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Editorial

Healthcare and Medical Education

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At the very beginning of a new millennium, it is a depressing reality that our health services delivery system fails to meet demand of the community. Health promotion encompasses a variety of activities aiming at improving the health status of the individual and the community as a whole. The health service in our country is known to run against a background of poverty, illiteracy and limited medical resources. Density of population is the highest in the world with the exception of the island states. Seventy six percent of the total population live in the villages, many of which are urbanized to a certain extent. These people present with advanced diseases due to lack of awareness, education and necessary financial support. Many of them can not afford to buy minimum medical requirements.

In the cities the urban poor and the lower middle class are rendered health services in overcrowded public hospitals where the patients, not infrequently, are forced to have a bed in the floor. The relatives provide much of the nursing services. Medicines, intravenous fluids, sutures or anything else, which is short supply, is to be provided by the patients. There are long queues for investigations and management facilities because the number of patients does not match with the whole infrastructure. The rich patients are provided healthcare in private clinics with high payment where sophisticated treatment modalities are available. Quite a good number of patients are running out of the country even for the common ailments.

In our country only 3.2% of the GDP is allocated per head for the health and family welfare sector which is truly inadequate. Although WHO recommends 34 dollars per capita per year in health services sector in the developing countries, we have only 13 dollars in the public and private sectors combined. The number of health services professionals e.g. doctors, nurses, technologists etc. is very much inadequate in the international standard. As a result poorly qualified village doctors, medicine shop owners, unqualified kabiraz and homeopaths etc go upper hand with all the grave consequences. Above all the latest achievements of medical science as well as advances in information and communication technology are not being adequately translated into the practical fields of health services delivery systems. In spite of certain successes in the preventive and primary healthcare sectors, the health services system in our country is not adequate to meet the full requirement of the majority of the people of the society.

With all the inadequacies in the circumstances, the blame is to be shared by the medical education system in our setup because it has not been able to respond to the needs of the community. The medical education in our institutions continues to be very much disease oriented. Undue importance is attributed to a few esoteric diseases of interest to the faculty but of minimal value to the community.

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The students look at their priorities from the point of view tempered almost entirely by faculty reactions and implications in the examinations.

Medical education is more than a training. As all professional learning, the medical education is expressed as competence. The professional competence in turn is defined as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions and values etc. and their reflection in daily practice for the benefit of the individual and the community being served. Medical education is to serve the society instead of an individual and in a much wider and holistic perspective of health rather than the cure and care of illness. So the curriculum design should be attempted on matters that drive internal motivation of the learners as well as the facilitators in order to foster a genuine learning environment and a true professional learning culture. One of the most important limitations in planning and implementation of the essential curriculum design, which remains largely unaddressed by the dominant policy making corners of the society, is utter inadequacy of the infrastructures of the educational setups. The public medical colleges are compelled to handle many fold patient loads with the existing facilities. Moreover some of the medical colleges are running postgraduate courses, again with the existing undergraduate facilities. That is how the curricular activities of the students are being automatically reduced. On the other hand the private medical colleges have very few patients those can be handled by the students for their optimum academic exercise. And again the academy is being inadequate.

The community demands an educated doctor – some one who not only has the requisite clinical knowledge, skills and experiences but also can appreciate each patient as an individual human being with thoughts and feelings. Implicit in the concept of ideal medical education is the ability of the doctors to think reflectively and learn continuously throughout the professional career. In any model of medical education, skills for communicating with the patients, other professionals and the people at large must be high on agenda.

An MBBS doctor on certification must be capable of functioning in the community carrying out clinical, managerial, administrative, preventive, and planning functions. They must be particularly concerned with the emotions, feelings and reactions to the illness and sufferings. So the curriculum as well as the academic setup should include components of biomedical, psychosocial, moral, managerial and behavioral skills that an individual physician is expected to acquire as well as practice in a real life scenario.

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