Rationale of Structural Reorganization in Medical Education

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BETWEEN the young graduate in medicine and his ultimate responsibility—human life—nothing interposes. The issues of life and death are all in the day's work for him. From the very first the training of the doctor is, therefore, much more complex and more momentous than that of the definition. So observes Abraham Flexner, the author of the Flexner Report which was responsible for momentous and radical changes in the field of Medical Education. At present in this country we have a situation which was present in the early years of this century in the United States where multiplicity of medical schools and large production of graduates with varying standards, constant pressures for review of medical education by the consumer to serve the needs of the community better are all facts of life. Whereas the teaching of traditional disciplines of medicine as anatomy, physiology, medicine and surgery is exposed to considerable stresses with rapid advances in scientific medicine and the ever-increasing number of specialities and super-specialities, the basic doctor, the one who has to take care of the human beings is slowly receding as a dream. The purpose of this Conference is to reorient Medical Education and also to adopt the two basic objectives of a national health and a national medical education policy. It has been frequently argued what the purposes of such a Conference should be? I cannot but here quote from Dr. Alan Gregg's address to the Medical Education Conference held in 1955 where he had summarised that Conference should be characterised by a free ranging and tolerant curiosity and immense amount of patience and willingness to show a high degree of selectivity in their relatively few actions taken. I thought that Alan Gregg's observation on that conference have a great deal of relevance to the present meeting and I am taking the privilege of circulating an extract from his speech which is being distributed at present.

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John Berril, a biologist, has often wondered what the purpose of entire education is and in his book on 'Readings of Human nature' states that 'I am a human being, whatever that may be. I speak all of us who move and think and feel and whom time consumes. I speak as an individual unique in a universe beyond my understanding, and I speak for man. I am hemmed in by limitations of sense and mind and body, of place and time and circumstances, some of which I know but most of which I do not. I am like a man journeying through a forest, aware of occasional glints of light overhead, with recollections of the long trail I have already travelled, and conscious of wider spaces ahead. I want to see more clearly where I have been and where I am going and above all I want to know why I am, where I am and why I am travelling at all'.

This quotation gives an idea of the purpose that a medical student must have in front of him because of the long trail that he has to follow and the final objective of service to humanity and also remember that the trails and tribulations of becoming a doctor are beset with a large number of caps, problems and trial.

I have tried to summarise the necessity for changes in medical education and the reasons for the difficulties which are frequently encountered. The most important of these are those existent in medical schools themselves. Educational change is always looked upon with a great deal of cynicism and departments within the institutions and the institutions themselves are constrained and strayjacketed so that educational changes to meet needs for health care are more easily said than done. This does not emphasise unbridled freedom to it and teach what a teacher believes to be taught but the basic needs must be identified before such health care needs are taught to student. The second important deficiency is overemphasis of medical science in the treatment of a disease leading to total neglect in the education and meaning of health care. This is

particularly true of so called centres of excellence where absence of generalists and primary care physiciaans on the teaching staff and over-exposure to specialists has become a constant feature resulting in neglect of primary health care so much so that necessary role models which have been clearly outlined in national policies are not given proper emphasis. Another important lacuna exists in the absence and inadequacy of training in the communities where health problems exist. Most teaching today is hospital-based and never at the community's doorstep. Even in the hospitals the proverbial wardrounds, clinical clerkship and the role of a dresser are all things of the past and a student who comes out of such an educational background well-versed in the latest biochemical changes does not know how to take care of the patient. There is also a serious lacuna in the medical education of inputs from the community and from the social sciences such as law, economics and sociology relevant at present to both health and disease. There is a gross impalance between the instructions in disease compared to instructions in health and instructions in hospital care compared to the instructions in community primary care. There is inadequate inter-play between medical students and other professional and auxiliary health personnel and this sense of superiority which the medical student develops persists right through his life and rarely does a doctor, therefore, function as a member of health team. He quite frequently becomes on autocrat leader of the medical education today and does not lay greatest emphasis on solving problems of health and disease relevant to the local milieu but spends most of his time memorising facts and this is further perpetuated by the academic reward system which entail scientific research achievements and performance in examinations over community health research or service to the public.

Teachers lack conceptually their responsibility towards students and are hardput to facilities learning and to encourage students to be socially conscious health workers. In almost all medical schools the absence of mechanism to guide the career choice of medical students and graduates to serve the health and medical needs of the country is conspicuous. There is lack or organised process of medical education and medical school contact for teachers to the problems in remote and undeserved areas which in itself hinders appropriate distribution of doctors. Finally, there is a failure to place adequate emphasis on preventive medicine, community medicine, tropical disseases, neonatology, paediatrics, national programmes like EPI, malaria eradication, lepsory control, Tuberculosis control, nutrition, the role of community health workers and the role of other para-medical personnel like multi-purpose workers, auxiliary nurse midwives and other members of medical and para-medical profession and the important part they play in delivery of health care services at the periphery and come in intimate contact with the common and health and medical problems of the population in marked contrast to those diseases requiring secondary or even tertiary care. If these difficulties can be found in medical schools, public policy and national developmental programmes inspite of many attempts and conferences, seminars, policy statements and reports have not taken into account the number and quality of students to be admitted to medical schools and there has been no reference to availability of resources or purposes of medical education. We are quite frequently aware that medical colleges have sprung up in sites where they are geographically least suitably located sometimes to suit political niceties.

