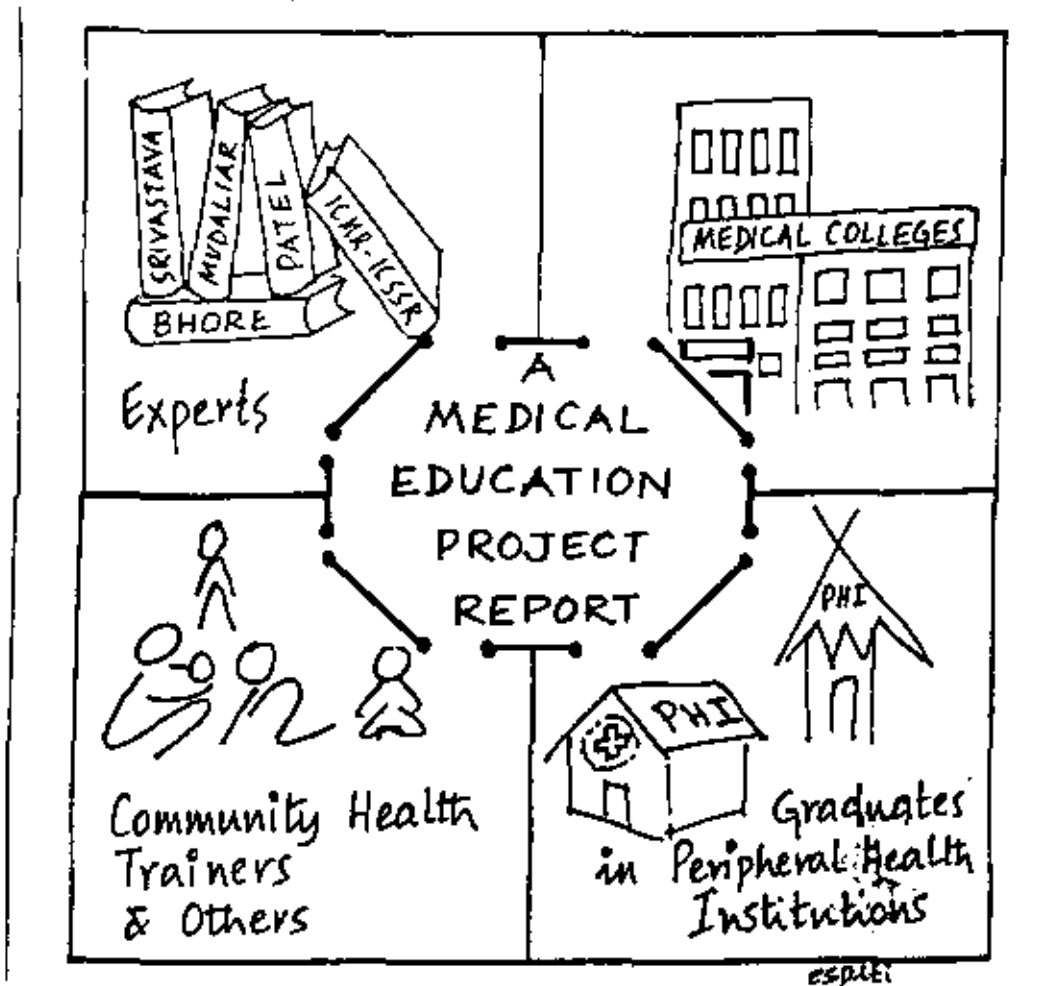



STRATEGIES FOR SOCIAL RELEVANCE AND COMMUNITY ORIENTATION - BUILDING ON THE INDIAN EXPERIENCE



- a C.H.C. - C.M.A.I. - C.H.A.I. project
march 1993



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It is released in a spirit of solidarity with the ongoing search and commitment towards social relevance and community orientation in health action and training.

The Society would be glad to be kept informed about the ways and means by which this publication supports initiatives by different institutions and groups and the outcome of such efforts.

**March 1993,
Bangalore.**

Community Health Cell

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**STRATEGIES FOR SOCIAL RELEVANCE AND COMMUNITY
ORIENTATION IN MEDICAL EDUCATION**

- Building on the Indian Experience

**[Report of an Interactive Research Project
(April 1990 - December 1992)]**

**Ravi Narayan, Thelma Narayan, and
Shirdi Prasad Tekur**

**Community Health Cell
Society for Community Health Awareness, Research and Action
326, Fifth Main, First Block
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March 1993

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FOREWORD

27th February 1993

An understanding of the determinants and dynamics of the change process in medical education is of crucial importance at this juncture. The rhetoric for reform in medical education has gone on for, far too long; it must yield place to Action and Action must follow Analysis and Assessment. The three As - "The Triple A Cycle" - hold the key to reform in medical education. Much of the literature on medical education had been filled with what was wrong, a case of over-diagnosis and under-treatment. There is a need to chronicle the efforts made in the past to introduce change, to evaluate critically the success and failures and out of such an exercise, to indicate the possible steps to be taken in the future.

This is precisely what the authors of this monograph - Dr. Ravi Narayan, Dr. Thelma Narayan and Dr. Shirdi Prasad Tekur, researchers from the Society for Community Health Awareness, Research and Action, from Bangalore - have attempted to do. The result is an outstanding success. Initiatives at reform in medical education are reviewed in extenso with special reference to their social relevance and community orientation, using both classical and interactive methods of study. Local initiatives and innovations are analysed. The views of medical college faculties, of medical education innovators and of young graduates working in Peripheral Health Institutions have been obtained. The findings presented in tables and supported by interesting animation give a realistic bird's eye - view of the strengths and weaknesses of the ongoing efforts. Some of the lesser known and inadequately reported initiatives in the Indian scene have been brought under review.

The principles of educational reform may be applicable globally but the solutions have a location specificity. The intrinsic elements of the change process are the teachers, students and institutional framework; the extrinsic elements are political will, administrative commitment and social pressure.

There is a message of hope in this monograph even as the obstacles to change are identified clearly and the many disturbing trends in medical education and practice are outlined. The monograph makes a positive contribution to reform in medical education and the authors deserve praise and gratitude.

V. Ramalingaswami

Chairman, Task force on Health
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C O N T E N T L I S T

1.	INTRODUCTION	1
2.	BASIC PREMISES OF THE STUDY	5
	a. Recognising Sectors of Innovation	
	b. Need for Dialogue Among Sectors	
	c. Faculty Development - The Key to the Change	
3.	EVOLVING THE OBJECTIVES	8
4.	METHODOLOGY	9
	a. Literature Review	
	b. Letters to Medical Colleges	
	c. Letters to Community Health/Development Trainers	
	d. Survey of Medical Graduates with work experience in peripheral rural hospitals and health care projects	
	e. Institutional Visits	
	f. Meetings and Interactive Dialogue	
	g. Approaches - Classical and Interactive	
5.	RESULTS AND FINDINGS	13
	a. Literature Review	
	b. Medical College Survey	
	c. Alternative Training Sector - Review	
	d. Survey of Graduates with Primary Health Care experience	
	e. An Overview from Field Visits	
6.	SOME REFLECTIONS ON CHANGE	37
	a. Factors Promoting Change	
	b. Obstacles/Barriers to Change	
7.	CHALLENGES FOR THE FUTURE	42
	a. Challenges before us	
	b. Tasks for the Future	
	c. In Conclusion	
8.	A POSTSCRIPT	47
9.	ACKNOWLEDGEMENTS	48
10.	REFERENCES	50

APPENDICES

1 -	Origin and Scope of the Study and its Linkages	52
1a-	Initiatives of the Researchers which formed the background to the study.	54
2 -	Some Organisational Details	55
3 -	Content of letters to Colleges	57
4 -	List of Medical Colleges	58
5 -	Alternative Training Sector	62
6 -	Institutional Visits and Meetings Linked to Project	63
7 -	Initiatives by Medical Colleges	64
8 -	Stimulating Collective Commitment - An Overview	69
9-	Reports/Publications/Papers Arising out of the Project	73

LIST OF TABLES

I	Graduate Survey Components	10
II	Research Approaches in the Study	12
III	Medical College Survey - Sample	14
IV	Medical College Strategies - Objectives and Curriculum Structure - General	16
V	Medical College Strategies - Preclinical Phase	16
VI	Medical College Strategies - Paraclinical Phase including Community Medicine Teaching`	17
VII	Medical College Strategies - Clinical Phase	17
VIII	Medical College Strategies - Internship Phase	19
IX	Pace-Setter Colleges - Some Features	20
X	Key Innovative Strategies in Pacesetter Institutions	22
XI	Alternative Training Sector - Health : Profiles of Some Courses	26
XII	Alternative Training Sector - Key Ideas	28
XIII	Graduate Survey - Summary I - Areas for Skill Development/Competence	29
XIV	Graduate Survey - Summary II - Curriculum Structure/Framework	30

LIST OF DIAGRAMS

A.	Medical Colleges and Community Health Trainers included in Study - A regional distribution.	25
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1. INTRODUCTION

A. MEDICAL EDUCATION REFORM

Medical Education and its social and community orientation has been, a subject for discussion and dialogue in India especially, since the Bhore Committee Report of 1946. During the first three decades after independence there were:

- i. many exhortations and much rhetoric;
- ii. a few concerted attempts by keen medical educators and institutions;
- iii. some progressive recommendations by the Medical Council of India (1) and other professional bodies,
but little overall change.

The Srivastava report in 1974 (2) diagnosed the problem and outlined the challenge very effectively. (See Box 1 & 2)

"DIAGNOSIS OF THE PROBLEM"

(1)

"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 specialisation 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"

(2)

"The greatest challenge to medical education in our country is to design a system, that is deeply rooted in the scientific method and yet is profoundly influenced by the local health problems and by the social, cultural and economic settings in which they arise....."

"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".

Since the Srivastava Report, there has been a growing spirit of introspection and some commitment towards reorientation of the curriculum, to suit our own 'needs' and 'socio-cultural realities'.

At the national level there have been many developments.(3) These include:

- i. Reorientation of Medical Education Scheme, 1975
- ii. ICSSR/ICMR Study group report on Health for All : An alternative strategy - 1981
- iii. The National Health Policy 1982
- iv. The Recommendations on Undergraduate Medical Education of Medical Council of India (1982)
- v. The National Education Policy, 1986
- vi. The development of the Health University concept, and
- vii. The draft National Educational Policy for Health Sciences (1989)

Within the medical college sector, there have been serious efforts by a few colleges to evolve community oriented training strategies based on the MCI guidelines and sometimes going beyond it. Their efforts have been interesting but of limited impact, due to many factors including inadequate faculty response and the changing social ethos and value system 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 curriculum or 'parallel tracks' is also an important factor.

