

Guest Editorial

TEACHING COMMUNITY MEDICINE TO UNDERGRADUATES, PROBLEMS & SOLUTIONS: A LOUD THINKING

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Subject of Community medicine is considered a game changer in improving the community health. It is lauded universally but receives only a lip service- be the political leaders, health planners or the administrators. Most of the medical students also neither perceive it important nor find it interesting and find it one of the least liked subjects during entire MBBS. Students read it just to clear the university exam or acquire factual knowledge needed to clear postgraduate (PG) entrance exams. All this necessitates taking stock of the situation and coming out with actions to make the subject popular amongst students, meaningful and addressing the community needs.

Before going any further let me put a disclaimer that the views expressed herein are purely mine and everyone has right to agree or disagree with them. Hence this article has been aptly titled as loud thinking. Target audience of this journal is the public health professionals, mostly the teachers in medical colleges making this issue very topical and relevant.

One of a good definition of Community Medicine as given by the WHO is "the study of health and disease in the population of defined communities or groups in order to identify their health needs, and to plan, implement and evaluate health programs to effectively meet these needs." What does MCI say about MBBS curriculum? "Undergraduate medical curriculum (shall be) oriented towards training students to undertake the responsibility of a physician of first contact, capable of looking after preventive, promotive, curative & rehabilitative aspects of medicine." Please note that it is the curriculum of MBBS and not of Community Medicine alone. WHO endorses for a "Five Star Doctors" who shall bear essential skills of (i) Care provider, (ii) Decision maker, (iii) Communicator, (iv) Community leader, and/or

(v) Manager. Which subject in entire MBBS enables students to acquire these skills?

The past 30 years of this subject witnessed several changes as its nomenclature, contents, teaching methods, teachers profile and importance accorded to this subject by the government, MCI and the students. Some of these changes are as follows

1. **Increase in contents:** Taking the text book of PSM by Dr. K Park (followed religiously by most colleges in India) as a yardstick and based on the increase in number of its chapters, pages and the size of each page, contents have increased by some 165 percent since 7th edition to the current 21st edition. Addition of new contents in chapters such as Health Economics, Epidemiology, Non Communicable illnesses, Planning & Management without proportionate removal of dead wood.
2. **Introduction of 3 community postings:** of total 12 weeks duration (225 hours) by MCI is an opportunity though elsewhere perceived as a burden to keep the students engaged.
3. **Teaching during I MBBS:** Thanks to MCI, 60 hours teaching has been added during 1st MBBS when the minds of students are fully occupied with Anatomy, Physiology and Biochemistry, it is difficult to make them to learn a subject where they will be assessed after three and half years; in between they will learn and will be evaluated for seven other subjects.
4. **Extension of learning phase:** Similar to the health services rendered to community "from womb to tomb", teaching of Community Medicine is also given during entire first, second and part of third (final) MBBS. Further the 2 months internship posting in the current format may lead to boredom and aversion.

5. **Field based training and inclusion of preventive, promotive and rehabilitative skills:** This requires the development of Rural and Urban Health Training Centers. This in itself is resource intensive and authorities at most colleges are reluctant to provide this unless the MCI pushes them to do so.
6. **Shortage of Teachers/Faculty members:** Doubling of medical colleges in past 20 years has resulted in a demand- supply gap of teaching faculty members. This has led to a shortage of teachers in medical colleges in terms of quality as well as quantity.

Some of the things which have not changed

1. **Continued emphasis on cognitive learning:** Lectures a vehicle largely meant for transfer of cognitive learning, are still the most preferred teaching methods. Lectures are important hence are taken by senior persons. Tutorials, group discussion and field visits are treated as inferior modes of teaching hence are taken by junior and inexperienced faculty. Unlike "breast feeding is the best" in maternal and child health, here students feel that "spoon feeding is the best feeding"
2. **Reliance on a single text book for both under and post graduate learning:** As mentioned earlier textbook of PSM by Dr. K Park provides exhaustive details of the subject with reliance at most of the colleges for both undergraduate (UG) and PG learning. This has been most damaging to the subject where for last 30 years; teachers have relied solely on one text book alone for both UG and PG learning. Ours is probably the only subject where the same book is read and considered adequate for teachers, PG and UG students. The dependence is so heavy that if this book does not cover say statistics strongly so it becomes a weakness of most of our teachers and students. If it does not include anything it is neither taught nor asked (during evaluation) in many colleges. Generally we start teaching/ asking particular aspects once included in this book.

