

TRAINING SCHEDULE FOR GENERAL PRACTICE AT UNDER-GRADUATE LEVEL

Introduction

Any medical educational system should be aimed at tackling the current and future needs of a community. It should be borne in mind that the medical care, health requirements and the philosophy of health and its delivery are quite dynamic (are not static) and keep changing from time to time, and many a time, much faster than the health planner and medical educationalist could plan for such a change—the conquest of infectious disease and emergence of such illnesses like ischaemic heart disease, cancer in epidemic forms and various methods. used in family planning are but a few examples. The increasing span of human life, adding more and more man-created problems of elderly, proportion of chronic diseases, more educated people with radically changed ethics, are sufficient reasons for change in the teaching schedule at the under-graduate level. This becomes particularly pertinent, when one realises, that 98 per cent of primary health centres are manned by general practitioners service and hardly 2 per cent are contributed by hospital, accident and emergency services departments.

Trends in Medical Education

Trends in medical education all over the world have been variable and non-uniform, from open admission policy, the quantity vs quality (in India and Brazil), rigid control of medical education such as in Japan and Europe, soaring of women studying medicine and their lack of dedication

to the practice of medicine- U.K. Further demands of the students for open admission, for curriculum reform, abolition of grading systems, dominant voice in revamping university policy are some of the trends in medical education in recent times.

It is interesting that in the great universities of earlier ages, students selected their professors. But now, ‘times have changed’ and many object to the idea of students playing any part, in assessing staff or in determining changes in the curriculum. An important advantage of student participation in planning their education, would be an earlier confrontation with realities of academic life, than would otherwise have been the case. Hopefully this would nurture an atmosphere where in students and faculty both feel actively involved in a common venture.

Selection of Candidates

When we ask for the right type of candidate, one should ask one self the ‘right type’—does this type exist?

Suppose a candidate enters the portals of a medical college intent on earning a lot of money, holding power of life and death in his hands, enjoys giving orders or because there is a doctor in the family, then probably he is taking up a profession for the wrong reasons and is not an ideal student material, to shape up to be a good doctor.

On the other hand, if a candidate is genuinely interested in how a human body works, has the compassionate urge in healing the sick, a fervent endeavour to human happiness, acquisition of scientific knowledge for application to heal and care, and a genuine admiration for the work done by the doctor in the family and to follow in his footsteps - this type of individual is the right choice.

In this context observations made by Smt. Indira Gandhi, Hon’ble Prime Minister for India, while speaking on the occasion of Dr. B.C. Roy Centenary Celebrations under the auspices of Medical Council of India, is apt and highly relevant.

“In admission (to medical) college the accident of a few marks difference seems to matter more than a young person’s

aptitude, his capacity to train and his desire to serve.”

Students’ Dilemma

A student enters the portals of a medical college with great expectations. The early period of training for the students is one of meeting unexpected challenges, correcting preconceived notions and spiritual orientation. They have to cope and strike a balance between their expectations and reality. One area of stress, is the meeting with the cadaver and its dissection. The student has difficulty in accepting the concept of dying patients and death itself.

Although the student may start by wanting to be a doctor, he is seldom sure, what sort of doctor he wants to become. Many a time, even after qualifying, he does not make a definite career choice.

Several studies have revealed the concern and at times dismay of the students at being confronted with vast amount of material, with very few clues to help them navigate this sea of knowledge. The million dollar question being what can and should be left out.

The Right Teacher

One of the greatest talents a teacher can possess, is to make his students comfortable in his presence, safe and able to voice their ignorance and misunderstanding and to ask for help. It is high time that teachers are appointed for their teaching ability rather than for general good conduct and participation in research.

Training courses for medical teachers are necessary to enable them achieve their maximum potential as teachers. Teaching and research are spoken of in one breath, as if they were synonymous, in fact they are atonymous. It is imperative that teachers have adequate basic knowledge, a suitable personality, and be personally inspired to scientific research and be able to communicate their enthusiasm to the students.

Good teaching is of course priceless but good teachers, are accomplished by vigour, originality and the freshness and approach a prepared mind expends on the day’s theme. Is it not true that most of our teachers are

remembered for their idiosyncrasies, their peculiarities and their anecdotes rather than the substance of their teaching?

What Makes a Good Teacher ?

The requisite of a good teacher consists of the capacity for self evaluation, to be aware of the fact that teaching is a complex activity that has many parts, to have the ability to decide and examine the aspect of teaching he is interested and to have a critical review of himself as a teacher and the effect he has on his students.

What do Teachers do to Help Students Learn?

The teacher should help the student by the right teaching which should consist of planning, communicating, providing resources, counselling, assessment and continuing self-education.