Innovation and experimentation in medical education has not always resulted in production of balanced graduates who serve the community better though this was expected from institutions like the All India Institute of Medical Sciences which were kept out of the purview of dictation of curriculum by the Medical Council of India. Further with the establishment of examinations and credentialisation processes, present curricular changes and thereby national health goals and means are quite frequently forgotten. There is quite frequently a lack of clearly defined communicative pathways between those responsible for education and those responsible for administration and deliver of health care services and physicians actually handling health care. There is quite frequently a failure to provide feedback from health resources on the performance of medical school graduates at the periphery resulting in non-changes and failure to keep pace with the role that community expects of them.

Very fortunately inspite of all the deficiencies that have been pointed out above, which have been done in the best of faith, we should be proud

that we have one of the largest scientific potential in the world second only to the U.S.A. and U.S.S.R. in the field of curative medicines. But we should admit our failure to define primary health needs and major disease problems so as to guide reorientation of training of physicians to keep with the requirements. There is quite frequently a resistance to changes in education because of vested interests and generalists are not recognised as members of a glamerous profession; education of generalists in the fundamentals of maternal and child health problems and family planning all leave much to be desired. There is also a total failure to analyse the needs for specialists to regulate entry in their own fields which quite frequently results in super-saturation in large urban areas and complete depletion at the periphery. Medical resistance to the use of auxiliary personnel in the delivery of health and medical care is also well-known.

The necessity for reoientation of medical education is thus apparent and what we do recommend should be meaningful, tangible, put into operation in all the States with a Central monitoring apparatus not for regimentation, but for evaluation and review. Would this be possible in the present context.

The relevance of internship in the Indian context has been the subject of heated debates. When it was introduced it was a pre-registration apprenticeship being like what pertains in many European, U.K. and American schools. Slowly it has degenerated to a scut boy's position. Should this apprenticeship training be shifted back into basic fundamental training in the medical college and the Ist year residency be made only necessary for post-graduate course is a thought that has been centrally hammering at the educators' mind. Let us remember that when we were students the basic purpose of the Ist Year programme of apprenticeship training or house surgeon was often rotating, not compulsory, seldom paid, residential and we went through all the various basic departments. Clinical responsibility was also plentiful because there were no postgraduates, junior registrars, senior registrars, pool officers, lecturers and the like, competing for the same clinical material. We had our fair share of medical and surgical emergency care. It would be possible even today if we make residency only in the District headquarters and Taluq headquarters hospital and not in the ivory tower which we have succeding in creating. But with the medical teachers like to loose their scut boys is a question which we must plainly ask ourselves.

Obligatory rural services for training prior to entry into postgraduation is easy to recommend, a laudable objective, but let us fact it do we have the teeth to implement such a decision even if unanimously recommended and accepted. Many States in the south where health personnel are recruited every year, such PHC postings have been in operation and this disease only exists in the areas where they are not implementable because of improper enforcement of existent rules. Should we not have an applied manpower requirement in each specific field outlined and tailor our postgraduate needs not to suit the interest of the profession but the requirements of the community.

I am aware of all exercises done in the field but they have remained pious platitudes and proliferation of postgraduates and postgraduate courses is the order of the day. There is a strong indication for curtailment of such proliferation.

By denigrating diploma courses in basic specialities we have denied the district headquarters of specialist services. By abolishing or not fostering DPH, DTM & H we have destroyed public health and tropical medicine and hygiene. By destroying DCH we have forgotten child health but gone into superspecialisation of Paediatrics into multiple specialities like paediatric cardiology, paediatric surgery etc., resulting in the failure of our basic presentation of child care programmes. These are some of the points that should keep our minds actively engaged in the coming hours.

I would like to end this by a sobering thought that inspite of all we have achieved in the last 32 years, we have been classified by the World Bank as belonging to the low income group, and our basic problems a projected population growth to 958 millions by 2000 A.D. and our NRR of 1 would be reached only in the year 2020 and that by the year 2150 our population would reach a stationary stage of 1593 million, 250% of what we are today. We should remember our 0-1 Infant mortality rate is still 122 and the percentage of population with access to safe water supply is 31% today. Lastly we must remember that only 65% of our male children and 52% of our female population go to primary school. But there is a precipitous drop in secondary education to only 29% and higher education beyond this between the ages 20-24 is only 5% leading to an overall literacy rate of only 36%. Let us soberly remember that what we are talking of restructing is a fraction of this 5% to serve the rest of the total community at large. Community and social relevance demand the same.