Some medical colleges have been involved more recently in networking around various new directions including 'epidemiological orientation', the 'alternative track' concept, and the 'inquiry driven' approaches to evaluation/innovation' (3 & 4).

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 at JIPMER, Pondicherry and PGI-Chandigarh have also been significant (3).

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

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. 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. SOME LACUNAE IN THE PROCESS

Alongside the above, evidence of the spirit of introspection and 'innovation', which could stimulate change in the 1990s, there are some associated features that are not so healthy and could be considered lacunae, and even going counter to the emerging process.

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 easily 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 instance, where this has been attempted, the results are not easily 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 in different educational systems. Some of the recommendations and suggestions are therefore not adequately grounded in local realities and experience.

Finally, 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.

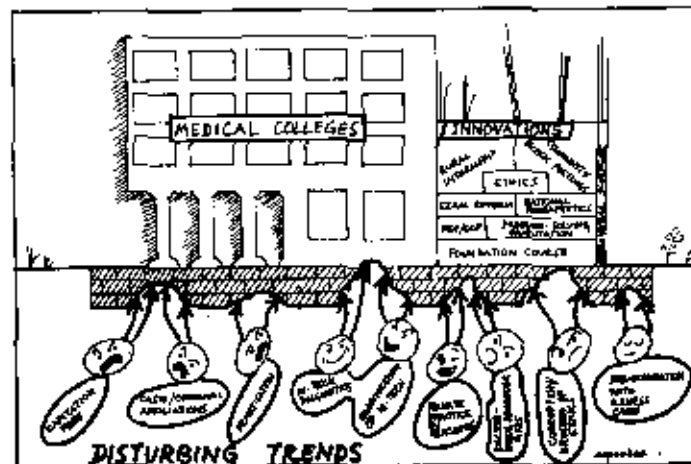
C. DISTURBING TRENDS

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 consequences, to the concept of social/community orientation of medical education (3).

These include:

- i) the growth of capitation fee 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'(11)
- vii) the rampant corruption that seems to be accepted as routine practice and the increasing erosion of norms of medical ethics, with resulting increase in medical mal-practice,
- viii) the preoccupation of medical educators with illness care in tertiary care centres, and the disregard for primary health/community health care.



Taken together, they are beginning to have 'an insidious but definitive, eroding effect on the focus and orientation of health service development in the country as well as the nature of the human power education' investment of the State.

This growing 'dialectical tension' between the increasing enthusiasm for reform of medical education towards greater social relevance and community orientation in the 1980s, with all its inadequacies and the simultaneously growing trends towards privatization, commercialisation and high-tech tertiary care form the background scenario for the CHC study which is described in subsequent chapters.

2. BASIC PREMISES OF THE STUDY

The basic premises of the study were the following:

A. RECOGNISING SECTORS OF INNOVATION

There are atleast four sectors of innovation from which stimulus for reforms in medical education can and have emerged (18):

i) The Expert Sector

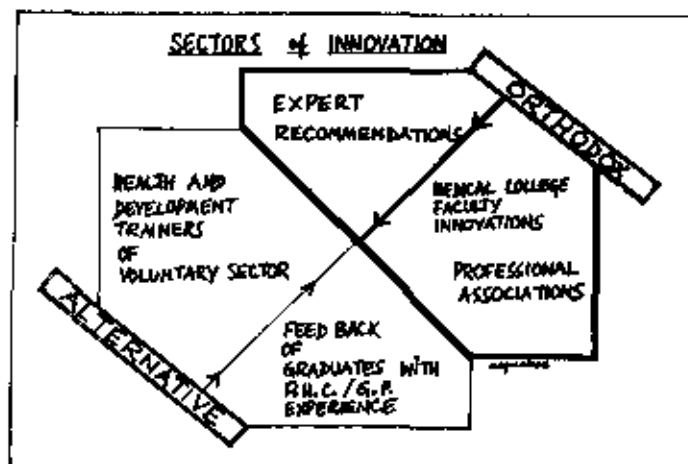
Starting from the Bhore Committee Report of 1946 till the recently circulated draft outline of the National Education Policy for Health Sciences (Bajaj Report - 1989) there have been a series of expert committees in India offering ideas and recommendations of great relevance to the Indian situation.(13, 11, 14)

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 the '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 material that has been regularly presented and discussed at the annual meetings of the IAAME and published in the Indian Journal of Medical Education.

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



iii) 'Voluntary' Training Sector

Since the 1970s a large number and variety of innovative community health oriented

training programmes for different types of health personnel have developed, especially within the 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 (15). A large number of 'alternative training experiments' supplementing these efforts have also emerged in other sectors. 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 manpower education in the country (10).

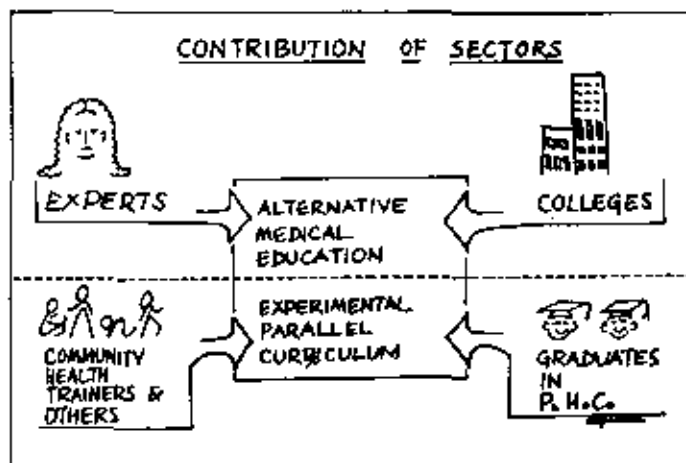
iv) 'The graduate with PHC experience'

There are a large number of young graduates of the existing 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 'graduate with PHC experience' would together constitute, what we would like to term as the 'alternative' expertise.

B) NEED FOR DIALOGUE AMONG SECTORS

The second premise of the '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 dialogue. Hence this expertise lies relatively unknown within sectors and between sectors. Medical college based innovators know little of what each other are doing; 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 orthodox expertise to dialogue with alternative expertise and evolve an integrated strategy.

C. FACULTY DEVELOPMENT - A NEGLECTED ISSUE

The third premise of the study, which has greatly determined its focus and scope, particularly in the context of the 'end products' is that the 'Faculty' of a medical college are very important for any reform process. Faculty development has however 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, not requiring much special effort or preparation.

If reform in the 1990s 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 was primarily oriented to supporting 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.

3. EVOLVING THE OBJECTIVES

A. The Steps in the Process

The objectives of the study, based on the premises described earlier evolved through 4 steps.

- i) A project proposal was drafted in January 1990 and circulated to the Advisory Committee, Peer group and a group of selected resource persons in the country. (Appendix 2)
- ii) Several comments, reactions, suggestions were received and were considered by the researchers.
- iii) At the first meeting of the Advisory Committee in May 1990 all the suggestions were considered and discussed. A modified set of objectives, keeping in mind limitations and constraints especially of time framework, were evolved.
- 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 process symbolised the interactive aspect of the action-research.

B. The Final Objectives

The Key final objectives of the study were:

1. *To document descriptively/analytically - key recommendations / experiments / innovation / experience in medical education.*
2. *To review key alternative training experiments to identify issues, perspectives, ideas, pedagogy relevant to medical education.*
3. *To build an Anthology of Ideas from a sample of recent medical graduates with primary/peripheral health care experience.*

4. METHODOLOGY

A multipronged data collection methodology was used that included both 'classical' and 'interactive' approaches. These were as follows:

A. 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 1960s to date.

b. Project Announcements in Bulletins and Journals

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

c. Peer contribution

Some 'peers' provided substantial information and materials.

B. LETTERS TO MEDICAL COLLEGES

- a. Letters were sent to the Deans/Principals and Professors of Community Medicine of 125 Medical Colleges in the country in June - July 1990. (Appendix 3 & 4)
- b. Reminders were sent in January and March 1991.
- c. All the responses received were followed up by correspondence eliciting further details about the initiatives, experiments and curricular changes described.

C. LETTERS TO COMMUNITY HEALTH/DEVELOPMENT TRAINERS

- a. Letters were sent to select group of Community Health and Development Trainers in October 1990. (Appendix 5)
- b. Reminders were sent in January 1991.
- c. Many trainers sent annual reports and training reports and further details wherever required, was elicited through ongoing correspondence.
- d. Informal discussions were also held with some of the trainers with whom the CHC team had contact due to ongoing linkages.
- e. The CHC documentation unit already had substantial material on many programmes.

D. SURVEY OF MEDICAL GRADUATES WITH WORK EXPERIENCE IN PERIPHERAL RURAL HOSPITALS AND HEALTH CARE PROJECTS(19)

- a. A preliminary proforma was developed by the researchers after a group discussion with a few doctors who had worked in peripheral rural hospitals and were presently

- faculty members of St. John's Medical College, Bangalore. This college has a rural placement scheme for its graduates as well as gives preference in PG and staff selection, to those with rural experience.
- b. This was pilot tested on 10 postgraduate students who had peripheral health care institutional experience and then finalised.
 - c. The pre tested questionnaire was distributed
 - i) at the post-graduate entrance examination of one college that gave specific preference to candidates with rural experience.
 - ii) to eligible respondents in another college by one of our advisory committee members
 - iii) to eligible respondents also at the medico friend circle annual meeting in Sevagram in September 1990.
 - d. The questionnaire was fairly extensive with 38 different sub-sections. Table 1 lists out the components of medical education on which feedback was elicited.

TABLE I
GRADUATE SURVEY COMPONENTS

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. & Gynaecology, 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.

Other Issues

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.

(Source : 19)

E. INSTITUTIONAL VISITS

- a. Visits were made to seven medical colleges which were identified; in 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.
- b. 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 visits and informal discussions helped us to identify, the strengths and 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.
- c. The institutions visited were:
Christian Medical College, Ludhiana; Christian Medical College, Vellore; Mahatma Gandhi Institute of Medical Sciences, Wardha; St. John's Medical College, Bangalore; King George Medical College, Lucknow; All India Institute of Medical Sciences, New Delhi; and JIPMER, Pondicherry. (Appendix 6)
- d. All the colleges included in the original protocol could not be visited but the 'seven college field visits' was a very useful experience and definitely gave additional perspectives that was not possible to get from reports and correspondence.

