From classroom to community: teaching Community Medicine in India

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Abstract

Despite the huge demand for public health doctors in India, the framework of public health remains unsatisfactory. Despite it being the preferred subject among postgraduate medical students, Community Medicine is considered to be at the bottom of the medical educational system. This paper explores the possible reasons for this, which may be attributed to faulty teaching methods, scarcity of career opportunities or personal choice. The Medical Council of India and Departments of Community Medicine in medical colleges and professional public health organizations have a pivotal role to play in arousing the interest of the student towards pursuing a specialization in this vital subject.

Keywords: medical college, assessment

Introduction:

"The aim of medical education is to produce doctors who will promote the health of all people, and that aim is not being realized in many places, despite the enormous progress that has been made during this century in the biomedical sciences. The individual patient should be able to expect a doctor trained as an attentive listener, a careful observer, a sensitive communicator and an effective clinician; but it is no longer enough only to treat some of the sick. Thousands suffer and die everyday from diseases which are preventable, curable or self inflicted, and millions have no ready access to health care of any kind.

Scientific research continues to bring rich rewards; but man needs more than science alone, and it is the health needs of the human race as a whole, and of the whole person that medical education must affirm".

(The Edinburgh Declaration, The World Congress on Medical Education, 1988)

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An eminent scientist once remarked "The unfortunate thing about medical education in India is that it makes the students "technical literates" but not "educated". Medical colleges have often been dubbed as "ivory towers isolated from the health service systems, training students for ill defined academic standards and dimly perceived requirements of the twenty first century". The above mentioned phrase can be applied to the current scenario of teaching of Community Medicine in India. Our country is in dire need for public health practitioners. One of the reasons for weak public health practices could be attributed to poor training and career structures (WHO, 2006). The lack of expertise in public health is evident at the planning and policy levels as seen from the national health data-base, policy documents and programmed formulation / evaluation processes as identified by an Expert Committee on Public Health System in 1996 (Ravi & Narayan, 2007). The standard of teaching in Community Medicine and the need to acknowledge its significance amongst the general public and medical fraternity need intense and conscious efforts. The present article aims to analyze the current teaching of Community Medicine in India at undergraduate and post graduate level and to present a framework of recommendations for bringing in a paradigm shift in the teaching strategies and status assigned to Community Medicine as a subject.

Situational analysis of current training in Community Medicine:

The number of medical colleges in India has risen from 30 since the time of independence from Great Britain to 269 with a total of 163 seats in M.D. who practice Community Medicine and 114 seats for D.P.H (Medical Council of India, 2007). According to the latest information available from Health Information of India (2005-06), in the year 2001, out of 3,181 degrees awarded, only 58 were in Community Medicine (National Knowledge Commission, 2005). This figure illustrates the low ranking of Community Medicine as a choice for pursuing post-graduate studies.

Below are possible reasons which are obstacles to promoting Community Medicine as a choice of major.

Commercial/Market value of the subject: services (government / NGO / private)

What exactly are the future prospects for a doctor who has specialized in Community Medicine in India? A Community Medicine post graduate has the prospect to work:

(i) As a faculty member in a medical college / teaching / academic institution;
(ii) At National level organizations, such as ICMR, NICD,ICSSR;
(iii) As Program manager / co-coordinator for various national health programs;
(iv) At Non-governmental organizations / voluntary health agencies;
(v) At International agencies – WHO, UNICEF, UNFPA, World Bank etc.;
(vi) At Health centers under public sector-dispensaries, maternal and child health centers, PHCs, CHCs.
(vii) At Private sectors as family physicians or preventive health care in corporate hospitals.

The initial remuneration of junior health specialists is between Rs 20,000 and Rs 30,000 per month (US $500 to $750). After a series of promotions, they can earn up to Rs 50,000 per month (US $1250). However, NGOs that are handling community health projects funded by international agencies are offering salaries between Rs 1 lakh and Rs 2 lakh per month - (US $2500 to $5000) a privilege enjoyed by a very lucky few.

Lack of opportunities
(Recommendations vs. reality)

Despite the above mentioned prospects, the status of Community Medicine in India is not satisfactory. There is scarcity of opportunities as the potential of the subject has not yet been realized. Out of a total of 4,712 seats in the Central Health Service, only 28 (1.6 %) exist in the Public Health Services cadre. (Although an assessment by the McKinsey consultancy firm shows a lack of over ten thousand public health specialists in the government sector). Moreover, the subject has not yet fully gained a respected position amongst medical fraternity. Clinicians still dominate the nation's healthcare system. There is also misdistribution of opportunities as most of these tend to be skewed towards remote / peripheral areas involving field work, where most of the specialists are not willing to relocate due to various reasons.

Aspirants / students of Community Medicine at postgraduate levels (Academic ranking & reasons behind choosing the subject)

The age old notion that a specialist in Community Medicine is "A Jack of all trades and King of none" is yet to be done away with. The notion dates back to the 1960s' when the concept of a public health specialist emerged in the American and British medical schools. The public health professionals most often implied, in common language, a Community Medicine specialist is a sanitary inspector dealing with water supply and sanitation. That is to say, preventive and social medicine as a postgraduate specialization settled into a low value option.

