurrent communication strategy. The June 1991 issue entitled Medical Education : Where Does it Lead brought together not only a detailed cover story by one of the researchers on Training of Doctors of India (which included subsections like the need for a 'new' doctor; prescriptions for change; how many doctors? the problems and challenges before us; Innovations and initiatives within the system; exploring new linkages; medical education and society-issues) but also many contributions about ideas and issues identified by the ongoing experiment. These included reflections by medical students on a community based experiential learning initiative at St. John's Medical College; unusual 'travel elective' by a CMC-Vellore final year medico (S. Prabir); reflections by a young doctor couple on the challenges of community health vis a vis their medical education at CMC-Vellore (Roopa & N. Devadasan); a report on Samaritan Medicine from CMC-Ludhiana (Dr. Alex Zachariah); an article on the history of medical education in India (Dr. C.M.Francis); a note on the challenges of Continuing Education from CMC-Vellore (Dr. Sara Verghese); an article on Medical Ethics, Medical malpractice and patients rights by the convenor of medico friend circle (Anil Pilgaonkar); a journalists view of an alternative project - the Kottayam experiment (Anil Aggarwal); the significant declaration of the World Conference on Medical Education of the World Federation of Medical Education at Edinburgh in August 1988 and a newspaper collage that represented the state of Medical Education today. **(Appendix - R)**

This issue was sent to all the medical colleges in India of the different systems - Allopathic, Ayurvedic, Unani and Homoeopathic, as well as to all the nursing, dental, pharmacy, veterinary science and physiotherapy colleges in the country (totally 626). It was also posted out to all our respondents and peers who had participated in the project by June 1991. Because of the journalistic-semi-professional style of this magazine, the communication effect and the contribution to lobbying would have been significant.

v) Three meetings provided the researchers an opportunity to present detailed papers on various aspects of the project scope and evolving perspectives.

a) The keynote address Towards Greater Social Relevance at the first CMC Network meeting in the pre-project phase was an opportunity to bring together all that the CHC researchers already knew about medical education at the beginning of the project process.

b) The presentation on An Alternative Vision of Education for Decentralised Health Care at the workshop on Towards a Decentralised Health Care : A fresh look at the National Health Policy, organised in September 1990 by the National Institute of Advanced Studies was an occasion to bring together primarily the ideas and contributions from the emerging alternative training sector.

c) The Late Dr. H.J. Mehta Oration at the Jubilee Celebration of the St. John's Medical College Alumni Association was an opportunity to weave together all that the project had discovered about Rebuilding Pre-clinical Medical Foundation which became the focus of the oration.

vi) Finally the 30th Annual Conference of the Indian Association for the Advancement of Medical Education at LTM Medical College, Sion, Bombay in January 1992 on the theme of Research in Education for Health Sciences was a very good opportunity for the presentation of two preliminary communications by the researchers from the project - the first an overview of the scope and objectives and premises of the study and the second a preliminary report of the graduate survey. These papers were distributed to all the participants and the conference opportunity was also used to try out a 'self evaluation' score sheet on knowledge of medical education innovation. **(Appendix - S)**

The concurrent communication strategy therefore consisted of a special issue of magazine on Medical Education and 17 technical and process-linked articles and reports sent to all the contacts of the medical education project.

e) Final Publication

The plan for the final publications of the project process and findings has been discussed at a review meeting of the Advisory Committee in October 1991 and has gone through several modifications.

The main thrust and probably the primary purpose of the study

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was to prepare a reference file/manual for use by 'medical college faculty' interested in exploring 'strategies for social relevance and community orientation'. However as the process evolved it was felt that the key findings and perspectives arising out of the project would have to be communicated to decision makers, policy makers and opinion leaders motivating them to lobby for change. So 'demand creation' and 'system development' would have to go hand in hand.

As of April 1992, the project final report was planned to consist of a 'resource manual' as well as 5-6 other complementary publications.

i) The Key to Change - the summary report of the 2 year project will include process experience of the project, why, who, how, where, when, what of the project, acknowledgements, key findings and perspectives, tasks for the future and descriptive directory of available resources.

ii) Step by Step - Towards appropriate medical education

A compilation of CHC reflections and initiatives on medical education before the project began. This arose out of a suggestion by the Advisory Committee at its first meeting. It was thought that such a compilation would help to put the basic premises of the study in perspective.

iii) Building on rural experience : Feedback from the Periphery

A detailed report and compilation of feedback from graduate doctors with peripheral health care experience collected through an exploratory survey.

iv) A to Z of Medical Education in India

A bibliography and a directory of innovations, ideas and recommendations. A decision will be taken after the compilation is completed whether this will be a joint publication or separate one?

v) A Faculty Resource Manual

A resource manual in a loose leaf file format will be the key end product of the project. It will bring together information on all the strategies for community orientation and social relevance identified from the review of Indian experiences and the surveys. It will incorporate all the ideas classified into 6-7 subsections which include

- Lessons from History and Culture;
- Exhorting Chage : from Bhore to draft NEPHS;
- Situation Analysis;
- Exploring Community Orientation in Medical College;
- Setting the pace for the 1990s;

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- Exploring New Horizons;
- Medicine and Society - Linkages

vi) Laying the Foundation

i) A collation of philosophy, objectives, pedagogy, learning experiences of 10 community health and development training centres in India.

ii) Suggested applications of above in the evolution of foundation courses/community based learning experience in medical college.

Since these experiments are built on an 'alternative framework', translating or extrapolation from them into the medical curriculum framework is time consuming though a creative task that will need to go through a more rigorous process before it is completed. An outline of this report will therefore emerge by the end of the study but the task will be completed only by the next Trainers Dialogue scheduled for November-December 1992.

All these reports are expected to be ready for distribution and dialogue by June 1992.

f) Towards a Collective Commitment - The Medical Educators Review Meeting - June 1992

Since Phase II of the project ends in June 1992, the process towards a meeting of medical educators from the CMC's and half a dozen other colleges in the country, identified by the project has been initiated. The objectives of this meeting are :

1. To consider the findings/output of the CHC/CMAI/CHAI Medical Education Project especially the Faculty Resource Manual and discuss possible follow up within institutions.

2. To share institutional plans/initiatives in Medical Education reform for the 1990's.

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

4. To build up a collective response to the mfc Anthology of ideas which has been submitted by CMC-L to Punjab University as a plan for an 'alternative track'.

The institutions involved apart from CHC, CMAI, CHAI and the 4 CMC's (the original partners of the project) are JIPMER, Pondicherry; CMET-AIIMS, New Delhi; MGIMS, Sevagram; NHL Municipal Medical College, Ahmedabad; Government Medical College, Bangalore; Foundation for Research in Community Health, Bombay; Voluntary Health Association of India, New Delhi; WHO-SEARO; KSSP-Kerala; King George Medical College, Lucknow and a few others.

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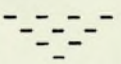
A preparatory process has already begun with an opinion survey among the participants on

i) Key changes to be introduced into Medical Education System.

ii) Innovations/experiments currently in practice which will help this reorientation.

iii) Critical reflections on different aspects of the mfc Alternative Curriculum Framework.

This meeting, will symbolise a sort of 'end point' for this two years exploratory and interactive project and will be a good indication of the level of collective commitment that has been stimulated by the medical education project.



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I. CHALLENGES FOR THE FUTURE

Our study on 'Strategies for Social Relevance and Community Orientation in Medical Education"- exploring Indian experience, led us to identify a large number of ideas, experiments, innovations and prescriptions that could stimulate the 'content' of change in the 1990's and which we are bringing together in the Faculty Resource Manual, Primarily, and also in the complementary publications, that are in the process of being completed.

Our field visits and interaction with peers, faculty, interns, junior doctors, postgraduates, principals, policy makers, academics, activists and a host of colleagues and associates from various backgrounds have all led us to conclude that there is an extreme dissatisfaction with all aspects of medical education - the content, the focus, the methodology, the process and the need for action is urgently felt.

What is also evident that 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 and a host of other levels as well. Curriculum change - both content and methodology has to be an integral part of this effort and with-in the context of the broader framework of change.

While our efforts in the study were to locate the content and framework of the 'curriculum change' in the context of the larger social reality, we consciously avoided getting too distracted by the pursuit of a broader situation analysis.

In terms of the more focussed objective we set ourselves, we would like to list out 10 factors that will promote and sustain change and 12 factors that will act as blocks or barriers to change within medical colleges in the 1990's. These are not in any order of priority because all along our data collection was purposely qualitative (interactive) and not quantitative except for the graduate survey.

We are suggesting that all these factors both positive and negative, are crucial. The challenge for medical college leadership for the 1990's is to promote and sustain the positive factors and counter or minimise the negative factors.

FACTORS PROMOTING CHANGE

1. The foremost factor is, an institutional mandate and charism towards social relevance and community orientation. This means a management commitment to primary health care, peripheral rural hospital service, general practice and or community health.

2. The availability of defined Institutional Objectives in the context of the mandate.

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3. The evolution of Instructional and Department level intermediate objectives,keeping institutional objectives and institutional mandate in context.

4. The presence of a critical mass of enthusiastic faculty in a formal linkage to a medical education cell, unit, or department which collectivises effort as well as establishes a continuity in the process of change.

5. The presence of a planned process of Faculty Development and enrichment towards their role as 'medical educators' and 'inspirers' and facilitators of change - i.e., creation of faculty role models who are 'professionally competent', 'socially relevant', 'community oriented' and 'educationally alive'.

6. Availability of or development of field practice areas and health service linkages beyond the teaching hospital, where viable, efficient and realistic community health and development service activity is an integral part of ground realities i.e., availability of a teaching community. Side by side, while building the teaching community there is need for promoting greater and greater linkages of all departments with the teaching community - through programmes evolved by voluntarism and creative choice and not through centralised edicts.

7. Development of an institutional policy of staff training and promotion in all departments which promotes/stimulates/operationalises staff experience, involvement and expertise in service, training and research efforts, in health care, beyond the existing teaching hospital focus and tertiary care orientation of medical colleges.

8. A conscious value orientation and cultural transformation in institutional ethos, management practice, staff and student values and aspirations with increasing institutional commitment to social justice issues and societal/national needs. This has to be brought about, through informal processes of discussion, dialogue and staff/management precept i.e., focussing on the needs of 'Bharat rather than the elitist aspirations of India' and the new market economy.

9. A commitment to networking and dialogue with a wide range of groups, enthusiasts, 'experimenters' and 'innovaters' within the formal medical college system and outside of it, so that academic environment of the medical college is allowed to be stimulated and cross fertilised by the evolving wealth of Indian grassroots experience i.e., towards a Medical college without walls in its true philosophical sense.

10. A commitment to concurrent reflective, evaluation of the change processes - (all the introduced changes, experiments initiatives) through regular faculty and student feedback and evaluation. This would also include regular feedback

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from all the 'consumers of medical education' especially those who are 'living out' professionally the aspirations of Indian medical education - the basic doctor goal.

OBSTACLES / BARRIERS TO CHANGE

The key obstacles and barriers to changes in the Medical Education system at medical college level which we would like to highlight are :

1. **Mental Disorientation**

   A confusion in medical college leadership thinking about the change process - primarily between the pursuit of technical excellence for the sake of professional satisfaction versus the pursuit of technical excellence for the state of social relevance.

2. **Nystagmus**

   Absence of clearly defined institutional and instructional objectives leading to a continous shift in focus between primary health care orientation and tertiary health care orientation in efforts.

3. **Optic Atrophy**

   Continuing 'cultural colonialism' manifesting in the belief system that 'what is west is best', resulting 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.

4. **Anemia**

   Promotion of individual professionalism in career advancement rather than collective institutional team work resulting in weak individual responses to reform or unidepartmental process.

5. **Cancer**

   Inadequate management planning including financial resource management leading to an initially insidious and later rapidly growing entry of market economy policies in private practice policy, cost of services, prescribing and technology policy in the institution.

6. **Mania-Depressive Psychosis**

   Planning for change far outweighing implementation of change, leading to increasing rhetoric and simultaneous growth in faculty cynicism or dissatisfaction. The

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institution then passes through manic phases followed by depression.

7. **Atopia - Allergy**

Absence of viable and effective linkages between colleges and 'teaching community' and health care delivery systems beyond teaching hospital resulting in adhoc, irregular, ill planned community exposure programmes that cause 'allergy' rather than excitement for students - in the context of future choice of vocations.

8. **AtherosClerosis**

Bureaucratization and routinization of efforts so that changes become 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.

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 schizophrenia responses in students and faculty alike.