F. MEETINGS AND INTERACTIVE DIALOGUE

- a. From the very beginning it has 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.
- b. Some of the meetings helped to clarify issues and ideas and others helped to stimulate further thinking on different aspects of the problem.
- c. The key meetings are listed in Appendix 6.
- d. This interactive dimension of the project was further emphasised by the following actions:
 - i) Many discussions with the Advisory Committee were not just organisational but interactive. Several issues were raised and explored at length.
 - ii) Discussions with peers with relevant experience were held whenever possible during visits to CHC and/or Bangalore or elsewhere.
 - iii) Correspondence with peers and contacts throughout the study.
 - iv) 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.

G. APPROACHES : CLASSICAL 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 'classical' as well as interactive (See Table II).

TABLE II
Research approaches in the Study

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)	* Correspondence with medical College respondents and Community Health Trainers.
* Questionnaire Survey (Graduates)	

While 'classical' 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.

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. In the final analysis combination of methods helped to get a wider qualitative impression of the diversity of innovations.

"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

5. RESULTS & FINDINGS

The outcome of the study in terms of the responses received, 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. An overview from field visits

A. LITERATURE REVIEW

- i) The literature review led to the identification and compilation of over 750 references on various aspects of Indian experience in Medical Education which have 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) 40 key titles were also identified and an annotated bibliography entitled **Stimulus for Change** was prepared as a basic collection for a medical education cell of a medical college.
- iii) An important aspect of the literature review was a thorough study of what the 'expert' committees have said about Medical Education and a detailed compilation of recommendations from Bhore Report (1946) till the Draft National Education Policy for Health Sciences (1989) under different sub headings/aspects of medical education. These included :

What's wrong with Medical Education; Type of Doctor; Objectives/aims of medical education; Learning objectives for undergraduate medical education; Recognition and control of colleges; Pre-medical education; Admission requirements and selection criteria; Duration of course; Medical curriculum : overall principles; Educational strategies; Nature and organisation of Teaching Hospital; Nature and organisations of community centres for teaching; Pre-clinical phase (Phase I); Para-clinical phase (Phase II); Clinical phase (Phase III); Preventive and Social Medicine (Community Health); Integration; Examinations; Internship; Teachers -selection/development; Research - General; Medical College facilities; General Practitioners; Electives; Continuing Education; and National System of Medicine and integration with ISM and a few other issues.

This 'ready reckoner' would help medical colleges to locate their own structure and curriculum framework against the key recommendations of the expert committees

TABLE III
Medical College Survey (Sample: 125)*

Respondents - Statewise Distribution and Sources

SL. NO.	STATE	NO. IN SAMPLE	RESPONDED TO SURVEY	FROM LITE-RATURE REVIEW	VISITED	TOTAL
			a	b		
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	1
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

* Source (16)

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

most of which focus on social relevance as well as community orientation.

- iv) The literature review also identified some ideas/innovation within medical colleges and within other sectors of innovation which were not identified by surveys and interactive methods.

All this will form part of a Faculty Resource book which is being compiled.

B. MEDICAL COLLEGE SURVEY

- i) 25 colleges responded to our project, 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-innovators, 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 (23.6%).
- iii) Table III shows a statewise distribution of the 'respondent' colleges including the sources of identification. 7 colleges, one each from seven States visited by researchers are also shown.
- iv) Recent 'guesstimates' of the Health Ministry and Planning Commission of the G.O.I. are that the number of medical colleges in the country as of 1992 is between 140-150. Most of these are of recent origin, mostly 'capitation fee' 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.(16)

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 IV-VIII list out key ideas/and innovations that were identified through various methods

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 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.	<u>Selection Procedures</u> other than academic merit (Psychological/Social skills/leadership/value orientation)
6.	<u>Curriculum development</u> including
	i) Integration,
	ii) identification of core abilities,
	iii) prioritization (curriculum planning committees)
	iv) identifying skills
7.	<u>Examination Reforms</u>
	i) objective examinations
	ii) restructuring assessment towards HFA/PHC priorities.
8.	Faculty/student involvement in Medical Education feedback/research.
9.	Tutorial system
10.	Student electives
11.	Students involvement in Research
12.	Regular faculty meeting/faculty-student meetings
	i) curriculum issues
	ii) Social-Societal issues
13.	Student nurture programmes - curricular/extracurricular
14.	Rural Bond (Placement) Scheme
15.	Continuing Medical Education for alumnus/others.

(for further details including colleges involved, refer Appendix 7)

TABLE V
Medical College Strategies
Pre-clinical Phase

16.	Foundation Course for entrants
17.	Community-based orientation programmes
18.	Introduction of New Subjects
	i) Behavioural Sciences
	ii) Ethics
	iii) First Aid
	iv) Nursing
	v) Integrated Growth & Development
19.	Clinical Orientation in pre-clinical phase
20.	Humanisation of pre-clinical practicals
21.	Samarytan Medicine - interpersonal skills
22.	Urban-slum based-multi-disciplinary student programmes.

(For further details including colleges involved refer Appendix 7)

TABLE VI
Medical College Strategies
Para-Clinical including Community Medicine Teaching

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

(for further details including colleges involved refer Appendix 7)

TABLE VII
Medical College Strategies
Clinical Phase

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

(for further details including colleges involved refer Appendix 7)

- vi. An overview of these fifty strategies shows that there are six broad thrusts in this re-orientation process
- a. **Educational Technology**
Improving pedagogy of Medical Education by clarifying objectives, goals, methodologies at institutional and departmental levels and improving staff skills in modern education techniques. (Items 1-9, 12, 15 and 50 fall into this category)
 - b. **Widening Horizons**
Introducing new areas, concepts and perspectives as sub-units of existing subjects or as additional subjects. (Items 18, 21, 23-29, 37, 48 fall into this category)
 - c. **Improving Skill Development**
By providing greater time in the curriculum for inservice training including graded responsibilities in actual procedures to allow skill development. (Items 13, 21, 28, 32, 35, 36, 41, 44, 47, 49 fall into this category)
 - d. **Moving Beyond the Teaching Hospital**
Exploring greater community based learning opportunities including experience at different levels of health care, primarily at Primary Health Care level and the periphery. (Items 17, 22, 26, 27, 30, 31, 33, 39, 41, 43-46 fall into this category)
 - e. **Transcending Compartmentalisation**
Introducing efforts at integration of subjects and phases of medical education and including greater problem solving orientation. These also include foundation/orientation experiences that help to link up different aspects of teaching. (Items 12, 13, 16, 19, 20, 21, 24, 25, 34, 35, 40, 42 fall into this category)
 - f. **Promoting Self Learning**
Improving opportunities for students to decide for themselves and explore new areas independently even outside the curriculum structure. (Items 10, 11, 14, 46 fall into this category)
- vii. These 6 thrusts and fifty strategies, taken together, collectively represent, an evolving, alternative medical curriculum, within the existing MCI determined framework. These also symbolise, the Indian experience, towards social relevance and community orientation. It is significant that even the recommendations of MCI on need-based education as recent as August 1992 does not represent all this existing wealth of experience and perspective, and we hope, that our study would be a major contribution to fill this lacunae.

TABLE VIII
Medical College Strategies
Internship Phase

42.	Interns orientation programme
43.	Community Health postings in Rural/Urban field Practice areas
44.	Community based camps/clinics by clinical departments
45.	Posting to Government PHCs and sub-centres
46.	<u>Involvement of interns</u> in special situations
	a) Epidemic control b) Disaster relief
	c) Plantations d) NGOs Health Projects
	e) Immunization programmes f) FP motivation
47.	Involvement of Interns in Primary Health Care Training of Health Workers, Dais, Auxiliaries
48.	Internship training in specific additional skills
	i) Rational Drug Use ii) Management
	iii) Ethics iv) Health Education
	v) Epidemiological Projects vi) Clinical Research
49.	Internship training in special clinics in Hospital situation - Curative General Practice Unit/GOPD etc.
50.	Internship Assessment/Evaluation.

(for further details including colleges involved refer Appendix 7)

- viii. It is important to clarify here that since the survey, through the letter, was open ended, initially, it primarily helped to build a wide-canvas, qualitative, picture of Indian experience, providing insights into the range and diversity of innovative strategies. The colleges, who have experience of these strategies have been indicated in Appendix 8 and also mentioned in the accompanying publication - Stimulus for Change. What percentage of our study respondents or of all the colleges in the sample, have actually experimented with each strategy, could not be quantified, because of the nature of our survey. This will require a State of Art Survey which has been described in our Post-script (See page 47)
- ix) 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 IX outlines some of the key characteristics of these colleges. It is evident from this table that the reasons for their sustained commitment to both 'quality' and

TABLE - IX

**Pacesetter Colleges
Some Features**

Sl. Feature No.	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 in India	For Training doctors peripheral rural hospitals	By Central Government for Quality education	Gandhi Centenary project to Gandhian idealism	For Training of women doctors and women health professionals.
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/ group observation tests.	Entrance Test + Interview	Entrance Test + Test on Gandhian thought	Written Test Aptitude and General awareness test
8. Hospitals	1,492 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 and Urban + Mobile Clinics (ROME)	Rural and Urban	Rural	Rural and Urban

SOURCE: CBHI - Directory of Medical Education, 1986.

'reform' include a combination of predisposing factors which are:

- a) Established with specific/focused mandates.
 - b) Smaller number of admissions (50-70).
 - c) Autonomous or private management.
 - d) Own entrance examinations and selection procedures.
 - e) Adequate teaching hospital beds.
 - f) Well organised rural and urban field practice areas.
- x) Table X 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 pace-setters had internalised all the innovations, though CMC-Vellore would probably be the one college with the maximum number of operational strategies. The other five pacesetters also had introduced multiple innovations.
- xi) 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 (NHMLC), BJ Medical College, Pune; SV Medical College, Tirupathi; Rangaraya Medical College, 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. KMC, Manipal was identified as a private institution with a large number of admissions which was also experimenting with some 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 of the researchers.
- xii) An interesting finding was, that a significant association like the Indian Association for the Advancement of Medical Education, was not adequately involved in keeping track of these innovations or initiating studies or interactive processes to document or research the evolving strategies. Though some of these ideas and innovations were presented by the colleges at IAAME annual conferences 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 were not fully in touch with evolving Indian experience in recent times. Considering the objectives of the association this was a growing lacunae in its efforts.
- The Indian Council of Medical Research had shown some interest in Medical Education research in the 1960s but from the mid 1970s it seemed to have been completely dropped from the agenda of research in the country.
- xiii) 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, a fore-runner

