NEED FOR REFORMS IN THE PRESENT SYSTEM — MEDICAL EDUCATION

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Changes in medical education are dictated by the changing disease patterns of a country, politics and philosophy of Medical care, demands of the people and the resources and technology available to manage a Health System.

During the last 50 years this country saw many changes in these areas. It gained independence, major communicable diseases were eradicated, and communicable diseases of childhood were brought to very low levels by effective expanded immunisation programmes. Deaths were reduced and morbidity patterns were changed by modern antibiotics, modern technology and welfare services. Population exploded and then came under control. Community Medicine was given its due place. Concepts of comprehensive care - the care that includes preventive, curative and promotive care as a package were involved. This led to the Primary Health Care concept as a means of providing care leading to Health for All by the end of the century.

Medical education being highly job oriented, had to be aware of the changing situations and adopt itself to the demands posed on it.

Since 1979, the WHO has been discussing these issues at the meetings entitled 'Reorientation of Medical Education (ROME). In 1987, a regional goal for reorientation of medical education in South-East Asia was identified. It reads thus :

> By the year 2000, all medical schools in the Region will be producing graduates or specialist doctors, according to the needs and resources of the country, who are responsive to the social and societal needs and who possess

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the appropriate social, ethical, scientific and management abilities so as to enable them to work effectively in the comprehensive health system based on primary health care that is developing in the countries in the Regions.

Based on these general objectives, some specific objectives of medical education could be drawn. The characteristics of the End Product of the Jaffna Medical School gives these specific objectives. A summary is as follows : (Medical Faculty Hand book, P 7-8)

The medical graduates of the Jaffna Medical Faculty should :

1. posses a sound knowledge of the health problems that cause high morbidity and mortality in the country.
2. be able to administer and deliver health care to the people in all circumstances. Eg : PHC and referral care
3. be able to organise and implement preventive measures with respect to specific health problems.
4. be conversant with problems relating to human rights, and be able to educate the patient, family and the community on health matters.
5. be able to discharge specific medico-legal duties.
6. be able to design, implement and submit a report on a research project.
7. be motivated to continue medical education.
8. be disciplined and maintain high ethical standards in their relationship with patients, colleagues and the community.

As you would recognize that the Faculty of Medicine has included many of the features desirable for training to suit present needs in a country like ours. Medical schools in the Island had the advantage of a continued awareness to the trends in medical education ever since the Medical education Unit was formed at the University of Peradeniya in 1973.

One of the changing ideologies in medical education was the changes that took place in the teaching of Public health. In the early 1960s the concept of teaching Public Health in isolation moved on to Social and preventive Medicine necessitating training in field practice areas. Finally the curriculum was called Community Medcine, which integrative preventive, curative and promotive aspects of Health Care, and where Paediatricians, Obstetricians, and Psychiatrists are partners in delivering the curriculum Community Medicine Field Practice areas have been extensively used for teaching, service and research. In recent years the students have not only been attached to families for family studies, but also used it for doing research projects. Apart from the traditional care of mothers and children, our area also had a load of refugees and displaced persons to be cared for. In the future a possible group for special care would be the people in the old age group and those disabled by the war.

A regards the structure of medical curriculum in the pre-clinical years, several improvements are necessary and these were attempted by us in the Faculty of Medicine. We have difficulties in the execution of these programmes due to severe dearth of teachers. Some innovations introduced by the Faculty of Medicine, to make the pre-clinical learning more meaningful are :

(1) Introduction of co-ordinated teaching in the Pre-clinical Departments, where the same system (eg. Cardio vascular System is taught as the same time by different department

(2) Introduction of principles of medical statistics, sociology and medical ethics in the 1st and 2nd years.

(3) Although fundamentals of Pathology and Pharmicology were introduced in the pre-clinical year, it was abandoned after a few lessons due to lack of staff.

(4) Similarly early clinical exposure of the student in the pre clinical years was not attempted as desired earlier, again due to shortage of consultants.