For PSM Departments to be promoters of change rather than obstacles - staff selection for this multidisciplinary, skill oriented and multi-situational responsive department must be very carefully done and PSM faculty will have to grow into inspirers and facilitators of change rather than 'individualistic' administrators of teaching communities.

10. **Graft Rejection**

Caution is required in the planning and evolution of community oriented experiments and innovations. Care must be taken to ensure that after having learnt over forty years, the problems of transplanting western high technology hospital model transplants, we do not now rush into unquestioningly accepting 'community oriented education models' that have been developed in different cultures, health care systems and educational systems. This will prevent costly and painful graft rejections at a later date.

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11. **Autism**

The danger of too much rhetoric and too little active promotion of change by managements; or of discontinuous experiments waxing and waning in intensity leads to faculty withdrawal by the change process. Such an autistic response 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 either a commitment to status quo or an defensive response to critical reflection and evaluation; a rationalisation of inadequacies and a lack of openness to criticism and new ideas setting in a senile dementia in the institution.

To reiterate the health of the medical education reorientation effort towards social/community orientation will depend primarily on the clinical acumen of medical college leadership in keeping away the pathologies of :

i) mental disorientation	ii) nystagmus
iii) optia atrophy	iv) anemia
v) cancer	vi) manic-depressive psychosis
vii) atopia - allergy	viii) atherosclerosis
ix) schizophrenia	x) graft rejection
xi) autism	xii) senile dementia

described above from setting into the college system.

TASKS FOR THE FUTURE

At the end of the study 5 key tasks come to mind in the light of our efforts and findings.

1. **Task to inform**

We hope that the outputs of our study particularly the faculty resource manual will help the process of faculty commitment to change, by putting them in touch with the 'inspirational stimulus' of Indian experience. All efforts must be made to reach the multi-sectoral publication to 'all' concerned with change in the 1990's.

2. **Task to build further**

There is need to stimulate a process within some institutions atleast to initiate a well planned faculty enrichment/ development process towards a commitment to an alternative experimental parallel curriculum. To start with these may be within the existing constraints but efforts could be initiated towards an alternative framework ultimately.

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This task will need institutional commitment to a medical education cell/unit or department that moves beyond educational technology to context/process of change as well.

3. **Task to Share**

The ongoing networks and fora including the CMC Network, the consortium of medical educators and the older IAAME need to be nudged towards a greater collective commitment, sharing and networking process. There is need to widen these network and fora and open them to all who are interested and committed to change. These networks also need to be made more open to pulling in inspiration from the diverse sectors of experience, identified by the study.

4. **Task to Integrate**

A carefully planned workshop should be organised between the medical college sector and the voluntary training sector to help in injecting and adapting the techniques and insights of the letter into the thinking and methods of the former ultimately working towards a mutually interactive commitment in efforts and goals, groups with strategic links with both sectors and commitment to cross-fertilization will have to facilitate this.

5. **Task to Critically Reflect, Collectivity**

All changes, innovations and experiments introduced should be subject to critical feedback by staff, students, interns, graduates in peripheral health care institutions, community health project initiators, general practitioners and health activists. This needs to move from adhoc events and research projects to an integral part of the 'planning cycle' within institutions.

6. **Task to Change**

Finally the most urgent task is the commitment all our energies and efforts to change itself, not for changes sake but because the urgent health needs of our people and our constitutional commitments towards their amelioration can wait no longer.

The process towards increasing social relevance and community orientation in all our efforts will probably be the most challenging professional tasks of the 1990's.

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J. SO WHAT? - A REFLECTION

As we reach the end of Phase II of the project one cannot help looking back to the nearly 30 months of a project related process and reflect on the experience and explore some of tasks ahead, beyond June 1992.

a) **Strengths**

i) Building on Multi Sectoral Indian Experiences

The first strength of the project has been a conscious effort to build on experience from four widely divergent sectors and attempt to study them methodically and through orthodox and interactive approaches.

ii) Linking ongoing network in dialogue

The second strength of the project has been a planned process to build linkages and initiate dialogue towards an 'alternative medical education network' with a host of organisations, institutions and individuals e.g., the four CMC's (an evolving network); the community health and development trainers (also an evolving network); the consortium network; groups like medico friend circle; Foundation for Research in Community Health, Kerala Sastra Sahitya Parishad and other issue raising and lobbying groups; and the three coordinating agencies of health related voluntary agencies - CMAI, CHAI and VHAI.

The Trainers Dialogue (October 1991) and the Medical Educators Dialogue (June 1992) are symbolic of this process.

iii) Integrating diversity of ideas into a Faculty Resource Manual

Keeping in mind the diversity of ideas and experiences and even issues and viewpoints on medical education of the different sectors of expertise the researchers have tried to put together in a somewhat integrated fashion a document/s that can stimulate further dialogue among the sectors and can primarily put 'medical college faculty' in touch with the wealth of Indian experience. Groups of faculty committed to change can evolve a reflection/process using the project outputs as stimulus to their efforts.

b) **Weaknesses**

i) Unrealistic Planning

In the context of the large 'canvas' and the multiplicity of methods and initiatives,the planning of the research team was rather unrealistic,putting a heavy burden on

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the primary researchers and the CHC team. Though the provision for part-time research assistants was made and some attempts to induct CHC contacts into this function was tried out - the 'specialist' nature of the tasks and the need to have some background about the context and 'structure' and 'situation' of medical education made it very difficult to identify suitable research assistants or associates. Though the advisory committee provided good support, the peer-group linkages did not prove to be that effective. Efforts to induct a 'medical college faculty member' as a researcher with CHC on a sabattical from his institution also did not prove fruitful. In retrospect we feel a project of this nature should have made provisions for atleast two full time research assistants with the requisite background and experience in medical college teaching.

ii) From individual enthusiasm to collective action - Can CHC foster a larger response?

Our project experience, has been that, at meetings and in correspondence many peers, whether medical college based, or outside the system, are enthusiastic about the need for change in medical education and are willing to discuss and explore new ideas. However translating these ideas into concrete action within the existing structure and framework is not easy especially for individual enthusiasts. There is urgent need for a critical masses of enthusiasts in each institution. This is not easy to build up and even less easy to sustain and a group like CHC can do little to facilitate a more concerted process - except by facilitating reference publications and 'stimulus' of the type provided by the two year process. Is more possible?

iii) Individual linkages to collective institutionalised Linkages - Will the process take off?

Much of the dynamics of the project has been the result of CHC team's established personal linkages with a wide variety of people in all the sectors of experience. These have evolved particularly since its catalyst open-ended facilitation work from 1984 have been built on further during the project. Many of these persons are today in positions of influence in decision making but the situation is fluid and often these positions are shortlived and incumbents change frequently, not necessarily continuing the work initiated by their predecessors.

One of the key discoveries of this project has been that even medical colleges, that are known for innovations, reported in literature in earlier phases by enthusiastic faculty members, seem to be blissfully unaware of their own institutional contributions. Even less is known about the experience of other institutions. There is a

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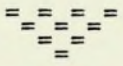
a problem of continuity and of collectivity typical of the Indian scene.

iv) Finally for the project not to lapse into a nice publication and meet the fate of many such efforts it is important that we translate the end products of all the project dynamics into the active planning/homework process of atleast one institution in the country as soon as possible so that project related 'ideas' can be tested out through praxis in the real-life situation of an actual alternative experiment. As the project reaches the Phase II milestone we wonder whether this will actually take place. As action researchers we are keen that the possibility of this practical examination begins as soon as possible.



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K. IN CONCLUSION

The Community Health Cell (the functional unit of the Society for Community Health Awareness, Research and Action) initiated the project entitled 'Strategies for Social Relevance and Community Orientation in Medical Education - Building on the Indian Experience' in April 1990 with two primary goals :

> The first one was to put together a handy reference manual of local innovation, an anthology of ideas emerging from local experience and a resource directory of local expertise in socially oriented medical education in India.
>
> The second one was to use the research project as a means to 'initiating a process seeking collective commitment to appropriate medical education'

The first goal was pursued by a multi-pronged methodology of literature review, letters and questionnaire surveys, institutional visits along with individual and group discussions which attempted to pull together the multifaceted and multi-dimensional experience in India and produce a set of documents that build on the totality of the generated experiences.

The second goal was pursued by an active communication strategy, peer group reviews and dialogue, planned meetings, opporutnistic use of ongoing network meetings and an active correspondence.

While the first goal is reaching completion through a series of project publications the second goal can be said to have been initiated only partially, in that so many people have been informed, involved and stimulated to think about the issues of medical education reform.

We hope the definitive output of goal one will itself become an instrument for goal two and take the 'initiated process' to its logical end.

As 'action oriented' researchers we are very glad that interaction, participation, collaboration and flexibility were the hallmarks of the evolving experience and we along with our two chief sponsors the CMAI and CHAI would strongly hope that this modest project output 'painted on the broad canvas of multisectoral Indian expertise' will be a stimulus as well as an instrument for change towards Educational strategies for the 'new type of Health Professionals' so urgently needed to lead and give direction to the primary health care services in the country. Moving beyond the 'philosophic rhetoric' that abounds in medical education circles we hope that our efforts will prove meaningful and relevant to all those (particularly faculty of medical colleges) who wish to be involved in initiatives towards an 'appropriate medical education' so that in the 1990's they could help to produce 'the doctor' the country has been waiting for all these decades

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- the Social Physician of the Bhore Report (1946) and the Mudaliar report (1961);
- the Basic doctor of the Patel report (1970);
- the family/community oriented general practitioners with social responsibility of the Srivastava Report (1975);
- the community oriented physician for comprehensive health care' of the ICSSR-ICMR Health for All report (1981); and
- the 'Community Physician' of the recent draft National Educational Policy for Health Sciences.

Building on the diversity of Indian resources/experiences integrated by the project, we hope the 'project' will be a meaningful contribution to health humanpower development for HFA-2000 particularly the above type of doctors.

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L. ACKNOWLEDGEMENTS

This project was a conscious effort to evolve a participatory and interactive research process so that the final output/s reflected as far as possible, as large a canvas of Indian experience and as wide a cross section of committed opinion on the subject. In this context we would like to acknowledge the support and participation of all those who responded to the processes initiated by the study, and express our special thanks to :

* to the sponsors of the study viz., the CMAI and CHAI and CMC-Ludhiana - Dr. Daleep Mukarji, Fr. John Vattamattom, and Dr. Victor Choudhrie in particular.

* to the advisory committee of the Project : Dr. C.M. Francis, Dr. V. Benjamin, Dr. George Joseph and Dr. P. Zachariah.

* to the leadership and peers from the supporting medical colleges, CMC-Vellore, SJMC-Bangalore, Miraj Medical Centre-Miraj and CMC-Ludhiana especially Dr. Benjamin Pullimood, Dr. B. Moses, Dr. Abraham Joseph of CMC-Vellore, Fr. Percival Fernandez, Dr. Alfred Mascarenhas, Dr. Prem Pais, Dr. G.D. Ravindran and Dr. S. Pruthvish of SJMC-Bangalore, Dr. Cherian Thomas of Miraj Medical Centre and Dr. Alex Zachariah of CMC-Ludhiana.

* to all the medical college peers who responded to the letter survey especially Dr. D.K. Srinivasa and Mr. B.V. Adkoli of NTTC-JIPMER, Drs. S.C. Gupta and Kum. S.N. Wahab (Nagpur Medical College); Dr. Mrs. D.D. Pandit (TN Medical College - Bombay); Dr. R. Venkatarama Raju (Rangaraya Medical College - Kakinada); Prof. R. Gopalakrishnan (PSG-Coimbatore); Dr. K.J. Nanavati (Municipal Medical College - Ahmedabad); Dr. S.B. Dixit (Goa Medical College - Goa); Dr. K.J. Mathew (Medical College - Kottayam); Dr. Reddy (LTM College - Sion, Bombay); Dr. Archana Parulkar (Grant Medical College - Bombay); Prof. R.D. Bansal (Lady Hardinge Medical College - New Delhi); Dr. P. Koteshwara Rao (S.V. Medical College - Tirupati); and Dr. Mrs. Rayate (V.M. Medical College - Sholapur).