TABLE - X
KEY INNOVATIVE STRATEGIES IN PACE-SETTER INSTITUTIONS

Sl. No.	Common Features	CMC (Vellore) 1	AIIMS (New Delhi) 2	SJMC (Bangalore) 3	JIPMER (Pondicherry) 4	MGIMS (Sevagram) 5	CMC (Ludhiana) 6
1.	Institutional Objectives	Defined	Defined	Defined	-	Defined	Defined
2.	Faculty Training (Pedagogy and other skills)	+	+	+	+	+	+
3.	Selection Procedures (other than academic merit)	-Psychological tests -Interview	-	-Psychological Test; -Group Observations on social skills, values/motivation.	-	Knowledge of Gandhian ideology	-
4.	Examination	-	Objectivised Exams (OSCE/OSPE)	-	Restructuring towards HPA/PHC	-	-
5.	Community/PSM Medicine Dept.	Community Health and Development Department	Centre for Community Medicine	Community Health Department	Community Medicine Department	PSM Department	PSM Department
6.	Student-nurture Programmes including Tutorial System	+	-	+	-	-	-

	1	2	3	4	5	6
7. Rural Bond Scheme	+	-	+	-	+	+
8. Foundation Course for Entrants	+	-	-	-	+	-
9. Community Orientation Programmes (Pre-clinical)	+	-	+	-	+	+
10. Block Postings in Community in clinical phase	CHP I & II	Community Clerkship	CHAP -I	+	+	+
11. Internship Rural/Community Posting	CHAD Hospital + Sub centres	Graded i.e., Base Hospital PHC-Sub centres	Village based centres in batches of 2 centres.	Rural/Urban posting	PHC/Rural Centres	Urban Stem/corporation centres/rural
12. Other programmes	* Clinical Epidemiology; * Extra mural peripheral hospital postings * Community specialist Camps;	* Family Care exercises (Urban); * Instructional Objectives * Clinical Clerkship. * Internship Assessment.	* Medical Ethics; * Plantation internship; * Community Specialist Camps; * Community Assessment; * Epidemiological Projects.	* Interns Orientation Programmes; * Rational Therapeutics Training * Emergency Medicine Training; Specialist Camps.	G.O.P.D	* Samaritan Medicine; * Problem Based Learning * multidisciplinary student team training

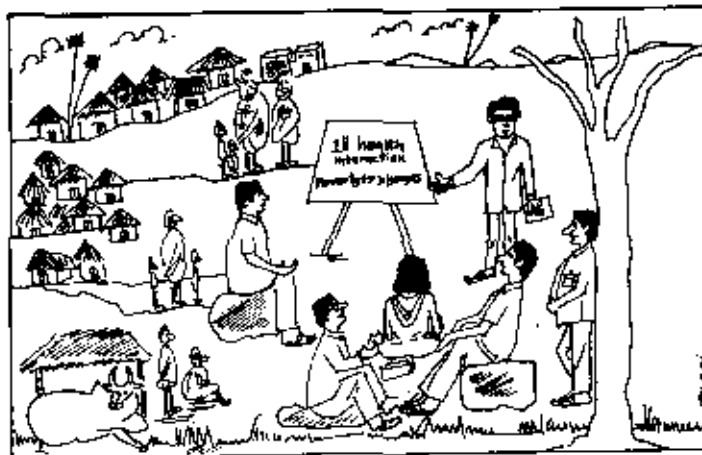
of its kind, when it was first established. However, the recent establishment of the formal consortium network and the informal CMC Network have both been positive steps in the direction of interactive dialogue for the 1990s.

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

- xiv) Our field visits to seven of the respondent colleges and informal interactive discussions with faculty and interns led to an identification of key factors that promoted change as well as major obstacles and barriers to change. These will be listed out in the next chapter. Some general observations and an overview from our field visits are mentioned in Section E.

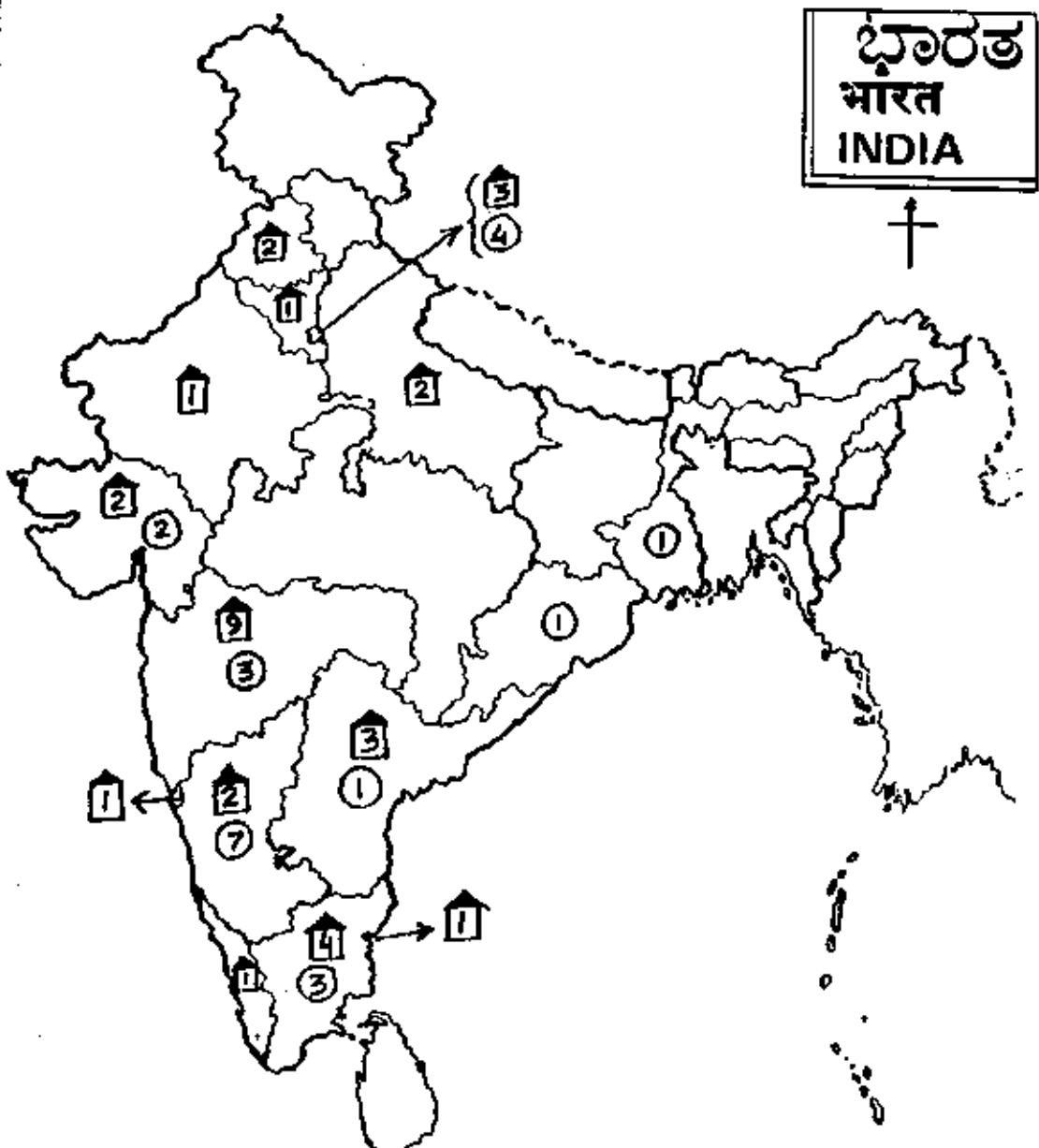
C. ALTERNATIVE TRAINING SECTOR - REVIEW

- i) Building on a sizeable 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.
- ii) Table XI lists out the key programmes included in the survey or studied through literature survey.
- iii) The major contributions of this group of trainers (10) 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.

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



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

TABLE - XI
ALTERNATE TRAINING SECTOR - HEALTH
(Profile of some courses)

Sl. Project No. A	Name/Type of course* B	Duration C	Target Group D
1.	Catholic Hospital Association of India, Secunderabad i) Community Health Team Training and other voluntary ii) Community Health Organisation Planning and Management	1 month	Candidates from CHAI member institutions agencies interested in community health action
2.	International Nurses Service Association - India (INSA) Bangalore, Karnataka i) Rural Health and Development Training Programme.	10 weeks + 1 year supervisory/ follow up.	i) Health and Development workers at supervisory levels.
3.	St. John's Medical College, Bangalore - Karnataka i) Basic Course in Community Health.	3 months	i) Health Workers (NGO Sector)
4.	National Institute of Mental Health & Neuro Sciences (NIMHANS), Bangalore i) Training in Mental Health Care	1-4 weeks	i) Doctors and Health Workers
5.	Institute of Health Management Pachod, Maharashtra nutritionists etc. i) Rural Health Management	6 weeks	i) NGO-sector Nurses, Doctors, social workers,
6.	Voluntary Health Association of India (VHAI) New Delhi i) Health Management (CHPOM) (Distance Learning)	1 year	i) Persons in Development Projects wanting to start a Community Health Programme

- * Strong community orientation in the methods since most of the training is community based and non-hospital oriented.
 - * Strong social analysis, which explores broader factors in society that affect health exploration of community/societal responses and initiatives to problem solution. This is very different from, the preoccupation with 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, needs assessment, participatory management, evaluation etc. There is greater emphasis on learning by doing.
 - * 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.
 - * 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 learning methods that help participants get 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 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.

TABLE XII

**Alternative Training Sector
(Key Ideas)**

Alternative Philosophy of Education	Small group techniques/methods
Strong Community Orientation	
Social Analysis and Societal/Community level problem solving	
Focus on skill development	
Participatory Planning/Evaluation	
Training in affective aspects	
Learning Exercises	
(Case Studies/Simulation Games)	
Source (10)	

- 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 hospitals and in health settings, lower down in the pyramid of health care, can learn a lot from this experimentation in the alternative sector.
- 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.

D. SURVEY OF GRADUATES WITH PRIMARY HEALTH CARE EXPERIENCE

- i) The pilot survey of graduates of the 1980s 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. This pilot survey was particularly significant since the graduates had two years field experience in the realities of Primary Health Care.

