THOUGHTLESS APING OF THE WEST

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MEDICAL education in India started in the early 19th century with the establishment of a medical college (1835) in Calcutta to train medical men equipped to serve the colonial population. The faith in the superiority of modern science and technology was steadily built among the Indian masses.

The medical education pattern has been a thoughtless aping of the West and has mostly been successful in producing medical graduates whose links with the masses and their traditions are feeble. This attitude held the field not only for 100 and odd years till India became independent, but has survived subsequently with little change in the system of either medical teaching or its application. The educated, sophisticated urban folk have learned to rely wholly on Western medicine.

Our doctors who have made the West their home seem to be appreciated for their Western orientated qualifications and capacity for work.

Little research was done or thought given to examine whether the present teaching system was ever pertinent or useful to the population,

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of whom the majority reside in rural India. The Government of India and the Indian Medical Council could draft a national educational policy to meet the requirements of our country, utilise the available knowledge of modern system of medicine and orientate medical education to the needs and aspirations of the Indian community.

Medical education including social behaviour are emulated en masse from the textbooks of medicine written in the language of a Western patient and in his atmosphere. No attempt has been made to realise the gross differences in the symptomatology and description of disease and as a result the qualified doctors coming out of the medical colleges find themselves in strange waters when they cannot communicate with the patient or understand his complaints.

The curriculum of which he is a product makes him suspect the intellect of the masses rather than profess his ignorance to understand their language. In fact, the patient-doctor rapport is at a low ebb. For this breed of doctors every patient's illness should have its clone in the textbooks of medicine. This may be one reason why quacks and physicians of other systems of medicine who understand the patient's description of symptoms fare better.

Selection of the candidate at present overestimates the range and value of marks and may exclude potentially creative students. Hence the outcome is 'promising students fail' and 'unpromising one's succeed'. In selection, social background, intelligence, personality, school grades should be taken into account. All in all, we have yet to find the ideal selection criteria. And even then students who excel in examination do not necessarily make the best doctors.

Learning medicine is not easy but it is attractive for it offers one an opportunity to serve humanity, engage in medical research, offers leadership in the community and enables one to make a decent living. When we should impart teaching in such a manner that the students would desire to continue learning throughout their professional career and utilise their knowledge for the benefit of their patients.

Undergraduate course in medicine should be primarily educational. Its object must be to produce not only a qualified doctor but also an educated man. The aim of medical education is to produce doctors who

have knowledge of medical and social sciences and also capable of patient cure *pari pasu* with social and preventive medicine.

Medical education of pre-clinical courses is devoted to studying anatomy, physiology and biochemistry followed by clinical and para-clinical courses including microbiology and pathology. With enormous expansion of medical knowledge many new subjects have been added and old ones expanded resulting in excessive factual content with doubtful practical educational value.

Medical teaching should be provided for students by sociologists and social administrators and be specifically adapted to their needs. Students should be given working knowledge of man in health and sickness and acquire an intimate acquaintance of his behaviour and social environment. The social, occupational, economic, educational and psychological forces and above all communication difficulties that hinder prevention and treatment of disease should find a place in the medical curriculum.

In India, where 70 to 90 per cent of the population live in villages, the art of healing should be taught and practised in a rural environment by establishing rural medical colleges. Words such as "seetha", "seethosha", "kapha", "vayu", etc., are symptomatic and a glossary of these words should be prepared related to different parts of the country.

A rural student is more willing to strike roots in his home town when he graduates from such a college rather than when he is trained in a city and then has to return to his rural setting.

The most important requirement of a teacher is to make his student feel comfortable, safe and willing to confess his ignorance and misunderstanding and ask for help. Training courses for medical teachers are necessary to enable them to achieve their maximum potential as teachers. Lectures need not be compulsory. A good lecturer is one who is a textbook plus a personality giving life to subjects and ideas which lay cold and dead even in the best textbooks.

Seminars and small group teachings are essential. Group teaching called "integration" is becoming popular. The best results are achieved by an 'integrated teacher' rather than by experts in different fields.

Clinical and bedside teaching are peculiar to medical education. The full compass of teaching would include laboratory teaching, dissection, and audiovisual aids. By improving the present hit-and-miss quality of teaching it would be possible to produce doctors of a very high calibre.

For the vast majority of our countrymen medical treatment will continue to be in their home surroundings. Since most of our graduates take to family practice, they should be adequately, qualified and equipped in general and community medicine with provision for psychiatry in the undergraduate course as nearly 30 per cent of patients have psychosomatic morbidity. Gradually the general practitioner should acquire advanced knowledge and training as the future patients will be better educated and better informed about health hazards.

Medical education should be need-based with a rural bias. It should incorporate the best of both ancient and modern medicine. The criteria for the selection of students should cover a wide spectrum of values rather than marks alone. Teachers with a flair for teaching in addition to acquisition of this skill by speical training must be encouraged rather than depending on seniority as the sole guideline. The curriculim should take congnisance of not only the latest advances but also equip the student to deal with patients as a whole rather than treating only the illness.

The trend should be to lessen the factual load on the students both in pre-clinical and clinical subjects and stress on practical and clinical know-how. Integrated teaching should spearhead the new approaches in medical teaching. Until such time we have a better method of evaluation, examination oral, practical, clinical and written will hold sway in the present curriculum.

While undergraduate medical education must have a rural bias the postgraduate centres could be housed in the sophisticated city hospitals. A good doctor once he passes out of his alma mater should continue to be a student all his life keeping abreast of the advances in medicine and giving his best to his patients. Once medical education has been able to achieve this ideal, its purpose will have been well and truly served.