* to all the medical college faculty who interacted with the researchers during the institutional visits especially Dr. M.L. Sharma (Pharmacology), Dr. Guliani (Community Medicine) of MGIMS - Sevagram; Dr. Siddarth Das (Medicine); Dr. Vinita Das (OBG), Dr. Sushma Pandey (OBG), Dr. R.C. Ahuja (Medicine) of KG Medical College - Lucknow; Dr. Asha (OBG), Dr. Shashindran (Pharmacology), Dr. Ananthakrishnan (Surgery), Dr. Sethuraman (Medicine), Dr. K.R. Narayanan (PSM) of JIPMER-Pondicherry; Dr. P.S. Sundar Rao, Dr. Molly Thomas and CHAD staff of CMC-Vellore

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Dr. Prema Zachariah, Dr. B. Cowan (Medicine), Dr. M. Verma Dr. Saha (Anatomy), Dr. Natu (Pharmacology) and other faculty involved in evolving alternative medical curriculum at CMC-Ludhiana; and the faculty members of the Medical Education Cell at SJMC-Bangalore; and the adjunct faculty of CMET of AIIMS-New Delhi; and also Drs. Narasimha Reddy of Osmania Medical College and Dr. Ajit Kumar of Nilufer Hospital, Secunderabad.

* to all the interns of the institutions visited who interacted with the researchers and added a 'consumer perspective' to the study especially Ganesh Srinivasan, Vaibhav Bhandari and Partha Pradhan of MGIMS-Sevagram; N.S. Bharath, Teresa Augustine, Suma B. and M.J. Vijayakumari of JIPMER-Pondicherry; Sanjeev Dayal and the students council of 1990 of CMC-Ludhiana; and Ashish Mahendra, Anju Goyal, S. Mukherjee of KG Medical College - Lucknow and the interns of CMC-Vellore.

* to all the junior staff of St. John's Medical College who having completed their rural bond scheme provided the stimulus and framework ofor the graduate survey including G.D. Ravindran, George D'Souza, Edward Jude, A. Mohan, Titus Augustine, Sheila Augustine, Mario Vaz, Kenneth D'Cruz, Ray Jude, Carlton Tavares, Hans Cyril Mathew, Dominic Misquith, Davies C.M., Vincent Sahayaraj and Jennifer George.

* to the 53 respondents of the graduate survey who cannot be named individually because of the process of confidentiality.

* to all our medico friend circle peers who sustained our interest in medical education since 1984 and provided some additional stimulus at the beginning of the study especially Dhruv Mankad, Amar Jesani, Anant Phadke, Padma Prakash, Sujit Das, S. Prabir, Rajesh Mehta, Anil Pilgaokar, Ulhas Jajoor, Abhay Bang and S.P. Kalantri.

* to all the community health and development trainers who responded to our letter survey and or participated in the Trainers Dialogue in October 1991 including Prof. D. Banerji (JNU), Dr. Amla Rama Rao and Dr. P.C. Bhatnagar (VHAI), Dr. K. Pappu (CINI), Ms. Sujatha de Magry (INSA), Dr. Rajaratnam Abel (RUHSA), Mr. Satish Samuel (SEARCH), Vijaya Sherry Chand (Behavioural Science Centre), Margaret and Desmond D'Abreo (ex DEED's/ANITRA), Prem and Hari John (Deenabandhu/ACHAN), Jeyaraman (ambilikkai), Uma Sridharan (THREAD), Sebastian Poomattom (ex CHAI).

* to all our peers and other resource persons not mentioned earlier including : Prof. V. Ramalingaswami (AIIMS/ICMR/WHO), Dr. Palitha Abeykoon (WHO-SEARO), Dr. N.H. Antia (FRCH - Bombay), Prof. Ashok Sahni (ISHA - Bangalore), Dr. P.V. Chalapathi Rao (AP Health University), Prof. P. Ramachandran (ICOR-Bombay), Dr. Siddarth Ramji (Indian Academy of Pae-

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diatrics), Valli Seshan (SCI), Dr. M.J. Thomas, Dr. Paresh Kumar (Dept. of Sociology - Mysore University), Dr.G.Gururaj (NIMHANS).

* to short term research assistants : Raphael Udayakumar, S.J. Chander and Dr. William Fullinfaw.

* to CHC team particularly M. Kumar, S. John, V.N. Nagaraja Rao, M.S. Nagarajan, Xavier Anthony and C. James for excellent office and secretarial support.

APPENDIX - A_1

CHC-CMAI-CMAI-CMC NETWORK PROJECT LINKAGES

The link up of CHC and CMAI and CHAI to give substantial attention to Medical Education as an area of interactive health policy research evolved somewhat accidently.

* CMAI facilitated a meeting of the four Christian medical colleges in the country in August 1989 (for the first time in the history of those colleges themselves) and invited the Coordinator of CHC to deliver the keynote address. The address entitled 'Towards Greater Social Relevance' (CMAI Journal, Vol. VI, April-June 1991, No.2) gave a bird's eye view of the history and development of medical education in the country as well as the ongoing search for relevance. It also listed out five possible challenges and tasks before the CMC Network, these being to:

  a) "take stock of the achievements and initiatives of the member colleges and their alumni and explore together the strengths and weaknesses of these achievements and initiatives".

  b) "move beyond the 'christian experience' and learn from the experience of all those initiatives and groups that share a similar commitment to patient care, quality medical education and community health.

  c) "build a new ethos of collaboration and cooperation amongst themselves and go beyond the histories of competition and comparisons, by reaffirming their shared value system and commitment".

  d) "resist the disturbing trends of politicisation and commercialization, of medicine by continuing to teach good quality, clinical rational medicine and exemplifying it in their day to day institutional practice, while at the same time searching for alternatives and exploring new dimensions in health care'.

  e) "seriously explore and experiment with alternatives in medical education as well as other health manpower training strategies to produce professionals with social vision, community orientation, technical competence and emotional preparedness to serve the needy and underprivileges in the most disadvantaged areas of the country".

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* At this meeting the CMC's shared their own plans for the future which included the Miraj Medical Centre's evolving project of a community based medical college (the Miraj manifesto); CMC-Ludhiana's efforts at evolving an 'alternative track' or 'experimental parallel curriculum'; and CMC-Vellore's efforts at evolving a community oriented medical education which was being considered by the MGR Health University in Tamilnadu as the prototype for all the Tamilnadu medical colleges.

* A few weeks after the meeting RN of CHC wrote to Daleep Mukarji (General Secretary of CMAI) on 27.9.1989

"After a long time it has been quite a stimulus to find lots of people questioning the existing system of Medical Education and willing to consider exploring alternatives. I am exploring the possibility of making Medical Education one of the main focus of our next year's plans. With the three CMC's talking about changes, with many new initiatives all over the country including the one in the North East which you mentioned; the new MCI bill in parliament and the possibilities of an alternative track - I think a time has come to take a rigorous stock of all that has been attempted by various Medical Colleges in the last few decades in the area of 'alternative programmes' or micro level nitty, gritty of innovations. In addition all of us community health trainers have in our own courses experimented with alternative pedagogy as well as explored Health and Development in innovative ways quite different from orthodox perspectives in ongoing Medical Education. All these need to be documented creatively and made available to the innovaters of 1990's as reference material ..... may be such an assignment would also be further stimulus to the CMC Network you have initiated".

* In his prompt reply Daleep Mukarji mentioned

"I was excited about the possibility of you and your CHC team taking up Medical Education as a serious focus in the years ahead ..... I believe we are at a critical juncture in Medical Education in India and we can see the different forces or pressures involved we need to contribute to the debate and the process that can influence MCI, the universities, some colleges etc., into new directions and experimental models. We also have our own pressures with various churches wanting to start medical schools!".....

"..... We also need to identify and record the actual Indian experiences in innovative approaches to Medical

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Education (and the education of other health professionals). This could be relevant alternatives developed byGGovernment, NGO or others".

* There was some further correspondence in the matter and in February1990 CMAI circulated the following memo on the study.to CMC-Vellore, CMC-Ludhiana, Medical Centre-Miraj and St.John's-Bangalore.

Extracts from letter No.GS/ND/90/960

dated 5th February, 1990

"Dear Colleagues,

Sub: CMAI Sponsored Study : Strategies for Social Relevance & Community Orientation in Medical Education.

It is our desire to facilitate a process by which the CHC team will interact with senior staff and faculty in the respective institutions of Vellore, Miraj and Ludhiana and assist them and us in various aspects of medical education in the context of Indian needs and problems. The researchers come with special interest and background in this area. I believe they would be an asset both to CMAI and to our 3 major institutions. It is proposed that this project begins 1st April 1990 and will continue till March 1991. Further details of the project are enclosed in the background paper with this letter.

It is our desire that this be truely a participatory process in which both for the planning and coordination out of the study our institutions and their staff are involved.

Amongst specific outcomes that the researchers can prepare to help us will be the following:

a) A handy reference manual of local innovations in health and medical education.

b) An anthology of ideas emerging from local experience in health and medical education.

c) Resources directory of local expertise in socially oriented medical education in India.

With the above it is hoped that they will also respond to the specific needs and issues of our institutions as they plan their medical education changes and other techings or medical training programme.

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I would like to take the opportunity of asking you to take this up with the institutions and your colleagues and let us hope that something can be worked out. I believe the CHC team would be able to help all of us and through us other in India in this search for a more need orientation in medical education within what is possible for India".

* Some correspondence had also been initiated with CHAI, Secunderabad and its sponsorship of the project was confirmed by the Executive Director in May 1991 in his letter to General Secretary of CMAI (3rd May 1991)

"At the very outset let me commit myself and assure you of our cooperation in all these joint ventures ..... All the proposals are agreeable to us and the amount will be made available in due course of time ..... Wishing you every success and assure you of our cooperation always".

* The four colleges which supported the project in addition to CMAI and CHAI also expressed the scope of the linkages in the following ways:

  i) This letter is an SOS to you and all the team members of the CHC to help CMC Ludhiana in this hour of need. In a short time we have to write a detailed curriculum which we believe must be community based and not just community oriented and could use recent advances in educational technology such as problem based learning, small group tutorials and so on ..... It is too late to start the experimental curriculum this year and if we go all out from now on and with the help of original thinkers like you and your team ..... Ludhiana could take off in starting with ten additional students on an experimental curriculum from 1991. The needs of the hour is 'collective action'. Our faculty must get in touch with you and your team as soon as possible. (letter from Principal, CMC Ludhiana to CHC on 19.1.1990).

  ii) After discussions with the concerned persons, we have designated Dr. Prem Pais to be the contact person from St.John's to liaison with....(the) project.

  It is not possible for St.John's to make any financial contribution but we will be extending our cooperation in this project. (letter from Principal, S.J.M.C. Bangalore to CMAI, July 18, 1990, No.3/CMAI/5449/90).

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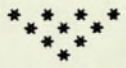
iii) "We would be happy to take part in the project pertaining to general objectives A_1 and specific objectives B_1 to document descriptively/analytically the recommendations/key experiments innovations and experiments in appropriate medical education in India ...

Our commitments in the project would be limited to providing the service of either the Principal or one of the Vice-Principals as a peer group member of the project. Unfortunately we are unable to contribute much in terms of money in this project". (letter from Principal, CMC-Vellore to CHC on 28.3.1990).

iv) I will be interested to know of further developments (in the project). Our own medical college project is still on the anvil and your work will have a bearing on our project. (letter from Director, MMC-Miraj to CHC on 25.6.1990).



APPENDIX - A_2

CHC - CMAI - PROJECT CONTRACT

Extracts from CMAI General Secretary's communication to CHC of 11th April 1990 (GS/ND/90/1452).

The Medical Education Project

"CMAI accepts your project to review 'Strategies for Social Relevance and Community Orientation in Medical Education' and seeks to have you both associated with us from 1.4.1990 for one year to undertake this assignment. We look forward to this process and are happy to invite CMC-Ludhiana, Miraj Medical Centre, CMC-Vellore and St.John's Bangalore. We appreciate that CHAI will also be supportive and involved....

To be more specific:

a) CMAI agrees with the aims, outlines, methodology and budget.

b) CMAI accepts the formation of the Advisory group and the peer group and leaves this to you.

c) CMAI requests three monthly progress reports. The progress can be shared with others (CHAI, the institutes and your groups as above).

d) CMAI would like to review progress, budget and participation from others about Oct/Nov 1990 .....

e) CMAI expects CHC to be responsible for accounts, reports and progress.

f) CMAI looks forward to joint publication, sharing and use of the review material for wider circulation in India and elsewhere.....".