TABLE XIII
Graduate Survey (Summary I)
Area for Skill Development/Competence

a)	Basic Nursing Procedures
b)	Emergency Medicine
c)	Minor Surgical Procedures
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 (19)

TABLE XIV

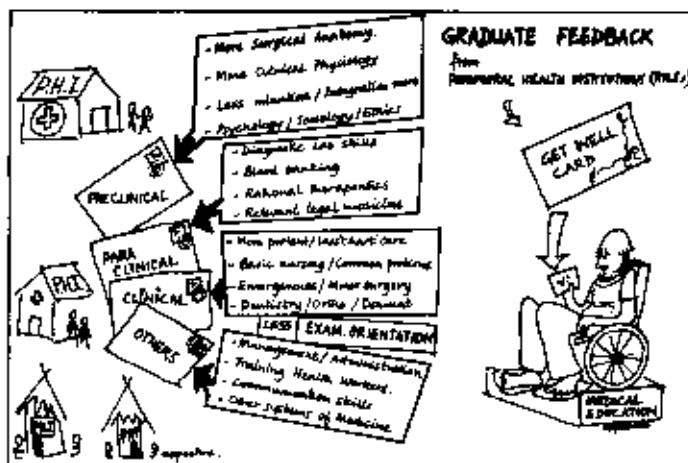
**Graduate Survey (Summary II)
Curriculum Structure/Framework**

-
- a) Introduce integrated teaching focusing on common 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 ancillary hospital departments:
Pathology laboratory/pharmacy/records department/blood bank/accounts section
 - h) Final MBBS/Internship - involvement in training of health workers.

Source (19)

-
- 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 Bhoré report of 1946 to the NEPHS Policy document 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. The focus is on general aspects and not what has been suggested, for each of the pre-clinical, para-clinical and clinical subjects. Table XIII and XIV summarise the main points about skill development and curriculum structure and framework.
 - 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;
 - Reflections on ethics and health practices of different religions;
 - Sharing of experiences with undergraduates by those who have worked in peripheral health institutions (PHIs);
 - Visits of specialists to PHIs;
 - Internship postings to PHIs
 - Career guidance cell; and
 - Preparation of graduates opting for rural services through orientation programmes.



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. While it supports some of the expert recommendations, it derives from practical experience and not just empiricism.

E. AN OVERVIEW FROM FIELD VISITS

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 this interactive dialogue and particularly in the context of field visits to the pacesetters are as follows :

i) A Peripheral Agenda

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. These include - the need to be competitive; to move towards high tech; and to pay well and provide perks to staff.

ii) Dialectics of Change

Where change is taking place the institutions are caught on 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) Changing Value Systems

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) Culture of Medical Education

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) Established Urban aspirations

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) **Culture of Faculty**

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, on the teaching of other departments.

vii) **Enthusiasm for 'High-tech/Foreign' medicine**

Faculty enthusiasm for high technology advances in medicine, the super specialist ethos of medical care and keeping up with the 'western model' 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. In terms of attitudinal change, they were working against a strongly established tradition.

viii) **'Arm Chair' Community Medicine**

Even among the innovators, 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'. They were caught up with the 'public health specialisation' 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 people's local health culture and traditions etc., were low priority, again reflecting the dominant culture.

ix) The 'Medical Council - Bogey or constraint ?

A reassuring finding was that, the Medical Council of India regulations were not the 'bogey', it is sometimes made out to be. Most of the innovators 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 hierarchy, in their own specialisations.

The two major constraints were the divisions into pre, para and clinical phases and the consequent phasing of the examinations; and the resulting compartmentalisation that they caused.

x) Resistance to Change

However, it is more than obvious, for the present atleast, that if these two components of the framework were accepted as 'basic structure', there was no other major obstacles 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 guidelines, will indicate a large amount of stimulus and freedom, to innovate and operationalise change.

Our study of the guidelines 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 them.

xi) Committed Leadership

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 many cases, thereby proving that there were no structural constraints but only attitudinal ones.

In this context, however we also found that waxing and waning of enthusiasm and commitment of the leadership of institutions, and the leadership of PSM departments, also contributed to phases of growth and phases of status quo.

Often routinisation and bureaucratization took over, affecting the enthusiasm of faculty and the stimulus to students.

Some institutions were not aware of innovations in their own institutions during earlier phases which we picked up through literature review !!

xii) Need for 'Inspirational' and 'Infectious' Community Oriented Faculty

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 'innovators' 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, community oriented/community based department of community medicine.

xiii) Staff Selection and Development

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 a 'facilitation' 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.

xiv) Total Faculty Involvement

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 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 collective responsibility of faculty, in their role as socially relevant and community oriented medical educators, was resulting in a more positive image and greater sustained enthusiasm.

xv) Basing Change on Feedback

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 stated institutional goals) in the planning process.

In conclusion, while the medical college survey, community health trainers survey and the graduate feedback survey led to the generation of a large amount of qualitative data on the initiatives towards social relevance and community orientation as well as practical suggestions for reform, the field visit observations and the interactive discussions led to the identification of issues and constraints that determine the long term success or failure of attempted reforms.

- * *To summarise Medical Education reform is still very much on the periphery of the agenda of medical educators, all the rhetoric notwithstanding.*
- * *Those involved are caught up in: the dialectics between the needs of Primary health care and the demands of secondary/tertiary health care; the changing value systems of students and teachers; the established middle class culture of education; the strong urban practice aspirations and the infectious enthusiasm for 'high-tech' and 'foreign' ideas.*
- * *While the Medical council of India regulations are not as constraining a factor as popularly imagined, a relatively arm chair Community medicine faculty have not been able to provide adequate inspirational leadership, to get over the resistance to 'moving out' by rest of the college faculty.*
- * *Inadequate staff selection and orientation have further compounded the problem.*
- * *Without the realistic stimulus of student and graduate feedback, efforts at reforms continue to be adhoc and empirical. Total faculty involvement is still a myth.*
- * *Change in the 1990s can be brought about only if all these contributing factors are tackled with a courageous, dynamic and creative collectivity.*

6. SOME REFLECTIONS ON CHANGE

The Srivastava Report (2) has outlined that there are 'three ingredients of every educational change' - These are content, structure and process. While efforts in India, have concentrated mostly on content and sometimes on structure, the process of change has not been adequately defined and evolved.

The interactive dimension of our study, including the field visits to various pacesetter colleges and discussions with faculty and interns, was mainly aimed, at trying to understand the process of change, in these institutions. Our informal discussions, helped us to identify several factors that seemed to predispose or promote change and many others that act as an obstacle or barrier. It is obvious that any change process initiated by any college has to give serious attention to both these factors.

A. FACTORS PROMOTING CHANGE

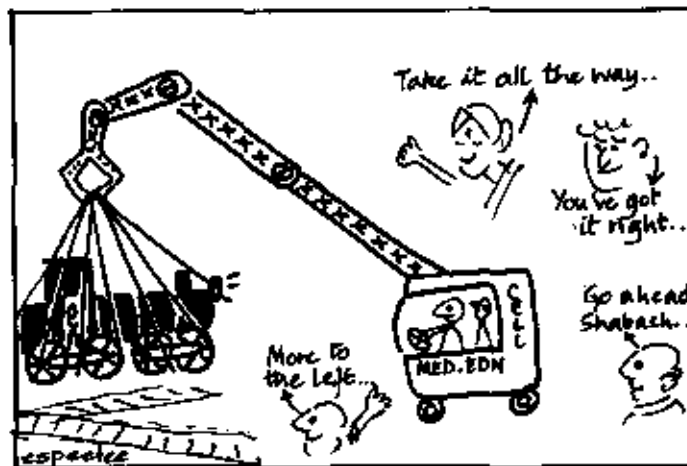
The key factors that promote change in a medical college are the following

1. Institutional Mandate

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

2. Institutional Objectives

The availability of defined Institutional Objectives, in the context of the mandate, are a great stimulus, to keep the management as well as faculty of all departments, aware of their focus and commitment to change



3. Instructional Objectives

The evolution of Instructional and Department level intermediate objectives, keeping

institutional objectives and institutional mandate in context, helps faculty commitment to change. It also ensures that the students will experience, the philosophic commitment of the institution at the practical level.

4. Medical Education Cell

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

5. Faculty Development Process

The presence of a planned process of Faculty Development and enrichment towards their role as 'medical educators' and 'inspirers' and 'facilitators' of change is very important. This means in practical terms the creation of faculty role models, who are 'professionally competent', 'socially relevant', 'community oriented' and 'educationally alive'.

6. Field Practice Areas

Availability of or development of field practice areas and health service linkages, beyond the teaching hospital, (a teaching community) where viable, efficient and realistic community health and development service activity take place, are a crucial requirement for change. 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 coercion.

7. Institutional Policy Supporting Community Health

Development of an institutional policy of staff training and promotion which is focussed towards community health and primary health care is very helpful. This means that in all departments, staff are encouraged, and facilitated towards greater experience, involvement and expertise, in health care - beyond the existing teaching hospital focus and tertiary care orientation of medical colleges.

8. Cultural transformation and Value Orientation

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 is an urgent task. This has to be brought about, through informal processes of discussion, dialogue and reinforced by staff and management precept. The focus should be on the needs of 'Bharat' (large majority of the rural poor) **rather than the elitist aspirations of the urban middle class and the market economy.**

9. Networking and Dialogue

A commitment to networking and dialogue with a wide range of groups, enthusiasts, 'experimenters' and 'innovators' within the formal medical college system and outside of it, helps the academic environment of the medical college, to be stimulated and cross fertilized by the evolving wealth of Indian grassroots experience. We need to move

towards a Medical college without walls, in its true philosophical sense.

10. Reflective Evaluation

A commitment to concurrent, reflective, evaluation of the change processes is crucial. All the introduced changes, experiments, initiatives should be subjected to review through regular faculty and student feedback and participatory evaluation. This should also include regular feedback from all the 'consumers of medical education' especially those who are 'living out' professionally the aspirations of Indian medical education - the basic doctor goal. (the general practitioners, the primary health centre doctors and the doctors in primary health care).

Among all the pace-setter colleges mentioned in the earlier chapter, which we visited during the study, we found that the first six factors, had been operative in stimulating change in their institutions. While the last four had occasionally been focussed upon, these had not received adequate long term commitment.

B. OBSTACLES/BARRIERS TO CHANGE

The obstacles and barriers to change at medical college level, which we identified through our discussions and field visits were many. For the purpose of description, we have given each obstacle a 'clinical label' to emphasise the key aspects of the 'pathology'.

1. 'Mental Disorientation'

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

2. Nystagmus'

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

3. Optic Atrophy'

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

4. Anaemia

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

5. **Cancer**

Inadequate management planning including improper financial resource management, lead to an initially insidious, and later rapidly growing, entry of the cancer of market economy in medical practice, cost of services, prescribing and technology policies in the institution. This defeats the purpose of reform by bringing in double standards.



6. **Manic-Depressive Psychosis**

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

7. **Atopia - Allergy**

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

8. **Atherosclerosis**

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

9. **Schizophrenia**

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

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

10. **Graft Rejection**

Caution is required in the planning and evolution of community oriented experiments and innovations. Care must be taken to ensure that, the problems caused by transplanting western high technology hospital models are not repeated when we accept 'community oriented education models' that have been developed in different cultures, health care systems and educational systems.