Medical Curriculum

The innumerable advances in medical knowledge and practice resulted in gross hypertrophy of the curriculum and over-growing of compartments. Medical curriculum all over the world contains too many subjects and too much material, due to information and knowledge explosion. Despite lip service fashionably paid to the principles of integration, courses in one department are still often arranged, in ignorance of what is being taught elsewhere in the same medical college. A syllabus is drawn up to account for the hours, the prestige and importance of a department is seen as proportional to the amount of teaching time it can hack out of the curriculum syllabus has become an onerous task.

Rigid curriculum and authoritarian teaching may produce good examination results but at the cost of inducing premature rigidity of mind. Many students can not see the problems for the formulae.

The development of more sophisticated techniques of physical examination shifted emphasis on physical signs. Something which could not be stained histologically or demonstrated electrically or chemically could not be accepted as responsible or important. At present, we are producing fine young physicians, who might be more competent scientists, anxious

to diagnose and manage the most complicated and rare syndromes and either desire to produce research papers or are feeling guilty that they do not. Most of them however do not seem very interested in or are good at caring for ordinary patients, with ordinary day to day problems. He may have been well learned on biographical details of Trendelenberg and Brode but not necessarily able to cope with a hysterical woman with a threatened abortion nor even have passed a catheter or performed a lumbar puncture or know how to deal with a dying patient. The concept of the patient as a whole person, has always been more honoured in the breach than in its observation.

Teachers often feel content, when they have once given a lecture on a subject and if the student does not learn, it is his problem and believes that the student only learns what he teaches them but the crux of the matter is, that what a student learns is not from the teachers but from colleagues, books and experience. Emphasis on concept than minute would really benefit the student. A class taught essential principles with little detail perform better in the tests than one snowed with considerably detail. It is also important to be aware of the time students spend studying individual subject, *e.g.*, it is common experience, that anatomy receives almost twice as much attention as physiology. One essential component of effective learning and possibly the important factor in learning is 'feed-back' information given to the student about his performance, without some feed-back, learning simply does not occur. Also feed-back must be as specific as possible.

Lectures

Lectures had a vital part to play, when books were in short supply but the current situation implies that lectures should not be compulsory. Sir Joseph Brocroft used to define a lecture as a process, by which information is transferred from the notes of the lecturer to the notes of a student, without going through the minds of either.

Group Discussion

In recent years, group demonstrations have not only become popular but are more widely used. Discussions may be led by the teacher or by

one of the students, who has specially prepared a topic. Discussion also facilitate more accurate assessment of group norms. Ideally, students should be attached in small numbers to group teachers—such as physiologist, cardiologist, general practitioner, etc.

Integrated Studies

Integrated medical education needs to be introduced, *e.g.*, when the group is studying heart disease, their initial suitable revision of the ‘anatomy and physiology of the heart’ together with pathological and clinical features of cardiac disease, ECG, catheter studies, radiology and heart surgery, etc. Ward rounds and clinical bed side teaching should not last more than 20 minutes at a time, lest the pupils be more pre-occupied with the discomfort in their legs, than with the wisdom of the discourse. Programme learning audio-visual aids are recent and useful method in teachings.

Shortcomings

There are two principle types of uncertainty, one resulting from incomplete or imperfect mastery of available knowledge, the second from the limitation of current medical knowledge itself. One of our main aims in medical colleges must surely be to induce a decent sense of humility in the face of what one does not know.

Illness in Medical Student

Relatively little attention has been paid to the incidence of serious illness among medical students. Despite the fact that medical students are selected from what are probably the healthiest section of population, generally screened medically prior to admission and are living and working near the best available medical facilities, still have a high over-all mortality rate and malignant disease rate etc. Medical colleges should put periodical medical health checks on its students, the high suicidal rate among students and doctors is another cause for alarm. Perhaps, less a person is integrated in society, more likely is he to commit suicide. Here is an important area for research and remedy.

Doctor-Patient Relationship

One of the most essential but irregularly taught areas of medicine, lies in the question of doctor-patient relationship. A major area of learning in this non-factual learning is by example and precept, in terms of behaviour and tradition. eg. doctors must not argue before the patients and seldom call each other by first names in front of non-doctors, nor if possible let a patient die on the operating table or in casualty. It is more convenient for relatives and nursing staff, if a patient is shifted and dies in the ward.

Making of a Doctor

Since the student needs to be made aware, that after qualifying, they will change from recipient to donor (doctor means *docere*, *i.e.*, to teach), his role will be reversed and would include the necessity to teach and convince his patient and the public. Whatever form of practice, the doctor is engaged in, his material is human life and application of scientific format to the solution of human problems, which is the art of medicine. The student needs also to develop a considerable degree of tolerance of uncertainty. Medicine indeed is becoming increasingly scientific but a purely scientific attitude and response is inappropriate to medical practice. The doctor must be able to act on probabilities and with usually unknown margin of error. He who is unwilling to treat except in certainty will never treat any patient. Hence our aim should be to induce and educate the under-graduates, imparting to all, the qualities necessary to make a good doctor.