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APPENDIX - B

RESOURCE PERSONS WITH WHOM THE PROJECT PROPOSAL WAS SHARED AS PART OF INTERACTIVE PROCESS

PROJECT ADVISORS

Dr. C.M. Francis*
Dr. George Joseph
Dr. V. Benjamin
Dr. P. Zachariah*

PROJECT SPONSORS

Dr. Daleep S. Mukarji (CMAI)
Fr. John Vattamattom (CHAI)
Dr. Victor Choudhrie (CMC-Ludhiana)

P E E R S

Dr. Benjamin Pullimood (Christian Medical College-Vellore)
Dr. Booshanam Moses (Christian Medical College - Vellore)
Dr. Alex Zachariah (Christian Medical College - Ludhiana)
Dr. Abraham Joseph (Christian Medical College - Vellore) *
Dr. Cherian Thomas (Miraj Medical Centre - Miraj)
Dr. Kalindi Thomas (Miraj Medical Centre - Miraj)
Dr. Alfred Mascarenhas (St.John's Medical College-Bangalore)
Fr. Percival Fernandes (St.John's Medical College-Bangalore)
Dr. Prem Pais - - - (St.John's Medical College-Bangalore)*
Dr. M.J. Thomas - (Ex -St.John's Medical College-Bangalore)*
Dr. Dhruv Mankad - (Medico Friend Circle)*
Dr. Anant Phadke - (Medico Friend Circle)*
Dr. Amar Jesani - (Medico Friend Circle)*
Prof. V. Ramalingaswami (All India Institute of Medical Sciences - New Delhi) *
Prof. S.K. Lal
Dr. Sujit K. Das (Medico Friend Circle/All India Drug Action Network) *
Dr. D.K. Srinivasa (National Teacher Training Centre-Pondicherry)*
Mr. B.V. Adkoli (National Teacher Training Centre-Pondicherry)

*Sent written responses / suggestions.

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APPENDIX - C

Medical education

Sir, – Medical education and its social and community orientation has been a subject for discussion in India since Independence and concern about the inadequacy of local efforts has been voiced in this newspaper as well.

There are definitive signs that the 1990s will see a greater commitment to concrete initiatives for change, since in the late 1970s and 1980s there has been a growth of initiatives, recommendations, micro-level experiments towards a more appropriate medical education. These have been by medical college teachers, professional associations, health and social activist organisations, community health trainers in the voluntary sector and medical educationists and policy makers. However, they have been inadequately documented.

We have just started a project to collate and study the key experiences and experiments and evolve a reference manual of local innovation, a resource directory of local expertise and an anthology of relevant ideas emerging from all these experiences. We request all readers of this newspaper to keep us in touch with relevant experiments and ideas that have emerged in the Indian milieu. All correspondence may be sent to at this address: C/o Medical Education Project, Community Health Cell, 47/1, St. Mark's Road, Bangalore-1.

Dr. Ravi Narayan &
Dr. Thelma Narayan
Community Health Cell,
47/1, St. Mark's Road,
Bangalore-1.

Source:

Indian Express
30th May 1990

Innovations in Medical Education

Over the last few decades there have been many recommendations by expert committees and professional groups on medical education and its community orientation. It is also believed that there have been a growing number of serious attempts by some medical college teachers and community health trainers in the NGO/ voluntary sector to experiment and initiate concrete changes.

'Community Health Cell' have initiated a project to bring together a reference manual of local innovation, a resource directory of local expertise and an anthology of ideas on this important theme. Those who are interested and concerned about medical education and who have initiated micro-level change and who would like to share their experience, are requested to get in touch with Dr. Ravi Narayan, Medical Education Project, Community Health Cell, 47/1, St. Marks Road, Bangalore – 560 001.

Source: British Medical Journal
(Indian Edition) Vol.6
No. 8, October 1990

Announcement

Medical Education and its social and community orientation has been a subject for dialogue and discussion in India since Independence. Though the situation at the level of integrated practice is still far from the desired goal, the last few decades have seen many recommendations and some experiments and innovations towards a more appropriate training for medical/health personnel. These have been by government policy makers, medical college teachers, professional associations and health and social activist organisations. Many training experiments in the voluntary sector also have experience relevant to professional education.

The Community Health Cell has just initiated a project to bring together this process into a reference manual of innovations in India, a resource directory of expertise and an anthology of ideas. The project seeks to interact with those who are interested or have experience through correspondence, field visits, focus group discussion and peer group review.

If you or your project have something to share on this theme, please write immediately sending reports, case studies, articles or other relevant material to the following address:

Ravi & Thelma Narayan
Medical Education Project
Community Health Cell
47/1, St. Mark's Road
Bangalore-560 001

Source:

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APPENDIX - D_1

COMMUNITY HEALTH CELL

47/1, St. Mark's Road,
(First Floor)
Bangalore - 560 001,
Phone : 212 313(P.P)

Ref. No. CHC 81:90 Date :

Dear

Sub : Medical Education and its Social and Community Orientation - a Project.

- - - -

Medical Education and its Social and Community Orientation has been a subject for discussion and dialogue in India since Independence. Over the last few decades there has been a gradual growth of committed introspection and initiatives/recommendations towards a more Appropriate Medical Education. These have been by different groups including Government Policy Makers, Medical College Teachers, Professional Associations and Health and Social Activist Organisations. In addition, innovative training experiments in the voluntary health sector as well as the non-health sector are of increasing relevance to professional education.

The 1990s have seen a series of new initiatives and plans towards an appropriate curriculum. Simultaneously there have been disturbing trends in the medical education and the health sector as well.

The project proposes to study the spectrum of key experiences developed during the last few decades, focussing primarily on all that is significant for social relevance and community orientation of Medical Education.

The Primary purpose of this project is to bring together :

a) A reference manual of local innovation

b) A resource directory of local expertise; and

c) An anthology of ideas emerging from all those interested in medical education.

If your college as a whole or any of the departments have experimented or innovated with any aspect of medical education, please send us details to be included in the anthology/directory. Any publications or evaluations of the efforts will also be very welcome.

The one year project will adopt orthodox approaches like literature search and questionnaires, and interactive approaches like field visits, focus group discussions and peer group review to bring together this experience.

We shall keep you informed about the process as soon as we get your participatory response.

The materials/communications may be sent to :

Medical Education Project,
Community Health Cell,
47/1, St. Mark's Road,
Bangalore - 560 001.

With best wishes and looking forward to a prompt reply in the matter,

Yours sincerely,

RAVI NARAYAN — MD DTPH DIH

THELMA NARAYAN — MBBS MSc(Epid)

CO-ORDINATORS

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APPENDIX - $D_{2/A}$

IInd REMINDER

STRATEGIES FOR GREATER COMMUNITY ORIENTATION AND SOCIAL RELEVANCE IN MEDICAL EDUCATION

(A Compilation)

COMMUNITY HEALTH CELL
(A Health Policy Research Group)

No.326, V Main, I Block
Koramangala, Bangalore-560034

To
The Principals and Professors of Medical colleges and all Medical Educators.

ATTENTION
Participation Requested

(1) *Over the last few decades there has been a gradual growth of committed introspection and initiatives/recommendations towards a more Appropriate Medical Education for India.*

(2) *These have been by different groups including Government Policy Makers, Medical College Teachers, Professional Associations and Health/Social Activist organisations. In addition, innovative training experiments in the Voluntary health/development sector are of increasing relevance to professional education.*

(3) *The 1990s have seen a series of new initiatives and plans towards an appropriate curriculum. Simultaneously there have been disturbing trends in the medical education and health sector as well.*

(4) *The project is studying the spectrum of key experiences focussing primarily on all that is significant for social relevance and community orientation of Medical Education.*

(5) *It is bringing together: a reference manual of local innovation; a resource directory of local expertise; and an anthology of ideas.*

(6) *If your college as a whole or any of the departments have experimented or innovated with any aspect of medical education, please send us details to be included in the anthology/directory. Any publications or evaluations of the efforts will also be very welcome. The areas of experience focussed upon are enclosed in the Appendix (Refer B1-15)*

(7) *Letters have been sent out in July 1990 and January 1991 about this project. About 25 colleges have responded so far. We believe there is much more relevant experience , still to be reported.*

(8) *Please respond promptly - **LATEST BY 1ST MAY 1991.** The materials/communications may be sent to the researchers at the above address.*

With Best Wishes, *Yours sincerely*

Ravi Narayan — Thelma Narayan

Ravi Narayan *MD, DTPH, DIH* **Thelma Narayan** *MBBS, MSc (Epid)*

FOR NOTICE BOARD

APPENDIX - $D_{2/B}$

Medical Education Project

(A) *The final report/manual (Tentative Framework as on 1.3.91)*

1. *Lessons from History and Tradition*
2. *Exhorting change-key Policy Recommendations*
3. *Situational Analysis*
4. *Exploring Reorientation (Medical College experiences)*
5. *Setting the pace for 1990s (Key developments)*
6. *Building on Rural experience (Graduate Survey)*
7. *Laying the Foundations (NGO training experience)*
8. *Exploring New Horizons*
9. *Medical Education and Society*
10. *Resources for change*
11. *Reflecting on the process*
12. *The key to change - key findings and tasks for the future.*

(B) **NOTE :** *The medical college experience in* **Section 4** *will be compiled under the following sub-sections:*

1. *Institutional Objectives*
2. *Instructional Objectives*
3. *Selection/Admission Criteria*
4. *Curriculum Framework*
5. *Training base*
6. *PSM/CM Department*
7. *Pre-clinical Reform*
8. *Para-clinical Reform*
9. *Clinical Reform*
10. *Selection/Reorientation of Teachers*
11. *Pedagogical Reform*
12. *Examination Reform*
13. *Internship*
14. *Rural Bond*
15. *Other Initiative*

(If you would like your college or department experience to be included, please send details/reports/papers by 1st May '91)

FOR NOTICE BOARD

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APPENDIX - E

LIST OF MEDICAL COLLEGES

(to which letters were sent)

ANDHRA PRADESH

1. Andhra Medical College, Vishakapatnam.
2. Gandhi Medical College, Hyderabad.
3. Guntur Medical College, Guntur.
4. Kakatiya Medical College, Warangal.
5. Kurnool Medical College, Kurnool.

*6. Osmania Medical College, Hyderabad.

*7. Rangaraya Medical College, Kakinada.

8. Sidhartha Medical College, Vijayawada.

*9. Sri Venkateshwara Medical College, Tirupathi.

ASSAM / NORTH EAST

10. Assam Medical College, Dibrugarh .
11. Gauhati Medical College, Gauhati.
12. Silchar Medical College, Silchar.

BIHAR

13. A.N.Magadh Medical College, Gaya.
14. Bhagalpur Medical College, Bhagalpur.
15. Darbhanga Medical College, Leheriasarai.
16. M.G.M. Medical College, Jamshedpur.
17. Nalanda Medical College, Patna.
18. Patna Medical College, Patna.
19. Rajendra Medical College, Ranchi.
20. Patliputra Medical College, Dhanbad.
21. Sri Krishna Medical College, Muzaffarpur.

GUJARAT

*22. B.J. Medical College, Ahmedabad.

23. Government Medical College, Surat.

*24. Medical College, Baroda.

25. Shri. M.P.Shah Medical College, Jamnagar.
*26. Smt. N.H.L. Municipal Medical College, Ahmedabad.
27. Seth K.M.School of Postgraduate Medicine and Research, Ahmedabad.

HARYANA

*28. Medical College Rohtak.

HIMACHAL PRADESH

29. Indira Gandhi Medical College, Simla.

JAMMU & KASHMIR

30. Government Medical College, Jammu.
31. Government Medical College, Srinagar.

KARNATAKA

32. Bangalore Medical College, Bangalore.
33. Dr. B.R. Ambedkar Medical College, Bangalore.
34. Government Medical College, Bellary.
35. Government Medical College, Mysore.
36. J.J.M. Medical College, Davangere.
37. Jawaharlal Nehru Medical College, Belgaum.
38. Karnataka Medical College, Hubli.
*39. Kasturba Medical College, Manipal.
40. Kempegowda Institute of Medical Sciences, Bangalore.
41. M.R. Medical College, Gulbarga.
42. M.S. Ramaiah Medical College, Bangalore.
*43. St. John's Medical College, Bangalore.
44. Al-Ameen Medical College, Bijapur.
45. BLDEA's Medical College, Bijapur.
46. Kasturba Medical College, Mangalore.
47. J.S.S. Medical College, Mysore.

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KERALA

*48. Medical College, Kottayam.
49. Shri Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
50. Medical College, Calicut.
51. Medical College, Trivandrum.
52. Medical College, Mulankunnathukava.
53. T.D. Medical College, Alleppy.

MADHYA PRADESH

54. Gajraja Medical College, Gwalior.
55. Gandhi Medical College, Bhopal.
56. Government Medical College, Jabalpur.
57. M.G.M. Medical College, Indore.
58. Pt. Jawaharlal Nehru Memorial Medical College, Raipur.
59. Shyam Shah Medical College, Rewa.

