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COMMUNITY-CENTERED TRAINING OF MEDICAL STUDENTS

by

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I DOCTORS AS HEALTH WORKERS PREPARED FOR TODAY'S TASK AND EQUIPPED TO BE THE LEADERS OF THE HEALTH TEAM

Changes in the outlook and scope of medical practice and education in recent years have become necessary due to both social and medical reasons. Socially, there has been a world-wide shift to community care covering all citizens instead of individual care of those who are privileged for one reason or another (economically, socially or geographically), and the state is, directly or indirectly, becoming responsible for providing this community care. Medically, the practice of medicine has shifted from mere care of the sick to the prevention of disease, and further to the concept that health is not merely absence of disease but the presence of full mental and physical normality.

Traditional medical education had its foundations established before these changes of outlook took place. This was reflected in a strong predominance of the study of organic disease and the methods of diagnosing it

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and treating it when it exists, this study being conducted almost solely on hospital patients.

It is obvious that the changes in outlook, from the individual patient studied under artificial hospital conditions to his study in his normal environment with its economic, cultural, psychological and other complexities, and from the concept of treating disease after it exists to the concept of preventing its occurrence, and of positive health consisting of the enjoyment of normal mental and physical qualities enabling the individual to play his part in society - it is obvious that these required corresponding changes in traditional medical education, which clearly did not fit the medical student in a satisfactory way for his new tasks.

If the need for change is realized in the developed countries, it is even more so in the developing countries of this Region, where a majority of graduates will staff the expanding health services, particularly in the rural areas. The inadequacy of the majority of graduates for their role is obvious to anyone who will make even a superficial study. Those graduated suddenly find themselves in a situation which their education did not prepare them for, and they make every effort to leave it on the earliest occasion. It has been said that the main reason is the absence of the amenities of city life in the rural areas. This is too simple an explanation; far more important is that they do not understand the society they work in, and the exact job they have to perform.

Nature of the Necessary Change:

We should now enquire into the nature and scope of the change which is indicated. We can sum it up as follows:

1. A general knowledge of sociology and of the cultural, economic and other factors which influence the structure and the working of human communities.
2. A knowledge of these factors in the particular community in which it will be required to work.
3. A knowledge of the medical and health problems of this community, and the structure and organization of the health services available.
4. Practical training, under expert guidance, in the health work in the community.

For the proper outlook to be obtained, it is necessary for this orientation to start early and to last throughout medical education, and that it should include various departments of the medical school, in so far as the nature of each will allow.

Ways of Effecting the Change:

If the need for change, the directions of this change, and its objectives as summarized above are accepted, it becomes obvious that there are many ways of tackling the problem, and that different medical schools may have different approaches suitable to their own circumstances.

An example in this Region of a strongly oriented community programme is the one conducted at Hacettepe University Medical School at Ankara, where the premedical studies include a course in sociology, and where in the first two years of the medical studies the student is assigned a family; during his clerkship he spends six weeks in a rural unit which is run by a resident in community medicine and supervised by members of the staff, which include representatives of clinical departments. Space does not allow of a detailed account of this excellent programme.

Most medical schools of the region, however, lack the organization and facilities which such a programme requires, and each of them faces the problems of how to achieve the required objectives under existing circumstances.

Certain basic requirements can however be stated:

1. Both educational and health authorities, as well as staff members must be convinced of the need for such a programme, and of its general nature.
2. Each medical school must have an assigned geographical area representing both urban and rural communities in which the various health centres are present, and in which teaching, training and field research are conducted alongside their normal services, the extent of such an area will be determined by agreement between the medical school and the health authorities.
3. The theoretical curriculum must be modified so as to include the necessary changes.
4. Material facilities must be available for transport, etc.

Each of these items presents difficulties, particularly with large student enrolments, and while theoretical curriculum modifications may be relatively easy; finding time and facilities for practical training is more difficult.

Community training for all medical students will make them better equipped doctors, whatever their future career, and must be considered an essential part of the formation of the "basic" doctor. For those who will actually work as community doctors, it is indispensable.

II A SUGGESTED PROGRAMME FOR "TRADITIONAL" MEDICAL SCHOOLS

1. Theoretical:

a) In premedical period: principles of sociology and social anthropology; genetics, biostatistics.

b) In preclinical period: psychology; environmental physiology, human growth and development, aging, human genetics.

c) In clinical period: mental health, influence of environmental factors on disease, with special reference to local conditions; epidemiology; socio-economic factors in disease, organization of health services.

(Wherever required, clinical departments should participate together with the department of public health.)

2. Practical Training:

a) General (non-specialized) centres, (v.i.): two weeks attendance on a rotating basis, to be during a free (elective) term or during the existing clinical terms. Students being allowed to leave their department for this period, (v.i.).

b) Specialized centres, may be taken as above or during the corresponding clinical terms.

(No lectures are to be given at the time of day required for attendance to allow students sufficient time to attend these extramural activities).

III TRAINING OF MEDICAL STUDENTS IN HOSPITALS AND IN HEALTH CENTRES

The student must be made to realize that health service and the treatment of the sick and disabled fall into an integrated system in which the various types of health centres, district, general and specialized hospitals play their equally important role. Moreover, that the services

are rendered through a team of organizers, medical and paramedical staff and the function of each of these must be properly understood.

Types of Health Centres:

These may be general (non-specialized) or special. Examples of the former are rural units and provincial (district) hospitals; examples of the latter are tuberculosis dispensaries and sanatoria, industrial health centres, maternity and child welfare clinics, psychiatric clinics and hospitals, etc.

The two may be combined, as in polyvalent community centres in which the various specialized departments are included. The presence of these latter offer obvious advantages from both service and training point of view, and this should be kept in mind whenever new services are being planned.

General Requirements:

a) The centres themselves, though similar in function, formation and organization to analogous centres in the country, should adhere to a standard of work commensurate with their educational and training functions.

b) To ensure this, co-operation between responsible health authorities on one hand, and educational authorities on the other must take place; the educational authorities can make use of capable health personnel from the health authorities, and vice versa.

c) Adequate facilities for transport and living conditions for staff and students must be available when and where required.

The principles followed in clinical hospital training must be adhered to, proper observation recording, problem discussion with the staff, with obligatory attendance and evaluation must be followed. Constant correlation with the knowledge obtained in the clinical and academic departments should be aimed at.

SUMMARY

1. The change of outlook from the treatment of disease to its prevention, and from concern for the individual as a unit to that of individuals as members of the community, necessitate corresponding changes in traditional medical education.

2. The scope and direction of this change include theoretical studies on human communities in general and the local community in particular, interactions of the individual with the community, and the study of community health problems and services; in addition, practical training in community health centres is necessary.

3. Different medical schools may have different approaches to the problem, depending on their circumstances and facilities. Examples are given.

4. Certain requirements for training in health centres are given; for the realization of these, co-operation between health and educational authorities on the one hand and between the medical school departments on the other, and the presence of adequate material facilities are necessary.