Examination

Our existing system of examinations are largely ill-conceived, inaccurate and variable. Examinations can be used to keep periodic check on the instructors themselves. It is mandatory that students should know how they are going to be examined, the range of subject matter of the examination, as well as to how they are going to be marked.

The opinion expressed by Dr. B.N. Sinha, President, Medical Council of India and the Indian Association for the Advancement of Medical Education, during the XIX annual conference of I.A.A.M.E. (Trivandrum 1980) is not only appropriate but worth emulating.

“Standards of any examination is only justified by the quality of the student produced and his capacity to handle the problems on a scientific basis. This has to be in keeping with ethical standard of the profession so that the candidate can face the challenge of the demands of the community and at times must realise the truth of ‘negative capability’ with a ‘positive capacity to serve the cause’.

Internship

A cynic once said that postgraduate education as telling the general practitioner a lot about new laboratory tests they cannot get done, and much about new diseases which neither they or any one else can treat. However there is a large grain of truth in this exaggerated view point. The practitioner of today has been over-trained for the job he is doing and under-trained for the job he is supposed to do. If the period spent as an intern is to serve any purpose, it should be seriously planned and coordinated. The house officers should be supervised by a consultant who is interested to do so. The consultant should have the time and ability to plan and carry out the most appropriate and helpful methods in the training of an internee. Each university and medical college should be actively responsible for ensuring that sufficient, suitable posts are available for all its graduates. Adequate time for study and assimilation of experiments should be provided for the interneers. Specialisation during this period should be strongly discouraged. The house man is very vulnerable especially in his early months, when he realises all those splendid examinations passed with aplomb are of little use now. They do not help to deal with his everyday medical life. Nurses are especially privileged to play an important part in his training at this state. A house man seldom gets his due help, guidance, training and experience more often than not, he has to cope with but little of the training he really needs and deserves.

The British Royal Commission on medical education proposed a system of post-graduate training in 4 stages.

(1) internee years followed by; (2) 3 years of general professional training; (3) further professional training with full professional responsibilities or a period of more intensive and advance training; (4) continuing training of all doctors keeping them abreast of their

developmental fields.

Challenge for the Future

It is interesting to note that the future of medical education in this country, depends not on legislation or medical audits but on the inculcation of a proper sense of devotion and dedication to its practice.

Accordingly, any changed programme of under-graduate teaching, should take into consideration - the changes and challenges that general practice has to face and tackle in the future, *viz.*, more educated patients with radically changed ethics, (b) more specialised secondary care, (c) a cost sensitive pattern of care. Similarly the four major variables influencing primary health care system, *viz.*, (1) the nature of society and its health problems, (2) the nature of the person providing primary care, (3) the relationship between primary, secondary and tertiary services, (4) a degree of socialisation on health care system.

The Government of India has echoed our feelings when Sri. B. Shankaranand, Union Minister for Health and Family Welfare, while addressing the members of medical profession during Dr. B.C. Roy Centenary Celebrations declared,

“Medical education requires to be made socially relevant and academically rewarding. The need is to shift the accent from disease orientated professional education (DOPE) to health orientated professional education (HOPE)”.

Conclusion

If we fail in our endeavours, it is not because of a defect in the system but perhaps in the methodology of its implementation as enunciated by Smt. Indira Gandhi, Hon’ble Prime Minister :

“We try too often to fit in the people to the schemes rather than schemes to the people and that is perhaps why we fail in delivering the goods”

Hence it is time for all concerned to rededicate, in planning appropriate medical education to shape the medical graduates, who will really be fit to deliver the medical needs of the community. As rightly pointed out by Dr. B. Ramamurthi, neurosurgeon.

‘It is imperative to note that if the medical profession as a whole and medical teachers in particular do not realise the gravity of the situation and take corrective steps, the initiative will go out of their hands and others who have less knowledge and less interest in the integrity of medicine will dictate the future’.

in his article entitled - Medical Education in India - Victim or Villain (*The Hindu*, 10th July 1984).

The President of the World Medical Association and one of our illustrious past Presidents IMA. (HQ), Dr. A.K.N. Sinha, writing in the Journal of IMA, Vol. 82, June 1984,

“We must see the writing on the wall or the future generation will curse us unless the present day doctor’s dilemma is unravelled now or it may for ever be a vicious spiral.

.... But nothing is possible unless there is generated ‘political will’ at the highest level. Let us all try to generate that will, which still does not seem to emerge”.

He has aptly given the clarion call to generate the political will at the highest level in order to bring about the desired change. Undoubtedly the political influences have made inroad into every aspect of one’s life and influences our actions, whether we want it or not. Therefore in case we fail to bring about the change in the political will, the right alternative would be to examine the feasibility of fielding medical men, who in their thousands, have uniformly blended along the length and breadth of the country and who have not only the highest educational standards but also an intimate knowledge of human behaviour, and constitutionally enter the policy making bodies at all levels, under the banner of IMA and thus usher in the much desired change, for the benefit of the masses, who are the sole and ultimate beneficiaries of the expertise of the medical profession.