MAHARASHTRA

*60. Armed Forces Medical College, Pune.
*61. B.J. Medical College, Pune.
62. Government Medical College, Sangli.
*63. Government Medical College, Nagpur.
64. Government Medical College, Aurangabad.
*65. Grant Medical College, Bombay
66. Indira Gandhi Medical College, Nagpur.
67. Krishna Institute of Medical Sciences, Satna.
*68. Lokmanya Tilak Municipal Medical College, Bombay.
*69. Mahatma Gandhi Institute of Medical Sciences, Wardha.
70. Seth G.S. Medical College, Bombay.
*71. Ramanand Tirth Rural Medical College, Ambajogi.
72. Dr. Panjabrao Deshmukh Memorial Medical College, Amravati.
*73. Topiwala National Medical College, Bombay.
*74. Dr. V.M. Medical College, Sholapur.

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75. Rural Medical College, Ahmednagar.
76. Regional Medical College, Imphal.

ORISSA

77. Maharaja K.C. Gajpati Medical College, Berhampur.
78. Sriram Chander Bhanj Medical College, Cuttack.
79. Veer Surendra Sai Medical College, Sambalpur.

PUNJAB

*80. Christian Medical College, Ludhiana.
*81. Dayanand Medical College, Ludhiana.
82. Government Medical College, Patiala.
83. Guru Gobind Singh Medical College, Faridkot.
84. Medical College, Amritsar.

RAJASTHAN

*85. Jawaharlal Nehru Medical College, Ajmer.
86. Ravindra Nath Tagore Medical College, Udaipur.
87. Dr. Sampurna Nand Medical College, Jodhpur.
88. Sardar Patel Medical College, Bikaner.
89. S.M.S. Medical College, Jaipur.

TAMILNADU

90. Chengalpattu Medical College, Chengalpattu.
*91. Christian Medical College, Vellore.
92. Coimbatore Medical College, Coimbatore.
93. Madras Medical College, Madras.
94. Madurai Medical College, Madurai.
95. Government Kilpauk Medical College, Madras.
96. Stanley Medical College, Madras.
97. Thanjavur Medical College, Thanjavur.
98. Tirunelveli Medical College, Tirunelveli.
99. Rajah Muthiah Medical College, Annamalainagar.
*100. PSC Institute of Medical Sciences and Research, Coimbatore.

101. Salem Medical College, Salem.

102. Sri Ramachandra Medical College & Research Institute, Madras.

UTTAR PRADESH

103. B.R.D. Medical College, Gorakhpur.

104. G.S.V.M. Medical College, Kanpur.

* 105. Institute of Medical Sciences, Varanasi.

106. Jawaharlal Nehru Medical College, Aligarh.

* 107. King George's Medical College, Lucknow.

* 108. L.L.R.M. Medical College, Meerut.

109. Maharani Laxmi Bai Medical College, Jhansi.

110. Motilal Nehru Medical College, Allahabad.

111. S.N. Medical College, Agra.

WEST BENGAL

112. Bankura Sammilani Medical College, Bankura.

113. Burdwan Medical College, Burdwan.

114. Calcutta National Medical College, Calcutta.

115. Medical College, Calcutta.

116. North Bengal Medical College, Darjeeling.

117. Nilratan Sircar Medical College, Calcutta.

118. R.G. Kar Medical College, Calcutta.

CHANDIGARH

119. Post Graduate Institute of Medical Education and Research, Chandigarh.

NEW DELHI

* 120. All India Institute of Medical Sciences, New Delhi.

* 121. Maulana Azad Medical College, New Delhi.

122. University College of Medical Sciences, New Delhi.

123. Lady Hardinge Medical College for Women, New Delhi.

OTHERS

* 124. Goa Medical College, Panaji.

125. Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry.

* Responded to letter.

COMMUNITY HEALTH CELL

No.326, V Main,
I Block,
Koramangala,
Bangalore 560 034.
INDIA

Ref No.CHC.

Date :

Attn : Participants of IAAME Annual Conference, Hyderabad.
January 1991

STRATEGIES FOR GREATER COMMUNITY ORIENTATION AND SOCIAL RELEVANCE IN MEDICAL EDUCATION

A summary of an ongoing project (March '90 - June '91)

* Medical Education and its social and community orientation has been a subject for discussion and dialogue in India since Independence.

* During the last few decades there have been examples of committed introspection, recommendations and new initiatives towards evolving a more appropriate medical education responsive to the health needs of the masses in our country. These have been made by different groups including Government Expert Committees, Medical College Teachers and Professional Associations.

* More recently some Health and Social Activist organisations have also begun to offer 'critical analysis' and evolve alternative strategies. The medico friend circle anthology (1991) entitled '*Medical Education : Re-examined*' is one such effort. Many innovative community health training experiments in the Voluntary Health Sector as well as in the non-health, development sector are also of increasing relevance to professional medical education.

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(Appendix-F (Contd.)

* Simultaneously, there have also been disturbing trends in medical education and in the health care sector as a whole.

* Unfortunately, orthodox medical educators and even a forum like IAAME or journals like I.J.M.E. have focussed inadequately on these experiements and issues.

* A project has been initiated to bring together the wide spectrum of key experiences developed during the last two decades in both the 'orthodox' and the 'alternative' sectors focussing primarily on all that is significant for enhancing the social relevance and community orientation of Medical Education. A feedback from a sample of recent graduates who have over two years of work experience in community health/primary health care situations is also being collated by the project.

* The project will shift emphasis from 'traditional, empirical, expertise' to new sectors of innovation and creativity which have been unrecognised so far and will bring together the following :

  i) a reference manual of local innovation,

  ii) a resource directory of local expertise, and

  iii) an anthology of ideas emerging from all those who are interested in medical education and health manpower training.

* The project will also formulate a curriculum outline for a proposed pre selection, community health oriented, foundation course for medicos, which some colleges would like to introduce in the 1990s. Components of this course will also be relevant for community based teaching within the existing MBBS Courses.

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(Appendix-F(Contd.)

* The fifteen month project is adopting orthodox approaches to research like literature review, letters and questionnaires as well as interactive approaches like field visits, focus group discussions and peer group review to bring together a large and varied experience.

* The project is being coordinated by the Community Health Cell, Bangalore, a professional Community Health Policy Research group working with the Voluntary Health Sector in India and is supported by CMAI, CHAI and a few collaborating medical colleges in the country. An advisory committee and a peer group are also supportive of the process.

/YOUR PARTICIPATION/CONTRIBUTION IS REQUESTED/

* *IF YOUR INSTITUTION/DEPARTMENT/CENTRE has undertaken any experimentation/exercise in Medical Education - towards greater community orientation and social relevance, please contact us immediately with copies of reports/papers, published or unpublished. We are focussing on concrete field and classroom experience and not adhoc, untested suggestions.*

  Results of studies or reports of evaluated experiments; Reports of changes/reforms introduced in the curriculum; Innovative approaches to training; and Concrete changes proposed even though only under consideration are all welcome.

* **PROMPT RESPONSE BEFORE FIFTEENTH MARCH 1991 WOULD BE APPRECIATED FOR INCLUSION IN THE PROCESS OF COLLATION.**

For all further enquiries and correspondence,
Please contact :

Dr.Ravi Narayan/Dr.Thelma Narayan,
Medical Education Project,
Community Health Cell,
326, V Main Road, I block,
Koramangala,
BANGALORE 560 034.

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COMMUNITY HEALTH CELL

47/1 St. Mark's Road
(First Floor)
Bangalore-560 001
Phone : 212313 (P.P)

Ref No. CHC /81/90

Date : 06.10.1990.

NGO Community Health and
Development Trainers,

Dear ,

Sub : Medical Education and its Social &
Community Orientation - A Project.

- - -

Medical Education and its Social and Community Orientation has been a subject for discussion, dialogue and experimentation in India since Independence. Over the last few decades there has been a gradual growth of committed introspection and initiatives/ recommendations towards a more appropriate Medical Education. These have been by different groups including government policy makers, medical college teachers, professional associations and health and social activist organisations. In addition, innovative training experiments in the voluntary health sector as well as the non-health sector are of increasing relevance to professional education.

The 1980s have seen a series of new initiatives and plans towards an appropriate curriculum. Simultaneously there have been disturbing trends in the Medical Education and the health sector as well.

The project proposes to study the spectrum of key experiences developed during the last few decades, focussing primarily on all that is significant for social relevance and community orientation of Medical Education.

The primary purpose of this project is to bring together :

a) A reference manual of local innovation,

b) A resource directory of local expertise, and

c) An anthology of ideas emerging from all those interested in medical education.

In this context we are particularly keen to study the alternative Community Health Training and Development Training experience in the Country and extract whatever is relevant, so that it can be incorporated into the framework of the alternative curriculum. We in the NGO sector have had the freedom to plan and organise our own training programmes, concretely basing it on the needs

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and dynamics of Community Health as we experience it at the field level. There was no problem of control or accreditation, central supervision, history, peer group opposition or any of the other problems that innovaters within the system experience. There are many other features that make the NGO training initiatives significant. They do not cater to medicos only but are available to all health action initiators. Many are focussing on development activists as well. Most of us have used participatory, interactive and community based approaches. Most of us have evolved case studies, field exercises, simulation games, group exercises and various other types of programmatic and pedogogical innovation.

We are very keen to review all this. You will be glad to know that some medical colleges with whom we are in touch are considering the possibility of a years foundation course in 'Community and Social Orientation' for all their entrants so that a substantial value reorientation can take place even before the medicos move into the formal course. This foundation course would be autonomous of the University and would therefore be able to include any innovative idea/methodology you have developed to help with this value/experience orientation. There is also a move to radically alter the professional course itself but this foundation course itself is a very significant development. We are convinced that the wealth of experience of alternative health and development trainers will be particularly relevant to this course.

We therefore earnestly request you to send us information covering as many of the following areas as possible :

a) Outline and content of your training programme,

b) Objectives and methodology,

c) Methods of selection of candidates and of evaluation both concurrent and terminal,

d) An outline of innovative exercises, field projects, case studies, games or other group based and community based methods which you employ. Even if these were not developed by you, please send them all the same mentioning the source or reference,

e) A detailed report of any one complete training programme in recent years,

f) Any papers you have written on your course,

g) If your team has had any reflections on methodology of training or evaluated your own methods this would be welcome,

h) Finally through your training efforts you must have also developed some perspectives relevant for the modification of formal medical/nursing/para medical education, please send us these as well.

We have begun to build resource files on each of the NGO training centres/courses from the material we have collected over the years. However we would like your active participation to bring it upto date.

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All materials included/mentioned in the final project report will give due credit to source (whether published or unpublished). The focus of this section will be to make the medical educators aware of all the efforts in Community Health training which could be incorporated into their programmes.

We do not know whether you are aware that a National Education Policy for Health Sciences has been formulated and is presently being circulated all over India for comments, suggestions and modification. Not surprisingly it completely ignores the contribution and the perspectives of the NGO trainers. The Bajaj Report as it is called needs our urgent consideration and all of us individually or in groups should respond to its formulation and send our contribution in the context of our own experience. If any of you are interested to get a copy of the draft report, please write to us immediately. If you send a response to the government on this we would like to have a copy for record. A joint response would have helped to ensure that we are not ignored in the future, but this may not be easy to organise now.

The materials/communication may be sent to Medical Education Project (Community Health Cell), 326, V Main, Koramangala I Block, Bangalore - 560 034 (Attn. : Ravi/Thelma Narayan). We would be glad if it could be sent before the 1st of November '90.

With best wishes and looking forward to your response,

Yours sincerely,

Ravi & Thelma Narayan,
Co-Ordinators.

P.S. : We enclose copies of some appendices of our project outline which will give you an idea of the scope and focus.

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APPENDIX - H

Alternative Training Sector

Community Health and Development Trainers Contacted for Study

State	Community Health Trainer	Development Trainer
A. Andhra Pradesh	1. Catholic Hospital Association of India, Secunderabad	--
B. Gujarat	*2. CHETNA, Ahmedabad	1. Behavioural Science Centre, Ahmedabad.
C. Karnataka	3. International Nurses Service Agency, Bangalore 4. St. John's Medical College, Bangalore 5. NIMHANS, Bangalore	2. SEARCH, Bangalore *3. Indian Social Institute, Bangalore 4. Institute for Cultural Research and Action, Bangalore
D. Maharashtra	6. Institute for Rural Health Management - Pachod *7. Comprehensive Rural Health Project - Jamkhed	5. Trace Team, Nandurbar
E. New Delhi	8. Voluntary Health Association of India 9. Jawaharlal Nehru University - Dept. of Social Medicine & Community Health 10. Christian Medical Association of India	*6. Indian Social Institute
F. Orissa	*11. Thread	
G. Tamilnadu	12. Deenabandhu Training Centre - Deenabandhupuram 13. Rural Unit for Health and Social Affairs, Karur *14. Christian Fellowship Community Health Centre, Ambilikai	
H. West Bengal	15. Child in Need Institute, Calcutta	

*No response to project letter but CHC Documentation Unit had material on courses.