During the years after the pre-clinicals, that is clinical years, the student is attached to the General Hospital Jaffna for his clinical training and learns other subjects known as para-clinical subjects in the class room. The field activity and field research components in Community Medicine introduce him to the community where he learns the elements of P. H C. However being exposed to a specialised hospital which is a referral hospital from the very beginning of his clinical years, the student does not get a chance of seeing diseases in their early stages. He is also not trained to diagnose and treat cases with the facilities the country can usually afford. When he is exposed to this type of facilities after his graduation, he gets frustrated. Hence a more objective type of training will be to attach him to hospitals at the District level and at more peripheral levels at the beginning of his clinical appointments. This would mean the availability of doctors in these institutions who are able to guide them.

This country introduced the concept of a combined preventive and curative care when Peripheral Units were established in the 1950s. This was not a success, as Peripheral Units remained curative institutions in the periphery, and did little or no preventive work. Later, after the global concept of Primary Health Care was enthusiastically formulated it never really took place so far. Under these circumstances it is not possible for any one to commit making a job description of a basic doctor. And without this job description, construction of new and appropriate curriculum is not possible. Medical schools will continue to follow the orthodox curriculum, as done in England, hoping that the teachers in Community Medicine would adjust suitably to make the curriculum look relevant to our needs.

Fortunately another incidental but useful addition in the Community Medicine research curriculum is the Health System Research Methodology course. This gives the theoretical frame-work for the study of real situations in Health Care in the country.

From the few instances of Health Services Research(H.S.R.) done by us and students, some salient features in the Health Service and its utilisation by the people can be identified. This has relevance to the existing medical education.

1. Under utilization of peripheral hospitals by patients.

   This is because, apart from the lack of certain facilities, it is manned by doctors who are not confident to deal with medical emergencies in the periphery and are unable to do minor surgical operations, or set simple fractures. It is questionable whether in the art of obstetrics, they are any better than the midwife. These proceedures can only be studied if students are attached to small hospitals during their early clinical years. Without this training, when he meets these cases as a doctor, his inclination is to refer the case to a provincial hospital.

2. Lack of co-ordination between prevention. therapy and rehabilitation. Although attempted several times, it is a continued failure because the medical curriculum has not produced the doctors who could adopt to this policy. Again this could be achieved only by the introduction of clinical teaching in small hospitals with a co-ordinated field visit to patients homes, as in North Korea, where the doctor visits his patient in the evenings.

   Attachment of students to general practice should also serve to give experiences in family medicine, but it could be done only if the GPs are given a course in teaching and a re-fresher course on recent medical advances.

3. Total lack of understanding of the methods of traditional medicine.

   Siddha and Ayurvedic medicine and in recent years accupuncture have been resorted to by the people for various diseases. Many combine them with Western Medicine. Some combine Western Medicine with the dietary and other restrictions of Siddha Medicine.

A holistic understanding of the patients behaviour during health and disease cannot be obtained without the knowledge of the fundamentals in traditional medicine.

A unit of traditional medicine is a necessity in the curriculum of undergraduade medicine. Infact, a future trend will be the use of some traditional medicine and its art wherever appropriate, together with Western Medicine.

At present the obstacle against this concept is not medical or scientific reasoning, but the remains of colonial politics perpetuated under the name of GMC and its local counterpart CMC.

4. Doctors who have no inclination for clinical work.

Some of our students follow a medical course because of the wish of their parents or due to other well known reasons, certainly not love for the abatement of human suffering.

These students do not do well in clinical years, atleast they show no attitude towards good practice. They should be allowed to leave the medical school after the 2nd MBBS with an appropriate BSc on a pre-clinical subject.

To summarise a future trend would be:

1. Make pre-clinical course more meaningful by more co-ordination that would lead to an integrated course.
2. Introduce Pathology & Pharmacology in the 1st & 2nd years.
3. Introduce early exposure of student to patients (from the first year.)
4. Use District and Base Hospitals and possibly Peripheral Units for first clinical appointments. Teaching should be done by a doctor having post-grade qualifications and a training in Medical Education. PHC should be incorporated with the training.
5. Introduce a unit on basic Nursing (being done now)

6. Introduce a unit on basic physiotherapy

7. Train the student in minor surgery and setting of fractureb and not be satisfied with theory of Surgery.

8. Introduce a unit of traditional medicine and accupuncture in the medical curriculum.

9. Introduce a 2 year internship, one year of which should be in a PHC complex.

10. Medical Education should be free to those who are prepared to serve this country for 5 years. It should be a paid course for others, who have qualified.