Some of the common reasons cited for choosing Community Medicine as a subject of specialization are as follows:

- Low ranking in merit list
- Aspirations to work in international / corporate organizations – recognition and financial attraction
- Lack of interest in clinical subjects
- Interest in joining the teaching line
- Attraction due to other reasons – no night duties / weekends off etc.
- Genuine interest towards public health needs / working with the community
- Family commitments

Teaching methods-undergraduate and postgraduate training

The current status of Community Medicine teaching and training in India is still not up to the mark.

(i) Traditional teaching methods: Most of the teaching in Community Medicine is restricted to didactic lectures and a few family visits and practical sessions. Thus, this has failed to stimulate a sense of curiosity and eagerness for

learning. Classroom practicum can barely simulate a real-world situation. Without active involvement, learning of Community Medicine is simply perceived as a pre-requisite for passing examinations without realizing the actual value of the subject.

(ii) Lack of community oriented field based programs: Most of the medical colleges are lack well designed community oriented field programs. As a result, these medical colleges tend to remain isolated from delivering public health services.

(iii) Unsatisfactory training of interns: Internship in community medicine is considered to be one of the weakest links in the teaching program and is considered by some as a "paid holiday" or vacation period. According to Medical College of India recommendations, an intern is supposed to receive 3 months of residential training at the health center attached to the Community Medicine Department. However, it is observed that most of the time of an intern in this department is spent in preparing for PG entrance exams.

***(iv) Scenario of postgraduate training*:** At present, there is no consensus as to what the essential and desirable skills those are to be acquired by a postgraduate student of Community Medicine. Due to lack of community-oriented and field-based programs in many medical colleges, postgraduate students are posted at clinical departments such as paediatrics and gynecology to acquire 'hands on training'. In most of these departments, no regular classes are held for the postgraduates and they are left to train themselves**.**

(v) Isolation from health system: Community Medicine departments are often found to function in isolation from the local health departments. This leads to an alienation of public health professionals from the community and failure to give their inputs into the public health care delivery system.

Teachers/Faculty members

The doubling of medical colleges during the past 20 years has resulted in creating a demand – supply gap of teaching faculty members. There are many medical colleges where even the sanctioned posts were not as per the MCI norms and out of these sanctioned posts too, almost 50% were laying vacant (Report on Medical Education, Rajya Sabha, 2001).

Assessment system

It has been observed that whether at UG or PG level, the student is evaluated once and for all at the end of the training period. At postgraduate level especially, the students are evaluated in terms of their "cognitive" domain (domain of intellectual activities), rather than in terms of the psychomotor (acquisition of motor skills) and affective domain (domain of communication skills). In other words, they are evaluated on the basis of their theoretical knowledge rather than practical skills.

Recommendations

The overall goal of Community Medicine Education should be to create a band of "Five Star Doctors" as endorsed by the WHO. These doctors will bear the following essential skills of a (i) care provider, (ii) decision maker, (iii) communicator, (iv) community leader, and/or (v) manager.

As a well-known quotation by Taylor Coleridge goes - *"He is the best physician who is the most ingenious inspirer of hope".*

(I) Role of Medical Council of India

Curriculum: The curriculum needs to be 'service-based' exposing students / residents to the knowledge, skills and attitudes necessary to address the health needs of a community; and encouraging health careers with a community focus.

Assessment: Instead of basing a student's performance on marks scored in the final professional exams, evaluation should be continuous and criterion referenced. Assessment techniques such as OSCE / OSPE should be increasingly adopted.

Accreditation of public health courses: To bring about quality assurance for the public health degrees, development of accreditation guidelines is essential. This would help in the development of accountability, thus bringing about reforms in public health education. Accreditation guidelines have already been laid down by the WHO-SEARO. (WHO SEARO, 2002)

(II) Role of departments

Teaching: Adopt multiple classroom teaching methods, improve feedback to students regarding their performance and promote cyber public health and e-learning.

Up-grades of departments: The Community Medicine departments need to be up-graded and renovated. This could be done by providing standard and world-class library services, public health laboratories, digital libraries and museums, practical rooms for students and reading rooms.

Encouragement of faculty development: The teacher is the cornerstone in any system of education. It is essential that provisions for

regular faculty development should be incorporated into the functioning of the department. This could be in the form of continuing Medical Education programs and development of a system of accountability and monitoring of the faculty with regard to teaching duties.

Engaging students in medical research: Health research plays an important role in contributing to the improvement of healthcare. Involvement of students in research would also facilitate publication outputs of the institution.

Develop linkages with local health departments: The department could function as a focal point for implementation of national health programs by acting as a center for program related data compilation, feedback, monitoring and evaluation.

(III) Role of professional bodies

Professional bodies such as the Indian Association of Preventive and Social Medicine (IAPSM) and Indian Association of Public Health (IPHA) could play a pivotal role in faculty development and funding for departmental up-grades.

Conclusion

Community Medicine education in India is still in the phase of facing a number of challenges. However, with concerted and proactive efforts, these challenges can be overcome. Bringing its teaching from the classroom to the community would help to provide a realistic picture to the subject and act as a stimulus to learning and an active involvement in its application and implementation. It is hoped that with the changing health needs of our country, Community Medicine would make its presence felt by addressing public health needs in the face of current epidemiological and demographic transitions.

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