APPENDIX - I-a

SALIENT FEATURES OF INSTITUTIONAL VISITS

Christian Medical College - Ludhiana (February 1990)

1. Discussion with Faculty interested in Medical Education.
2. Discussion with Student Council.
3. Discussion with PSM Faculty.

Mahatma Gandhi Institute of Medical Sciences, Wardha(August 90)

1. Discussion with some Faculty.
2. Discussion with interns group.
3. Discussion with PSM Professor.

King George Medical College - Lucknow (October 1990)

1. Discussion with a joint faculty/student group.

Christian Medical College - Vellore (December 1990)

1. Visit to Pre-clinical Community Orientation Programme.
2. Discussion with some faculty.
3. Discussion with interns group.

Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry. (January 1991)

1. Visit to NTTC, Rural field practice area and Urban field practice area.
2. Discussion with some faculty interested in Medical Education.
3. Discussion with interns group.
4. Discussion with PSM faculty.

All India Institute of Medical Sciences, New Delhi(April 1991)

1. Discussion with adjunct faculty of Centre for Medical Education Technology.

St. John's Medical College, Bangalore

1. Discussion with Junior staff with rural experience(July 90).
2. Discussion with faculty members of Medical Education Cell (January 1991)

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APPENDIX - I-b

MEETINGS LINKED TO PROJECT

Project Related

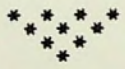
1. Peers meeting, Bangalore (July 1990).
2. Graduates with Rural Experience (November 1990).
3. Community Health Trainers Dialogue - Bangalore(October 1990).
4. Advisory Committee Meetings.

Complementary

1. CMC Network Meeting I (August 1989)
2. CMC Network Meeting II (March 1990)
3. CMC Network Meeting III (March 1991)
4. CMC Network Meeting IV (February 1992)

Others

1. NIAS Health Policy Workshop (September 1990)
2. IAAME Annual Conference (January 1992)
3. Annual Conference of Indian Association of Physiologists and Pharmacologists (December 1991)



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APPENDIX - J

CODE FOR MEDICAL COLLEGES INCLUDED IN PROJECT REPORT

(Used in Tables)

'Pacesetter' Colleges

Christian Medical College - Vellore	-	1
All India Institute of Medical Sciences - New Delhi	-	2
St.John's Medical College - Bangalore	-	3
Jawaharlal Institute of Postgraduate Medical Education and Research - Pondicherry	-	4
Mahatma Gandhi Institute of Medical Sciences - Sevagram	-	5
Christian Medical College - Ludhiana	-	6

Other Colleges

Rangaraya Medical College - Kakinada	-	7
Sri Venkateshwara Medical College - Tirupathi	-	8
Smt. N.H.L. Municipal Medical College - Ahmedabad	-	9
Baroda Medical College - Baroda	-	10
Rohtak Medical College - Rohtak	-	11
Kasturba Medical College - Manipal	-	12
Kottayam Medical College - Kottayam	-	13
Armed Forces Medical College - Pune	-	14
B.J. Medical College - Pune	-	15
Government Medical College - Nagpur	-	16
Grant Medical College - Bombay	-	17
Lokmanya Tilak Municipal Medical College - Bombay	-	18
Ramanand Tirth Rural Medical College - Ambajogai	-	19
Topiwala National Medical College - Bombay	-	20
Dr. V.M. Medical College - Sholapur	-	21
Dayanand Medical College - Ludhiana	-	22
J.L.N. Medical College - Ajmer	-	23
PSG Institute of Medical Sciences & Research - Coimbatore	-	24
Institute of Medical Sciences - Varanasi	-	25
King George Medical College - Lucknow	-	26
Maulana Azad Medical College - New Delhi	-	27
Lady Hardinge Medical College for Women - New Delhi	-	28

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Goa Medical College	- 29
L.L.R.M. Medical College - Meerut	- 30(N)
Thanjavur Medical College - Thanjavur	- 31
Osmania Medical College - Hyderabad	- 32
Government Kilpauk Medical College - Madras	- 33

Others

Consortium	- 34
Medical Council of India	- 35

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APPENDIX - K

Medical College Initiatives(with college code)(refer Appendix J)

A. General / Structural / Process

01. Defining Institutional Objectives (1,2,3,5,6,9)

02. Defining intermediate (Departmental and instructional objectives (1,2)

03. Development of Medical Education Cell with adjunct faculty (2,3,4,6,9,12)

i) Conducting workshops
ii) Evolving objectives;
iii) Developing MCQ banks, etc.

04. Faculty Training/Development (1-4,6,9,12,15)

i) Educational Technology
ii) Problem based learning
iii) Tutor training for PBL
iv) Assessment / Evaluation technique
v) Research
vi) Self learning methods.

05. Selection Procedures other than Academic merit (3,1)

i) Psychological tests
ii) Group observations on social skills/ values orientation/motivation
iii) Problem solving abilities
iv) Leadership skills.

06. Curriculum development / content through curriculum planning committee

i) Integration of teaching (9)
ii) Identifying core abilities / skills (3,25)
iii) Prioritization of topics within departments (9)

07. Examination Reform

i) Objectivised assessment OSPE / OSCE (2)
ii) Restructuring assessment towards HFA-PHC (4)

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08. Faculty / student involvement in Medical Education Reform (1,2,4,6)

i) Faculty survey - curricular defficiencies (4,1,2)
ii) Student survey - curricular defficiencies (4)
iii) Intern survey - curricular defficiencies (1)
iv) Department programme evaluation- students (6)
v) Department programme evaluation - faculty (6)
vi) Self Assessment by faculty (6)

09. Tutorial system for student support counselling, development (1,3)

10. Students Electives - during clinical years (1,3)

11. Student involvement in Research Pre/Para/Clinical phases (1,3,7)

12. Regular Faculty Meeting (inter and intra departmental) and Faculty-students meetings (9)

13. Student nurture programmes (1-6,7)
Curriculur/cocurricular activities including NSS/NCC.

14. Rural Bond Scheme (1,3)

i) Placement in peripheral/rural hospitals for 2 years post-internship experience.
ii) Preference for RBS candidates in PG selections.

15. Continuing Medical Education (1,3)

Programme for alumni/graduates especially those in general practice or small peripheral hospitals and health projects.

B. Pre-clinical phase

16. Foundation Courses for entrants

i) Community oriented - Gandhian Philosophy and values course-self help, dignity of labour, simple living, etc. (5)
ii) Study skills course - Group dynamics, Educational Objectives, Tests for learning skills, communication reading skills, History of Medicine, National Health Policy. (21)
iii) Foundation Course - Group dynamics, Team concept, linkages between basic sciences and health care, self directed learning communication skills, value based education. (1)

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17. Community Orientation Programmes (Rural)

i) COP - 3 weeks block posting (1)
ii) ROP - 2 weeks rural camp (3)
iii) Social Service Camp - 2 weeks (5)
iv) COTP - 2-3 weeks (24)
v) Post COP/ROP knowledge attitude evaluation (1,3,24)
vi) Involvement of preclinical faculty (nonPSM) (1,3)

18. Introduction of additional subjects

i) Behavioural Sciences (1,3,24)
ii) Ethics (3)
iii) First aid (3)
iv) Nursing (3)

19. Clinical orientation in preclinical phase

i) Implementation of MCI 1982 guidelines (26)
ii) As an adjunct to preclinical teaching (3)

20. Humanization of Physiology/Biochemistry practicals (1,2)

21. Samaritan Medicine - to make students attentive listeners, compassionate and skilled in interpersonal relationships (visiting patients and their relatives in hospital) (6)

22. Multidisciplinary student teams training in urban slum setting (urban equivalent of COP) (6)

C. Para-clinical Phase / Teaching

23. Reorienting pharmacology Training

i) Instructional objectives (15)
ii) Human experiments (15)
iii) Orientation to Rational Drug use and Essential Drug Concept (1,3,4)
iv) Clinical orientation (5)

24. Synchronization of Theory lectures in Medicine/pharmacology/pathology (9)

25. Involvement in Integrated Teaching (8,29)

i) integrated seminars
ii) clinico-pathological-social conferences.

D. Community Medicine

26. Family care programme - community based

i) Family care programme (rural) 1st year till internship (5,13,20)

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ii) Family care practice (Urban) throughout studentship (2)

iii) Family Health Advisory Service in 4th year Three week family study + one week clinico-social case review. (28)

27. Community Block Posting (first clinical year)

i) CHP-I-block posting in first clinical year to be exposed to Epidemiology, Health planning, health administration and national health programmes(Health Planning exercises) (1)

ii) Community Diagnosis Camp 2nd clinical level (24)

28. Junior clinical clerkship in Community Centre (2)

i) 12 weeks urban health centre posting.

29. Special focus training programmes in

i) Epidemiology and statistics (through problem oriented teaching methods) (1,2,3,28)

ii) Health Education methods and preparation of HE aids (20)

iii) Clinical Epidemiology (1)

iv) Health Economics (1)

v) Managerial skills (1,4,34)

vi) Integrated Health team (1,6,34)

vii) Orientation to other systems of medicine (3)

30. Rural/urban slum health trips to peripheral centres (7)

(Health Education/minor ailment care/MCH motivation/ referrals).

31. Community block posting in 2nd clinical year (1)

i) CHP-II for learning experiences in epidemiological studies, evaluating national health and development programmes at periphery, organising health education.

32. Senior clinical clerkship in Community Centre (2)

i) Posting in rural health centre/sub centre in second clinical year.

33. Epidemiological/Public Health Research Projects for Final M.B.B.S students. (13)

E. Clinical Phase / Teaching

34. Integrated Teaching (inter departmental coordination)

i) Medicine synchronised with Pathology and Pharmacology (9)
ii) PSM/Paediatrics/Obst. and Gyn. integration (20)
iii) Special focus integration courses/seminars
a) Human reproduction, FP and population dynamics (8)
b) Human sexuality and FP (16)
c) Epidemiology and control of TP, leprosy, smallpox, preventable blindness. (29)
d) MCH, FP, and School Health (29)
e) Integrated leprosy course (35)

35. General Out Patient Department for training in general practice and primary health care -
-Run by CM Department - coordinated with Medicine/ Surgery/Paediatrics/Obst. & Gyn.

i) G.O.P.D. Programme (5)
ii) Curative/preventive general practice unit (CPGP) (10)

36. Clinical clerkship in Primary Departments

i) Posting in Obs. & Gyn. Department (all colleges)
ii) Student clerkship in Medicine/Surgery Paediatrics (1,34)

37. Training in Emergency care / Medicine (4)

38. Community visits/programmes by clinical departments

i) Field visits by OBG department for family welfare motivation and services (7)
ii) Specialist camps in field practice areas (diagnostic and surgical) (1,3,5,7)

39. Reorientation of Medical Education(ROME) Scheme of GOI(3,13,29)

i) First year till internship-graded exposure and responsibilities (13)
ii) Two month posting in 2nd/3rd clinical year (29)

40. Inter departmental coordination in clinics in Hospital programme itself (11)

i) Antenatal/postnatal clinics
ii) Under five clinic/well baby clinic
iii) Immunization clinics
iv) Family Welfare Programme
v) Health Education in Hospitals
vi) Hospital extension services to neighbourhood.

41. Peripheral Hospital Posting

i) Posting to small peripheral mission hospital for a month during vacation in pre final year. (1)

F. Internship

42. Interns Orientation Programme

i) Integrated orientation programme (4)
(doctor patient relationship, Rational drug prescriptions and investigations, medical records, medico legal aspects)

ii) Interns Orientation Programme (17)
(Hippocrates Oath, Attitudes-relationship building, Diagnosis and treatment within resource/knowledge update/research)

43. Community Health posting in compulsory rotating internship 3-6 months

i) Three months posting with specific objectives (1)
ii) 6 months = 2 months GOPD + 2 months PHC + 2 months sub centre (5)
iii) Village based CH clinics in batches of 2 (3)
iv) 6 months - CH internship in 2 week units (17)
v) Internship detailed guidelines for posting (1,3)

44. Community based camps and clinics with clinical departments (interns accompany clinicians)

i) Departmental Scheme in coordination with PSM (1,3,5,15)
ii) ROME scheme (13,29)
iii) Mobile Rural Hospitals scheme (11)

45. Interns posting experience at Government Primary Health Centre and sub centre

i) Orientation to functions / organisation
ii) Orientation to work of specific team member.