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

11. **Autism**

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

12. **Senile Dementia**

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

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

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 the 1990s, keeping away the pathologies described above, from setting into the college educational planning system. As in clinical medicine, prevention will prove better and cheaper than cure.

7. CHALLENGES FOR THE FUTURE

Our study, led us to identify a large number of ideas, experiments, innovations and prescriptions that could stimulate the 'content of change' in the 1990s. An overview has been given in previous chapters and details are being brought together in the Faculty Resource Book and in the complementary publications, that are in the process of being completed. (Appendix)

While our efforts 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 social analysis.

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 led us to identify some challenges ahead:

A. CHALLENGES BEFORE US

The key challenges before medical educators in the 1990s, are the following:

I. Urgent Need for change

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

II. Multi pronged effort

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

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

III. Curriculum change

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

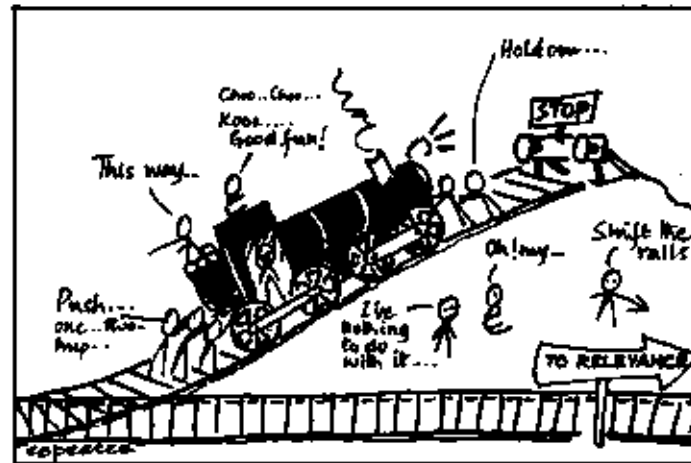
IV. Emerging new Framework

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

V. Experimental Curriculum

There is urgent need, to evolve the concept of an experimental parallel track or curriculum and allow a few selected colleges, to integrate these 50 strategies and go

beyond, the constraints of the existing compartmentalisation of phases and examinations in medical education. Colleges selected for this purpose, must have demonstrated their competence to evolve, sustain and evaluate the process of change.



VI. Graduate Feedback

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

VII. Positive Factors for change

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

VIII. Negative factors affecting change

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

IX. Inspiration from Alternatives

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

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

X. Faculty Development Key to Change

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

B. TASKS FOR THE FUTURE

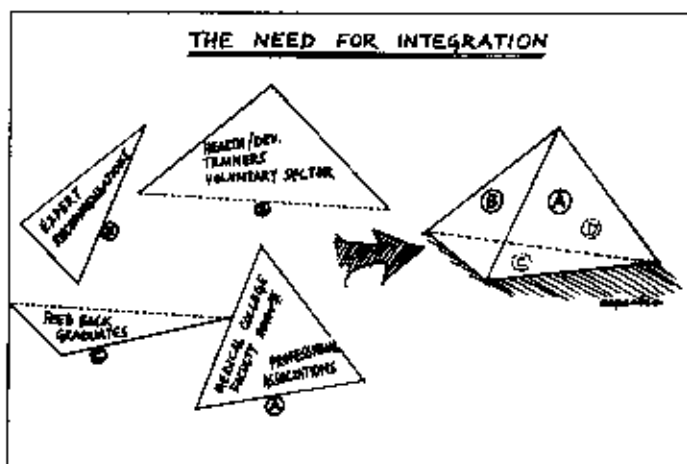
At the end of the study, 6 key tasks come to mind in the light of our efforts and findings.

1. Task to inform

We hope that the outputs of the study - the publications and the faculty resource book will help the process of faculty commitment to change, by putting them in touch with the 'inspirational and creative stimulus' of Indian experience. All efforts need to be made to reach these publications, to all those concerned with change in the 1990s.

2. Task to experiment with alternatives

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 experimental parallel curriculum. To start with, these may be within the existing constraints, but efforts could be initiated towards an alternative framework ultimately. This task will need institutional commitment to a medical education cell/unit or department, that moves beyond educational technology, to content/process of change as well. A core team of faculty with enthusiasm and creativity, will be a pre-condition.



3. Task to Network

The ongoing networks and fora including the IAAME, the Consortium of medical colleges and the CMC Network, need to be nudged towards a greater collective

commitment and a networking process. There is need to widen these networks 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. Equally important, is the need to move their reflections from focussing on expert empiricism, to inquiry and evaluated experiences.

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 latter into the thinking and methods of the former. Ultimately this could grow into a mutually interactive and enriching process, recognising the common commitment of efforts and goals. Groups with strategic links with both sectors and commitment to cross-fertilization will have to facilitate this.

5. Task to Evaluate Collectively

All changes, innovations and experiments introduced, should be subject to critical feedback from 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 making these efforts an integral part of the 'planning cycle', within institutions. Ultimately, peers from other institutions, initiating similar changes, should be involved in such process evaluation as well.

6. Task to Change

Finally, the most urgent task is the commitment of all our energies and efforts, to change. This is not for the sake of change, but because the urgent health needs of people, particularly the impoverished and disadvantaged 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 1990S

C. IN CONCLUSION

The Community Health Cell 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 pull together a handy reference book of local innovation, an anthology of ideas emerging from local experience and a resource directory of local expertise, in socially relevant and community oriented, medical education in India."

The second one, was to use the research project, as a means to 'initiate a process seeking collective commitment to appropriate medical education'

The first goal, was pursued by a multi-pronged methodology 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 national experience.

The second goal was pursued by an active communication strategy, peer group reviews and dialogue, planned meetings, opportunistic 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. (Appendix 8).

We hope, that the definitive outputs of GOAL ONE will itself become instruments 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. Along with our two chief sponsors, the CMAI and CHAI we hope that this modest project 'painted on the broad canvas of multisectoral Indian expertise' will be a stimulus as well as one of the instruments for change in promoting the experimentation towards producing the 'new type of Health Professional' who is both socially relevant and community oriented.

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' in the 1990s. We hope that these initiatives will then help to produce 'the doctor,' the country has been waiting for all these decades

- the Social Physician of the Bhole 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.

HEALTH FOR ALL 2000 AWAITS THIS RESPONSE.

8. A POSTSCRIPT

Since the Society is committed to action-research, the methodology for the project evolved from a basic framework in a flexible manner. Inter-active dimensions were given great importance without diluting technical rigour.

In retrospect, some reflections on limitations and suggestions for follow-up include :

- i. Orthodox literature review and exploring cross referencing was of great value, as always. While the use of 'letters to the Editor' of professional journals and newspapers was not very useful, personal correspondence with known enthusiasts and peers proved to be very productive.
- ii. The overall response to the sending of letters of enquiry to medical colleges, inspite of three reminders, was not very encouraging. This was not only in terms of quantity of materials received, but also in terms of quality and relevance, to the overall project objectives.
This could primarily be due to lack of actual innovations/experiments in medical colleges and partially due to absence of a check-list of ideas/issues as a stimulus in the beginning. This was however, added in the reminders and the response improved slightly.
- iii. The response to letters to community health and development trainers, was much better, both in quality and quantity. This supports our basic premise, that dialogue with the alternative sector would be extremely beneficial to the progress of medical education in the country.
- iv. While qualitatively, the graduate survey was valuable in generating ideas supportive of change, i.e, responsive to grassroots experience, a word of caution is necessary. The sample formed only part of the primary health care sector - because it focussed only on small mission hospitals and community health programmes. To get a more comprehensive picture, atleast two more sub-samples of primary health care practitioners should be studied, viz.,
 - i. Medical officers of government Primary Health Centres and Primary Health Units.
 - ii. General practitioners in small towns and villages.The feedback from these two sub-samples would further enrich the ideas that have been identified by our study and help the development of a more comprehensive Primary Health Care oriented curriculum.
- v. The institutional visits were not standardised due to problems of logistics, communication and time schedule. However, since the facilitators of the focus group discussion were the same in all the insitutional visits, many generalisations from discussions could be made. The absence of rigorous standardisation however meant that inter-college comparisons were not possible. However, comparison and evaluation were not key aspects of the study. The focus was on compilation/ collection of ideas on the content, structure and process of change and this objective was admirably served by the field visits.
- vi. From the findings of the study, there is now a phenomenal scope for developing a more detailed check-list proforma and initiating a State of the Art survey covering all the medical colleges once again. However to ensure a greater response, the survey would gain credibility if it was sponsored by MCI, ICMR, IAAMF or all of these.
While our project efforts have contributed to a qualitative picture of Indian experience, the State of the Art survey would help to have a quantitative estimate of where we are in 1990s, in the context of the totality of medical education in the country.
- vii. Building on the qualitative picture, that has emerged from our study, and the quantitative picture, that could emerge from such a follow-up State of the Art survey - policy makers and medical educators would get adequate stimulus, to move from 'expert empiricism', to change based on 'grassroot realities' and a rigorous situation analysis.

9. ACKNOWLEDGEMENTS

This project was a conscious effort to evolve a participatory and interactive research process so that the final output reflected 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 :

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(Medicine) and Dr. Pramesh Bhatnagar (PSM) of VHAI, New Delhi; Dr. Mani Kalliath (Community Health) of CHAI, Secunderabad; and also other resource persons at that meeting which included Dr. N.H.Antia (FRCH, Bombay), Mr. Desmond D'Abreo (Development trainer, Mangalore) and Dr. Zafarallah Chowdhury (Gonokshasthya Project, Bangladesh) and Prof. S.V.Rama Rao (Community Medicine - retired).

- * to all senior 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). Also to Dr. Siddharth Ramji (Indian Academy of Paediatrics), Valli Seshan (SCF), Dr. M.J.Thomas (Psychiatrist), Dr. Paresh Kumar (Dept. of Sociology - Mysore University), and Dr. G.Gururaj (NIMHANS).
- * to short term research assistants : Raphael Udayakumar, S.J. Chander and Dr. William Fullinaw.
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(Nos 18 and 19 are Preliminary communication presented at the 30th Annual Conference of the Indian Association for the Advancement of Medical Education, Bombay January 1992.)

APPENDIX 1

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) respectively. 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 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 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'. It was these varied experiences, that led to the evolution of the project so that the researchers could build further on all the past efforts (refer Appendix 1A).

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 around 2,700 institutions in the country. By virtue of their commitment to health care particularly focused 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 it evolved and they were contacted for support.

C. OTHER LINKAGES

The facilitation of the first network meeting of four 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. All these colleges were interested in community oriented and community based education and therefore agreed to participate as an 'interactive peer group' in the evolving study.