How students feel?

1. **Lack of relevance:** Adult learning has a principle that people learn what they want to. Most students when join MBBS view themselves either as surgeons or physicians.

Learning of Community Medicine does not fit in their dreams. Questions often asked are - How I am concerned? Why should I learn statistics or entomology or occupational health?

2. **Uninteresting subject** Textbook (I am referring the same) has been written in a boring way with no stories and hardly any photographs. This book provides excellent information to teachers but is definitely not written in a student friendly manner.
3. **Too vast subject** Along with increase in contents, students perceive that the subject has a very wide range from dimensions of a borehole latrine to clinical features of metabolic syndrome. Students feel that learning this subject lead to their becoming jack of all trade and master of none (not a bad idea altogether!). Overlapping areas such as research designs with pharmacology, agent characteristics in communicable diseases with microbiology, vaccination with pediatrics, certain treatment guidelines with Medicine often leave the students confused as different things are taught for the same problems.
4. **No attitude/ skill building:** The subject is full of facts meant for cramming. While other subjects if clinical, provide some skill development and if non clinical, support the learning of major clinical subjects (Anatomy to Surgery & Physiology to Medicine), our subject does not have any such feature. One can become a successful (money making?) clinician or super specialist without learning this subject. Though touted as a clinical subject, skills as clinical examination and communication (with patients) are lacking.
5. **Least priority by students in I & II MBBS:** Students have short term goals and initially they are focused more on the subjects of I and II MBBS. Community Medicine comes under focus only during 6th & 7th semester (1 year before university exams) and by that time our major teaching is already over.
6. **Unsatisfactory training of interns:** An internship posting of 2 months in Community Medicine is the weakest links in the teaching program and is considered by some as "paid holiday" or vacations. With stiff entrance tests competitions, interns in this department spend time in preparing for entrance exams.

Some solutions

Currently teaching in Community Medicine is lecture based in the Ivory towers of medical colleges with little interaction with community and public health services, while ideally it should be student centered, evidence based and problem solving type of active learning and capable of addressing to the community needs.

1. Motivate students by marketing the subject in terms of expanding horizons & job avenues.
2. Make it relevant and interesting by linking with current events generating interest and inclusions of ice breaking, brain storming and news/ video clip as preludes.
3. Use multiple text books for learning.
4. Provide for computer skills for literature search, data entry/ analysis and presentations. I am not aware that under any subject students are provided these skills though every college has a computer lab. We can do this during community postings as by assigning projects to students in small groups.
5. More participatory and interactive teaching during community posting by taking students in small groups for Role play for attitude building; Mini projects for skill development; Group based activities like discussions & presentations.
6. Use real life examples & success stories - A major criticism made against most of the PSM departments across the country is that they work in isolation from health system. Teaching departments need to be active participants in health programs citing real life examples rather quoting bookish examples.
7. Development of urban and rural training centres for imparting field based training and clinical skills to students in community settings. Adoption of centres will help teachers to update their knowledge and skills as well and reaching to the solutions mentioned above as 6 and 7.
8. Integrate teaching with other subjects vertically or horizontally. A case presentation covering various subjects by a group of students in front of panel of teachers from different subjects is also helpful.
9. Use of multiple teaching methods/ technologies and avoid too much emphasis on didactic learning and use of PowerPoint

(overused & most abused teaching technology today).

10. Reprioritizing contents for learning in terms of essential/ desirable/ good to know and same must be followed in evaluation as well.
11. Evaluation: More importance is attached to end evaluation than concurrent evaluation. Students are evaluated in "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 more for theoretical knowledge than practical skills. Introduction of multiple choice/ short questions and assessment techniques such as OSCE / OSPE in teaching / evaluation can be helpful in evaluating more areas in less time in more objective manner. An evaluation should be a perfect blend of carrot and stick whereby appreciation, awards (for contest, activities), publications/ presentations of reports can be introduced as carrot part of evaluation. It is also worth to do occasional evaluation of our teachers and their teaching/ evaluation methods - best achieved by students' feedback (anonymous).

Community Medicine education in India is 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.

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