46. Involvement of Interns in special situations (3,9)

i) Epidemic control (9)
ii) Disaster relief (3)
iii) Plantations (3)
iv) Voluntary Health Projects (3)

47. Involvement of Interns in training of Primary Health Care workers (3,13)

48. Interns Training in specific skill areas

i)	Rational Drug concept and essential drug use	(4)
ii)	Management skills	(4)
iii)	Ethics	(1,3)
iv)	Health Education skills	(20)
v)	Epidemiological projects	(3)
vi)	Clinical research (elective)	

49. Internship training in special clinics in Hospital situation

i)	GOPD	for general practice	(5)
ii)	CPGP Unit	orientation	(10)
iii)	ANC/PNC/Family Welfare clinic		(11,17)
iv)	Under five clinic/Immunization clinics		(12)

50. Internship Assessment / Evaluation (1,3,8)

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APPENDIX - L

PROJECT SCHEDULE - I

(Based on Actual Experience)

Pre-Project phase : (February 1989 till March 1990)

February - March 1989

Completion of two additional articles for mfc anthology - Medical Education Re-examined

i) Recent initiatives towards an alternative;
ii) Anthology of ideas - the framework of an alternative.(Compilation).

April 1989

Meeting with Dr. P. Zachariah at CHC (with CHC contacts) on the Miraj Manifesto for an Institute of Health Sciences at Miraj for Appropriate Medical Education.

July 1989

The mfc articles and alternative framework sent to CHC advisors, CMC-Vellore and NTTC-JIPMER, Pondicherry, and others.

August 1989

Keynote address : Towards Greater Social Relevance in Medical Education, at the first meeting of the Christian Medical College Network facilitated by CMAI.

September 1989

A detailed CHC response to the 'Miraj Manifesto'.

November 1989

Draft Medical Education Project proposal formulated and sent to two 'referees'.

January 1990

i) SOS from CMC-Ludhiana to CHC to assist them in their initiatives towards an experimental parallel curriculum.
ii) Medical Education Project proposal sent to CMAI sponsorship.

February 1990

i) Letter from CMAI to CMC's about project proposal and initiation to support/participate (see Appendix A_1)
ii) Visit to CMC-Ludhiana and interaction with management faculty and students on proposed initiatives.
iii) Invitation and Medical Education Project proposal sent to Advisory Committee members.

March 1990

i) Second meeting of the Christian Medical College Network and sharing of evolving project plans.
ii) Project proposal sent to CHAI for sponsorship.

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PROJECT SCHEDULE - II

Phase I : (April 1990 till June 1991)

April 1990

i) CMAI sponsorship confirmed (Appendix A_2).
ii) CMC - Ludhiana sponsorship confirmed.
iii) Literature review initiated.

May 1990

i) First Advisory Committee meeting to finalise objectives and methodology.
ii) Letter to bulletins / journals / press (Appendix C).

July 1990

i) First letter to 125 Medical Colleges sent (Appendix D_1).
ii) Local 'peer' group meeting held on evolving project.

August 1990

i) Visit to MGIMS, Sevagram .
ii) Discussion with 'medico friend circle' peers.
iii) Meeting with junior faculty of St.John's Medical College-Bangalore, who have completed rural bond - to evolve graduate survey forms (RBS Staff).

September 1990

NIAS National Workshop on 'National Health Policy - Towards a Decentralised Health Care'. (Paper on 'Educational Perspectives' presented).

October 1990

i) Letter to Community Health and Development Trainees sent (Appendix G).
ii) Visit to King George Medical College - Lucknow.
iii) Project Advisory Committee Meeting.

November 1990

i) Graduate survey proforma evolved in a participatory way with RBS staff (Appendix I).
ii) Pilot testing of proforma.
iii) First project report sent to all concerned.

December 1990

i) Graduate survey forms distributed at post-graduate entrance exams at St.John's Medical College-Bangalore.

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ii) Request to other institutions/network to identify potential respondents.

iii) Visit to CMC-Vellore and RUHSA-Kavanur.

January 1991

i) Discussion with St.John's Medical Education Cell.

iii) Letters with enclosures sent to IAAME annual Conference participants in Hyderabad (Appendix F).

iii) First reminder sent to all medical colleges who had not responded.

iv) Visit to JIPMER - Pondicherry.

v) mfc-Anthology 'Medical Education:Re-examined' published and some lobby work initiated.

February 1991

Discussion with A.P. Health University Coordinator.

March 1991

i) Project Advisory Committee.

ii) Third meeting of CMC Network.

(paper on mfc Alternative framework as well as initial findings of graduate survey presented).

iii) Discussion with Department of Community Medicine (Osmania Medical College) and Social Paediatric Unit (Nilufer Hospital) in Secunderabad.

iv) Second reminder sent to all medical colleges (Appendix D_2).

April 1991

i) Visit to Delhi for discussion with
a) CMAI;
b) WHO-SEARO Medical Education Unit;
c) Prof. V. Ramalingaswami, Professor, Emeritus, AIIMS.

ii) Visit to AIIMS and interaction with CMET adjunct faculty.

iii) Community Health Trainers Dialogue - background work initiated including opinion survey.

iv) Phase II project proposal formulated and sent to CMAI and CHAI for approval.

v) Resource in Community Health Trainers training in programme organised by CSI Ministry of Healing.

May 1991

Second Project report sent all concerned.

June 1991

Special issue of Health Action (monthly magazine of HAFA Trust-Secunderabad) on Medical Education facilitated by us.
(Theme : Medical Education - Where does it lead?).

-x-x-x-

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PHASE - II (July 1991 - June 1992)

July 1991

i) Visit to Bombay to brief lawyer for MMC-Miraj's writ petition on Community Oriented Medical College application.

ii) Project data analysis and compilation started.

iii)

September 1991

i) Three chapters of Project Manual sent to Advisory Committee for review.

ii) Response sent to CMC-Ludhiana's project on Child Survival through a slum Health and Development Project.

October 1991

i) Project Advisory Committee on review of four initial chapters.

ii) Community Health Trainers Dialogue on 'National Educational Policy for Health Sciences'.

November 1991

Advisory Committee review meeting minutes and summary circulated.

December 1991

i) Late Dr. H.J. Mehta Oration at St.John's Medical College-Bangalore, on the theme 'Rebuilding Preclinical medical foundation'.

ii) 'Medical Education' Seminar at Annual Conference of Association of Physiologists and Pharmacologists of India, Bangalore Medical College.

January 1992

i) Third project report circulated.

ii) Preliminary communications presented at 30th Annual Conference of IAAME at LT Medical College, Sion, Bombay.

iii) Visit to Delhi to discuss Medical Education Project follow up with CMAI, WHO-SEARO, CMET-AIIMS,

-Meeting with Prof. V. Ramalingaswami and Dr. Mohan Garg-CED Illinios (consortium Consultant).

February 1992

Fourth meeting of Christian Medical College Network,
Theme: Ethics in Medical Care and Ethics in the medical curriculum.

March 1992

i) Compilation on basic skills in medical education from Graduate Survey for SJMC research project.

ii) Preliminary planning process on Medical Education Review Meeting initiated.

April - June 1992

i) Work on final reports and manual.

ii) Opinion survey of Medical Education review meeting participants on 'Medical Education Innovations' and 'collective response to mfc alternative curriculum' initiated.

iii) Background papers for Medical Educators Review Meeting.

June 1992

Medical Educators Review Meeting to consider findings and follow up of project.

CMAI / CHAI sponsored project ends.

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APPENDIX - M

AN OVERVIEW OF THE FINANCIAL SUPPORT FOR THE PROJECT

1. Total Project Outlay and Partnership in funds

Contributors	Phase I April 1990 to June 1991	Phase II July 1991 to June 1992	Phase II Additional
	Rs.	Rs.	Rs.
C.M.A.I.	90,000/-	30,000/-	75,000/-
C.H.A.I.	60,000/-	60,000/-	75,000/-
C.M.C.-L	30,000/-	--	--
C.H.C.	32,400/-	--	--
TOTAL	2,12,400/-	90,000/-	1,50,000/- *

* This includes support tofor C.H.T. Dialogue MER Meeting and Rs. 50,000/- for publications.

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APPENDIX - N (Contd.)

2. **Break-up of Total Outlay**

Head of Account	Phase I Apr. 90 to Jun. 91	Phase II July 91 to June 92	Total April 90 to June 92	Percentage
	Rs.	Rs.	Rs.	%
1) Salaries/ Allowances	1,26,900/-	45,000/-	1,71,900/-	38.0
2) Travelling	25,050/-	22,500/-	47,550/-	10.5
3) Meetings				
a) Advisory Committee	6,150/-	2,250/-	1,08,400/-	24.0
b) C.H.T.D. I & M.E.R.M. I	--	1,00,000/-		
4) Publications				
a) Publications	--	50,000/-	52,250/-	11.5
b) Media	--	2,250/-		
5) Administration				
a) Postage/ Stationery	8,100/-	2,250/-	72,300/-	16.0
b) Xerox/Reports/ Cyclostyling	7,800/-	4,500/-		
c) Contingency	2,400/-	6,750/-		
d) Rent	6,000/-	4,500/-		
e) Others (CHC Contr. for team services, office accdn. etc.)	30,000/-	--		
Total	2,12,400/-	*2,40,000/-	4,52,400/-	100.0

N.B. * Revised mid-Phase I (Refer Document 2 dated 9.1.91 of the project proposal and budget estimates compilation of CHC-CMAI-CHAI Medical Education Project)

- All figures are rounded off to the nearest 50.

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APPENDIX - O

REPORTS / PUBLICATIONS / PAPERS ARISING OUT OF THE CHC/CMAI/ CHAI MEDICAL EDUCATION PROJECT APRIL 1990 TILL JUNE 1992.

01. Strategies for Social Relevance and Community Orientation in Medical Education : Building on the Indian Experience (A project proposal).

02. Towards Greater Social Relevance in Medical Education - a keynote presentation at the first Network of CMC Medical College in India, March 1991, CMAI Journal, Vol.VI, April-June 1991.

03. An Alternative Vision of Education for Decentralised Health Care - paper presented at a Workshop on "Towards a Decentralised Health Care : A fresh look at the National Health Policy", organised by the National Institute of Advanced Studies, Bangalore. (Proceedings of workshop being published by Wiley & Co.)

04. A brief progress report of the Project-15th November 1990.

05. A brief progress report of the Project-1st May 1991.

06. Medical Education - where does it lead - special issue of 'Health Action' magazine (Vol.IV, No.6, June 1991) published by HAFA Trust, Health Action, P.B. No.2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad - 500 003.

07. Key components which should form part of an education policy for Health Sciences in India - collective concerns from an opinion poll. (Community Health Trainers Dialogue-Background Paper II).

08. Key issues which are important to review in order to enhance the contribution of Community Health Trainers in India - collective concerns from an opinion poll - (Community Health Trainers Dialogue, Background Paper III).

09. Overcoming Nebulous thinking and action on medical education in India (Debabar Banerji) (Community Health Trainers Dialogue - Background Paper IV).

10. The Bajaj Report - some view points - I
Amla Rama Rao, Rajaratnam Abel, C.M. Francis, Ulhas Jajoo, George Joseph and M.J. Thomas (Community Health Trainers Dialogue - Background Paper V).

11. The Bajaj Report - some view points - II
Vijaya Sherry Chand, Thelma Narayan (Community Health Trainers Dialogue - Background Paper VI)

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12. Rebuilding the Foundations : Re-examining preclinical Medical Education - H.J. Mehta Oration-1991, delivered by Ravi Narayan at St.John's Medical College in December 1991.

13. Medical Education in the 1990's - Towards greater participation and value orientation - a reflection on the project, for LINK Newsletter of Asian Community Health Action Network (submitted in September 1991).

14. Education Policy for Health Sciences - A statement of shared concern and evolving collectivity - a collective statement from the Community Health Trainers Dialogue, October 1991.