D. SCOPE

The study emerged through an interaction between the three groups mentioned above. The scope of the study was to explore, research and document 'innovations' and relevant reflections on Medical Education in India, which would be of practical use to those, who wish to explore medical education reform in the future.

The study focused primarily on Indian experience and used a multipronged and an interactive process. (described in chapter 5)

The study sought to put together:

“a handy reference manual (resource book) 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. (12)

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

Other target groups were also identified during the process and it was decided that, a summary document of the key findings and conclusions of the study, would also be sent to these other groups as a ‘lobbying for change’ process.

The researchers and the CHC team had good contact and linkages with the ‘alternative training sector’ and with ‘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.

APPENDIX 1A

INITIATIVES OF THE RESEARCHERS WHICH FORMED THE BACKGROUND TO THE STUDY

YEAR	INITIATIVE	PUBLICATION/REPORT
1972	Refugee Camp Experience	Making Medical Education Relevant to the needs of Society - Intern's reflections.
1973	Dissertation for Diploma in Tropical Public Health (London University)	Training Doctors for Community Health Service (Trends in Undergraduate Medical Education in India).
1973-83	Community Orientation of Medical Education - St. John's Medical College, Bangalore (various experiments)	Moving beyond the Teaching Hospital.
1977	Term Project for MD at AIIMS, New Delhi (Interactive Evaluation)	The Kottayam Experiment: Training Programme for Community Nurses/Health Supervisors.
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 Education).
1984	i. mfc Annual Meeting on Medical Education - (Calcutta) ii. Workshop for Rural Bond Scheme Pioneers (SIMC/CHAI/CHC)	Background paper :150 years of Medical Education - Rhetoric and Relevance . Report of a Workshop for Rural Bond Scheme Pioneers.
1989	i. Network of Christian Medical Colleges ii. Facilitation of first dialogue of Community Health Trainers in India (VHAI)	<u>Keynote Address</u> : Towards Greater Social Relevance. Report on Proceedings of the Trainers Dialogue.
1990-91	mfc Anthology - Medical Education Re-Examined (Planning and <u>Collective Process</u>)	3 articles in Anthology including <u>Anthology of Ideas - Alternative Framework of a Curriculum</u> (Compilation).

APPENDIX 2

SOME ORGANISATIONAL DETAILS

Three components of the Organisational dynamics of the project are outlined. These include:

- a. The Advisory Group
- b. Peer Group Support
- c. Project time and process schedule

a. 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 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 different types of experience, viz., pre-clinical teaching, community medicine teaching, administration and research. This greatly enhanced the overall planning of the study.

b. Peer Group Support and Institutional Linkages - Formal and Informal

The project proposal had envisaged 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 to a larger number of people and initiatives in the 1990s.

As the two year project evolved the following linkages were established:

1. Formal

- i) CMAI (New Delhi) and CHAI (Secunderabad) co-sponsored and funded both Phase I and Phase II of the project.
- ii) CMC-Ludhiana provided some financial support for Phase I of the project and offered peer group support through their Principal.

- iii) CMC-Vellore, St. John's - Bangalore and Miraj Medical Centre offered some peer group support through their nominees.

2. Informal

Informal links and contacts with some of the faculty/members of a larger number of institutions and initiatives was established. Some previous links already established by CHC were further strengthened. These included :

Voluntary Health Association of India, New Delhi; Evolving network of Community Health Trainers in India; Foundation for Research in Community Health, Bombay; medico friend circle (Bombay - Pune); Centre for Social Medicine and Community Health, (Jawaharlal Nehru University), New Delhi.; National Institute of Advanced Studies, Bangalore; Network of Christian Medical Colleges; National Teacher Training Centre (NTTC), JIPMER, Pondicherry; Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha; King George Medical College, Lucknow; Centre for Medical Educational Technology, AIIMS, New Delhi; NHL Municipal Medical College, Ahmedabad; Indian Association for Advancement of Medical Education; A.P.Health University; Osmania Medical College and Social Paediatric Unit, Nilufer Hospital.

c) 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.
- 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.
- iii) Phase II from July 1991 to December 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 included the Community Health Trainers dialogue in October 1991, and the Medical Educators Review Meeting in June 1992. (See Appendix 8)

APPENDIX 3

Content of letters to Colleges

STRATEGIES FOR GREATER COMMUNITY ORIENTATION AND SOCIAL RELEVANCE IN MEDICAL EDUCATION

COMMUNITY HEALTH CELL
(A Health Policy Research Group)

No 326, V Main, 1 Block
Koramangala, Bangalore-34

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 focusing 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 innovations, 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 focused upon are listed below.
7. 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 MD,DTPH,DIH

Thelma Narayan, MBBS, MSc (Epid)

Note: The medical college experience 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 and 15. Other Initiatives.

(If you would like your college or department experience to be included, please send details/reports/papers by 1st May 1991).

APPENDIX 4
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, Kurnool.
5. Kurnool Medical College, Kurnool.
- *6. Osmania Medical College, Hyderabad. (32)
- *7. Rangraya Medical College, Kakinada. (7)
8. Sidhartha Medical College, Vijayawada.
- *9. Sri Venkateshwara Medical College, Tirupathi. (8)

ASSAM/NORTHEAST

10. Assam Medical College, Dibrugarh.
11. Gauhati Medical College, Gauhati.
12. Silchar Medical College, Silchar.
13. Regional Medical College, Imphal.

BIHAR

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

GUJARAT

23. B.J. Medical College, Ahmedabad.
24. Government Medical College, Surat.
- *25. Medical College, Baroda. (10)
26. Shri. M.P. Shah Medical College, Jamnagar.
- *27. Smt. N.H.L. Municipal Medical College, Ahmedabad. (9)
28. Seth K.M. School of Postgraduate Medicine and Research, Ahmedabad.

-
- *1. indicates the colleges which responded to letters.
 2. Numbers in brackets indicate the code number given to these colleges (refer Appendix 7)

HARYANA

- *29. Medical College, Rohtak. (11)

HIMACHAL PRADESH

30. Indira Gandhi Medical College, Simla.

JAMMU & KASHMIR

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

KARNATAKA

33. Bangalore Medical College, Bangalore.
34. Dr. B.R.Ambedkar Medical College, Bangalore.
35. Government Medical College, Bellary.
36. Government Medical College, Mysore.
37. J.I.M. Medical College, Davangere.
38. Jawaharlal Nehru Medical College, Belgaum.
39. Karnataka Medical College, Hubli.
*40. Kasturba Medical College, Manipal. (12)
41. Kempegowda Institute of Medical Sciences, Bangalore.
42. M.R. Medical College, Gulbarga.
43. M.S.Ramaiah Medical College, Bangalore.
*44. St. John's Medical College, Bangalore. (3)
45. Al-Ameen Medical College, Bijapur.
46. BLDEA's Medical College, Bijapur.
47. Kasturba Medical College, Mangalore.
48. J.S.S. Medical College, Mysore.

KERALA

- *49. Medical College, Kottayam. (13)
50. Shri Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.
51. Medical College, Calicut.
52. Medical College, Trivandrum.
53. Medical College, Mulankunnathukava.
54. T.D.Medical College, Alleppey.

MADHYA PRADESH

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

MAHARASHTRA

- *61. Armed Forces Medical College, Pune. (14)
- *62. B.J. Medical College, Pune. (15)
- 63. Government Medical College, Sangli.
- *64. Government Medical College, Nagpur. (16)
- 65. Government Medical College, Aurangabad.
- *66. Grant Medical College, Bombay. (17)
- 67. Indira Gandhi Medical College, Nagpur.
- 68. Krishna Institute of Medical Sciences, Sama.
- *69. Lokmanya Tilak Municipal Medical College, Bombay. (18)
- *70. Mahatma Gandhi Institute of Medical Sciences, Wardha. (5)
- 71. Seth G.S. Medical College, Bombay.
- *72. Ramanand Tirth Rural Medical College, Ambajogi (19)
- 73. Dr. Panjabrao Deskmukh Memorial Medical College, Amravati.
- *74. Topiwala National Medical College, Bombay. (20)
- *75. Dr. V.M. Medical College, Sholapur. (21)
- 76. Rural Medical College, Ahmednagar.

ORISSA

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

PUNJAB

- *80. Christian Medical College, Ludhiana. (6)
- *81. Dayanand Medical College, Ludhiana. (22)
- 82. Government Medical College, Patiala.
- 83. Guru Gobind Singh Medical College, Faridkot.
- 84. Medical College, Amritsar.

RAJASTHAN

- *85. Jawaharlal Nehru Medical College, Ajmer. (23)
- 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. (1)
- 92. Coimbatore Medical College, Coimbatore.
- 93. Madras Medical College, Madras.
- 94. Madurai Medical College, Madurai.

- *95. Government Kilpauk Medical College, Madras. (33)
- 96. Stanley Medical College, Madras.
- *97. Thanjavur Medical College, Thanjavur. (31)
- 98. Tirunelveli Medical College, Tirunelveli.
- 99. Rajah Muthiah Medical College, Annamalainagar.
- *100. PSG Institute of Medical Sciences and Research, Coimbatore. (24)
- 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. (25)
- 106. Jawaharlal Nehru Medical College, Aligarh.
- *107. King George's Medical College, Lucknow. (26)
- *108. L.L.R.M. Medical College, Meerut. (30)
- 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. (2)
- *121. Maulana Azad Medical College, New Delhi. (27)
- 122. University College of Medical Sciences, New Delhi.
- *123. Lady Hardinge Medical College for Women, New Delhi. (28)

OTHERS

- *124. Goa Medical College, Panaji. (29)
- *125. Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry. (4)

APPENDIX 5

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 Services 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, Kavanur. *14. Christian Fellowship Community Health Centre, Ambilikai.	-
H. West Bengal	15. Child in Need Institute, Calcutta.	-

indicates nil response to project letter but CHC Documentation Unit had material on courses.

