

## Letter to the Editor

Sir

With regard to Azizi's article [1] evaluating the community-oriented medical education in two medical schools in Sudan, nobody should deny the importance of conducting comparative studies in medical education, but these should be carefully planned and implemented and based on strict scientific methodology.

In the introduction, the statement, "it is possible that graduates of community-oriented schools do not maintain the knowledge, skills and attitudes that they acquire in medical schools years after graduation" has been made without any basis. It not only reveals where the writer stands from the outset, but also that references have not been sought in this area where they clearly indicate that the contrary is correct [2,3].

The abstract is misleading. It has not been successful in reflecting the conclusions that could be drawn from the results. Our major problem with this is that many of our health professionals, especially in this part of the world, are not good readers. They usually look at the abstract without questioning and even generalize and might spread the idea that there is no difference between classical and community-oriented medical education (COME) programmes. However, if we look at the study more closely, we find that it has the following limitations which raise a number of questions on its design, basic methodology and conclusions.

The numbers of students, graduates and health personnel on which the study was based are too small to rely on, let alone generalize from. In all 54 Khartoum and 59 Gezira students were said to be "all current medical students", while there should have been at the time of the study

more than 1000 students in Khartoum and more than that number in Gezira. The number of graduates (registrars) selected is also quite small (only 2 from Khartoum and 17 from Gezira); and the health personnel were 18 and almost all of them (16) were nurses giving their opinions about 18 registrars (7 from Khartoum and 11 from Gezira).

The methodology depended largely on an opinion questionnaire completed by the small number of participants. This cannot be used to pass value judgments on the extent of knowledge and competencies and on qualities such as self-learning. In this connection the reader is referred to the study by Abdel Rahim, Mustafa and Ahmed [4].

It is also mentioned that the health personnel were randomly selected with no mention of how randomization was made. Was it systematic or using random sampling numbers?

The description of the programmes was also based on what the deans wrote, whereas everybody in medical education should be aware that there is always the written curriculum, which is not necessarily the same as the implemented curriculum, which is not necessarily the same as the used curriculum or hidden curriculum. Without study and observation of what is actually happening on location, no worthwhile conclusions can be drawn from education programmes. By comparison, the external visitor, who was assigned by the The Network: Towards Unity for Health to report on Gezira as one of the 9 exemplar COME institutions in the world, examined the programme on loca-

tion including a surprise visit to the students working in one of the villages [5].

Calling community-based education (CBE) activities as visits is a misnomer if they were activities in the real sense and not just visits to health service facilities or field tours where students are not actively involved. Seven criteria for effective and successful CBE have been described [6].

Apart from the limitations mentioned, if we study the results carefully, we will not come out with the conclusions given in the abstract. The author gives the impression that any school which has no community representatives is not community-oriented, but there are many other factors to consider. In this regard the 6 components of a COME programme may be consulted [7]. Taking this and item 5 into account, a different set of statements on the extent of community orientation in each school will emerge.

The statement, "the university hospital of both medical schools" (page 94) is not

correct as Gezira has no such hospital (but strong partnership with the Ministry of Health) while Khartoum has its own Soba hospital.

In addition, 2 facts need to be considered. The first is that Khartoum is not a typically classical school in the real sense of the word and the second is that Gezira gets, in admission, secondary-school students of a lower level of achievement than Khartoum, so if the graduates from both are even the same level, credit must go to the system in Gezira.

In spite of all the shortcomings of the study, I would like to express appreciation for the efforts of Professor Azizi in addressing this difficult area of comparative studies where research is lacking and very much desired, and I hope he continues his research in this line.

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### References

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### *Author's response*

Sir

It gives me great pleasure to know that one of the pioneers of community-oriented medical education (COME), Professor Bashir Hamad, has expressed his eminent opinion with regard to my comparative studies in medical education in two medical schools in Sudan.

As a worker in COME in the Islamic Republic of Iran, if I had a bias, it would have been in favour of Gezira rather than Khartoum. Therefore the sentence in the introduction reflects my working hypothesis and not a bias. None of the studies referred to by Professor Hamad has been conducted in developing countries and in the exact manner of the present study; hence it is not fair to state, "... the references ... clearly indicate that the contrary is correct ..."

I feel that the abstract clearly reflects the conclusions drawn from the results. I, myself, was astonished to see that the graduates of both schools behaved exactly the same professionally, and in the eyes of co-workers (nurses and paramedical staff) and consumers (patients) there was no difference between them. Would it not have been misleading had I obscured this very important result?

I agree that if a larger number of participants had been available, the study would have been more valid. However,

considering the aims of this comparative study, the number of subjects studied seems adequate.

The questionnaire for the study was taken from the painstaking work of Professor Richards of Detroit and myself in a WHO/EMRO consultation. Ten experts of medical education verified it and I believe it is complete enough to pass value judgments on the extent of knowledge and competencies.

The opinions expressed by Professor Hamad are his own beliefs and I respect all of them because he has spent his life developing such an educational environment. However, the results of the Sudan study showed that although Gezira University had more emphasis on COME than Khartoum, graduates of both universities adapted themselves to the environment dictated by the health care delivery system and cultural values; therefore a few years after graduation, the differences between them had narrowed. These findings should remind stakeholders of medical education that COME should be accompanied by a serious change in strategies in health care delivery; the extensive work in the medical school environment may otherwise disappear gradually when graduates work in the society.

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