15. Proceedings of the Community Health Trainers Dialogue, October 1991.

16. A brief progress report of the Project - 1st January 1992.

17. Strategies for greater community orientation and social relevance in Medical Education - Building on the Indian Experience - (A preliminary communication) - presented at the 30th Annual Conference of the Indian Association for the Advancement of Medical Education on the theme 'Research in Education for Health Sciences' held at LTM Medical College, Sion, Bombay, - January 1992.

18. Curriculum Change : Building on graduate doctor feedback of peripheral health care experience - an exploratory survey - (A preliminary communication) - presented at the 30th Annual Conference of the Indian Association for the Advancement of Medical Education on the theme 'Research in Education for Health Sciences' held at LTM Medical College, Sion, Bombay - January 1992.

19. The CHC/CMAI/CHAI Medical Education Project - A process report (April 1990 to May 1992).

20. Towards an alternative medical education - step by step (an anthology of CHC papers and initiatives).

IN THE PROCESS OF COMPLETION

21. The key to change : Reflections on strategies for social relevance and community orientation in Medical College (summary of Project findings).

22. Towards curriculum change : Building on graduate doctor feedback from peripheral health care experiences - the final report of an exploratory survey.

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23. A faculty resource manual on 'Strategies for Community Orientation and Social Relevance in Medical Education: Building on the Indian experience.

24. Laying the Foundation - towards foundation community experiences in medical education.

25. A to Z of Medical Education in India .
(A bibliography with some annotations of key materials).

IN ANTICIPATION

26. Key changes and innovations towards social/community need based medical education in India - an opinion survey.

27. The mfc Anthology of ideas - a collective response.

28. Collective Commitment for Change : Proceedings of a Medical Education Review Meeting, June 1992.

> NOTE: Items 26 and 27 are background papers arising out of an opinion survey conducted among the participants of the Medical Educators Review Meeting, June 1992.

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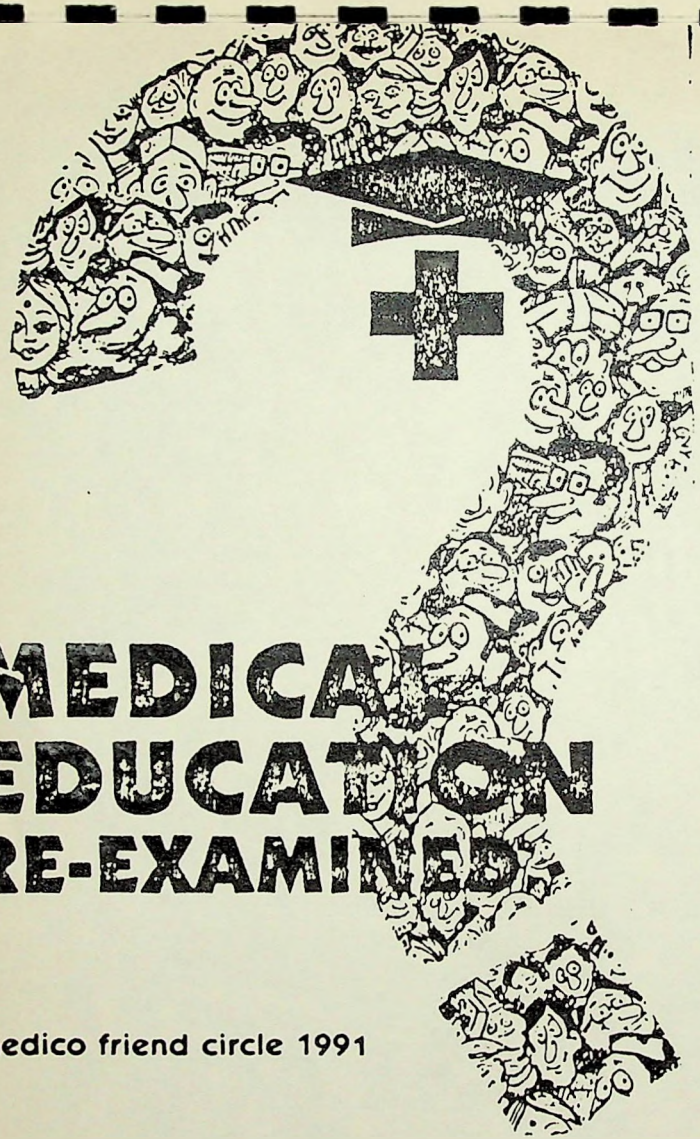

MEDICAL EDUCATION RE-EXAMINED

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FOR NOTICE BOARD

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APPENDIX I P

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APPENDIX - Q

MODIFICATIONS FROM ORIGINAL PREPARED FOR CMC - LUDHIANA

(to be used as a framework by any college interested in the process in the post-project lobbying phase)

A Workshop on 'Exploring Objectives and Methodology' for enhancing Community Orientation, Social Relevance, problem based, learner centred medical education within the existing framework of the MCI recommended MBBS Curriculum.

- Building on the Indian experience.

FOR WHOM

For a core team of faculty from any Medical College interested in a 'planning exercise' on the theme.

BY

Facilitated by Community Health Cell, Bangalore.

FROM

Resource persons from an informal network of resource persons/ institutions interested/involved in appropriate medical education.

OBJECTIVES

1. To outline the relevant objectives of medical education in India, particularly for the college.
   What do we want to do?

2. To review the existing educational programme at the college in the context of the above as well as in the context of the 1982 MCI Curriculum.
   What are we doing?

3. To explore new objectives, roles and programmes in the context of the Indian experiences particularly from ongoing experiments and the mfc alternative.
   What else can we do?

4. To assess these possibilities in the ocontext of the r resources and constraints in the college.

5. To evolve a plan of action to be operationalised by a medical education cell and or a core group of faculty of the college interested in the 'exercise'.

****

(Appendix-Q (Contd.)

DRAFT PLAN FOR WORKSHOP

(This is a tentative plan subject to modification / finalisation by the college faculty team)

Day	Time	Type of session	Theme	Background Material
First Day	Session I	i) Introduction to workshop and objectives. ii) Getting to know each other iii) Getting to know 'instruments' of change.	What do we want to do? What could be the ideal objectives of Medical Education in the Indian context? Both general for the institution and specific to some of your/other departments.	i) Defining Objectives ii) Objectives of some of the Indian 'innovater' colleges.
	Session II	Group Work		
	Session III	Five presentations and discussion	" " Modifying and redefining the above.	
Second Day	Session IV	Discussion	What are we doing? Reviewing existing educational programme of the medical college Why is it happening that way? What is the student expected to do?	
	Session V	Study and group work.	Read the 1982 MCI guidelines and asses the college objectives/ actuals in that context.	MCI 1982 guidelines.

(Appendix-Q(Contd.)

Day	Time	Type of session	Theme	Background Material
Third Day	Session VI	SWOT Analysis	What else can we do? Given the MCI 1982 guidelines what are the possibilities and constraints in the college.	
	Session VII	Input session	Learning from each other Exploring initiatives of other institution (Medical Education Project check list)	Objectives/ reports of other institutions.
	Session VIII	Individual Work	Reflect on a pla of action for the year for the college as a whole and especially for one's own Department.	
	Session IX	Group Discussion	A plan of action for the year for the college.	
Fourth Day	Session X	Input Session	What are the resources available in India?	
	Session XI	Exploring CHC/CMAI/ CHAI Project manual and reports	Evolving a plan to use these resource materials in an ongoing process of a formal/informal medical education cell of a college.	
	Session XII	Final Session	Summing up/Feedback from participants.	

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A HAFA NATIONAL MONTHLY FROM THE HOUSE OF CHAI

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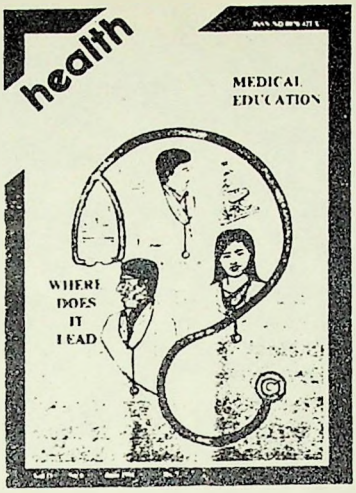

Thought for the Month....

The physician turned from the telephone and said to his wife, "I must hurry to Mrs. Jones' boy — he's sick".

"Is it serious?"

"Yes. I don't know what's the matter with him, but she has a book on what to do before the doctor comes. So I must hurry. Whatever it is, she mustn't do it."

Contents

Appendix - S

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CURRICULUM CHANGE : BUILDING ON GRADUATE DOCTOR FEEDBACK OF PERIPHERAL HEALTH CARE EXPERIENCE - AN EXPLORATORY SURVEY.

NARAYAN THELMA, & NARAYAN RAVI.

(COMMUNITY HEALTH CELL, SOCIETY FOR COMMUNITY HEALTH AWARENESS, RESEARCH AND ACTION, BANGALORE 560 034.)

This paper is a preliminary report of a questionnaire survey of over 50 young graduates doctors. This survey was a component of a larger study entitled Strategies for greater Community Orientation and Social Relevance in Medical Education : Building on the Indian Experience undertaken by Community Health Cell.

There have been some attempts in recent years to build curriculum change and innovation through feedback of medical students and interns but this is probably the first survey which focuses on graduate doctors who had completed atleast two years work experience in a peripheral health care institution in the 1980's. They were asked to reflect on medical education and how it could be made 'more supportive and relevant to present day peripheral hospital practice and community health action'.

The proforma sought ideas and feedback on 26 subjects in Medical Education which included (1) Anatomy (2) Physiology (3) Biochemistry and Biophysics (4) Biostatistics (5) Behavioural Sciences (6) Others (7) Pathology (8) Microbiology (9) Pharmacology (10) Forensic Medicine (11) Medicine (12) Surgery (13) Obs. & Gyn. (14) Pediatrics (15) PSM (16) Psychiatry (17) Dermatology (18) Ophthalmology (19) ENT (20) Radiology (21) Anesthesiology (22) Dentistry (23) Orthopedics (24) Medical Ethics (25) Other (specify) (26) Internship.

Feedback was also elicited on few additional skill areas which included (1) Basic Nursing Procedures (2) Communication (3) Management and (4) Training of Health Workers and Personnel and five aspects of Medical Education which included (1) Selection Process (2) Teaching Methodology (3) Curriculum Structure/Framework (4) Examination System (5) Other aspects of content, process, environment and base of teaching.

The respondents were also asked to give suggestions of methods/ experience that would enhance the social/ emotional preparedness of graduates for such work.

The survey is being analysed presently. This preliminary communication highlights the key findings.

Source :

Souvenir of XXXI Annual Conference of the Indian Association for Advancement of Medical Education - Free Paper Abstract - Page Nos. 32 & 33.

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STRATEGIES FOR GREATER COMMUNITY ORIENTATION AND SOCIAL RELEVANCE IN MEDICAL EDUCATION : BUILDING ON THE INDIAN EXPERIENCE

NARAYAN RAVI, NARAYAN THELMA, TEKUR SHRIDI PRASAD.

(COMMUNITY HEALTH CELL, SOCIETY FOR COMMUNITY HEALTH AWARENESS, RESEARCH AND ACTION, BANGALORE - 560 034.)

The Indian experience of innovation and reorientation of medical education can be built up from a study of ideas/ experiments from four sources.

(i) Recommendations of Expert Committees from Bhore (1946) to Bajaj (1989).

(ii) Experiments within medical colleges/ departments

(iii) Alternative training experiments in Community Health / Development in the voluntary sector.

(iv) Reflections of graduate doctors who have worked in Primary Health Care / Community Health Situations.

The Community Health Cell, a policy research group in the voluntary sector has just completed an eighteen month exploratory and interactive study covering all the four sources. The aim was to build a reference manual on the Indian experience for faculty of medical colleges exploring innovation in the 1990's. This paper is a preliminary report and gives an overview of the study process and findings.

The study included a communication to all deans/ principals and professors of PSM of 125 medical colleges in India with two reminders; interactive field visits and discussions with staff/interns of some medical colleges; a questionnaire survey of over 50 young graduates with work experience in peripheral health institutions; communication and dialogue with health and development trainers in the voluntary sector; and a comprehensive literature review.

The manual to be ready later this year will include -

(i) Lessons from History and Tradition

(ii) Exhorting Change - Key policy recommendations

(iii) A situation Analysis

(iv) Exploring medical college experiences

(v) Key innovations/experiments for the 1990's

(vi) Building on rural experience (graduate survey)

(vii) Laying alternative foundation (NGO training experience)

(viii) Exploring new horizons/areas in medical education

(ix) Medical Education and Society (Linkages)

(x) Resources and Key to Change