APPENDIX 6

INSTITUTIONAL VISITS AND MEETINGS LINKED TO PROJECT

A. Institutional visits

1. Christian Medical College - Ludhiana (February 1990)
2. Mahatma Gandhi Institute of Medical Sciences, Wardha (August 1990)
3. King George Medical College - Lucknow (October 1990)
4. Christian Medical College - Vellore (December 1990)
5. Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry, (January 1991)
6. All India Institute of Medical Sciences, New Delhi (April 1991)
7. St. John's Medical College, Bangalore

B. Meetings Linked to Project

i) Project Related

1. Pccrs Meetings, Bangalore (July 1990)
2. Graduates with Rural Experience (November 1990)
3. Community Health Trainers Dialogue - Bangalore (October 1991)
4. Advisory Committee Meetings (5 formal and several with individual members)
5. Medical Educators Review Meeting (June 1992)

ii) 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)

iii) Others

1. NIAS Health Policy Workshop, Bangalore, September 1990.
(Paper on Alternative vision of Education for Decentralised Health Care was presented)
2. Annual Conference of Indian Association of Physiologists and Pharmacologists, Bangalore, December 1991.
(Resource person in UG Medical Education symposium)
3. IAAME Annual Conference, Bombay, January 1992.
(Two Preliminary communications from project were presented)

APPENDIX 7

Initiatives by Medical College*

- A. General/Structural/Process**
- | | | |
|-----|---|------------------|
| 01. | Defining <u>Institutional Objectives</u> (1,2,3,5,6,9) | |
| 02. | Defining intermediate (Departmental) and <u>Instructional objectives</u> | (1,2) |
| 03. | <u>Development of Medical Education Cell with adjunct faculty</u> | (2,3,4,6,9,12) |
| | i) Conducting Workshops | |
| | ii) Evolving objectives; | |
| | iii) Developing MCQ banks, etc. | |
| 04. | <u>Faculty Training/Development</u> | (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. | <u>Selection Procedures</u> 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. | <u>Curriculum development/content</u> through curriculum planning committee | |
| | i) Integration of teaching | (9) |
| | ii) Identifying core abilities/ skills | (3,25) |
| | iii) Prioritization of topics within departments | (9) |
| 07. | <u>Examination Reform</u> | |
| | i) Objectivised assessment OSPE/OSCE | (2) |
| | ii) Restructuring assessment towards HFA-PHC | (4) |
| 08. | Faculty/student involvement in medical <u>Education Reform</u> | (1,2,4,6) |
| | i) Faculty survey - curricular | (4,1,2) |
| | ii) Student survey - curricular deficiencies | (4) |
| | iii) Intern survey - curricular deficiencies | (1) |

**Note:* Numbers in bracket refer to college code - see Appendix 4. Colleges are included if they sent us information about this aspect/or strategy. Since the survey was through an open letter and not a checklist questionnaire, this table only indicates possible sources of further information on this strategy. Other colleges may have similar programmes but this information has not been sent to us.

- iv) Department programmes evaluation - students (6)
 - v) Department programmes 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 Curricular/cocurricular activities including NSS/NCC (1-6, 7)
 - 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)
 - 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 (non PSM) (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 (9)
in Medicine/pharmacology/pathology
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)
 - 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
- i) 12 weeks urban health centre posting. (2)
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 HIE 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 PSM/CM Department - coordinated with Medicine/Surgery/Paediatrics.Obst. & Gyn.
- i) G.O.P.D Programme (5)
 - ii) Student clerkship in Medicine/Surgery Paediatrics (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 newighbourhood.
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 (doctor patient relationship, Rational drug prescriptions and investigations, medical records, medico legal aspects) (4)
 - ii) Interns Orientation Programme (Hippocrates Oath, Attitudes-relationship building, Diagnosis and treatment within resources/knowledge update/research) (17)

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 (many)
- 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) Clinical research (electives) (3)
49. Internship training in special clinics in Hospital situation (5)
- i) GOPD for general practice orientation (10)
 - ii) CPGP Unit
 - iii) ANC/PNC/Family Welfare clinic (11,17)
 - iv) Under five clinic/Immunization clinics (12)
50. Internship Assessment/Evaluation (1,3,8)

Note : All these Strategies are included in the Faculty Resource Book which is a companion publication

APPENDIX 8

STIMULATING COLLECTIVE COMMITMENT

- An Overview

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".

Therefore given this additional objectives of the project, the 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.

Six types of 'interactions' emerged from the project, as part of the process.

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 appropriate medical education.

Five colleges - the four CMCs and JIPMER, Pondicherry (especially through the NTTC) have begun to gradually involve the primary researchers in some aspects of development of medical education innovations/initiatives. This involvement has been mutually supportive, providing the researchers with a lot of opportunities 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.

The opportunities have included:

- I. Feedback and responses to proposed courses and initiatives
- II. Discussion with adjunct faculty of the medical education cells
- III. Participation in group observation tests during college entrance selection procedures.
- IV. Lectures and orations at college meetings, and
- V. Interactive dialogue on proposed research projects and studies.

b) The Community Health Trainers Dialogue - October 1991

CHC initiated a process to organise a 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 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 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 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.

c). Participation in the Network of Christian Medical Colleges

The regular meetings of this network since 1989 is an important development, and has been a great opportunity to the project researchers providing a regular forum for sharing and dialogue.

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.

d) Stimulus through concurrent publications

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 peers. From the 28 publications listed in Appendix - 9 of the report, 18 appeared concurrently and were circulated as part of ongoing stimulus from the project.

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

e) The Medical Educators Review Meeting - June 1992

Since Phase II of the project ended in June 1992, a meeting of medical educators from the CMCs and half a dozen other colleges in the country, identified by the project was organised. The objectives of this meeting were:

1. To consider the findings/output of the CHC/CMAI/CHAI Medical Education Project especially the proposed Faculty Resource Book and discuss possible follow up within institutions.
2. To share institutional plans/initiatives in Medical Education reform for the 1990s.
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 CMCs (the original partners of the project) were 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. While all were involved in the interactive process which preceded the meeting, some were unable to attend the actual Review Meeting.

A preparatory process included 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, symbolised a sort of 'end point' for this two years exploratory and interactive project and was an indication of the level of collective commitment that has been stimulated by the medical education project. A detailed proceedings is available separately.

f. Final Publication

The resource materials emerging from the project will consist of a 'resource book' as well as 5-6 other final complementary publications.

- i) Strategies for Social Relevance and Community Orientation in Medical Education - Building on the Indian Experience. This project report will highlight the findings from the different sub-units of the study and outline the key aspects of the process.
- ii) Step by Step - Towards an Alternative Medical Education (an anthology of CHC papers and initiatives before the project was initiated).
- iii) Evolving Medical Curriculum through graduate doctor feedback: based on experience in peripheral health institutions.
A detailed report and compilation of feedback from graduate doctors, with peripheral health care experience collected through an exploratory survey.
- iv) Stimulus for Change
A Bibliography with some annotations and a directory of resources in India.
- v) The Key to Change
A small booklet, that brings together the salient features, the key findings and the recommendations of the study for lobbying purposes.

vi) **A Faculty Resource Book**

A resource book, 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.

A note on the tentative content list has been sent to a wide circle of peers, requesting further suggestions.

vii) **Laying the Foundation:**

This monograph will include a collation of the philosophy, objectives, pedagogy, learning experiences of community health and development training centres in India. It will also suggest applications of this experience in the evolution of foundation courses/community based learning experience in medical colleges.

Since these experiments are built on an 'alternative framework', translating or extrapolation from them into the medical curriculum framework is a creative task, that will need to go through a more rigorous process. This task will be completed as an ongoing assignment in 1993-94.

Note: In order to continue, to stimulate collective commitment and to share ideas in solidarity, draft pre-publication manuscript reports of items (i) to (iv) of the final publications have been circulated to many peers who participated in the project and also to MCI, ICMR, IAAME, IMA and some of the participating colleges.

APPENDIX 9

REPORTS/PUBLICATIONS/PAPERS ARISING OUT OF THE CHC/CMAI/ CHAI MEDICAL EDUCATION PROJECT APRIL 1990 TO OCTOBER 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 Meeting of CMCs in India, August 1989, 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)
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.)

Includes lead article "Training of Doctors for India" by T. Narayan
07. Key components which should form part of an education policy for Health Science 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
Arnia Rama Rao, Rajaratnam Able, 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)
12. Education Policy for Health Sciences - A statement of shared concern and evolving collectivity - a collective statement from the Community Health Trainers Dialogue, October 1991.
13. Proceedings of the Community Health Trainers Dialogue, October 1991. - Towards an Educational Policy for Health Sciences.
14. 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.

15. Medical Education in the 1990s - Towards a culture of participation and value orientation - a reflection on the project, LINK (Newsletter of Asian Community Health Action Network) Vol. 10, No. 2, Dec 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). Narayan, R, Narayan, T, and Tekur Shirdi Prasad.
18. Curriculum Change: Building on graduate doctor feedback of peripheral health care experience - an exploratory survey - (A preliminary communication). Narayan, T and Narayan, R.
{No. 17 and 18 were 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' Bombay - January 1992}
19. Key changes and innovations towards social/community need based medical education in India - an opinion survey. (Background paper for Medical Educators Review Meeting, June 1992)
20. Step by Step - Towards an alternative medical education - (an anthology of CHC papers and initiatives before the project).
21. Stimulus for Change - An Annotated Bibliography and a directory of resources in India.
22. Strategies for Social Relevance and Community Orientation in Medical Education (Building on the Indian Experience)
A Project report, April 1990 - June 1992.
23. Evolving Medical Curriculum through Graduate Doctor Feedback: based on experience in peripheral health institutions - an exploratory study, June 1992.
24. Collective Commitment for Change : Proceedings of a Medical Education Review Meeting, June 1992.

IN ANTICIPATION

25. The Key to Change : Summary of the Project.
(A Booklet for lobbying)
26. A Faculty Resource Book on 'Strategies for Community Orientation and Social Relevance in Medical Education : Building on the Indian Experience'.
27. The mfc Anthology of ideas - a collective response.
(Pre workshop survey for Medical Educators Review Meeting, June 1992)
28. Laying the Foundation - Towards community experiences in medical education - A CHC monograph to be compiled in 1993-94.

The Community Health Cell (CHC) is the functional unit of the Society for Community Health Awareness, Research and Action - a registered autonomous Society in Bangalore, Karnataka.

Its aims and objectives include:

- * creating an awareness in the principles and practice of community health and
- * promoting community health action in the voluntary and governmental sector.
- * undertaking research;
- * evolving educational strategies;
- * dialogue with health planners and decision makers and
- * providing information and advisory service.

For further information contact:

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Society for Community Health Awareness, Research and Action,
326, Fifth Main, First Block,
Koramangala
BANGALORE 560 034.

Complementary Publications from Medical Education Project:

1. Graduate Feedback Survey
2. The Key to Change
3. Stimulus for Change
4. Faculty Resource Book

"The physician of tomorrow,
who will naturally be concerned
with the promotion of the new era of social medicine -
will be scientist and social worker,
ready to cooperate in team work,
in close touch with the people he disinterestedly serves,
a friend and leader,
he directs all his efforts towards the prevention of disease, and
becomes a therapist where prevention has broken down,
the social physician
protecting the people, and
guiding them to a healthier and happier life".

- BHOORE REPORT (1946)